STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Countryside	3825 Countryside Blvd N Palm Harbor, FL 34684

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51062 Based on observation, interview, and record review, the facility failed to ensure advance directives were updated per resident's request for two (#406, #455) of 22 residents sampled. Findings included: A review of Resident #406's Admission Record revealed she had diagnoses which included chronic kidney disease stage 3 and chronic systolic congestive heart failure. A review of Resident #406's physician's order dated [DATE] revealed full code. A review of Resident #406's 5-day Medicare Minimum Data Set (MDS) dated [DATE], revealed: Section C - Brief Interview for Mental Status (BIMS) 14 which indicated intact cognition. A review of Resident #406's care plans revealed a care plan initiated on [DATE] by the Director of Social Services for full code. A review of Resident #406's Electronic Medical Record (EMR) documents revealed an Advance Directives Discussion Document signed by Resident #406 and the Director of Social Services on [DATE] which indicated Resident #406 wished to have Cardiopulmonary Resuscitation (CPR) withheld. During an interview on [DATE] at 3:59 p.m., the Director of Social Services stated she told the resident to sign her part of the Advance Directives Discussion Document and then she would have the physician sign his part so it could be uploaded into the [electronic medical record (EMR)]. She stated residents could not be put into the [EMR] as a DNR (Do Not Resuscitate) until the doctor signed the form. She stated the resident knew the physician still needed to sign the form. She stated if the resident went into cardiac arrest, they would have to give her CPR because the DNR had not been signed yet. She stated she did not know how long it would take for the DNR to be signed, but it usually took a couple of days. During an interview on [DATE] at 4:20 p.m., Resident #406 stated if she were to stop breathing, she would not want to be hooked up to hoses and all the gear. She stated she did not really know what would happen, but she thought they would leave her and not try to bring her back. She remembered signing the DNR form and thought it was in effect now. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #406's physician's order dated [DATE] revealed the order for full code was discontinued on [DATE] at 9:30 a.m. An order dated [DATE] revealed do not resuscitate with an indefinite end date. A review of Resident #406's EMR documents revealed the Advance Directives Discussion Document signed by resident #406 and the Director of Social Services dated [DATE] was no longer in the resident's documents. A DNR order document signed by the resident on [DATE] and signed by the physician on [DATE] was uploaded into the EMR on [DATE]. An Advance Directives Discussion Document signed by the resident, unsigned by facility staff, dated [DATE] indicated the resident wanted CPR withheld and was uploaded into the EMR on [DATE]. 46234 Review of Admission Records showed Resident #455 was admitted with diagnoses which included spastic hemiplegia affecting right dominant side and respiratory failure with hypoxia or hypercapnia. Review of Resident #455's orders on [DATE] showed an active order for Do Not Resuscitate that was put in place on [DATE]. Review of the Advanced Directives Discussion Form dated [DATE] was signed by the resident saying he would like Cardiopulmonary Resuscitation (CPR) to be performed if needed. An interview was conducted on [DATE] at 2:51 p.m. with Staff C, RN. She said the nurses looked at the computer charting program dashboard to see a resident's code status. She said the code status on the dashboard came from the orders. An interview as conducted on [DATE] at 3:32 p.m. with Staff D, LPN. She reviewed Resident #455's medical record and confirmed he was listed as Do Not Resuscitate (DNR). An interview was conducted on [DATE] at 3:24 p.m. with the Social Services Director (SSD). She said she had a discussion with all residents, filled out the Advanced Directives Discussion Form and had the resident sign. She said she compared the form to the orders to make sure it matched. When asked if she compared every form to orders she said if there was a resident that wanted to change to DNR she let nursing know. The SSD reviewed Resident #455's Advanced Directives Discussion Form and confirmed it was signed saying he would like to have CPR performed in an emergency. She also reviewed Resident #455's orders and confirmed he had a DNR order in place. The SSD had no explanation as to why Resident #455's code status orders had not been changed. An observation was conducted on [DATE] at 3:34 p.m. of the SSD speaking with Resident #455. She confirmed with the resident that he did want CPR to be performed in case of an emergency. The resident said he did. An interview was conducted on [DATE] at 3:40 p.m. with the Nursing Home Administrator. He reviewed Resident #455's medical record. He said when the Advanced Directives Discussion Form was completed on [DATE] and the resident signed saying he would like CPR to be performed, the order should have been changed immediately. