STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105866	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza West	912 American Eagle Blvd Sun City Center, FL 33573

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete the Nursing Home Transfer and Discharge Notice, notify the receiving facility, and document a discharge summary for two residents (#98 and #8) out of two residents sampled.Findings included:1. Review of Resident #98's admission record revealed an admission date of 05/22/2025 and was discharged to an acute care hospital on [DATE]. Resident #98 was admitted to the facility with diagnosis to include nonrheumatic aortic (valve) stenosis, encounter for surgical aftercare following surgery on the nervous system, and acute on chronic diastolic (congestive) heart failure.Review of Resident #98's Nursing Home Transfer and Discharge Notice dated 05/29/2025 revealed Resident #98 was discharged to a hospital because Residents medical needs were unable to be met. The Physician/Designee Name and Signature were blank. The Resident or Representative Name and Signature were blank. The notice given to: resident, legal guardian or representative date was blank. The local Long Term Care Ombudsman Council date was blank and the resident clinical record date was blank.Review of Resident #98's medical record did not reveal a discharge summary or documentation of notification to the receiving facility for Resident #98's discharge on [DATE].2. Review of Resident #8's admission record revealed an initial admission date of 04/07/2025. Resident #8 was admitted to the facility with diagnosis to include traumatic subarachnoid hemorrhage without loss of consciousness, subsequent encounter, contusion and laceration of right cerebrum without loss of consciousness, subsequent encounter, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Review of Resident #8's change of condition dated 05/03/2025 revealed, outcome of physical assessment: fall. Primary care provider feedback: send to emergency room for eval (evaluation).Review of Resident #8's medical record revealed no discharge summary or documentation of notification to the receiving facility for Resident #8's discharge on [DATE].Review of Resident #8's Nursing Home Transfer and Discharge Notice dated 05/03/2025 revealed the Physician/Designee Name and Signature were blank. The Resident or Representative Name and Signature were blank. The notice given to: resident, legal guardian or representative date was blank. The local Long Term Care Ombudsman Council date was blank, and the resident clinical record date was blank.During an interview on 07/30/2025 at 12:08 p.m., Staff T, Licensed Practical Nurse (LPN) stated when a resident is being discharged to the hospital they complete a change of condition, get an order from the physician, and they send them out. She did not know what the Nursing Home Transfer and Discharge form was.During an interview on 07/30/2025 at 12:14 p.m., Staff U, LPN stated when a resident is being transferred to the hospital they get an order, complete a change of condition, and notify the hospital the resident is being discharged to them. She was not sure what the Nursing Home Transfer and Discharge form was.During an interview on 07/30/2025 at 2:18 p.m., Staff V, Medical Records, stated she is responsible for the Nursing Home Transfer and Discharge form when residents leave for the hospital. She sends the Nursing Home Transfer and Discharge form to the resident's representative by mail either the day after discharge or two to three days later. She includes a copy for them to keep and one for them to return to the facility at their earliest convenience. They are all kept in a binder in her office. I mail them and do nothing else with them.During an interview on 07/30/2025 at 3:41 p.m. Staff U, Social Services stated medical records is responsible for completing the Nursing Home Transfer and Discharge form and getting the resident or resident representative's signature. We do not get the physician signature for residents going to the hospital or going home.During an interview on 07/31/2025 at 10:22 a.m., the Director of Nursing (DON) stated we call and do report with the hospital when the resident is being discharged to the hospital. One of the hospitals asked for us to hold off calling and doing report because they are trying to get a better system for reporting. They just started this process, and she is reminding the nurses they should be documenting the discharge in the chart. Social Services and Medical Records are responsible for completing the Nursing Home Transfer and Discharge form.Review of the facility's policy titled Transfer or Discharge, Facility-Initiated, dated October 2022, revealed, Policy StatementOnce admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Notice of Transfer or Discharge (Emergent or Therapeutic Leave) .3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: a. The health and our safety of individuals in the facility would be endangered due to the clinical or

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review and staff interviews, the facility failed to ensure care plan interventions were implemented for one resident (#6) of three sampled residents related to positioning during enteral nutrition administration.Findings included:Review of Resident #6's care plan revised on 07/25/2025 revealed Resident #6 required tube feeding related to dysphagia. The goal was for the resident to remain free of side effects or complications related to tube feeding through the review date. Interventions included: Resident #6 needs head of bed (HOB) elevated 45 degrees during and thirty minutes after tube feed. On 7/28/25 at 2:00 p.m. Resident #6 was observed in his room lying on his bed with the head of the bed (HOB) elevated approximately 30 degrees as his enteral nutrition pump was administering his tube feeding. On 7/29/25 at 9:10 a.m. Resident #6 was observed in his bed with his eyes closed and his HOB elevated less than 45 degrees as his enteral nutrition pump was administering his tube feeding. On 7/30/25 at 8:20 a.m. Resident #6 was observed in his bed with his eyes closed and his HOB elevated less than 45 degrees as his enteral nutrition pump was administering his tube feeding. Review of Resident #6's medical record revealed he was admitted to the facility on [DATE] with diagnoses to include: unspecified protein calorie malnutrition, dysphagia, oropharyngeal phase, aphasia, cognitive communication deficit, gastrostomy status and need for assistance with personal care. Review of Resident #6's Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8 out 15 indicating moderately impaired cognition. On 7/30/25 at 4:45 p.m. during an interview with Staff B, Licensed Practical Nurse (LPN), he stated the HOB needs to be between 30 and 45 degrees. Staff B, LPN says the Certified Nursing Assistants (CNAs) know to keep the HOB 30 to 45 degrees. On 7/30/25 at 5:00 p.m. an interview was conducted with Staff R, CNA. Staff R, CNA stated they keep the HOB elevated for residents receiving enteral tube feedings. Staff R, CAN stated the head needs to be higher than the feet. On 7/31/25 at 9:40 a.m., an interview was conducted with the Clinical Unit Manager who stated the practice is to keep the HOB elevated during enteral tube feedings but admitted she was unable to verbalize the policy regarding how many degrees. During an interview on 7/31/25 at 10:00 a.m. with Staff C, LPN, Staff C stated the HOB needs to be between 30 and 90 degrees when residents are receiving enteral tube feedings and that the CNAs are educated on the practice. On 7/31/25 at 2:40 p.m. an interview was conducted with MDS Coordinators, Staff D and Staff E. Staff D stated some residents with gastrostomy tubes may be care planned for 45 degrees. Staff D and Staff E reviewed Resident #6's care plan and physician orders and confirmed there were no orders for HOB degree positioning. They stated they would contact the physician. Review of the facility policy titled Enteral Tube Feeding via Continuous Pump revised November 2018 revealed: PurposeThe purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings Steps in the Procedure.4. Position the head of the bed at 30 to 45 degrees (semi-Fowler's position) for feeding, unless medically contraindicated.Review of a facility's policy titled Care Plans, Comprehensive Person-Centered revised on March 2022 showed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan:.e. reflects currently recognized standards of practice for problem areas and conditions. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide quality care and services related to wound care for three residents (#56, #58, #11) out of three sampled residents. Findings Included: 1. During an observation on 07/28/2025 at 12:23 p.m., Resident #56 was observed sitting in a wheelchair with undated white bandages around both of her lower legs. Review of Resident #56's admission record revealed an initial admission date of 04/17/2025. Resident #56 was admitted with diagnosis to include partial intestinal obstruction, unspecified as to cause, acute embolism and thrombosis of unspecified deep veins of left lower extremity, and peripheral vascular disease, unspecified. Review of Resident #56's Medicare 5-day Minimum Data Set (MDS) revealed Section M. Skin Conditions, revealed venous and arterial ulcers, skin tears, and application of nonsurgical dressings (with or without topical medications) other than to feet. Review of Resident #56’s physician orders revealed: Dated 07/07/2025 Right Lower Leg skin tear: cleanse with normal saline (NS), pat dry, apply triple antibiotic ointment, xeroform sheet, and ABD (abdominal) pad, wrap with Kerlix as needed. Dated 7/23/2025 Left Lower Leg Skin Tear: Cleanse with NS, pat dry, apply Santyl and silver alginate, ABD Pad and wrap with Kerlix. Do not use island dressing/tape every evening shift and as needed for soiled or dislodged dressing. 