STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quinn Meadows Rehabilitation and Care Center	1033 W Quinn Road Pocatello, ID 83201

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an Advanced Directive. This was true for 6 of 12 residents (Resident # 13, 14, 18, 22, 27, and 141) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include: The facility's Residents' Rights Regarding Treatment and Advanced Directives policy, dated 2/3/23, documented on admission the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advanced directive. Should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff. Any decision-making regarding resident's choices will be documented in the resident's medical record. 1. The following resident's records did not include an advanced directive or documentation information about an advanced directive was provided to the resident or the resident's representative. a. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure and hypertension. A Social Services assessment, dated 11/9/23, documented Resident #13 had an advanced directive and the facility had received a copy of her advanced directive. Resident #13's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her or [NAME] representative. b. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) and Type 2 diabetes. A Social Services assessment, dated 9/13/23, documented Resident #14 had an advanced directive and the facility had received a copy of his advanced directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with him or his representative. c. Resident #22 was admitted to the facility on [DATE], with multiple diagnosis including cervical vertebra fracture and respiratory failure. A Social Services assessment, dated 3/11/24, documented Resident #14 had an advanced directive. Resident #22's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her or her representative. d. Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnosis including sepsis (a life-threatening complication of an infection) and respiratory failure. Resident #27's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her or her representative. e. Resident #141 was admitted to the facility on [DATE], with multiple diagnosis including acute respiratory failure and urinary tract infection. Resident #141's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her or her representative. On 4/16/24 at 2:16 PM, the SSD stated the residents' social services assessments documented a copy of their advanced directive was documented by mistake. She stated when she completed the assessment she was thinking of the POST (Physicians Orders for Scope of Treatment). The SSD also stated she did not document that she offered to assist residents or resident representatives with completing an advanced directive. 36193 2. Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness) and diabetes. A Social Services evaluation, dated 2/5/24, documented Resident #18 had an advanced directive. Resident #18's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with him or his representative. On 4/17/24 at 10:24 AM, the SSD stated she discussed the advanced directive with Resident #18 and his family, and remembered asking for a copy of it, but did not document the conversation. The SSD stated she was unable to find Resident #18's advanced directive.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on record review, policy review, and staff interview, it was determined the facility failed to provide a summary of residents' baseline care plans to residents or their representative. This was true for 5 of 12 residents (#13, #14, #22, #27, and #141) reviewed for baseline care plans. This failure placed residents and their representative at risk of not being informed and having input in their care plan. Findings include: The facility's Care Plan - Baseline Plan of Care policy, revised 12/22/23, documented the Baseline Care Plan was to be developed within 48 hours of admission. The person providing the written summary of the baseline care plan should have obtained a signature from the resident or representative to verify that the summary was provided and make a copy of the summary for the medical records. If the summary was provided verbally by telephone, the nurse would indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident representative. The following resident records did not include documentation their baseline care plan was provided and discussed with the resident and/or their representative: a. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure and hypertension. A MDS assessment, dated 2/15/24, documented Resident #13 was cognitively intact. Resident #13's record did not include documentation a baseline care plan was provided and discussed with her or her representative. b. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it) and Type 2 diabetes. A MDS assessment, dated 3/22/24, documented Resident #14 was cognitively intact. Resident #14's record did not include documentation a baseline care plan was provided and discussed with him or his representative. c. Resident #22 was admitted to the facility on [DATE], with multiple diagnosis including cervical vertebra (spinal) fracture and respiratory failure. A MDS assessment, dated 3/14/24, documented Resident #22 was cognitively intact. Resident #22's record did not include documentation a baseline care plan was provided and discussed with him or his representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnosis including sepsis (a life-threatening complication of an infection) and respiratory failure. A MDS assessment, dated 3/26/24, documented Resident #27 was cognitively intact. Resident #27's record did not include documentation a baseline care plan was provided and discussed with her or her representative. e. Resident #141 was admitted to the facility on [DATE], with multiple diagnosis including acute respiratory failure and urinary tract infection. Resident #141's record did not include documentation a baseline care plan was provided and discussed with him or his representative. On 4/16/24 at 4:31 PM, the SSD stated there was no documentation residents' baseline care plans were reviewed or signed by residents or their representative. On 4/16/24 at 4:50 PM, the CRN stated there was no documentation baseline care plans were reviewed or signed by residents or their representative.