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on [DATE] at 3:58 p.m. with the NHA and the Assistant Director of Nursing (ADON). The ADON reviewed the record of Resident #405 and confirmed she had a Full Code order in place. She reviewed the resident's Advanced Directives Discussion Form and confirmed the resident signed the document saying she did not want CPR to be performed in an emergency. The NHA said there had been a breakdown in communication in the cases of Residents #455 and #405. The ADON said in both cases, social services did not communicate to nursing so they could call the doctors and get orders changed. The ADON confirmed there was no documentation for either resident that a doctor had been contacted about the change in code status requests. The NHA agreed that if either resident had coded over the previous weekend, it would have been an issue. The ADON and NHA both stated the residents' doctors should have been notified immediately of the change in code status request by each resident. Review of a facility policy titled Advanced Directive, revised [DATE] showed the following: Policy: The center will abide by state and federal laws regarding advanced directives. The center will honor all properly executed advanced directives that have been provided by the resident and/or resident representative. Process: 4. Upon completion of Advanced Directives Discussion Form Document, Social Services or nurse will notify the physician of the resident's wishes and procure a state approved Do Not Resuscitate Order, if necessary. Notification will be documented in the medical record 5. Upon notification from resident and/or resident representative of the desire to change or revoke an advanced directive, or any issue concerning the capacity comma the physician will be notified and the medical record will be modified accordingly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37999 Based on observation, record review, and interview, the facility failed to ensure that the medication error rate was less than 5.00%. Twenty-eight medication administration opportunities were observed and seven errors were identified for four (#59, #55, #44, and #66) of four residents observed. These errors constituted a 25% medication error rate. Findings included: 1. On 9/17/24 at 9:32 a.m., an observation of medication administration with Staff E, Registered Nurse (RN), was conducted with Resident #59. The staff member dispensed the following oral medications: - Lamotrigine 25 milligram (mg) - 2 tablets - Amlodipine 10 mg tablet - Sertraline 25 mg tablet - Folic Acid 400 microgram (mcg) tablet - 2 tablets The staff member turned from the medication cart and entered the resident room, Staff A was asked to confirm dispensing 5 tablets, the staff member applied a glove removing one of the tablets of Folic acid stating 2 tablets of Folic Acid had been poured into the cup. Staff A confirmed dispensing 5 tablets after the removal of the second Folic acid tablet. Review of Resident #59's Medication Administration Record showed the resident was to receive Folic Acid Oral Tablet 1 mg - Give 1 tablet by mouth once daily related to Anemia, unspecified. The order was started on 1/20/23. 2. On 9/17/24 at 9:38 a.m. an observation of medication administration with Staff E, RN, was conducted with Resident #55. The staff member dispensed the following medications: - gabapentin 600mg tab - one long caplet in bottom drinking cup - Citalopram 10 mg tablet - Clopidogrel 75 mg tablet - Eliquis 5 mg tablet - Hydrochlorothiazide 25 mg tablet - Isosorbide mono 30 mg Extended Release (ER) tablet - Lisinopril 2.5 mg tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Metoprolol Succinate 25 mg ER tablet - Nifedipine 30 mg ER tablet - Tamsulosin 0.4 mg tablet - Insulin Glargine The staff member primed the insulin pen with 2 units, removed the used needle then applied another needle. Staff E dialed the insulin pen to 4 units then was asked to verify the dosage, the staff member dialed the pen to 5 units. Staff E confirmed dispensing 10 tablets. The staff member watched as the resident swallowed the oral tablets before injecting 5 units of the long-acting insulin into the right lower quadrant (RLQ) of the resident. Staff E reported having to go to the electronic medication dispenser on the north unit as they changed the dosage of Resident #55's Xanax. The staff member was unable to obtain the ordered Xanax from the medication dispenser. Staff E spoke with an unknown nursing supervisor who informed Staff E that psych was in the building and was reviewing the order. Review of Resident #55's Medication Administration Record (MAR) showed the following physician orders: - Lantus SoloStar Subcutaneous solution