2. During an observation on 07/28/2025 at 12:23 p.m., Resident #58 was observed with a bandage to her left forearm dated 07/26/2025. Review of Resident #58's admission record revealed an admission date of 07/16/2025. Resident #58 was admitted to the facility with diagnosis of encounter for other orthopedic aftercare, spondylolisthesis, lumbar region, spinal stenosis, lumbar region without neurogenic claudication. Review of Resident #58's Medicare 5-day MDS dated [DATE] revealed Section M. Skin Conditions, surgical wound, skin tears, moisture associated skin damage (MASD), and application of nonsurgical dressings. Review of Resident #58’s physician orders revealed: Dated 07/21/2025 Left forearm cleansed with normal saline apply dry dressing daily until healed monitor any s/s (signs and symptoms) of infection at bedtime for skin tears. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #11's admission record revealed an admission date of 07/08/2025. Resident #11 was admitted to the facility with diagnosis to include unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing, presence of right artificial hip joint. Review of Resident #11's admission MDS dated [DATE] revealed Section M. Skin conditions, surgical wound. Review of Resident #11’s medical record revealed a handwritten order dated 07/25/2025, wound care- please clean wound two to three times daily with betadine and redress. Review of Resident #11’s electronic medical record revealed a physician order with a start date of 07/31/2025, Right Hip: Wound care clean with betadine pat dry apply island dressing. Two times a day for surgical wound. During an interview on 07/31/2025 at 10:50 a.m., the Assistant Director of Nursing (ADON) stated resident’s bandages should be labeled with the date, nurses’ initials, and the shift they work. Resident #56’s bandages should have been dated. Resident #58’s bandage should have been dated for 07/27/2025 since the order is for daily dressing changes during the evening shift. During an interview on 07/31/2025 at 1:18 p.m., the Director of Nursing (DON) stated the nurses are responsible for entering the handwritten orders into the electronic medical record. Resident #11’s wound care order should have been started on 07/25/2025. The facility was asked to provide a policy related to wound care and it was not provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to assist with the placement of hearing aids for one resident (#17) out of one resident sampled. Findings Included: During an interview on 07/28/2025 at 10:21 a.m. Resident #17 stated You will have to come closer and speak louder, I don't have my hearing aids in, so I can't hear you. I don't know where my hearing aids are you will have to check with my son. Resident #17 was observed to not have hearing aids in during the interview.During a phone interview on 07/29/2025 at 1:08 p.m., Resident #17's Family Member (FM) stated he has spoken with the facility a few times about helping his mom with her hearing aids. He stated they always forget to charge them so she can't use them. We have family who want to call and talk with her, but if she does not have her hearing aids in, she cannot use the phone. I have to remind them to put them on the charger for her. They called me last week because her hearing aids broke. I came and picked them up last week and dropped them off to be fixed on 07/28/2025.Review of Resident #17 admission record revealed an admission date of 06/28/2025. Diagnoses included pneumonia, unspecified organism, and adjustment disorder with other symptoms.Review of Resident #17's admission Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) score of 12 out of 15 showing intact cognition.Review of Resident #17's physician orders revealed:A start date of 07/03/2025, put bilateral hearing aids on in am (morning) and take off at night and place on charger. One time a day and at bedtime.Review of Resident #17's Treatment Administration Report (TAR) revealed Resident#17's hearings aids were marked as being on for 07/28/2025 and 07/29/2025.Review of Resident #17's Care Plan dated 06/30/2025 revealed:Focus:Resident #17 has a communication problem related to hearing deficit.Goal:Resident #17 will be able to make basic needs known on a daily basis through the review date.Interventions:.put bilateral hearing(sic) on in am and take off at night and place on charger.During an interview on 07/30/2025 at 11:59 a.m., Staff X, Certified Nursing Assistant (CNA), stated Resident #17 does not have any issues with hearing. I have not seen her with hearing aids today. The nurses are responsible for putting in and taking out the hearing aids.During an interview on 07/30/2025 at 12:07 p.m., Staff U, Licensed Practical Nurse (LPN) stated Resident #17 does where hearing aids and she has them in today. Resident #17 has had them in all week. The nurses are responsible for helping her with the hearing aids. We document on the TAR (treatment administration record) when she has them in. She was not aware of any concerns with Resident #17's hearing aids being broken and her son having to come and pick them up last week.During an interview on 07/03/2025 at 1:00 p.m., Staff I, LPN, Nurse Manger stated Resident #17 can't hear if she does not have her hearing aids. There are orders to put in her hearing aids and to put them on the charger at night. The nurses are responsible for helping her with her hearing aids. The nurses document the use of hearing aids on the TAR. If Resident #17 does not have her hearing aids in they should be documenting no or off.During an interview on 07/30/2025 at 2:08 p.m., the Director of Nursing (DON) stated Resident #17's family had spoken with them when she first admitted to the facility about putting in her hearing aids. She stated that is why she asked them to add it to the Kardex, so they could remember to place them on the charger at night. I don't think it should have been an order. They should be documenting appropriately whether Resident #17 has her hearing aids in or not.Review of the facility's policy, titled Hearing Aid, Care of, with a revision date of February 2018 revealed, Purpose The purpose of this procedure is to maintain the resident's hearing at the highest attainable level.General Guidelines,Checking the Batteries:1. If the hearing aid is not functioning properly, check the battery. Placement of the Hearing Aid1. Turn the hearing aid off and the volume all the way down before placing the hearing aid into the ear.2. The hearing aid should fit securely, but comfortably, into the ear. Documentation:The following information should be recorded in the resident's medical record:1. The date and time the hearing aid was checked and/or battery was replaced.2. The name and title of the individual(s) who checked the hearing aid and changed the battery.3. If the resident refused the procedure, the reason(s) why and the intervention taken.4. The signature and title of the person recording the data.Review of the facility's policy titled Activities of Daily Living (ADL), Supporting with a revision date of March 2018 revealed, Policy StatementResidents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to accurately assess and implement appropriate interventions for two residents (#2 and #8) of six residents sampled for accidents. Findings included: On 07/28/25 at 9:53 a.m. Resident #2 was observed sitting in a wheelchair alone at table in the common area between rooms [ROOM NUMBERS]. The resident’s wheelchair was pushed up to table with both wheelchair brakes in a locked position. The resident was observed pushing at the table. During the observation, Staff N, Licensed Practical Nurse (LPN) reported the resident’s diagnosis and was Spanish-speaking only. On 07/28/25 at 11:04 a.m. Staff L, Certified Nursing Assistant (CNA) was observed unlocking both of Resident #2’s wheelchair brakes. The staff member reported going to take the resident to assist with toileting and confirmed unlocking the brakes on each side of the wheelchair. Staff L stated the resident moves arms and legs when sitting at tables. On 07/29/25 at 11:12 a.m. Resident #2 was observed sitting at the table in the common area, facing resident rooms with back to hallway, the brakes on each side of the resident’s wheelchair were locked. On 07/31/25 at 8:58 a.m. Resident #2 was observed sitting at the table in the common area in a wheelchair with the brakes locked on each side of the chair. Staff S, Restorative CNA, confirmed both brakes were locked. Staff L stated the resident was able to unlock the brakes. The resident stated “no” when asked if (pronoun) could unlock the brakes. Staff Y, CNA translated and asked the resident if (pronoun) could unlock brakes, again the resident said “no”. The resident did respond appropriately in Spanish when this writer said hello. Staff N, LPN reported the resident could unlock the brakes, does it better in the evenings, doesn’t do it in the mornings. Staff N stated they lock both brakes and push Resident #2 into the common area to watch for (pronoun) safety. Review of Resident #2’s admission Record showed the resident was admitted on [DATE] with a primary diagnosis of subsequent encounter for closed fracture with routine healing (of) displaced intertrochanteric fracture of right femur. The record included additional diagnoses not limited to Parkinson’s disease without dyskinesia without mention of fluctuations, unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, difficulty in walking not elsewhere classified, subsequent encounter (of) unspecified fall, and psychotic disorder with delusions due to known physiological condition. Review of Resident #2’s hospital History and Physical, dated 07/06/25, showed the resident presented to the facility after being found on the floor by family. The Xray results revealed an acute displaced intertrochanteric proximal right femur neck fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2’s 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was interviewed for a Brief Interview for Mental Status (BIMS) score. The resident scored “00” of 15 indicating a severe cognitive impairment. The functional abilities assessment revealed the resident had bilateral lower extremity range of motion limitations and was