STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145379	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Valley Ridge Rehab & Hcc	275 East Army Trail Road Bloomingdale, IL 60108

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 34506 Based on observation, interview, and record review, the facility failed to provide a resident with privacy during activities of daily living (ADL) care for 1 of 33 residents (R17) reviewed for privacy in the sample of 33. The findings include: R17's Admission Record shows he was admitted tot he facility on September 7, 2007 with diagnoses including dementia, non pressure chronic ulcer of skin, depressive episodes, and kidney disease. R17's Care Plan initiated on June 10, 2024 shows R17 is incontinent of bowel and bladder. On August 19, 2024 at 9:56 AM, V4 and V5 (Certified Nursing Assistants/CNA) were preparing to provide incontinence care for R17. V5 CNA folded R17's incontinence brief downward in between in legs while he was laying on his back. R17's curtain was not closed and R17's roommate was in his bed, facing R17, and talking with V4 and V5. R17's front peri area was exposed. On August 20, 2024 at 1:32 PM, V14 CNA said resident's curtains should be closed during incontinence care so the resident has privacy. The State of Illinois Residents' Rights revised November 2018 shows, You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.

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 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. 35541 Based on observation, interview and record review the facility failed to ensure staff-dependent residents were provided incontinence care for 2 of 33 residents (R34, R51) reviewed for activities of daily living (ADL's) in the sample of 33. The findings include: 1. R34's current care plan showed R34 was dependent on staff for incontinence care and toileting. R34 was cognitively intact. On 8/19/24 at 9:32 AM, R34 was in bed, eating breakfast. R34 stated, They really treat me good here but, lately it seems like it's taking longer for someone to come change me. There have been times that I have waited over five hours for someone to come. I wear a brief. This last time someone changed me today was around 4 AM. At 9:38 AM, V12 (Certified Nursing Assistant/CNA) entered R34's room to provide cares. V12 stated this was her first time providing incontinence care to R34 for the day. V12 removed R34's brief which was saturated with urine. Urine had leaked out of R34's brief, onto R34's sheet and mattress. 2. R51's current care plan showed R51 was dependent on staff for incontinence care and incontinent of bowel and bladder related to his diagnoses of dementia, impaired cognition, and cerebral infarction (stroke) with left arm and leg hemiplegia (paralysis). The plan showed, Provide incontinence care after each incontinent episode. On 8/19/24 at 9:53 AM, R51 was in bed. A strong foul odor of urine and stool was noted in the room. At 9:55 AM, V13 (CNA) entered R51's room. V13 (CNA) was asked about the odor in R51's room, V13 stated, I don't know what that is. I last changed him at 7 AM. V13 repositioned R51 to check his incontinence brief. R51's brief was saturated with urine and stool. Urine and stool had leaked out of R51's brief, onto R51's bedding. R51's buttocks appeared bright pink. V13 stated incontinence care should be provided every two hours to resident's that require staff assistance or are dependent on staff for incontinence care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to have a physician ordered treatment in place for a resident with open areas to his buttocks for 1 of 33 residents (R17) reviewed for quality of care in the sample of 33. The findings include: R17's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including dementia, non pressure chronic ulcer of skin, depressive episodes, and kidney disease. R17's Care Plan that was provided by the facility did not include any skin issues on R17. On August 19, 2024 at 9:56 AM, V4 (Certified Nursing Assistant/CNA) and V5 (CNA) provided incontinence care to R17. When R17 was turned onto his side, there was multiple open areas noted to R17's buttocks. There was spots of dried blood on R17 incontinence brief. R17 said Ow! each time V5 wiped R17's buttocks. V5 said she was going to tell the nurse about R17's buttocks. There was no dressing or treatment in place to R17's buttocks. On August 20, 2024 at 1:07 PM, V14 (CNA) and V3 (CNA) transferred R17 back into his bed from his chair to perform incontinence care on him. R17's penis was raw and bright red. R17 said OW! as V3 wiped the tip of R17's penis. V3 turned R17 onto his side. There was no dressing to R17's buttocks. R17's buttocks area still had open areas. V3 got R17's nurse, V15 (Registered Nurse/RN). V15 came into R17's room and placed zinc to R17's buttocks. V3 showed V15 R17's penis. V15 said, Oh . V15 was not aware of the sores to R17's