Pen-injector 100 unit/milliliter (mL) (Insulin Glargine) - Inject 5 unit subcutaneously one time a day for diabetes. Hold for blood glucose level (BGL) < (less than) 100. The observation did not show a blood glucose level had been obtained for the resident prior to the injection. - Xanax Oral Tablet 0.5 mg (Alprazolam) - Give 1 tablet by mouth three times a day related to unspecified anxiety disorder. Hold for sedation. The medication was started on 9/12/24 and scheduled for 9:00 a.m., 1:00 p.m., and 5:00 p.m. Review the Resident #55's MAR, on 9/17/24 at 11:25 a.m. revealed the resident had not received the 9:00 a.m. scheduled dose of Xanax. Review of Resident #55's MAR, printed on 9/17/24 at 1:36 p.m. showed the physician order had not been changed and the resident had not received the scheduled 9:00 a.m. dose of Xanax. Review of a progress note, effective 9/17/24 at 12:53 p.m., for Resident #55, which was provided by the facility, showed Resident currently out of Xanax 0.5 mg. The note revealed the facility obtained authorization to use the Xanax 0.25 mg in the cart and Two tablets will be administered for resident 1300 doses. On 9/17/24 at 10:01 a.m., an observation of the medication profiles on one hall with Staff A, RN, showed 10 resident profiles were colored red, showing the involved residents had late medications/documentation. The staff member reported not signing off on medications until finished. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 9/17/24 at 10:05 a.m., an observation of medication administration with Staff A, RN, was conducted with Resident #44. The observation showed the resident's Eliquis profile was colored red, revealing the medication was late. The staff member stated the resident did not have the Eliquis and would have to look over there pointing towards the 200 hallway. The staff member dispensed the following medications: - Amlodipine 5 mg tablet - Multi Vitamin (without minerals) tablet - Loratadine 10 mg over-the-counter (otc) tablet - Artificial Tears eye drops - Vitamin E 180 mg (400 International Unit (IU)) otc tablet Staff A entered Resident #44's room, administered one drop of Artificial Tears into the resident's left eye then one drop into the right eye, returning to the med cart in an attempt to locate the bottle's box (which was lying on bedside dresser), returned to the resident's bedside and administered the oral medications. The staff member pushed the cart away from the doorway and went to the 200-hall med room. Staff A attempted to obtain Resident #44's Eliquis from the electronic medication dispenser, returned to the cart, reviewed spelling of the medication, then on 9/17/22 at 10:22 a.m. Staff A obtained 2 - 2.5 mg tablets of Eliquis, returning to the resident's room where two aides were performing care for the resident. After the resident was repositioned, on 9/17/24 at 10:28 a.m., Staff A administered 2 tablets of 2.5 mg Eliquis. Review of Resident #44's Medication Administration Record revealed the resident was scheduled at 9:00 a. m. to receive Eliquis. 4. On 9/17/24 at 10:32 a.m. an observation of medication administration with Staff A, RN, was conducted with Resident #66. The observation showed the resident's Vitamin B-12 and Polyethylene Glycol orders were colored red, revealing the medication was late. The staff member dispensed the following medications: - Vit B-12 1000 mcg otc - 2 tablets (2000 mcg) - ClearLax capful - Docusate Sodium 100 mg tablet - Senna S 8.6-50mg tab (sennoside and docusate) - 2 tablets - Sodium chloride 1 gram (gm) tablet - Vitamin D 25 mcg (1000 iu) - 2 tablets. The staff member confirmed dispensing 8 oral tablets and one liquid. The staff member entered the resident's room and observed the resident take the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #66's Medication Administration Record (MAR) showed the following physician order: - Cyanocobalamin oral tablet 500 mcg - Give 2 tablets by mouth one time a day for B12 deficiency (1000 mcg), scheduled for 9:00 a.m. - ClearLax, scheduled for 9:00 a.m. - Senna 8.6 mg tablet - Give 2 tablets by mouth twice daily (BID) for constipation. The observation showed the resident received tablets of senna and docusate. An interview was conducted with the Director of Nursing (DON) on 9/18/24 at 11:00 a.m. The findings of medication administration was reviewed and discussed with the DON. The DON stated physicians should be notified of late medications when staff know there going to be late. She stated they all use their cell phones so they have them (available). The DON stated blood glucose levels should be taken when the insulin is due. She reported they were fixing the orders to add parameters. The DON stated the physician should bed notified right then when a medication was not available. Review of the policy - Oral Administration of Medication, revised 8/15/19, instructed the following procedures: - Review physician's order. - Review the MAR or EMAR should there be any uncertainties