STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115621	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryan County Hlth & Rehab Ctr	127 Carter St Richmond Hill, GA 31324

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41914 Based on observations, staff interviews, record review, and the review of the facility policies titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol and Residents Federal and State Rights, the facility failed to ensure four of eight residents (R) (R37, R84, R11, and R45) were provided privacy during wound care treatment. Specifically, the facility failed to ensure R37, R84, R11, and R45 full privacy was provided by ensuring window blinds were closed and the privacy curtains were fully engaged when conducting wound care treatments. Findings include: Review of the facility policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated April 2018 on page 5: Dressings, Dry/Clean under preparation. number 5. Explain procedure to the resident and provide privacy. Review of the facility's undated policy titled, Residents Federal and State Rights, revealed under Privacy and Confidentiality number 1. You have a right to personal privacy and confidentiality of your personal privacy which includes privacy in accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and residents groups.Number 5. You have a right to respect and privacy in your medical, personal, and bodily care program. Your care discussion, consultation, examination, treatment, and care shall be confidential and shall be conducted in privacy. 1. Record review for R37 revealed resident was admitted to the facility with the diagnoses of but not limited to generalized muscle weakness, lack of coordination, moderate protein calorie malnutrition, and pressure ulcer of sacral region stage four. Review of the physicians orders located in the Electronic Medical Record (EMR) revealed a treatment order for the Sacrum: Cleanse with normal saline, pat dry, apply Santyl (wound ointment) then collagen, cover with dry protective dressing such as bordered gauze daily and PRN (as needed) per dislodgement/soiling. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for R37 revealed under focus: R37 has present skin breakdown as follows and is at risk for complications related to skin breakdown such as infection, increased pain, inability to participate in activities and socialization, anxiety/mood disorders. Coccyx: Stage 4 pressure wound. Goals included: Present skin breakdown will be healed without complications by next review date. Wound care observation on R37 on 4/12/ 2025 at 11:05 am with the Wound Care nurse revealed the nurse proceeded to cleanse wound care tray with a Micro-kill germicidal wipe and allowed to air dry, after the tray was dry, the nurse proceeded to place a barrier on the tray before placing wound treatment supplies on it for treatment that included normal saline in a 30 ml (milliliter) cup, Medi fil II Collagen, Santyl ointment (the two were mixed together in 30 ml plastic medicine cup to make a paste), dry gauze, and bordered gauze. The Wound Nurse proceeded to sanitize hands with hand sanitizer and donned (put on) a gown and clean gloves after entering the residents room. The Wound Nurse informed R37 that wound care treatment was being completed and permission for surveyor to observe was obtained. The Wound Nurse pulled the privacy curtain; however the residents' blinds were pulled up with full view from the courtyard. During the observation it was noted that full privacy was not provided to the resident while treatment was being conducted. Interview on 4/12/2025 at 11:30 am with the Wound Care Nurse revealed that she was able to verbalize the process of the wound care treatment process. During the interview, the Wound Care Nurse acknowledged that full privacy was not provided for R37 during the wound dressing change. The staff member stated that she was not thinking about closing the blinds while the treatment was being conducted. Interview on 4/12/2025 at1:30 pm with the Director of Nursing (DON) revealed that her expectations was for whenever there was any kind of care being provided to the residents, that full privacy was provided, including the full engagement of the privacy curtains and ensuring that the blinds were closed for residents that were next to the window. During the interview, the DON also disclosed that infection control practices were expected to be followed during wound care treatments. 41165 2. Record review for R84 revealed resident was admitted to the facility with the diagnoses of but not limited to dementia, history of falling, essential hypertension, hyperkalemia, lack of coordination, and unsteadiness on feet. Review of the physician's order in the EMR revealed an order to cleanse the sacral area with normal saline, pat dry, apply Santyl, cover with dry protective dressing daily and prn per dislodgement/soiling. Review of the care plan revealed a focus of R84 has present skin breakdown upon admission and is at risk for complications related to skin breakdown such as infection, increased pain, inability to participate in activities and socialization Unstageable to Sacrum Stage III L (left) Upper Buttock. Goals included present skin breakdown will improve without complications by next review date. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound care observation of R84 on 4/12/2025 at 10:40 am with Wound Care Nurse revealed the nurse proceeded to cleanse the wound care tray with a Micro-kill germicidal wipe and allowed it to air dry, after the tray was dry the nurse proceeded to place a barrier on the tray before placing wound treatment supplies for treatment that included normal saline in a 30 ml (milliliter) cup, Santyl ointment (wound ointment), Medi-honey (wound medication), bordered gauze, Medi-pore tape, dry gauze, tongue blades, measuring tape, and a bag for dirty wound products used. The Wound Care Nurse proceeded to sanitize hands with sanitizer and donned a gown and clean gloves after entering the resident's room. The Nurse informed R84 that wound care treatment was being completed and permission for surveyor to observe was obtained. R84's bed was repositioned and the nurse proceeded to remove the G-tube (gastrostomy tube-inserted into abdomen for feeding) dressing from stoma (opening in abdomen) site without providing privacy. The resident's privacy curtain remained open in view of the resident's roommate as well as the blinds were open during the start of the treatment. After removing the dressing from the insertion site and cleaning the treatment area, the nurse proceeded to wash hands with soap and water and donned clean gloves before applying a clean dressing. R84's brief was loosened, and the resident was repositioned to the right side, curtains still open and window blinds open as well. The old dressing was removed, no drainage was noted on the dressing removed. The area to the sacral wound base was pale pink in color, area measured 1 x .03 cm (centimeters) x .01 cm, no drainage was noted during observation. The nurse proceeded to wash hands with soap and water and donned clean gloves before applying a clean bandage. R84was repositioned back to his back. The Wound Care Nurse completed the treatment on R84 without providing privacy during the total process. 3. Record review for R11 revealed resident was admitted to the facility with diagnoses of but not limited to cerebral infarction, unspecified, unspecified diabetes mellitus without complications. Review of the physician's order in the EMR revealed the following order: Lt (left) Ankle Lateral (away from middle or center): Cleanse with WC (wound cleanser) or NS (normal saline), pat dry, apply gentamicin 0.1% ointment, cover with dry protective dressing such as ABD (abdominal) pad then rolled gauze with tape daily and PRN per dislodgement/soiling. Wound care observation for R11 at 11:48 am, performed by Licensed Practical Nurse (LPN) II revealed LPN II sanitized her hands, donned gloves, sanitized plastic tray, placed a paper chux (protective pad) pad on top of the tray, and then removed a bottle of saline, 30cc (cubic centimeter) plastic cup, gauze, bordered dressing, rolled gauze, and gentamycin ointment from the treatment cart and placed the items on top of the tray. LPN II stated that she was not going to use the rolled gauze as ordered because when R11 rubs her legs together it might come off. She stated that she knew that there was a PRN order to replace if dressing becomes dislodged, but she did not do it because she didn't use the rolled gauze. LPN II removed gloves, sanitized hands, donned gloves, put on a gown, and repositioned R11 in the Geri-chair (geriatric recliner). LPN II removed the boot from R11's left foot and asked the resident where the dressing to her left foot was. R11 was sitting in a Geri-chair near the window. The window blinds were observed to be open. The window showed full vision of the front parking lot and front porch. There were visitors entering and exiting the facility. There was a resident sitting in the front parking lot in her wheelchair facing R11's room window. LPN II continued with wound care, cleaning the area to the left heel. LPN II washed hands, donned gloves, and applied gentamycin ointment as per MD order. LPN II covered the wound with a bordered dressing. LPN II again stated that she was not going to use the ordered rolled gauze. LPN removed gloves, removed gown and placed the gown in a trash can. LPN II removed the gown from the trash can and exited the room stating that she was going to put the gown in the laundry. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Record review for R45 revealed resident was admitted to the facility with the diagnoses of but not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region. Review of the physician's order in the EMR revealed the following order to Sacrum Wound: Cleanse with NS, pat dry, apply Santyl then collagen, cover with dry protective dressing such as bordered gauze dressing daily and PRN per dislodgement/soiling. Wound care observation for R45 on 4/12/2025 at 11:26 am revealed LPN II sanitized her hands, donned gloves, sanitized plastic tray, and placed a paper chux pad on top of the tray. LPN II removed a bottle of saline, 30cc plastic cup, gauze, bordered dressing, Santyl, and collagen paste from the treatment cart and placed the items on top of the tray. LPN II removed gloves, sanitized hands, donned gloves and gown. LPN II removed