dependent upon others for toileting, bathing, lower body dressing and putting on/taking off footwear. The resident was shown to be dependent with bed mobility, transferring, walking 10 feet, and walking 50 feet with two turns. The MDS revealed the resident had a fall in the last month prior to admission/entry, and a fracture related to a fall in the six months prior to admission/entry, no falls since admission/entry, and had a major surgery in the 100 days prior to admission. Review of the Fall Risk Evaluation, dated 07/09/25 at 6:05 p.m. showed Resident #2 had one to two falls in the past three months, was disoriented x3 (disoriented to person, place, and time) at all times, was ambulatory and incontinent, had one to two predisposing disease(s), no change in condition in the last 14 days, and a recent hospitalization in the last 30 days. The Gait/Balance portion of the evaluation showed the resident’s gait/balance was normal, balance problem while standing, balance problem while walking, decreased muscular coordination, and jerking or unstable when making turns. The evaluation did not show a care plan focus or interventions were initiated to show the resident was a high risk for falls or a risk for falls. Review of Resident #2’s Post-Fall Evaluation, dated 07/27/25 at 2:20 p.m. showed the resident had an unwitnessed fall on 07/27/25 at 2:15 p.m. in the resident’s room. The evaluation revealed the resident was attempting to self-toilet and no injury had occurred. Review of Resident #2’s Fall Risk Evaluation, dated 07/27/25, showed the resident had one to two falls in the past three months, had intermittent confusion, was chairbound and incontinent, and had three or more predisposing diseases. The Gait/Balance of the resident showed a balance problem while standing, balance problem while walking, decreased muscular coordination, and required use of assistive devices (i.e. cane, wheelchair, walker, furniture). Review of Resident #2’s care plan focus initiated on 7/10/25 showing the resident was at risk for falls related to (r/t) Parkinson’s disease, dementia, medication side effects, and history of falls. The interventions included: - Be sure (the resident’s) call light is within reach and encourage the resident to use it for assistance as needed, initiated 07/10/25 and revised on 07/27/25. - Encourage and assist resident to keep bed in the lower position during rest periods with floor mats at bedside, initiated on 07/28/25. - Encourage (resident) to wear appropriate non-skid footwear/gripper socks, initiated 07/10/25 and revised on 07/28/25. - Observe for restlessness when in bed. Offer and assist up to the wheelchair/common area for activities, socialization, and increased monitoring, initiated and revised 07/28/25. - Physical Therapy (PT) screen and treat as ordered, initiated on 07/10/25. - Fall Risk, initiated on 07/10/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2’s care plans and focuses did not reveal staff were to place Resident #2 close to table and lock both of the wheelchairs brakes. During an interview on 07/30/25 at 3:32 p.m., the Director of Nursing (DON) stated she doubted Resident #2 would be able to unlock the wheelchair brakes. She stated having the resident pushed up to the table and both brakes locked would be a restraint. The DON stated just because the resident moves legs and arms was not a reason to lock brakes. 2. During an observation on 07/28/2025 at 11:03 a.m., Resident #8 was observed sitting in a wheelchair in the common area. An attempt was made to interview Resident #8, and she was not able to answer questions related to her care. During an observation on 07/29/2025 at 12:14 p.m., Resident #8 was observed sitting in a wheelchair in the dining room. During an interview on 07/29/2025 at 1:30 p.m., Resident #8’s Family Member (FM) stated Resident #8 had a fall in her assisted living apartment and that is what brought her to the nursing facility. He stated she fell at the nursing facility and had to be sent to the hospital. After that incident she has fallen twice, with her most recent fall last week. “She was very independent before the fall that brought her to this facility and still thinks she can do things on her own. She had vertigo for years and I feel like this is what is causing her more recent falls.” Review of Resident #8’s admission record revealed an initial admission date of 04/07/2025 and a re-admission date of 05/06/2025. Resident #8 was admitted to the facility with diagnosis to include traumatic subarachnoid hemorrhage without loss of consciousness (04/07/2025), contusion and laceration of right cerebrum without loss of consciousness (04/07/2025), contusion of scalp (05/06/2025), difficulty in walking (04/07/2025), cognitive communication deficit (04/07/2025), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (04/07/2025) and unspecified fall (04/07/2025). Review of Resident #8 Significant Change Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of two out of 15 showing severe cognitive impairment. Review of Section GG. Functional Abilities revealed Resident #8 needed partial/moderate assistance showing the helper does less than half the effort. The helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort. For roll left and right, sit to lying, lying to sitting, sit to stand, chair/bed transfers, toilet transfers and wheelchair mobility. Resident #8 was dependent showing the helper does all of the effort, resident does none of the effort to complete the activity, or, the assistance of two or more helpers is required for the resident to complete the activity for walking 10 feet, walking 50 feet, and walking 150 feet. Review of Resident #8’s Care Plan dated 04/08/2025 revealed: Focus: Resident #8 is at risk for falls related to history of falls, dementia and syncope. Date Initiated: 04/08/2025 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: Resident #8 will not sustain serious injury through the review date. Interventions: • anti-rollback to wheelchair (date initiated 05/07/2025) • Be sure Resident #8 call light is within reach and encourage the resident to use it for assistance as needed. (date initiated 04/08/2025). • Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. (date initiated 07/26/2025). • Encourage and assist resident to keep bed in the lower position during rest periods (date initiated 05/08/2025). • Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. (date initiated 07/26/2025). • Encourage Resident #8 to wear appropriate non-skid footwear/gripper socks when ambulating or mobilizing in wheel chair (date initiated 04/08/2025). • Floor mats at bedside during rest periods (date initiated 05/08/2025). • Medication Review (date initiated 06/02/2025). • Offer and assist resident out of room to the common area during the day, or if noted to be restless when in bed, for activities, socialization and increased monitoring (date initiated 05/07/2025). • Offer and assist resident to the bathroom during waking hours such as before/after meals or programs, upon awakening and at bedtime. Observe for any symptoms of urinary retention and report to nurse/MD (medical doctor) (date initiated 06/02/2025). • One way glide pad to wheelchair seat (Date Initiated 05/08/2025) • Provide cueing/supervision as indicated (Date Initiated 07/26/2025) • Provide rest periods. (Date Initiated 04/08/2025) • room change closer to the nurses station. (Date Initiated 05/06/2025) • The resident needs activities that minimize the potential for falls while providing diversion and distraction (date initiated 07/26/2025). • Fall risk (date initiated 05/06/2025). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	• Provide resident appropriate assistive devices as ordered (date initiated 07/26/2025). • Keep needed items in reach (date initiated 07/28/2025). • Encourage and assist resident to keep wheelchair brakes in locked position when not mobilizing (date initiated 07/28/2025). Focus: Risk for falls (date initiated 07/26/2025). Goal: Resident #8 will be free of falls. Interventions: • Assist resident with ambulation and transfers, utilizing therapy recommendations (date initiated 07/26/2025). • Determine residents ability to transfer (date initiated 07/26/2025). • Evaluate fall risk on admission and as needed (date initiated 07/26/2025). • If fall occurs, alert provider (date initiated 07/26/2025). • If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol (date initiated 07/26/2025). • If Resident is a fall risk, initiate fall risk precautions (date initiated 07/26/2025). Review of Resident #8’s fall risk evals revealed 04/07/2025 Fall risk score of 11.0, 05/02/2025 Fall risk score of 18.0, 05/06/2025 Fall risk score of 10.0, 05/09/2025 Fall risk score of 22.0, 05/31/2025 Fall risk score of 11.0, and 07/26/2025 Fall risk score of 22.0, indicating Resident #8 as a high risk for falls with a score of 10 or higher. Review of Resident #8’s Change in Condition Evaluation dated 05/03/2025, revealed Fall, this condition, symptom, or sign has occurred before. Functional Status Evaluation, Falls (one or more). Pain Evaluation not clinically applicable to the change in condition. Neurological Evaluation not clinically applicable to the change in condition being reported. Review of Findings and Provider Notification: “history of fall prior to admission, called into the room by Certified Nursing Assistant (CNA),observed resident lying on her back near the bathroom door, resident was previously seen lying in bed eating dinner, call light within reach but not on, resident stated that she walked out to use the bathroom, slipped and fell, the floor was dry and clear. Resident was assessed for injury, a bump on the back of her head, no other injury and no complaint of pain. MD was immediately notified, order to send to emergency room (ER). 911 called and resident was transported to ER for evaluation.