verify the MAR or EMAR with the physician's order sheet (POS) and seek clarification as indicated. - Compare the medication unit/ dose label against the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingesting the medication. Review of the policy - Administering Medications, revised April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed. The implementation of the policy showed the following: - Medications are administered in accordance with prescribers orders, including any required time frame. - Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). - The individual in administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. - The following information is checked/ verify for each resident prior to administering medications: - a. Allergies to medications; and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- b. Vital signs, if necessary.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview, the facility failed to ensure one (South Front) of five carts were locked when unattended, failed to date medications with limited life when opened in one (South Front) of five med carts, failed to ensure three medical devices were discarded when expired, and failed to ensure medications were stored appropriately in four (#302, #304, #305, and #306) of 14 resident rooms sampled. Findings included: On [DATE] at 3:40 p.m., the South Front medication cart was reviewed with Staff E, RN. During the observation Staff E left the keys to the unlocked medication cart in the lock, leaving the area to speak with an unknown staff who was standing in a doorway on the other side of the nursing station. Staff E had her back to the med cart, with this writer and a confused unknown resident at the med cart. The observation revealed an undated bottle of Latanoprost (Xalatan) 0.005% ophthalmic drops. The clear bag holding the box of Latanoprost revealed an open date of [DATE] and expiration date of [DATE]. On [DATE] at 3:42 p.m., the South unit medication room was observed with Staff E. The observation revealed two expired silicone urinary catheters ([DATE]) and one expired latex urinary catheter ([DATE]) in a drawer containing multiple other urinary catheters. Review of the website, Medlineplus.gov (https://medlineplus.gov/druginfo/meds/a697003.html) revealed information regarding storage of Latanoprost was Once opened, the bottle can be kept at room temperature for either 6 weeks (Xalatan) or 30 days (Iyuzeh). On [DATE] at 12:42 p.m. an observation was conducted in room [ROOM NUMBER] B. Three medications were sitting on the resident's nightstand: hydrogen peroxide, soothing nerve pain spray and antifungal powder. On [DATE] at 12:00 p.m. an observation occurred in room [ROOM NUMBER] A. A medication was sitting on the resident's nightstand: antifungal powder. On [DATE] at 11:57 a.m. an observation occurred in room [ROOM NUMBER] A. Two medications were sitting on the resident's nightstand: wound cleanser and antifungal powder. On [DATE] at 11:55 a.m. an observation occurred in room [ROOM NUMBER] B. A medication was sitting on the resident's nightstand: antifungal powder. On [DATE] at 11:54 a.m. an observation occurred in room [ROOM NUMBER] B. Two medications were sitting on the resident's nightstand: bottle of multi-vitamin for 50+ and soothing throat spray. On [DATE] at 8:54 a.m. an observation occurred in room [ROOM NUMBER] A. Two medications were sitting on the resident's nightstand: wound cleanser and antifungal powder. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:00 p.m. Staff H, Registered Nurse (RN) said medications should not be left at bedside. During an interview on [DATE] at 3:30 p.m. the Director of Nursing (DON) stated medications should not be left at the resident's bedside. Antifungals, wound sprays and other over the counter medications are considered in the category of medications and no they should not be left in resident rooms. Photographic Evidence Obtained. Review of the facility's policy and procedure titled 5.0 Medication Storage, not dated revealed: Policy - medications will be stored in a manner that maintains the integrity of the product and ensures the safety of the residents and is in accordance with the Florida Department of health guidelines. Procedure: A. With the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel . B. Would you take the head to the left medications for external use will be stored separately from medications for internal use. Ophthalmic, otic and nasal products will be stored separately from other medications for internal use. F. Expired, discontinued and/or contaminated medications Review of the policy - Administering Medications, revised [DATE], revealed Medications are administered in a safe and timely manner, and as prescribed. The policy interpretation and implementation included the following: - The expiration/ beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. - During the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. 46234 48223