the gown and threw it in the trash can stating that she forgot the gauze. LPN II returned to the treatment cart, sanitized hands and removed 4x4 gauze from the treatment cart. LPN II returned to the room, sanitized hands, donned gloves and gown. LPN II placed the tray with treatment supplies on top of R45's feet. LPN II removed the tray from R45 feet and held the tray in her right hand. LPN II, while holding the tray in her right hand, used her left hand to unclamp R45's catheter bag from the bed. LPN II threw the catheter bag on the bed near R45 feet. LPN II again placed the tray on R45's bed near her right foot. LPN II rolled R45 on to her left side, removed gloves, washed her hands and donned gloves. LPN II removed the old dressing, removed gloves, washed her hands, and donned gloves. The window blinds were observed to be open. The window showed full vision of the front parking lot and front porch. There were visitors entering and exiting the facility. There was a resident sitting in the front parking lot in her wheelchair facing R45's room window. LPN II continued with wound care cleaning the sacral area. LPN II measured the area, removed gloves, washed hands, donned gloves and applied the Santyl/collagen mixture as per order, and covered area with a dressing. LPN II removed the tray from R45's bed and held it in her left hand. With her right hand, LPN II attached the foley catheter bag back to the bed. With the tray in her left hand, LPN II moved the bed side table, removed gloves, and put tray on top of treatment cart. LPN II then removed the gown and threw it in the trash can. With ungloved hands, LPN II removed two gowns from the trash can and folded them up and exited the room with the unbagged gowns, stating that she was taking the gowns to the laundry because they were re-washable. LPN II did not wash/sanitize hands after removing gloves, and did not sanitize the tray before placing it back on the treatment cart. Interview with LPN II on 4/12/2025 at 3:32 pm revealed LPN II acknowledged that full privacy was not provided for R11, and full privacy was not provided for R45 during the wound dressing change . LPN II stated that she was not thinking about closing the blinds while the treatment was being conducted, but she did ask the residents if it was ok for the surveyor to watch the treatment. Interview with the Director of Nursing (DON) on 4/12/2025 at 3:47 pm, the DON stated that her expectation was for privacy to be provided to the residents during wound care to include closing the privacy curtains and closing the window blinds.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49681 Based on observations, record review, staff interviews, and review of the facility policy titled, Environment Rounds/Repairs, the facility failed to ensure that the environment was safe, clean, comfortable, and homelike in two rooms on A hall (room [ROOM NUMBER] and room [ROOM NUMBER]) located on two of four halls. Specifically, plaster on the wall was missing and cracked in two areas on Hall C, and chipped floor tile, black marks on privacy curtains, and a dirty feeding pump pole were noted on hall A. Findings include: 1. Review of the facility policy titled Environmental Rounds/ Repair revealed under Policy Statement: name of facility is committed to maintaining a home-like environment and to repair issues in acceptable time frame. Under Procedures: Maintenance Director will make environmental rounds every week. Any noted areas that are in need of repair will be repaired as soon as possible.Facility also has a part-time painter employed who is available to repair sheet-rock issues and paint and/or retouch as needed. Observation on 4/12/2025 at 9:51 am on C hall before entering D Hall by the double doors, the corner wall needed to be repaired. Plaster was missing and cracked in the area before the handrail. The wall near room [ROOM NUMBER] had missing plaster. Interview on 4/13/2025 at 11:28 am with the Maintenance Director confirmed that the plaster needed to be repaired on both walls and that he would repair both walls. He stated that staff could have reported this using the facility name Repair Requisition form. He revealed that this form could be completed by any staff. This form could be found behind the nurse's station. 41165 2. During the initial tour of the facility on 4/11/2025 at 8:40 am the following environmental concerns were observed on A hall: room [ROOM NUMBER] revealed chipped floor tile near A bed, and the privacy curtain observed with black marks on the front and yellowish stains on the back. room [ROOM NUMBER] revealed a feeding pump with a dried, brownish substance on the pole. There was also a dried, brownish substance observed on the floor around and near the feeding pump pole. Observations throughout the day revealed the environmental issues remained. Observations on 4/12/2025 at 7:30 am revealed environmental issues remained. Environmental issues (dried substance on feeding pump, pole) observed were verified by Housekeeper (HK) CC on 4/12/2025 at 9:30 am. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Environmental issues (dried substance on feeding pump, pole, floor, privacy curtain) observed were verified by the Director of Nursing on 4/12/2025 at 9:58 am. Environmental issues (dried substance on feeding pump, pole, floor, privacy curtain) were verified with the Housekeeping Supervisor HK BB on 4/12/2025 at 10:44 am. Environmental issues (chipped floor tile) were verified with the Maintenance Director (MD) on 4/13/2025 at 8:58 am. Interview with HK CC on 4/12/2025 at 9:30 am revealed HK CC just finished mopping the room and placed a wet floor sign at the door. HK CC stated that the brownish substance on the floor and feeding pump and pole looked like milk that had dried up. She stated that she would probably be the one to clean it up. She stated that she mops fast because the Certified Nursing Assistants (CNA) were in and out the room. Interview with the Director of Nursing (DON) on 4/12/2025 at 9:58 am, the DON stated that the nurses were responsible for cleaning the feeding pump and pole. She stated that housekeeping was responsible for cleaning the floor. The DON further stated that the brownish substance observed on the feeding pump, pole, and floor looked like dried tube feeding formula. Interview with the Housekeeping Supervisor HK BB on 4/12/2025 at 10:44 am, HK BB revealed she expected the housekeepers to clean the floor. She stated that maintenance takes the curtains down and changes them. Interview with the Maintenance Director (MD) on 4/13/2025 at 8:58 am revealed he was not aware of the chipped floor tile. He stated that they have a box with communication slips that staff used to communicate any maintenance/environmental issues. He revealed there was no slip addressing the chipped floor tile.

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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. 41914 Based on observations, staff interviews, record review, and review of the facility policies titled, Care Planning- Interdisciplinary Team and Care Plans, Comprehensive Person-Centered, the facility failed to ensure a care plan for oxygen use was developed for one of nine residents (R) (R52) using oxygen. The facility also failed to ensure a care plan was developed for one of three residents, R35 that had an indwelling catheter. The deficient practice had the potential to increase the probability of R52 and R35's needs not being met according to their care needs. Findings include: Review of the facility policy titled Care Planning- Interdisciplinary Team dated March 2022 revealed under Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Under Policy Interpretations and Implementation number 2. Comprehensive person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). Review of the facility policy titled Care Plans, Comprehensive Person- Centered dated March 2022 revealed under Policy Statement: A Comprehensive, person-centered care plan that includes measurable objectives and time tables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each residents. 1. Record review revealed R52 was admitted to the facility with diagnoses of Parkinson's disease, essential hypertension, anxiety disorder, and depression. Review of the physician orders located in the Electronic Medical Record (EMR) system under orders revealed an order for oxygen (02) via nasal cannula (NC) at 2 liters per minute (LPM) as needed for Shortness of Breath (SOB), wheezing or 02 Saturations (Sats) <92% (under 92 percent). Review of the care plan for R52 did not indicate O2 use was being utilized. Review of the Quarterly Minimum Data Set (MDS) for R52 dated 2/28/2025, Section O (Special Treatments) indicated that resident was receiving O2 therapy while in facility. Review of the resident care plan initiated 12/2024 did not indicate O2 use for R52. Interview on 4/12/2025 at 3:10 pm with MDS Coordinator DD revealed that the MDS team were responsible for ensuring that the resident's care plans were developed and updated. During the interview, it was confirmed that R52 did not have a care plan developed for the current use of O2. Interview on 4/12/2025 at 3:30 pm with the Director of Nursing (DON) revealed that her expectation was for each resident to have a comprehensive care plan that identified all of their care areas and to ensure the residents' needs were met. During the interview it was confirmed that R52 did not have a care plan that was developed in reference to her O2 usage. 41165 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed R35 was admitted to the facility with diagnoses of but not limited to displaced fracture of greater trochanter of left femur, subsequent encounter for closed fracture without healing, chronic kidney disease, stage 3, unspecified, cystitis, unspecified with hematuria. Review of the physician orders for R35 located in the EMR system under Orders revealed an order for an indwelling foley catheter for Urinary Retention, 16 fr (French- catheter size) with 10 ml (milliliter) balloon to bedside drainage. Review of the Quarterly MDS for R35 dated 1/9/2025 Section H (Bladder and Bowel) indicated that resident had an indwelling foley catheter. Review of the resident care plan last revised on 2/15/2025 did not indicate R35 had an indwelling foley catheter. Interview on 4/12/2025 at 4:12 pm with MDS Coordinator DD revealed that the MDS team were responsible for ensuring that the resident's care plans were developed and updated. She stated that she communicated with the nursing team, but MDS was responsible for putting the foley catheter in the care plan. During the interview, it was confirmed that R35 did not have a care plan developed for an indwelling foley catheter. MDS Coordinator DD stated that she was going to put a care plan in for R35. Interview on 4/12/2025 at 4:30 pm with the DON revealed that her expectation was for each resident to have a comprehensive care plan that identified all of their care areas and to ensure the residents needs were met. During the interview it was confirmed that R35 did not have a care plan that was developed for indwelling foley catheter.