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of eINTERACT Change in Condition Evaluation dated 05/31/2025 revealed Situation, Fall. This condition, symptom, or sign has occurred before, unknown. Functional Status Evaluation, Falls (one or more). Pain Evaluation is not clinically applicable to the change in condition. Neurological Evaluation is not clinically applicable to the change in conditions being reported. Review of Findings and Provider Notification: This nurse was notified by CNA that Resident was found on floor, upon entering resident's room, resident was found sitting on bathroom floor in front of toilet. Resident stated, I needed to go to the bathroom, and I slid out of the chair. Resident was assessed, no signs of injury, bruising or hematoma noted. Resident denies pain. Resident was transferred from floor to toilet with assistance of two, neuro (neurological) checks initiated. MD and family notified. No new response from physicians, family notified. Review of eINTERACT Change in Condition Evaluation dated 07/26/2025 revealed Situation, Fall. This condition, symptom, or sign has occurred before, unknown. Functional Status Evaluation, Falls (one or more). Pain Evaluation residents has no pain. Neurological Evaluation no changes observed. Review of Findings and Provider Notification: Patient is unsteady and is unable to ambulate independently. Patient fell and landed on the back of head. Bump on the back of head - Right side, Writer observed resident lying flat on the floor in the common area of 2 south. Writer assessed resident for any skin alterations (bump noted to right side of back of head). Resident denies pain and states that she was ready to eat lunch. Vitals were assessed. Resident was assisted off of the floor via two person assist utilizing a gait belt. Neurological checks initiated. Hospice notified of fall and will visit resident this afternoon to assess. On call MD also notified of fall. Family notified. During an interview on 07/30/2025 at 12:3 p.m., Staff Z, CNA, stated Resident #8 is incontinent and needs help with going to the bathroom, she is confused a lot. “I think she is a fall risk because she tries to get out of bed by herself. She has mats in her room and a anti-lock thing on chair. We also keep her bed low. I am not aware of her having any falls.” During an interview on 07/30/2025 at 12:16 p.m., Staff U, Licensed Practical Nurse (LPN) stated Resident #8 is a long-term resident who is on hospice. She had a fall with a brain bleed before she was admitted . She has had a few falls since being here with her most recent being on the 26th. We do frequent rounds, make sure she has been toileted, if she is in her room. We make sure everything is in reach of her. Sometimes we put her in the common area, and we ensure that her brakes on her wheelchair are locked. Interventions are set in place at admission. If a resident comes in because of a fall we make sure that their bed is in a low position, fall mats and keep them in a room near the nurse’s station. Resident #8 was not her resident when she fell for the first time at the facility. Resident #8 was on a different unit further away from the nurse’s station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/30/2025 at 2:34 p.m., the Director of Nursing (DON), stated Resident #8 has had three falls at the facility. After the first fall they called and spoke with her son who told them she has been battling vertigo for 20-30 years but did not have an official diagnosis. Resident #8 will sometimes want to get up and change positions because of that she falls. Her cognition fluctuates a lot. “When she first got here, she only wanted to stay in bed. It was a surprise when she wanted to get out of bed.” In the beginning of May Resident #8 was found on her back on the floor outside of her room very close to the bathroom. She told us she was going to the bathroom and slipped and fell. Resident #8 had to go to the hospital after the fall at the beginning of May and was admitted because she had a subdural hematoma that was new. Their risk manager did the investigation. “Alot of times we pre deem residents as a fall risk. They do fall risk assessments at admission and after each fall.” Her initial care plan interventions were “use call lights, no skid footwear. At the time of her admission we did not feel she was a fall risk. ” After a resident falls, we update their care plans. During an interview on 07/30/2025 at 5:30 p.m., the Risk Manager stated on 05/03/2025 staff observed Resident #8 lying on her back on the floor in her room. They evaluated her found a “bump” on her head. They notified the physician and transferred her to the emergency room (ER). She was out of the facility for a few days and then returned to them on 05/06/2025. At the time of this fall she reviewed the care plan and Resident #8 was care planned for call light in reach and no skid footwear. At the time of her admission we thought those were appropriate interventions for her. They changed Resident #8’s care plan when she got back and added therapy screen to evaluate her, anti-rollback to her wheelchair, since there was potential for her to stand. Assist her to the common area, for socialization and activities. When in her room bed in lower positions and floor mats at the bedside. We added one way glide pad to her wheelchair. We also moved Resident #8’s room in front of the nurse’s station. She called Resident #8’s son with the DON, who told them Resident #8 had a history of vertigo, that was never really diagnosed. Resident #8 had another fall on May 31st. It was an unwitnessed fall. Resident #8 was observed sitting on the floor in her room. Ten minutes earlier Resident #8 was observed lying in bed in lowest position. Her call light was not activated. Resident #8 was not able to verbalize what she was trying to do. That’s when they added for staff to offer toileting assistance, at the time she was incontinent and was not aware of needs to void. We also added offer routinely to go to the bathroom “we thought that maybe she was trying to get up and go to the bathroom.” We also added another therapy screen and requested a pharmacy review. Resident #8 had another fall on July 26th, and the investigation is ongoing. Nurse stated Resident #8 went to music program and she sat her in the common area after. The nurse left for about five minutes and when she went around the corner, she saw Resident #8 sitting on the floor. Resident #8 did not have any injuries. Resident #8 told the nurse, she saw a piece of paper and leaned forward, and just bounced out of the chair. She reviewed the interventions in the care plan with the nurse, and everything was in place on her wheelchair. After this fall they added, keeping items within reach and having staff lock the wheelchair brakes, “that may keep her from bouncing.” They discuss falls at their morning meetings and Resident #8 was just added to the list to go over her case. Review of the undated facility policy titled “Fall Prevention and Management” revealed, “Policy: It is the policy of our community to ensure a safe environment with least restrictive measures while promoting the highest possible level of independence and quality of life. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: A fall prevention program is used to provide a safe environment for resident of the Health Care Center. This program is designed to identify residents at risk of falls; define interventions for the prevention of falls; improvement quality assurance measures to monitor progress; and provide ongoing staff education. Definition: This community follows the long-term care/CMS guidelines for the definition of a fall. CMS RAI definition of a fall-Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, and an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person-this is still considered a fall. CMS understands that challenging a residence balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. admission: 1. All residents will be assessed for the risk of falling using a standardized fall assessment. 2. The fall risk evaluation will be completed upon admission, quarterly, annually, and/or if a changing condition requiring completion of a new MDS occurs (significant change MDS) and after every fall. An evaluation of all the casual factors leading to a resident fall should be completed. 3. The baseline care plan will address interventions based on the fall risk evaluation results, history, and resident and resident representative input. 4. All residents should be considered at risk for falls for 72 hours following admission due to change in environment. 5. Residents who are identified as high risk will have a prevention care plan in place and individualized precautions will be noted to avoid falls. 6. Shift report will include communication to all nursing staff regarding fall risk for new residents or residents who experience a change in condition. 7. Nursing assistants will be made aware of residents at high risk for falls via resident care information records found in the EMR [electronic medical record] or other tool. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment and care planning: 1. the baseline care plan will be followed (and updated as necessary) until the MDS is completed. Following completion of the MDS, if triggered the CAA [Care Area Assessment] for falls will be completed and appropriate interventions will be implemented in the care plan. 2. LCS Does [sic] not recommend the use of restraints as a fall prevention strategy. As noted in the State Operations Manual (Appendix PP), “there is no evidence that the use of physical restraints including but not limited to bed rails and position change alarms will prevent or reduce falls. Additionally falls that occur while a person is physically restrained often result in more serious injuries (e.g., strangulation, entrapment). ” Steps following a fall: 1. Head to toe evaluation by a licensed nurse is completed before the resident is moved. 2. If the fall is unwitnessed neurological assessments will be conducted according to the neurological assessment policy. 3. Emergency care will be provided to the resident following appropriate procedures if necessary. Emergency care will be provided to any resident who has had head trauma unless the physician, resident, or family refuses such treatment. 