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observation, interview and record review, the facility failed to coordinate dental services in accordance with professional standards of practice for one (#75) of six residents sampled. Findings Included: During an interview and observation on 9/16/2024 at 11:52 a.m., Resident # 75 was observed to have missing and broken teeth on the lower jaw. Resident #75 stated the teeth caused him pain and had seen the dentist months ago but no follow up had occurred. Resident #75 stated everyone knew but no one did anything and he continued with pain regarding his teeth. Review of the facility Admission record showed Resident #75 was admitted to the facility with diagnoses to include but not limited to Normal Pressure Hydrocephalus, Type 2 diabetes, chronic obstructive pulmonary disease (COPD), mild bipolar disorder, joint pain, and other comorbidities. Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed in Section C- Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated intact cognition. Review of the dental care plan focus, with a revision date of 5/3/24 and target date of 8/27/2024, showed Resident #75 had full a denture on the top with natural missing teeth on the bottom. The care plan goal for Resident #75 would be free of infection, pain or bleeding in the oral cavity by review date. Review of the care plan intervention showed: Administer medications as ordered. Monitor/document for side effects and effectiveness; Coordinate arrangements for dental care, transportation as needed/as ordered; and provide mouth care as per personal hygiene. Review of Resident #75's Dental Service Report from Vendor A, dated 4/18/2024 revealed, Patient presents for consult regarding exam for lower partial. Patient originally states he wants to have all lower teeth extracted and complete dentures. Patient considering lower partial, #25 would need to be extracted prior to making a lower temp partial, pending approval. Review of the Resident #75's Dental Service Report dated 5/2/2024 revealed, Resident was interested in extracting tooth #25, pending medical clearance. Approval granted per spouse. Review of the Resident #75's Dental Service Report from Vendor B dated 8/16/2024 revealed, Resident presented for initial exam and teeth cleaning. No images completed due to camera malfunction. Resident denied pain or discomfort. During a follow-up interview with Resident #75 on 9/18/2024 at 12:11 p.m., he stated, The dentist came and cleaned my teeth. The dental person did not have any comments regarding my interest in my broken teeth as the x-ray machine was not working. No follow up has occurred, my pain has not been awful as I receive pain medication for my joints and headaches. On 9/18/2024 at 12:57 p.m., an interview was conducted with the Regional Social Service Director (RSSD). The RSSD reviewed both Vendor's information and stated, there seems to have been a disconnect with the Vendor transitions. I will contact Vendor B for follow up. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Dental Services revision date 11/27/2017, showed Policy: the center will contract with the dentist licensed by the board of dentistry to provide routine and 24 hour emergency dental services. Procedures: . * the nurse or designee will if necessary or if requested assist the patient/good resident in making the appointment and arranging for transportation to and from the dentist office. * Residents with lost or damaged dentures will be referred promptly within three days to the dentist. * If a referral does not occur within three days the nurse will evaluate and document changes and ability to eat and drink. Review ability with physician and obtain orders as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Countryside	3825 Countryside Blvd N Palm Harbor, FL 34684