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 41165 Based on observations, record review. and staff interviews, the facility failed to follow the Physician Orders related to wound care for one of four residents observed during wound care (R11). The deficient practice had the potential for R11's wound to worsen. Findings include: Record review for R11 revealed resident was admitted to the facility with diagnoses of but not limited to cerebral infarction, unspecified, unspecified diabetes mellitus without complications. Review of the Physician's orders in the Electronic Medical Records (EMR) revealed the following order: Lt (left) Ankle Lateral: Cleanse with WC (wound cleanser) or NS (normal saline), pat dry, apply gentamicin 0. 1% ointment (antibiotic), cover with dry protective dressing such as ABD (abdominal) pad then rolled gauze with tape daily and PRN (as needed) per dislodgement/soiling. Wound care observation for R11 on 4/9/2025 at 11:48 am performed by Licensed Practical Nurse (LPN) II revealed she sanitized her hands, donned (put on) gloves, sanitized plastic tray, placed a paper incontinence pad on top of the tray, and removed a bottle of saline, 30 cc (cubic centimeters) plastic cup, gauze, bordered dressing, rolled gauze, and gentamycin (antibiotic) ointment from the treatment cart and placed the items on top of the tray. LPN II stated that she was not going to use the rolled gauze as ordered because when R11 rubs her legs together it might come off. She stated that she knew that there was a PRN (as needed) order to replace if dressing becomes dislodged, but she did not do it because she didn't use the rolled gauze. LPN II removed gloves, sanitized hands, donned gloves, put on a gown, and repositioned R11 in the Geri-chair (geriatric recliner). LPN II removed the boot from R11's left foot and asked the resident where the dressing to her left foot was. LPN II continued with wound care cleaning the area to the left heel. LPN II washed hands, donned gloves, and applied gentamycin ointment as ordered. LPN II covered the wound with a bordered dressing. LPN II again stated that she was not going to use the ordered rolled gauze. LPN removed gloves, removed gown, and placed the gown in a trash can. LPN II removed the gown from the trash can and exited the room stating that she was going to put the gown in the laundry. Interview with the Director of Nursing (DON) on 4/12/2025 at 4:00 pm, the DON stated that the nurses must follow physician's orders. She stated that if physician's orders were not followed, it was a delay in care and would be neglect.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49675 Based on observations, staff interviews, and record review, the facility failed to ensure an environment free from potential accident hazards by failing to properly secure an oxygen (O2) tank for one of 10 residents (R) (R28) receiving oxygen therapy. The deficient practice had the potential to harm R28 or other residents that could come in contact with the unsecured O2 tank. Findings include: A policy on accident hazards was requested, however the Director of Nursing (DON) revealed the facility did not have one. Review of R28's electronic medical record (EMR) revealed the resident was admitted with diagnoses of but not limited to acute respiratory distress and heart failure, unspecified. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of Physician order's for R28 revealed an order dated for Oxygen as needed at two liters per minute (LPM). Observations on 4/11/2025 at 9:00 am and 3:00 pm revealed a free-standing, unsecured O2 tank located behind the resident's bed. Observation on 4/12/2025 at 9:15 am revealed a free-standing, unsecured O2 tank located behind the resident's bed. Interview on 4/12/2025 at 10:16 am with Certified Nurse Assistant (CNA) KK revealed that free- standing O2 tanks should not be stored in residents' rooms. She revealed that she must have forgotten to remove it after patient care. She revealed a free-standing tank could easily fall and injure someone. Interview on 4/12/2025 at 10:18 am with Registered Nurse (RN) II revealed she was unsure if the free-standing O2 tank should be in the resident's room because she had only been employed for four days. After asking another nurse, she revealed that a free-standing tank should not be stored in a resident's room due to the risk of injury. She revealed gases could escape and someone could be injured, and it could fall and hit the floor and cause injury. She had a CNA remove the tank. Interview on 4/12/2025 at 10:22 with the Director of