4. Documentation will include incident report/event report completion, the nurses notes, and a fall investigation. 5. Documentation and the nurses notes will include physician and responsible party notification. Notification will occur within two hours if the fall resulted in an injury. 6. During this shift in which the fall occurred an initial review of the circumstances leading to the fall will be completed by the nurse on duty, an initial identification of the root cause of the fall will be determined, and an immediate new fall prevention intervention will be implemented. 7. Physician orders will be obtained and documented for any needed treatment for injury as a result of the fall. 8. The director of nursing[sic] will be notified immediately for any fall that results in significant injury or the needed for emergency medical care. 9. If the fall was a result of staff error, the nurse on duty will provide documented education to the staff on the shift during which the fall occurred. 10. For referral to therapy after a fall to prevent repeat occurrences should be considered. 11. Additional review of the fall will include a root cause analysis, causative factors, fall prevention interventions, care plan, and a fall risk evaluation will be completed. The care the plan[sic] will be updated to reflect the additional fall prevention interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Follow up resident assessment and documentation for 72 hours will be completed in the medical record. 13. Nursing staff will make appropriate interventions upon the completion of the report to prevent reoccurrence of a fall or to minimize injury. 14. A review and revision of the side rail assessment, physician order, and authorization should occur as needed. 15. IDT [interdisciplinary team] risk review of fall should occur during the daily clinical meeting, within 24 hours of the event, or by the next business day. Documentation of this review should be included in the resident’s clinical record. 16. The fall information will be added to the facility fall tracking list.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to accurately assess and notify the physician related to resident's pain and ineffectiveness of the prescribed pain medication for one resident (#38) of two sampled residents.Findings included:On 07/28/25 at 3:30 p.m. Resident #38 was observed sitting in the wheelchair in the resident's room. Resident #38 stated staff would not give acetaminophen because they had already given the resident something (for pain). Resident #38 reported a jabbing pain. The observation revealed a wound dressing to the left lower extremity.Review of Resident #38s admission Record showed the resident was admitted on [DATE] with a primary diagnosis of unspecified peripheral vascular disease. The resident's diagnoses included but not limited to cellulitis of left lower limb, unspecified systemic lupus erythematosus, unspecified site unspecified osteoarthritis, and cervical region spinal stenosis. Review of Resident #38's Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 14 of 15 indicating an intact cognitive status. The assessment revealed the resident had pain in the five days prior to the assessment, had not limited the resident's sleeping, rehabilitation therapy or day-to-day activities. The resident rated the worst pain felt was 8 of 10, 10 being the worst. On 07/30/25 at 1:28 p.m. Resident #38 explained (pronoun) was not getting pain medication on time and not wanting the prescribed opioid and they were making the resident suffer and wait. The resident reported telling staff of not wanting the prescribed opioid and asked why did they make (pronoun) suffer, the prescribed opioid did not work, and the alternative was 650 milligrams of acetaminophen. The resident stated therapy was going slow. An interview was conducted with Resident #38's assigned nurse Staff M, Licensed Practical Nurse (LPN) on 07/30/25 at 2:39 p.m. The staff member reported giving the (pain) medication to residents to see if the pain medication really wasn't working, then contacted the physician to let them know the pain medication isn't working. Staff M then reported an assessment was done to determine if pain medication was not working. Staff M, LPN stated Resident #38 had informed (pronoun) yesterday the opioid was not working, Staff M had contacted the physician and was waiting for a response and had not followed up on it. Staff M, LPN stated the residents pain scale assessments can be done whenever during the shift and always rates the pain a 1 (out of 10) since everyone has pain. An interview was conducted with Staff M, LPN on 07/30/25 at 2:55 p.m. Staff M, LPN stated (pronoun) the text message to the physician never went through regarding Resident #38's pain medication not working. Review of Resident #38's July Medication Administration Record (MAR) Resident #38's pain level related to the administration of Tramadol on 07/29/25 at 8:20 a.m. was a 7 and effective according to Staff M's documentation despite the staff member reporting Resident #38 had voiced the Tramadol was not working. Resident #38 did not receive any doses of acetaminophen on 07/29/25. Resident #38 had received another daily dose of Tramadol on 07/29/25 at 10:33 p.m. The MAR showed Resident #38 had not received any pain medication on 07/30/25. The MAR revealed no non-pharmacological interventions had been attempted with the resident. Review of Resident #38s care plan showed the resident was at risk for experiencing pain related to (r/t) osteoarthritis, spinal stenosis, (and) lupus. The associated interventions included:- Administer pain medication as per orders, give 1/ 2 hour before treatments or care as needed, initiated 7/14/25.- Encourage resident to report pain, initiated 7/14/25.- Monitor/ record/ report to nurse resident complaints of pain or request for pain treatment, initiated 7/14/25.- Notify physician if interventions are unsuccessful or if current compliant is a significant change from residents past experience of pain, initiated 7/14/25.- Provide non pharmaceutical pain interventions as indicated: repositioning, back rub, offer food/ drink, music, and adjust lighting/ temperature in room, initiated 7/14/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not ensure timely administration of medications, as prescribed by the medical provider, and did not ensure medications were administered by a medical professional for one Resident (#106) out of one resident reviewed. The facility also failed to administer scheduled psychotropic medication per physician orders for one resident (#110) out of five medication administration observations. Findings included: 1. On 07/28/25 at 2:35 p.m., an interview was conducted with Resident #106 and their family member. Resident #106 stated to speak with their family member due to them being able to, Speak faster and hear better. Resident #106 and the family member expressed the resident was not being administered blood pressure (BP) medications on a timely basis. Resident #106's family member explained Resident #106 had many issues with BP being high and had a systolic reading of 200 multiple times. The family member said Resident #106 is supposed to be provided Losartan 50 milligrams (MG) twice a day, as needed, anytime the residents had a systolic BP of 160 or greater. Resident #106's family member said they had given their personal prescription of hydralazine to Resident #106 whenever the resident's systolic BP was over 170. Resident #106's family member said they sometimes wait over an hour for the resident's medications to be administered. A review of documentation provided by the family member revealed a recent recording of a BP of 217/91 and then provided a dose of hydralazine. On 07/28/25 at 2:55 p.m., a follow-up interview was conducted with Resident #106 and family member. The family member said Resident #106's medications are to be administered every 6 hours but will self-administer the resident's hydralazine after it has been one in a half to two hours after the medications are passed due. The family member said Resident #106 is given hydralazine from previously prescribed medications. The family member said the nursing staff know Resident #106 is being provided the self-administered hydralazine. The family member stated, when they come late to give the medications, I tell them I gave it to the resident half an hour ago and not to give the resident a second dose. The family member confirmed the nursing staff has advised the family member not to do that, but the family member tells them they should have been on time with administering Resident #106's medications. A review of Resident #106's admission Record revealed an admission date of 07/22/2025 with diagnoses of muscle weakness, hyperlipidemia, hypothyroidism, chronic pain and difficulty in walking.A review of Resident #106's quarterly Minimum Data Set (MDS) assessment, dated 07/29/25, in section C - Cognitive Patterns revealed a Brief Interview for Mental Score (BIMS) of 14 out of 15, indicating the resident is cognitively intact. On 07/28/25 at 3:00 p.m., an interview with Staff I, Unit Manager (UM) was conducted and she said she does not know of any residents who self-administer medications. She stated none of the residents on her unit have been evaluated to self-administer medications. On 07/28/25 at 3:15 p.m., an interview with the Director of Nursing (DON) was conducted and she said she was not aware of Resident #106's family member self-administering medications due to late medication administration. On 07/28/25 at 3:25 p.m. an interview with the DON was conducted and she said she talked to Resident #106's family member who confirmed giving extra doses of hydralazine. She said the family member confirmed he made staff aware of him self-administering the medication and has asked for the BP monitoring to be changed from six hours to four hours daily. The DON said they reached out to Resident #106's physician to see if the order can be changed. She said she expected the nursing staff to document when the physician is spoken with. A review of Resident #106's medical record did not reveal documentation related to notifying the physician of late administration of medications and the reasoning for the late administration of medications. A review of Resident #106's care plan revealed the following, [Resident #106], has altered cardiovascular status, dx [diagnosis] of hypertension, hyperlipidemia . The resident will be free from s/sx [signs and symptoms] of complications of cardiac problems through the review date. Administer medications as ordered by physician. Vital Signs as ordered. Notify physician of any abnormal readings. A review of Resident #106's physician orders revealed the following: - Vital signs to be checked every shift, with a start date of 07/22/25. - Losartan potassium 100 mg tablet (tab), give 1 tablet by mouth two times a day for hypertension (htn), with a start date of 07/22/25. - Propranolol 20 mg tablet, give 1 tablet by mouth two times a day for hypertension, with a start date of 07/22/25. - Hydralazine 25 mg tablet, give 1 tablet by mouth every 8 hours for hypertension hold for systolic blood pressure (SBP) less than 110, with a start date of 7/29/25. A review of Resident #106's Medication Administration Audit Report from 07/22/25 through 07/29/25 revealed the following administration times to