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46234

Based on observations, record reviews, and interviews the facility failed to implement an effective Infection Control program related to 1. failure to ensure third-party vendors wore Personal Protective Equipment (PPE) appropriately and per posted instructions for one (#37) out of two residents under Contact isolation on one of two units, 2. failed to ensure staff conducted hand hygiene and donned PPE while providing high contact care activities per posted Enhanced Barrier Precautions for one (#44) of four residents observed during medication administration, 3. failed to cover respiratory masks when not in use for one (#5) of three sampled residents, 4. failed to ensure contact precautions were put in place in a timely manner for one (#457) of two sampled residents, and 5. failed to ensure

proper storage of food trays for one of four meal carts.

Findings included:

1. On 9/16/24 at 10:11 a.m., showed the door to Resident #37's room was posted with a Contact Precaution sign. The observation showed a female visitor was in the room and was not wearing any Personal Protective Equipment (PPE). The resident was not observed in the room.

On 9/16/24 at 11:14 a.m. Resident #37 was observed propelling wheelchair in hallway.

On 9/16/24 at 11:59 a.m. an unknown visitor was observed standing within inches of Resident #37's bed with a tablet sitting on the over-bed table doing what appeared to be a tele-health visit with an unknown person. The unknown visitor was not wearing any PPE.

On 9/16/24 at 12:04 p.m., the visitor/vendor came out of room with the healthcare vendor still on tablet. The visitor stated oh when asked about the signage on door and confirmed PPE should have been worn and would go sanitize hands.

On 9/17/24 at 8:32 a.m. Resident #37 was observed in room lying on bed. The door to the room continued to posted for Contact Precautions.

Review of Resident #37's Admission Record revealed the resident was admitted with diagnoses which included but not limited to Enterocolitis due to Clostridium difficile not specified as recurrent, dehiscence of amputation stump, and type 2 diabetes mellitus with diabetic neuropathy.

Review of Resident #37's laboratory results revealed a report, dated 9/10/24, of positive C. Diff toxin amplified probe.

Review of Resident #37's physician orders showed orders for:

- Isolation type - (Contact) every shift for C. Diff until 10/14/24 (at) 23:59. The order started on 9/11/24 and scheduled to end on 10/10/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Vancocin 125 milligram (mg) (Vancomycin) - Give 1 capsule by mouth every 6 hours related to Enterocolitis due to Clostridium difficile not specified as recurrent for 14 days, started on 9/11/24 and scheduled to end on 9/24/24. Review of the facility's Contact Precautions sign posted at Resident #37's door instructions: Contact Precautions In Addition To Standard Precautions. STOP All Family and visitors: Please report to nurses station or see staff BEFORE entering room. Everyone MUST: Perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water before entering and exiting. Wear Gown - Before entering and remove upon exiting. Wear Gloves - Before entering and remove upon exiting. 2. On 9/17/24 at 10:05 a.m. Staff A, Registered Nurse (RN) was observed dispensing medications for Resident #44. The door to the resident's room was posted for Enhanced Barrier Precautions. The staff member donned gloves without performing hand hygiene, administered eye drops, and removed gloves without performing hand hygiene. Staff A left the area to obtain a medication from the electronic medication dispenser returning to Resident #44's room as aides were performing hygiene for the resident. The observation showed neither of the aides were wearing PPE during incontinency care of the resident. One of the unknown aides left the room, Staff A asked Staff F, Certified Nursing Assistant (CNA) to assist with repositioning the resident. Staff A did not dress in a gown nor don gloves as the folded blanket was used to lift resident up in bed. The staff member administered the medication (obtained from electronic dispenser) to the resident. On 9/17/24 at 10:32 a.m. Staff A was observed dispensing and administering medications for Resident #66. The staff member was not observed performing hand hygiene in between the repositioning of Resident #44 and dispensing medications for Resident #66. An interview was conducted with Staff A on 9/17/24 at 10:41 a.m. The staff member confirmed not wearing gown or gloves when assisting in lifting Resident #44 in bed and confirmed the two aides had not been wearing gowns when changing the resident. Staff A confirmed no hand hygiene had been performed. Review of Resident #44's physician orders revealed an order dated 9/11/24 at 10:33 a.m., Enhanced Barrier Precautions every shift for skin. 3. An observation on 09/16/24 at 10:51 a.m., revealed Resident #5's nebulizer mask laid on top of the provided respiratory storage bag on the nightstand at bed side. Photographic evidence obtained. During an interview on 09/16/24 at 10:51 a.m., Resident #5 stated she used the nebulizer mask and nebulizer machine daily. Resident #5 stated when the nebulizer treatment was over the nurse took the nebulizer mask and laid it right there pointing to the mask that laid on top of the provided respiratory storage bag on the nightstand at bed side. Review of the Admission Record showed Resident #5 was admitted to the facility with diagnoses that included but not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Chronic Obstructive Pulmonary Disease unspecified, Unspecified Asthma uncomplicated and shortness of breath. Review of the Order Summary Report showed the following physician order.: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG [milligrams]/ML [milliliters]- 3 ml inhale orally every 4 hours as needed for Nebulizer Respirator. Check lung sounds, heart rate, ad respirations pre-post - nebulizer treatment. Record minutes of nebulizer treatment. - Budesonide Inhalation Suspension 0.5 MG/2 ML- 2 ml inhale orally twice daily related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation acute respiratory failure with hypoxia. Respiratory: Check lung sounds, heart rate, and respirations pre- and post-nebulizer treatment. Record minutes of nebulizer treatment. - Arformoterol Tartrate Inhalation Nebulizer Solution 15 MCG [microgram]/2 ML- 2 ml inhale orally via nebulizer every morning and at bedtime related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation acute respiratory failure with hypoxia. Respiratory: Check lung sounds, heart rate, and respirations pre- and post-nebulizer treatment. Record minutes of nebulizer treatment. Review of the Medicare 5-Day Minimum Data Set (MDS) showed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. Review of Resident #5's Care Plan showed Focus- [Resident #5] is at risk for complications related to diagnosis COPD with exacerbations, respiratory failure, interstitial lung disease, pneumonia. Goal- [Resident #5] will be free of sign and symptoms of respiratory distress requiring hospitalization through review date. Interventions: Monitor for difficulty breathing on excerption. Remind not to push beyond endurance. Monitor for s (sign)/sx (symptoms) of acute respiratory insufficiency. Anxiety, Confusion, Restlessness Monitor/Document/Report PRN (as needed) any s/sx of respiratory infection. Oxygen setting 02 via nasal prongs as ordered and as needed. During an interview on 09/18/24 at 12:04 p.m., the DON stated that any nebulizer masks would need to be stored in the respiratory bag when not in use to be sure the mask stayed clean and sanitary. Review of the facility's policy Nebulizer (small volume nebulizer) revised date 03/20/18 showed, Small nebulizers are used to deliver medication aerosols to the respiratory tract to relieve bronchospasm, to deliver medications, to improve the effectiveness of the cough and to relieve mucosa edema . Procedure: Place entire unit in a bag to be maintained in the resident's room. 4. An observation was conducted on 9/16/24 at 11:30 a.m. of Resident #457's room with no transmission-based