Nursing (DON) revealed under no circumstances should a free-standing O2 tank be stored in a resident's room. She revealed the resident was admitted back into the facility with the tank approximately two weeks ago and the facility was waiting for an O2 concentrator, which was already present and working. She revealed the tank should have been removed from the resident's room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41914 Based on observation, staff interview, and review of the facility policy titled, Oxygen Administration, the facility failed to ensure one of nine residents (R) (R52) oxygen (O2) was administered as ordered by the physician. Specifically, the facility to failed to ensure R52's O2 rate was set on 2 liters per minute (LPM) instead of 4 LPM via nasal cannula (NC). Findings include: Review of the facility policy titled, Oxygen Administration, dated October 2010 revealed under Preparation, number 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Record review revealed R52 was admitted to the facility with diagnoses of Parkinson's disease, essential hypertension, anxiety disorder, and depression. Review of the physician orders for R52 located in the Electronic Medical Record (EMR) system under Orders revealed an order for oxygen (02) via nasal cannula at 2 liters per minute as needed for Shortness of Breath (SOB), wheezing or 02 Saturations (Sats) <92% (under 92 percent). Review of the care plan for R52 did not indicate O2 was being utilized. Review of the Quarterly Minimum Data Set (MDS) for R52 dated 2/28/2025 Section O (Special Treatments) indicated that resident was receiving oxygen therapy while in facility. Observation on 4/11/2025 at 8:30 am revealed R52's O2 concentrator set on 4 LPM. Resident was receiving O2 via NC. Observation on 4/11/2025 at 3:00 pm revealed R52's O2 concentrator set on 4 LPM. Resident continued to receive O2 via NC. Observation on 4/12/2025 at 11:30 am revealed R52's O2 concentrator set on 4 LPM. Resident was receiving O2 via NC. Interview on 4/12/2025 at 11:35 am with Licensed Practical Nurse (LPN) AA revealed that the charge nurses were responsible for ensuring that the residents that were receiving O2 were receiving O2 as ordered by the physician. LPN AA confirmed that R52's O2 was set on 4 LPM and the order was for O2 to be delivered at 2 LPM as needed. Continued interview revealed that the O2 levels were checked once a day and that R52's concentrator had not been checked for the day. Interview on 4/12/2025 at 3:30 pm with the Director of Nursing (DON) revealed that residents that were receiving O2 therapy flow rates should be checked throughout the day to ensure that the correct amount of ordered O2 was being delivered. During the interview the DON confirmed that R52 had a current order for O2 at 2 LPM and not 4 LPM. The DON also confirmed that R52 did not have a care plan that addressed the use of O2 therapy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49681 Based on observations, staff interviews and review of the facility policy titled, Food Storage, the facility failed to ensure that all opened food was labeled and dated. The deficient practice had the potential to affect all residents who were on an oral diet. Findings include: Review of the facility policy titled Food Storage revealed under POLICY: It is the policy of the Food and Nutrition Department that food storage occur in a strictly defined manner as outlined in the procedures below, PURPOSE: To prevent the transmission of disease carrying organisms. ACTION: .2. Stock is rotated so that older items are used first. Products are dated to assure First-In, First-Out procedure is followed. Observation during a tour of the kitchen on 4/14/2025 at 9:45 am revealed the following: Pork sausages, chicken breasts, chicken nuggets, French fries, okra, crispy fried onions, located in the freezer, were not labeled or dated. In an interview on 4/14/2025 at 9:45 am with the [NAME] confirmed that there should be an open date and a use by date labeled on items that have been opened. In an interview on 4/14/2025 at 9:50 am with the Assistant Dietary Manager confirmed that all kitchen staff were responsible to label opened food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41914 Based on observations, staff interviews, record review, and review of the facility policy titled, Standard Precautions the facility failed to ensure infection control practices were followed for two of eight residents (R) (R37 and R84) during wound care, the facility failed to ensure infection control practices were followed when disposing of used Personal Protective Equipment (PPE), and the facility also failed to ensure infection surveillance was conducted monthly. The deficient practices had the potential to affect all residents residing in the facility. Findings include: Review of the facility policy titled Standard Precautions dated October 2018 revealed under Policy Statement: Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 1. Record review revealed R37 was admitted to the facility with diagnoses of but not limited to generalized muscle weakness, lack of coordination, moderate protein calorie malnutrition, and pressure ulcer of sacral region stage four. Review of the physicians