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated. This was true for 1 of 6 residents (Resident #15) whose care plans were reviewed. This created the potential for harm if cares/or services were not provided appropriately due to inaccurate information in the care plans. Findings include: The facility's Care Plan Revisions Upon Status Change, revised 12/22/23, documented comprehensive care plans should be reviewed, and revised as necessary when a resident experiences a status change. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including bladder cancer and muscle weakness. A physician's order, dated 2/15/24, directed staff to irrigate Resident #15's neobladder (new bladder made from a piece of a person's own small intestine that is formed into a pouch and positioned inside the body in the same position as the original urinary bladder) two times a day with 500 - 1,000 cc of saline. The order documented to push 2-3 syringes full, then remove, and repeat. Resident #15's care plan did not include documention his neobladder was to be rrigated two times a day. On 4/17/24 at 3:46 PM, the Clinical Resource Nurse reviewed Resident #15's care plan and stated irrigation of his neobladder was not in the care plan. The Clinical Resource Nurse stated residents' care plans should be updated as needed and quarterly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure residents received bathing assistance consistent with their needs. This was true for 1 of 4 residents (Resident #28) reviewed for ADLs. This failure created the potential for residents to experience embarrassment, isolation, and decreased sense of self-worth, due to lack of personal hygiene. Findings include: The facility's Resident Showers policy, revised 1/2/24, directed staff to assist residents with their bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. On 4/15/24 at 6:15 PM, Resident #28 was in the dining room wearing a gown with a blue shirt over it. Resident #28 was also observed with small white hairs on his chin. On 4/16/24 at 10:23 AM, Resident #28 was in his room wearing a gown with a blue shirt over it. When asked how he was doing, Resident #28 looked at the surveyor and closed his eyes. A Bath/Shower Flowsheet, dated 3/13/24 through 4/14/24, documented the following: - Resident #28 did not receive a shower/bath between 3/13/24 and 3/20/24, 7 days and NA (Not Applicable) was documented on his flowsheet. - Resident #28 refused a shower on 3/21/24 and NA was documented on 3/24/24 and 3/31/24. - Resident #28 refused a shower on 4/4/24 and NA was documented on 4/7/24. - Resident #28 refused a shower on 4/11/24 and NA was documented on 4/14/24. On 4/18/24 at 9:46 AM, the DON reviewed Resident #28's Bath/Shower Flowsheet and stated Resident #28 refused a lot of his cares. The DON stated Resident #28's refusals of his bath/showers should have been documented in his record.

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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** 36193 Based on record review and staff interview, it was determined the facility failed to ensure residents receiving opioid pain medications were monitored appropriately and offered non-pharmacologic pain interventions. This was true for 1 of 5 residents (Resident #15) reviewed for unnecessary medications. This failure created the potential for residents to experience adverse reactions due to lack of appropriate monitoring or experienced increased pain due to not offering non-pharmacologic pain interventions. Findings include: The facility's PRN Medications policy, revised 12/27/23, directed staff to offer non-drug interventions prior to giving PRN medications. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including bladder cancer and muscle weakness. Resident #15's physician order, dated 6/24, included the following: - Monitor pain every shift using Pain Scale of 0-10 if non-verbal or unable to respond to pain scales rating, utilize [NAME] (combines pictures and numbers for pain ratings, with 0 [zero] being no pain and 10 being the highest pain level) face scale. - Non-medication interventions must be attempted before administration of pain medications as follows: 1. ROM 2. reposition 3. warm blanket 4. cold therapy 5. massage 6. music 7. decrease lightning/noise/stimuli 8. offer drink/snack 9. other. - Oxycodone (opioid medication) 10 mg, one tablet every 6 hours as needed for pain. Resident #15's MAR, dated 3/1/24 through 4/16/24, documented Resident #15's pain level ranged from 3 to 5 on the pain scale. Resident #15 was given oxycodone 10 mg one time a day for 27 days and two times a day for 9 days. Resident #15's MAR did not include documentation non-pharmacologic interventions were offered to him prior to administering his as needed pain medications. On 4/16/24 at 4:16 PM, the DON stated non-pharmacologic interventions should have been offered to Resident #15 prior to giving him his PRN pain medications. The DON stated there was no documentation in Resident #15's record non-pharmacologic interventions were offered to him.