precaution sign on the door and no PPE at the door. Photographic evidence obtained. Review of Resident #457's orders showed an order, dated 9/13/24, for contact precautions. There was a discontinued order that started on 9/3/24 and ended on 9/6/24. There was an active order, dated 9/13/24, for Meropenem Intravenous Solution (an anti-infective agent) 1 gram every 12 hours for ESBL of urine. Review of Admission Records showed Resident #457 was admitted on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI) and extended spectrum beta lactamase (ESBL) resistance. Review of the [patient transfer form] dated 9/1/24, showed UTI, ESBL in urine and Contact Precautions. The [patient transfer form] dated 9/13/24, showed resident continued to have ESBL in the urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/16/24 at 12:56 p.m. with the facility's Infection Preventionist (IP). The IP confirmed there was no sign on Resident #457's door and the resident had contact precaution orders. The IP said a contact precaution sign and PPE should have been placed on the door immediately upon admission. An interview was conducted on 9/16/24 at 4:27 p.m. with the Director of Nursing (DON). She said contact precautions should have been put in place with a sign on the door and PPE when she was admitted . 5. An observation was conducted on 9/16/24 of lunch trays being delivered on the 200 hall. Staff B, Certified Nursing Assistant (CNA) was observed taking a dirty breakfast tray out of a resident room and placing it in the tray cart above the clean lunch trays that were being delivered. A second dirty tray was also observed to be in the tray cart with clean lunch trays. Photographic evidence obtained. An interview was conducted on 9/16/24 at 12:01 p.m. with Staff B, CNA. She confirmed dirty trays had been placed in the cart with clean trays. When asked if dirty trays should be placed in the cart with clean trays, she said no. When asked if she knew where to put dirty trays she did not seem to understand the question and nodded. An interview was conducted on 9/18/24 at 2:24 p.m. with the Certified Dietary Manager (CDM). She said dirty trays that were in resident rooms when the next meal was delivered should be put in a plastic bag and taken to the baking cart that was in the dining room. She said it stayed there for staff to put dirty trays on. The CDM said a dirty meal tray should never be placed in the tray cart while clean/new food trays were still in it. She agreed it was an infection control concern. An interview was conducted on 9/18/24 2:50 p.m. with the DON. She said dirty lunch trays should not be placed in a cart with clean lunch trays. She said dirty lunch trays that had not been picked up should be taken directly to the kitchen. An interview was conducted on 9/19/24 at 9:42 a.m. with the facility's Infection Preventionist (IP). She said all staff and visitors should always follow the precaution sign posted on the door. If a room was on contact precautions, everyone should put on a gown and gloves prior to entering the room every time. She said if a resident was on enhanced barrier precautions staff should wear a gown and gloves any time they were giving care to the resident, including transferring, pulling up in bed, dressing, or touching anything to do with an opening on the body (e.g. catheter, IV, etc). The IP said during medication administration nurses were educated to wash hands before and after entering a resident room. She said hands should be washed between each resident's medication administration. The IP confirmed dirty food trays should not be placed in a food cart with clean food trays. She said that was disgusting and was an infection risk. The IP also stated respiratory masks should always be stored in the plastic bag at the bedside. She said nurses knew they were not to be left out on the bedside table. The IP said when a resident was admitted or had new orders, the precaution signs should be placed immediately. She said nurses knew where the signs, PPE carts, and supplies were. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Enhanced Barrier Precaution sign, provided by the facility revealed: STOP ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urine catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. Review of the policy - Administering Medications, revised April 2019, revealed staff follows established facility infection control procedures (e.g. Hand washing, antiseptic technique, gloves, isolation precautions, etc.) For the administration of medications, as applicable. Review of the policy - Hand Hygiene, revised 2/5/21, showed The CDC defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic rubs (i.e. alcohol based sanitizer including foam or gel). The purpose was To reduce the spread of germs in the health care setting. The process included when hand hygiene should be performed as After contact with inanimate objects (including medical equipment) in the immediate patient vicinity and after glove removal. The policy revealed use of soap and water to perform hand hygiene is recommended when caring for a resident(s) with known or suspected Clostridium difficile, when caring for a resident(s) with known or suspected infectious diarrhea or Norovirus outbreaks. Review of the policy - Infection Control revealed The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. - 1. The facilities infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source. - 4. All personnel will be trained on their infection control policies and practices upon higher and periodically thereafter, including where and how to find the use of pertinent procedures and equipment related to infection control period the depth of employee training shall be appropriate to the degree of direct resident contact in job responsibilities. 41015 48223 37999