orders located in the Electronic Medical Record (EMR) revealed a treatment order for the Sacrum: Cleanse with normal saline, pat dry, apply Santyl (wound treatment) then collagen, cover with dry protective dressing such as bordered gauze daily and PRN (as needed) per dislodgement/soiling. Review of the care plan for R37 revealed under focus: R37 has present skin breakdown as follows and is at risk for complications related to skin breakdown such as infection, increased pain, inability to participate in activities and socialization, anxiety/mood disorders. Coccyx: Stage 4 pressure wound. Goals included: Present skin breakdown will be healed without complications by next review date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Wound care observation of R37 on 4/12/ 2025 at 11:05 am with the Wound Care Nurse revealed the nurse proceeded to cleanse the wound care tray with a germicidal wipe and allowed it to air dry, after the tray was dry, the nurse proceeded to place a barrier on the tray before placing wound treatment supplies for treatment that included normal saline in a 30 ml (milliliter) cup, Medi fil II Collagen (wound treatment), Santyl ointment (the two were mixed together in 30 ml plastic medicine cup to make a paste), dry gauze, and bordered gauze. The Wound Care Nurse proceeded to sanitize hands with hand sanitizer and donned (put on) a gown and clean gloves after entering R37's room. The nurse informed R37 that wound care treatment was being completed and permission for surveyor to observe was obtained. The nurse pulled the privacy curtain, however the residents blinds were pulled up with full view from the courtyard. Residents brief was loosened, and resident was turned to the right side, old dressing was removed and area was cleaned. The area measured 0.3 cm (centimeters) X 0.1 cm X 0.1 cm; wound bed was not visible due to area being more of a pin hole shape. The nurse proceeded to wash hands with soap and water and new gloves were applied, resident was rolled back over on to his back, and the nurse returned to the resident and proceeded to apply paste of Santyl and collagen without recleaning area to buttocks and applied a dressing. Record review for R84 revealed resident was admitted to the facility with the diagnoses of but not limited to dementia, history of falling, essential hypertension, hyperkalemia, lack of coordination, and unsteadiness on feet. Review of the physician orders for R84 in the EMR revealed an order to cleanse the sacral area with normal saline, pat dry, apply Santyl, cover with dry protective dressing daily and prn per dislodgement/soiling. Review of the care plan revealed a focus of R84 has present skin breakdown upon admission and is at risk for complications related to skin breakdown such as infection, increased pain, inability to participate in activities and socialization Unstageable to Sacrum Stage III L (left) Upper Buttock. Goals included Present skin breakdown will improve without complications by next review date. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Wound care observation on 4/12/ 2025 at 10:40 am with the Wound Care Nurse revealed the nurse proceeded to cleanse wound care tray with a germicidal wipe and allowed it to air dry, after the tray was dry, the nurse proceeded to place a barrier on the tray before placing wound treatment supplies for treatment that included normal saline in a 30 ml cup, Santyl ointment, Medi-honey (wound treatment), bordered gauze, Medi-pore tape, dry gauze, tongue blades, measuring tape, and a bag for dirty wound products used. The nurse proceeded to sanitize hands with and donned gown and clean gloves after entering the resident's room. The nurse informed R84 that wound care treatment was being completed and permission for surveyor to observe was obtained. R84's bed was repositioned and the nurse proceeded to remove the G-tube (gastrostomy tube placed in abdomen for feeding) dressing from stoma site without providing privacy. The residents privacy curtain remained open in view of resident's roommate as well as the blinds were open during the start of the treatment. After removing the dressing from the insertion site and cleaning area, the nurse proceeded to wash hands with soap and water and donned clean gloves before applying a clean dressing. R84's brief was loosened, and the resident was repositioned to the right side, curtains still open and window blinds open as well. The old dressing was removed, no drainage was noted on the dressing removed. The area to the sacrum wound base was pale pink in color and the area measured 1 cm x .03 cm x. 01 cm, no drainage was noted during observation. The nurse proceeded to go to the bathroom to wash hands with soap and water. During this time R84 was left unattended by staff and rolled back on his back. The nurse returned from the bathroom and donned clean gloves, the resident was repositioned from his back to his right side, and the nurse applied the clean bandage without ensuring the wound area was cleaned again after resident was on the contaminated linens. Interview on 4/12/2025 at 11:30 am with the Wound care Nurse revealed that she was able to verbalize the wound care treatment process. During the interview, the Wound Care Nurse acknowledged that she did not clean R37's wound after the resident had rolled back on to the contaminated bed linens. Interview on 4/12/2025 at 1:30 pm with the Director of Nursing (DON) revealed that her expectation was for infection control practices to be followed at all times. During the interview it was disclosed that she expected the wound care nurse to ask for assistance with residents that have concerns with mobility and needed assistance with positioning while conducting wound treatments. 