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medications had resident-specific target behaviors identified and monitored. This was true for 1 of 5 residents (Resident #28) reviewed for psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include: The facility's Unnecessary Drug-Without Adequate Indications for Use policy, revised 1/2/24, documented that each resident's drug regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being from unnecessary drugs. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including dementia and depression. A physician's order, dated 3/21/24, documented Resident #28 was to receive the following medications: - Trazodone (anti-depressant) 50 mg, one tablet by mouth at bedtime, for his depression - Aripiprazole (anti-psychotic), 15 mg, one tablet by mouth once a day for his depression Resident #28's care plan, did not document he was taking psychoactive medications and what specific target behavior he manifested for depression. On 4/16/24 at 5:02 PM, the SSD reviewed Resident #18's record, and stated she did not find Resident #28 had specific target behavior documented.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 33 medications (6.06%) which affected 1 of 4 residents (Resident #27) whose medication administration were observed. This failed practice placed residents at risk of not receiving their prescribed medication or dosage of their medication. Findings include: The facility's Medication Errors policy, revised 12/27/23, documented the facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error rates. Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnosis including sepsis (a life-threatening complication of an infection) and respiratory failure. 1. A physician order, dated 4/15/24, documented to administer Amiodarone HCl 200mg tablet by mouth to Resident #27 in the morning for heart failure. On 4/16/24 at 7:41 AM, RN #1 placed a 200 mg tablet of Amiodarone HCl in a medication cup. She then placed Resident #27's other medication into medication cup including another 200mg Amiodarone HCl for a total of 400 mg of Amiodarone HCl. On 4/16/24 at 7:44 AM, RN #1 stated Resident #27 had an order for Amiodarone HCl 200mg and she had not realized she had already put the Amiodarone in the medication cup. She also stated Resident #27 should have only received 1 tablet of Amiodarone. 2. A physician order, dated 4/15/24, documented Resident #27 was to receive 17 grams of Polyethylene Glycol powder one time a day for bowel maintenance. On 4/16/24 at 7:51 AM, RN #1 documented in Resident #27's MAR that Resident #27 received her Polyethylene Glycol powder. On 4/16/24 at 7:53 AM, RN #1 stated she had not administered the Polyethylene Glycol powder to Resident #27 because she usually refuses the medication. RN #1 also stated she should have offered the Polyethylene Glycol powder to Resident #27.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were labeled and dated. This was true for 2 of 2 medication carts inspected. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: The facility's Labeling of Medication and Biologicals policy, revised 12/27/23, documented medication labels must be legible at all times. Labels for multi-use vials must include a) the date the vial was initially opened; and b) all opened vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial. The facility's Insulin Pen policy, dated 12/27/23, documented insulin pens should be disposed of after 28 days or according to manufacturer's recommendations. The insulin pen expiration date is to be checked before use and discarded if expired. 1. On 4/16/24 at 8:44 AM, 2 insulin pens, not dated, 2 opened multiuse insulin vials, not dated, and a Lispro insulin vial that was dated 2/2/24, were found inside the top drawer of the 100-hall medication cart. On 4/16/24 at 8:49 AM, RN #1 stated she did not know how long the insulin pen or vial was good for. RN #1 also stated the insulin vial and insulin pen should have been dated when it was opened. 2. On 4/16/24 at 11:50 AM, 5 insulin pens and 1 opened vial of insulin were found inside the top drawer of the 300-hall medication cart. On 4/16/24 at 11:54 AM, LPN #1 stated the insulin pens and vials should have been dated when they were opened and are good for 28 days from opened date. LPN #1 stated the insulin pens and vials should have been discarded when they expired and new insulin pens and vials should have been used.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation and staff interview, it was determined the facility failed to monitor, discard outdated food items, and maintain the kitchen in a sanitary manner. These deficiencies had the potential to affect the 36 residents residing in the facility who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. The facility's Date Marking for Food Safety policy, revised [DATE], stated the facility adhered to a date marking system to ensure safety of food. The policy also stated the food should be clearly marked to indicate the date by which the food shall be consumed or discarded. 