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure an anti-anxiety medication had an appropriate indication for it's use for one resident (#10) out of five residents sampled.Findings included: During an observation on 07/29/2025 at 9:35 a.m., Resident #10 was observed in bed, eyes closed, dressed for the day. Review of Resident #10's admission Record revealed an admission date of 06/16/2025. Resident #10 was admitted to the facility with diagnosis to include Alzheimer's disease, unspecified, vascular dementia, moderate, with other behavioral disturbance, major depressive disorder, recurrent, unspecified severity, with other behavioral disturbance.Review of Resident #10's admission Minimum Data Set (MDS) dated [DATE] revealed Section N. Medications, Antipsychotic, Antianxiety, and Antidepressant.Review of Resident #10's physician orders revealed: A start date of 07/03/2025 for lorazepam oral tablet 0.5 milligrams (MG). Give one tablet by mouth every 12 hours related to Alzheimer's disease, unspecified.During an interview on 07/30/2025 at 12:02 p.m., Staff X, Certified Nursing Assistant (CNA) stated Resident #10 does not have any behaviors related to anxiety. She calls out to ask for help and is always looking for her husband. She does not have anxiety as far as she knows. During an interview on 07/30/2025 at 12:25 p.m., Staff T, Licensed Practical Nurse (LPN) stated when Resident #10 yells out, Resident #10 takes Ativan. Ativan is for anxiety. Alzheimer's is not an appropriate diagnosis for Ativan. During an interview on 07/30/2025 at 1:00 p.m., Staff I, LPN Nurse Manager, stated Ativan is for anxiety. Resident #10 screams and is always anxious. She reviewed Resident #10's order for Ativan and stated the diagnosis is Alzheimer's. That's how the orders came to them when she was admitted . Ativan is not normally prescribed for Alzheimer's. During an interview on 07/30/2025 at 2:51 p.m., the Director of Nursing (DON) stated the diagnosis for Resident #10's Ativan is Alzheimer and that is not appropriate. They reconcile residents' orders every day. They typically review newly admitted residents orders the day after they admit and would correct any errors. Review of the undated facility policy titled Psychotropic Medication Use revealed, Policy Statement Residents will not receive medications that are not clinically indicated to treat specific conditions. Policy Interpretation and Implementation, 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Antipsychotics; b. Antidepressants; c. Anti-anxiety medications; and d. Hypnotics. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes a. Indications for use;.4. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident signs and symptoms to identify underlying causes. Resident evaluations 1. Situations which may prompt an evaluation or reevaluation of the resident include a. admission or re admission, b. It is clinically significant change in condition/status; c. A new, persistent, or recurrent clinically significant symptom or problem; d. A worsening of an existing problem or condition; e. An unexplained decline in function or cognition. A new medication order or renewal of orders; or g. irregularity identified in the pharmacist medication regimen review.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations and interviews the facility did not ensure food service standards were followed related to hand hygiene and sanitary practices in the main kitchen and in one of three satellite kitchens. Findings included: On 07/28/25 at 9:10 a.m., an initial tour of the kitchen was conducted with the Associate Dining Director. An observation of Staff F, Utility Technician revealed he was using the high temperature dish machine. He was the only staff member using the dish machine during the observation. Staff F was taking the test strip out of a clear tube to check the temperature of the dish machine. He was observed to drop the test strip on the floor and used the same one to verify the final rinse temperature. During the observation he did not have gloves on. After dropping the test strip on the floor, he put the test strip in the water and determined the temperature was appropriate. Staff F, Utility Technician, did not perform hand hygiene after picking up the test strip from the floor and moving on to another task.On 07/28/25 at 9:15 a.m., an observation of Staff H, Dietary Aide revealed she was handling fruit by cutting and plating them on the food preparation table. Staff H, Dietary Aide took off her gloves and put new ones on. Staff H, Dietary Aide did not perform hand hygiene between taking off soiled gloves and putting new ones on. On 07/28/25 at 9:19 a.m., an observation of the prep refrigerator revealed a 16-ounce, clear plastic water bottle. The Associate Dining Director said it could belong to a resident. She said it should have been labeled with resident information. The Associate Dining Director was observed asking Staff H, Dietary Aide who it belonged to, and she responded that she did not know.On 07/28/25 at 9:21 a.m., an observation of the ice cream and bread freezer revealed there was a frozen 16-ounce, clear plastic water bottle. The Associate Dining Director said she did not know who it belonged to and confirmed it should not be there.On 07/28/25 at 9:23 a.m., an observation of the walk-in refrigerator revealed a box of vegetables with stems and leaves that appeared to be a faded green color with multiple black spots. The Associate Dining Director said those were the stems of tomatillo's and proceeded to take one out. An observation of the tomatillo revealed they were a mushy texture with multiple white and black spots. She stated, I didn't know they were like that.On 07/28/25 at 9:25 a.m., an observation of the walk-in freezer revealed ice build-up on top of a white box on the rack next to a box with raisin cinnamon thins. The Associate Dining Director said she was not aware of the ice build-up. She said the unit worked fine and did not have any issues.On 07/28/25 at 9:28 a.m., an observation of one of the racks in the dry storage area, next to multiple cartons of beverage thickeners, revealed a 16-ounce plastic water bottle with approximately 1/4 of liquid left. The Associate Dining Director did not know who it belonged to.On 07/29/25 at 9:21 a.m., an interview with Staff H, Dietary Aide was conducted, she said she switched gloves when cutting and separating fruit. She said she takes off her gloves and washes her hands in between preparation. She said the fruit she was handling on 07/28/25 was for all residents.On 07/29/25 at 11:41 a.m., an observation was conducted of Staff G, Dietary Aide who was moving food items from the meal cart to the steam table. Staff G, Dietary Aide was wearing gloves during the observation. She started taking the meal temperatures without performing hand hygiene. Staff G, Dietary Aide was observed touching the removable divider that was on another preparation table. Then, she put the divider on the steam table to separate two shallow pans of food items. Staff G, Dietary Aide then went back to taking temperatures of the food. Hand hygiene was not performed between changing tasks. Staff G, Dietary Aide was observed taking the temperature of minced and moist vegetables, then took the temperature of chicken without wiping the thermometer probe between the two food items. On 07/30/25 at 4:40 p.m., an interview was conducted with the Associate Dining Director. She said if the testing strip for the dish machine fell on the floor, she expected it to be thrown away. She said another one should have been used. The Associate Dining Director said Staff F, Utility Technician should have washed his hands if he had picked up the testing strip from the floor. She confirmed he was not wearing gloves during the observation. The Associate Dining Director said no staff should have anything personal such as drinks in resident-used refrigerators and freezers. She said there is an associate break room where they can store their personal items. She said staff are aware of those expectations through floor and computer training that she conducts herself or with the primary supervisor. The Associate Dining Director said the utility technician/dish washer or sous chef assisted with putting away vendor delivered items. She said herself or the primary supervisor reviewed the refrigerators and freezers. She said she conducted a daily and weekly audit which included taking pictures of food items. The Associate Dining Director said the observation of the tomatillo's were, not okay for them to be like that. Regarding the ice buildup observed on 07/28/25, she stated the vendor came today and, Something up in the ceiling