41165 2. Record review for R45 revealed resident was admitted to the facility with diagnoses of but not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region. Review of the physician's order in the EMR revealed the following order for the Sacrum Wound: Cleanse with NS, pat dry, apply Santyl then collagen, cover with dry protective dressing such as bordered gauze dressing daily and PRN per dislodgement/soiling. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Wound care observation for R45 at 11:26 am revealed LPN II sanitized her hands, donned gloves, sanitized plastic tray, and placed a paper chux pad on top of the tray. LPN II removed a bottle of saline, 30 cc plastic cup, gauze, bordered dressing, Santyl, and collagen paste from the treatment cart and placed the items on top of the tray. LPN II removed gloves, sanitized hands, donned gloves and donned gown. LPN II removed the gown and threw it in the trash can stating that she forgot the gauze. LPN II returned to the treatment cart, sanitized hands and removed 4x4 gauze from the cart. LPN II returned to the room, sanitized hands, and donned gloves and gown. LPN II placed the tray with treatment supplies on top of R45's feet. LPN II removed the tray from R45's feet and held the tray in her right hand. LPN II, while holding the tray in her right hand, used her left hand to unclamp R45's catheter bag from the bed. LPN II threw the catheter bag on the bed near R45's feet. LPN II again placed the tray on R45's bed near her right foot. LPN II rolled R45 on to her left side, removed gloves, washed her hands and donned gloves. LPN II removed the old dressing, removed gloves, washed her hands, and donned gloves. The window blinds were observed to be open. The window showed full vision of the front parking lot and front porch. LPN II continued with wound care cleaning the sacral area. LPN II measured the area, removed gloves, washed hands, donned gloves and applied the Santyl/collagen mixture as ordered, and covered area with a dressing. LPN II removed the tray from R45's bed and held it in her left hand. With her right hand, LPN II attached the foley catheter bag back to the bed. With the tray in her left hand, LPN II moved the bedside table, removed gloves, and put the tray on top of treatment cart. LPN II then removed gown and threw it in the trash can. With ungloved hands, LPN II removed two gowns from the trash can and folded them up and exited the room with the unbagged gowns stating that she was taking the gowns to the laundry because they were re-washable. LPN II did not wash/sanitize hands after removing gloves, and she did not sanitize the tray before placing it back on the treatment cart. Interview with LPN II on 4/12/2025 at 3:32 pm revealed she acknowledged that she transported the soiled gowns down the hall to the laundry room in her ungloved hands, unbagged. LPN II stated that she should have placed the gowns in a plastic bag to transport to the laundry room. Interview with the DON on 4/12/2025 at 3:47 pm revealed the DON stated that her expectations were for infection control be followed before, during, and after wound care. 49675 3. Record review revealed the facility failed to complete surveillance by not calculating infection control rates for the months of January, February, and March of 2025. In addition, there was no evidence the facility had reviewed its infection control policies annually. Interview on 4/12/2025 at 10:30 am with the Infection Control Preventionist (ICP) revealed when asked about infection rates, she said she does not calculate infection rates. She said she looked at monthly infections and based education and training on what was going on in the facility. She said she had never been taught how to calculate the rate and that the prior DON and/or corporate office was figuring the monthly infection rates. She verified that surveillance relating to infection rates had not been done from January through March 2025. She revealed she did not know when the infection control policies were last reviewed. Interview on 4/13/2025 at 11:30 am with the Administrator revealed he did not know whether surveillance related to infection rates were currently being completed. In addition, he did not know the last time the infection control policies were last reviewed, stating they were not done annually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/13/2025 at 11:35 am and 1:31 pm with the DON revealed that she started in February 2025. She stated she cannot find where any surveillance related to infection rates were being completed since she got to the facility and planned on training the ICP on how to do it. She revealed she had no idea when the last time the infection control policies were last reviewed.