1. a. On [DATE] at 1:20 PM, the following seasoning containers had a sticker with the following dates on it: - All Spice - [DATE] - Cream of Tartar: [DATE] - Whole Fennel seeds: [DATE] - Cayenne Pepper: [DATE] - Curry Powder: [DATE] - Ground Ginger: [DATE] - Dill Weed, [DATE] - Chives: [DATE] - Hungarian Paprika: [DATE] - Ground Nutmeg: [DATE] - Ground Mustard: [DATE] The above seasonings had a handwritten use by date which was one or two years from the date on the sticker except for the All Spice. Some of the seasonings had two different use by dates written on it. b. The following seasonings had no date on the sticker but had use by dates as follows: - Poppy Seed: use by [DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Whole Oregano: use by [DATE] c. The following food items had an expiration date as follows: - Maple Flavor: [DATE] - Red Food Color: [DATE] - [NAME] Imitation Maple Flavor: use by [DATE] - [NAME] Red Food Color: [DATE] - Yellow Food Color (Egg Shade): [DATE] - Red Food Color: [DATE] - 2 bags of Couscous with best by [DATE] On [DATE] at 2:00 PM, the Chef stated the date on the sticker was the date it was received in their warehouse, and they would add one or two years from it for the use by date. The Chef also stated the expired food items should not be in the kitchen. On [DATE] at 1:59 PM, the DM stated the facility added one or two years from the date on the sticker as the use by date. When asked why some of the containers had two different use by dates written on them, the DM stated, I don't know why, unless we did a refill and mistakenly wrote two dates on it. The DM stated some of the spices are in their original container and some might have been refilled. When asked if the original container of the spices should be kept or thrown away when they have been consumed, the DM stated some of the containers were thrown away and some were refilled. The DM also stated some of the spices were hard to get so she would get them from the store and refill the container. 2. On [DATE] at 2:20 PM, during the kitchen tour with the DM, the following was observed in the kitchen: - The metal shelf where the oven was had a collection of dark debris along the sides of the oven and rusted areas were observed on the corners of the shelf. Food droppings were also observed on the shelf. - The oven door from the outside had whitish dried splatters. Both sides of the oven looked dirty. Also, a whitish splatter was observed on top of the oven. The inside of the oven was observed to be heavily soiled with grease. - The can opener was observed to have white splatter on its side. On [DATE] at 1:59 PM, the DM stated the shelves were being cleaned every three months and the oven was being cleaned every week. The DM was unable to provide documentation the oven and shelves were being cleaned as scheduled.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on record review, observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 3 of 12 residents (#2, #19, and #27) observed for infection control. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The CDC Website for Healthcare-Associated Infections, last reviewed 7/27/22, accessed on 4/23/24, states: - Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). - Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. 1. Resident # 19 was admitted to the facility on [DATE], with multiple diagnosis including Cerebral Palsy (congenital disorder of movement, muscle tone, or posture) and septicemia (serious bloodstream infection). A physician's order documented Resident #19 was to be placed on Enhanced Barrier Precautions due to his Foley catheter (a semi-flexible plastic tube where one end is inserted into the bladder and the other end is attached to a bag that collects urine, which is used when a person cannot urinate normally) and gastric tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth). Staff were required to wear a gown and gloves for high-contact care (catheter care and gastric tube care). Staff were not required to wear a gown and gloves when not performing high-contact care. a. On 4/15/24 at 6:26 PM, a 2-drawer, plastic container containing gowns and gloves was observed outside Resident #19's room. There was no isolation signage outside Resident #19's door identifying what type of precautions were to be taken. When asked, the IP stated Resident #19 had a tube so that was why he had PPE outside his door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135136	A. Building B. Wing	04/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 2:25 PM, a sign was posted outside Resident #2's room which stated Enhanced Barrier Precautions. The sign stated staff were to don (put on) gloves and a gown for the following high contact resident activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring dressing. On 4/17/24 at 1:42 PM, during wound dressing observation, the Wound Nurse performed hand hygiene, donned gloves, and cut the Kerlix (a bandage roll) covering Resident #2's right foot. The Wound Nurse then showed the surveyor Resident #2's wound on her right heel and explained how it happened. The Wound Nurse was stroking the top and bottom of Resident #2's right foot with her gloved hand as she was explaining to the surveyor. The Wound Nurse then took a gauze moistened with normal saline and wiped Resident #2's wound on her heel, without changing her gloves. After wiping the wound, the Wound Nurse removed her gloves, put on gloves without performing hand hygiene and wiped Resident #2's wound with a wet gauze for the second time. The Wound Nurse then removed her gloves, put on gloves, and wrapped Resident #2's right foot with Kerlix and dated it. The Wound Nurse did not wear a gown during Resident #2's wound dressing change. On 4/17/24 at 1:52 PM, the Wound Nurse stated she should have changed her gloves and performed hand hygiene before cleaning Resident #2's wound. The Wound Nurse stated Resident #2 was on Enhanced Barrier Precautions and she should have worn a gown before performing Resident #2's wound dressing change and she did not.