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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** Based on observations, record reviews, and interviews the facility failed to implement an effective infection control program related to the storage of urinary catheters for one resident (#104) of one resident sampled, failed to perform appropriate hand hygiene during the administration of medications for one resident (#33) of six residents observed during medication administration observation, failed to ensure one Staff (C) out of 25 staff fingernails were kept in a manner that allowed for hand hygiene to be completed in a sanitary manner, and failed to implement Enhanced Barrier Precautions (EBP) for three residents (#56, #58 and #11) of seven residents sampled for infection control practices. 1. Review of Resident #56's admission Record revealed an initial admission date of 04/17/2025. Resident #56 was admitted with diagnoses to include partial intestinal obstruction, unspecified as to cause, acute embolism and thrombosis of unspecified deep veins of left lower extremity, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, and peripheral vascular disease, unspecified. Review of Resident #56's Medicare 5-day Minimum Data Set (MDS) revealed Section M. Skin Conditions, revealed venous and arterial ulcers, skin tears, and application of nonsurgical dressings (with or without topical medications) other than to feet. Review of Resident #56’s physician orders revealed no orders for enhanced barrier precautions. 2. During an observation on 07/28/2025 at 12:23 p.m., Resident#58 was observed with a bandage to her left forearm dated 07/26/2025. Review of Resident #58's admission record revealed an admission date of 07/16/2025. Resident #58 was admitted to the facility with diagnoses of encounter for other orthopedic aftercare, spondylolisthesis, lumbar region, spinal stenosis, lumbar region without neurogenic claudication. Review of Resident #58's Medicare 5-day MDS dated [DATE] revealed Section M. Skin Conditions, surgical wound, skin tears, moisture associated skin damage (MASD), and application of nonsurgical dressings. Review of Resident #58’s physician orders revealed no orders for enhanced barrier precautions. 3. Review of Resident #11's admission Record revealed an admission date of 07/08/2025. Resident #11 was admitted to the facility with diagnosis to include unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing, presence of right artificial hip joint. Review of Resident #11's admission MDS dated [DATE] revealed Section M. Skin Conditions, surgical wound. Review of Resident #11’s physician orders revealed no order for enhanced barrier precautions. (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 Resident #11’s lab results revealed 07/25/25 Wound Culture: Heavy pseudomonas aeruginosa (Sens: aztreonam), Moderate E.coli. During an interview on 07/31/2025 at 10:50 a.m., the Assistant Director of Nursing (ADON) stated she is the one who decides what type of precautions, if any, a resident should be on. Residents who have indwelling devices, wounds with heavy draining that cannot be contained in a dressing, or they have a history of multi drug resistant organisms are put onto enhanced barrier precautions. Residents with wounds that have Methicillin/oxacillin-resistant Staphylococcus aureus (MRSA), Extended-spectrum beta-lactamases (ESBL), Vancomycin-resistant enterococci (VRE) and certain bacteria would be put on contact precautions. Residents with a surgical wound that is not draining would not be put on any barrier precautions. There is a bandage covering the surgical wound. “We follow the physicians orders and a lot of times they don’t want us to mess with the area. As long as the wound is not draining, they would not be put on any kind of barrier precautions.” Resident #11 had a wound culture done on 07/25/25 and they got the results on 07/28/25. The results came back positive for pseudomonas and Escherichia coli (E. coli) in the wound. That can be from contamination. Staff would need to be educated on hand hygiene. Resident #11 came in with a surgical wound. She came in with an aqua cell dressing. She was not on any precautions. I was out of on medical leave when she admitted to the facility so I’m not sure if her wound had drainage at that time. Resident #11 was put on contact precautions on 07/30/25 because of her lab results and her wound is draining. During an interview on 07/31/2025 at 11:22 a.m., Staff K, Registered Nurse (RN), Nurse Manager, stated residents with wound drainage, or any tube would be put on enhanced barrier precautions. If it is a dry wound, she would not put the resident on barrier precautions. Surgical wounds do not get any precautions unless it is draining. Contact precautions are mostly infections, like contact with E.coli, or pneumonia. They can also come in on contact isolation from the hospital and she would look at the admission forms and look at the discharge notes. Resident #11 has a right hip surgical wound. The nurse called her the last time she was doing a dressing change and noticed it was red and draining so they did a culture, and it came back positive for pseudomonas and Escherichia coli (E. coli). It could be from stool, the wound not being cleaned correctly, it could be from the linen, or it could be from their clothing. She was not on any precautions when she was admitted . The facility was asked to provide a policy related to enhanced barrier precautions and it was not provided. 4. On 07/28/25 at 11:40 a.m. an observation was made of Resident #104’s shared bathroom. The observation revealed a large urinary catheter drainage bag hanging from the shower’s handrail, urine was observed in the tubing, and the bag was near other items stored in the shower. An observation and interview were conducted on 07/28/25 at 11:46 a.m. with Staff P, Certified Nursing Assistant (CNA) of the urinary drainage bag in the shower. Staff P observed the drainage bag hanging from the handrail and stated it was Resident #104s bag. Review of Resident #104’s admission Record revealed the resident was admitted on [DATE]. The record included diagnoses not limited to benign prostatic hyperplasia without lower urinary tract symptoms, displaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, and unspecified subsequent encounter fall on same level. (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 Resident #104s care plan showed the resident had a urinary catheter related to neuromuscular dysfunction of bladder, initiated on 7/28/25. The interventions did not address storage of the drainage bag when not in use. An interview was conducted on 07/30/25 at 1:19 p.m. with Staff Q, CNA, who was assigned to Resident #104. The staff member stated the resident does have a foley urine catheter, (pronoun) checks the resident in the morning, takes the large (drainage) bag off and puts on the resident’s leg bag. Staff Q stated the (large) drainage bag was placed in a plastic bag and stored in the resident’s bin in the bathroom. A large drainage bag was observed in a plastic bag in a drawer of a plastic drawer system in the bathroom. During an interview on 07/30/25 at 2:39 p.m. Staff M, Licensed Practical Nurse (LPN) stated as far as (pronoun) knows “they” put the drainage bag in a bag and store it in the bathroom after draining it. The staff member stated it was not appropriate to hang the drainage bag from the handrail in the bathroom. An interview was conducted on 07/30/25 at 3:30 p.m. with the Director of Nursing (DON). The DON stated the process was the drainage bag is removed, placed into a plastic bag, and stored in a drawer. She stated hanging from the handrail in the bathroom was not appropriate. During an interview on 7/31/25 at 11:22 a.m. the Infection Preventionist (IP) stated a urine drainage bag could be re-used if not dirty, stored in a plastic bag (when not in use), and should not be stored hanging from the handrail in the shower, “not appropriate”. Review of the policy – Urinary Catheter Care, copyrighted 2001, revealed “The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.” The general guidelines included but not limited to: Infection Control: 1. Use aseptic technique when handling or manipulating the drainage system. 2. Be sure the catheter tubing and drainage bag are kept off the floor. The policy did not address storage of a drainage bag when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. An observation was conducted on 07/29/25 at 4:10 p.m. with Staff J, LPN of the administration of medication for Resident #33. The staff member dispensed three oral medications, removed a paper tray from the bottom drawer of the medication cart and placed a blue barrier inside of it. The staff member donned gloves, without hand hygiene, removed a bleach wipe from a container and wrapped a glucometer in it before placing it on the barrier. Staff J placed a bottle of glucose testing strips and lances on the barrier and removed gloves (no hand hygiene) before entering the residents room. The staff member returned and assisted the resident with a cup of water, donned gloves (no hand hygiene), removed bleach wipe from glucometer. The staff member obtained a blood glucose level from the resident’s right ring finger. Staff J returned to the med cart, donned gloves (no hand hygiene), cleaned the glucometer with bleach wipe, removed gloves (no hand hygiene) and propelled the resident to the dining room in wheelchair, unwrapped the resident’s dining utensils and placed a napkin in the resident’s lap, then returned to the medication cart. The staff member donned gloves (no hand hygiene), took a blue barrier from drawer, placed it in the paper tray, and placed the glucometer on top of the barrier. The staff member accessed Resident #33’s medication profile saying the resident was to receive insulin per sliding scale. The nurse returned the resident to the room and completed hand hygiene with hand sanitizer. The staff member removed the resident’s bottle of insulin, asked the resident where (pronoun) would like the injection, and donned gloves. The staff member drew up insulin, laid an orange syringe cap on the cart, and inserted the needled syringe into the cap while holding it, removed gloves (no hand hygiene) and donned gloves. The staff member injected the resident, returned to the medication cart, and completed hand hygiene. An interview was conducted with Staff J, LPN on 07/29/25 at approximately 4:40 p.m. The staff member stated hand hygiene was supposed to be done before and after care of each patient and before and after glove use. The staff member confirmed hand hygiene was not done after each glove use. 6. On 07/30/25 at 8:42 a.m. an observation was conducted of Staff C, LPN, standing at a medication cart, dispensing medications. The observation showed the staff member had lavender-tipped fingernails extending ¾ to one inch past the fingertip. Staff C reported knowing (pronoun) fingernails needed to be cut, just got back from vacation and had wanted them to match hair. The staff members hair had untethered purple curls extending to mid-back. On 07/30/25 at 9:03 a.m. an observation was conducted with Staff C, LPN for the administration of medications for Resident #110. The staff member moved the medication cart in front of the resident’s room, placed a blue barrier on the cart, and opened the top drawer, the staff member’s hair drifted into the top drawer of the med cart. Review of Resident #110’s July Medication Administration Record (MAR) showed Staff C, LPN had previously administered seven of eight Sertraline doses to the resident between the dates of 07/22 and 07/29/2025 and documented the resident had refused the dose on 07/30/25. During an interview on 07/31/25 at 11:22 a.m. the Infection Preventionist (IP) reported educating staff on hand hygiene on a weekly basis. The IP stated staff should perform hand hygiene before and after giving medication to a resident using hand sanitizer or washing hands, after removing gloves staff need to use hand sanitizer. Review of the observation with Staff J, LPN during medication administration and lack of hand hygiene, the IP stated donning and doffing (removing) gloves without hand sanitizing was not appropriate and syringes should not be recapped. The IP stated fingernails need to be short and demonstrated when holding palm towards face should not be able to see the back of fingernail, color should be neutral, cannot be long or have diamonds, and should not be fake. (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 Centers of Disease Control and Prevention (CDC) guidance – Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, revealed the Key Points was to “Protect yourself and your patients from deadly germs by cleaning your hands” and “All healthcare personnel should understand how to care for and clean their hands.” The guidance showed “Cleaning your hands reduces: the potential spread of deadly germs to patients, the spread of germs, including those resistant to antibiotics, and the risk of healthcare personnel colonization or infection caused by germs received from the patient.” The guidance addressed when to wear (and change) gloves revealing “Gloves are not a substitute for hand hygiene.” - If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. - Always clean your hands after removing gloves. The guidance addressed maintaining fingernail and jewelry safety: - Natural nails should not extend past the fingertip. - Do not wear artificial fingernails or extensions when having direct contact with high-risk patients like those at intensive care units or operating rooms. o Germs can live under artificial fingernails both before and after using an alcohol- based hand sanitizer and hand washing. 7. On 07/28/25 at 9:24 a.m. Staff O, Certified Nursing Assistant (CNA) was observed coming out of Resident #38’s room with a bag of linen. The area outside of the resident’s room did not have an available personal protective equipment (PPE) caddy and there was not one nearby. Review of Resident #38’s admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified peripheral vascular disease and cellulitis of left lower limb. Review of the Skin & Wound Evaluation, effective 7/22/25 at 11:31 a.m. revealed the resident had a left medial proximal malleolus venous ulcer that was present on admission. The wound measured 3.6 x 2.4 x 0.2 centimeter (cm), with 50% granulation and 50% slough, moderate serosanguineous exudate, and erythema of surrounding tissue. The treatment consisted of enzymatic debridement, calcium alginate, and a silicone secondary dressing. On 07/28/25 at 9:39 a.m. Staff K, Registered Nurse (RN) Manager was observed placing a PPE caddy outside Resident #38’s door. The staff member stated on 7/28/25 at 9:41 a.m. that (pronoun) decides who gets put on Enhanced Barrier Precautions based on wound care providers documentation, Resident #38 had a vascular wound that the wound providers visited last Tuesday (7/22/25) and the staff member had reviewed last night. On 07/28/25 at 9:45 a.m. Staff O, CNA was observed dressing in a PPE gown outside of Resident #38’s room, the staff member reported being in the room this morning without PPE, prior to the placement of the PPE cart, and did not know how long the resident had a wound. (continued on next page)

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	105866	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza West	912 American Eagle Blvd Sun City Center, FL 33573

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/28/25 at 4:06 p.m. Resident #38 was observed with a dressing to left lower leg dated 07/27/25 and initialed “MV”. During an interview on 07/31/25 at 11:22 a.m. the IP stated the CDC recommends the use of EBPs to prevent infection to the resident, they aren’t infected but we may be infected. The IP stated anybody with an indwelling catheter, wound vacuum (vac), percutaneous endoscopic gastrostomy (PEG), peripherally inserted central catheter (PICC)/midline, Jackson Pratt (JP) drain, (and/or) any type of drain should be placed on EBP. She stated anybody with a wound with a lot of drainage that cannot be contained with a dressing, if they are draining a lot they would be exposed and then placed on EBP. Supervisors know when to put (a resident) on EBP and when they have a lot of drainage that cannot be contained by a dressing, moderate or severe drainage, so there’s a risk of the drainage causing the dressing to fall off, get saturated and the dressing falls off. The IP reviewed the EBP policy stating Resident #38 should have been on EBP prior (to observation), EBP should have be placed at admission. The IP stated during an admission nurses can place a resident on barrier precautions. Review of the facility policy – Enhanced Barrier Precautions, revised March 22, 2024 revealed “Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents.” The policy interpretation and implementation included but not limited to: 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resist organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied before performing the high-contact resident care activity (as opposed to before entering the room). 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: a. Dressing; b. Bathing/ showering; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc.); and h. Wound care (any skin opening requiring a dressing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/ or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident stay or until resolution of the wound or discontinuation of the indwelling medical device that places them increased risk. 9. Staff are trained prior to caring for residents on EBPs. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available near or outside of the resident rooms. Review of the CDC guidance – Implementation of Personal Protective Equipment (PPE) us in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms (MDROs), dated 4/2/24, showed the Key Points: how to implement personal protective equipment (PPE) use in nursing homes to prevent spread of multi-drug resistant organisms (MDROs). The updates as of 7/12/22 showed: 1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased health care costs. 2. Enhanced barrier precautions (EBP) alright an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: a. Wounds are indwelling medical devices, regardless of MDR O colonization status; b. Infection or colonization with an MDR O. 4. Effective implementation of BP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. The guidance described Enhanced Barrier Precautions: “Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.” Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing. “Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.” The CDC guidance revealed when implementing EBP signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves and to make PPE, including gowns and gloves, available immediately outside of the resident room. Review of the policy – Infection Prevention and Control Program, revised on October 2018, showed “An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections.” 1. The infection prevention and control program is developed to address the saw this specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. 2. The Program is based on accepted national infection prevention and control standards. 3. The infection prevention and control program is a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. 11. Prevention of Infection: a. Important facets of infection prevention include: (1) identifying possible infections or preferential complications of existing infections; (2) instituting measures to avoid complications or dissemination; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) educating staff and ensuring that they adhere to proper techniques and procedures; (4) communicating the importance of standard precautions and cough etiquette to visitors and family members; (5) enhancing screening for possible significant pathogens; (6) immunizing residents and staff to prevent illness; (7) implementing appropriate isolation precautions when necessary; and (8) following established general and disease specific guidelines such as those of the Centers for Disease Control (CDC).