penis. V15 said she was going to contact the hospice nurse. On August 20, 2024 at 1:39 PM, V15 said she did not know that R17 had an order for a dressing to his buttocks. V15 said that night shift places the dressing onto R17's buttocks. V15 said a foam dressing is used for extra protection. R17's Order Summary Report dated August 19, 2024 shows an order dated August 5, 2024 for optifoam dressing apply to right buttocks every evening shift for skin condition and apply to left buttocks every evening shift for skin condition. There's an order dated May 30, 2024 optifoam adhesive island apply to left buttock topically as needed. R17's skin/wound progress note dated August 19, 2024 shows, right buttocks slightly red. R17's skin/wound progress note dated August 21, 2024 shows R17 has excoriation to his buttocks. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations dated March 2, 2021 shows, Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. Revise Care Plan approaches as needed based on resident's response and outcomes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35541 Based on observation, interview and record review the facility failed to ensure pressure injury treatments and pressure relieving interventions were in place for 1 of 7 residents (R9) reviewed for pressure injuries in the sample of 33. The findings include: R9's care plan dated 10/19/2018 showed R9 was at risk for developing pressure injuries due to her history of a previous pressure injury to her left buttock, inability to reposition herself, and history of bowel incontinence. The care plan showed R9 had diagnoses of multiple sclerosis, spinal stenosis, and quadriplegia. The plan showed R9 was cognitively intact. R9's wound note dated 2/21/23 showed a Stage III pressure injury to R9's left buttock had resolved and was completely healed. R9's progress note dated 6/5/24 showed an open area and redness was identified to R9's left buttock. R9's wound note dated 6/11/24 showed R9 was seen by the facility's wound physician for a re-opened Stage III pressure injury, to her left buttock, that measured 9 centimeters (cm) x 9.5 cm x 0.2 cm. R9's wound note dated 8/6/24 showed R9's left buttock Stage III pressure injury measured 5.7 cm x 7 cm x 0. 2 cm. The note showed to monitor R9 for incontinence and change after each episode. The note showed staff were to reposition R9 every two hours and offload R9's heels with a pillow or heel boots while in bed. The note showed facility staff were to apply treatment ointments and a foam dressing to R9's pressure injury once a day and as needed. On 8/19/24 at 10:03 AM, R9 was in bed, lying on her right side. R9's heels rested directly on mattress of her bed. R9 was alert and cognitively intact. R9 stated she could not lay on her left side in bed due to a wound on her left buttock. When asked about her wound, R9 stated, I got the wound here because they didn't reposition me. I can't move myself because I have MS (multiple sclerosis). On 8/20/24 at 8:45 AM, R9 was lying in bed. R9's heels rested directly on the mattress of her bed. R9 stated she was seen by the facility's wound physician around 7 AM that morning. R9 stated, I don't have a dressing on my wound. They never put one back on after the doctor looked at it. At 8:47 AM, V10 (Certified Nursing Assistant/CNA) and V11 (CNA) entered R9's room to provide cares. V10 removed R9's incontinence brief as R9 was incontinent of stool. No dressing was noted to the large, circular, open wound to R9's left buttock. Stool was noted in and around the wound. As V10 cleansed R9's buttocks, R9 complained of pain when V10 wiped R9's left buttock wound. V10 and V11 placed a clean incontinence brief on R9 with no dressing in place to her buttock wound. A scant amount of bleeding was noted from the wound. As R9 was repositioned in bed, she complained of pain to her left buttock. R9 stated, It just hurts because there is no dressing on there. V10 and V11 exited R9's room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 8:54 AM, V9 (Registered Nurse/RN) stated if staff observe that a resident's wound does not have a dressing in place, staff are to report it to a nurse immediately to have a dressing put in place. On 8/20/24 at 10:47 AM, V8 (previous Wound Nurse/RN) stated R9 was at risk for developing pressure injuries due to her history of previous pressure injuries and her diagnosis of multiple sclerosis. V8 stated, (R9) can't reposition herself. She has very limited movement. She can only move her left hand to pick up a cup. She had Stage III pressure injury to her left buttock before. She has no wounds to her heels, but they should be offloaded with a pillow. When V8 was asked what caused R9's left buttock pressure injury to reopen, V8 stated, Her skin is fragile, but I would say it was also likely because of infrequent repositioning and not making sure peri-care isn't done right away. On 8/20/24 at 12:46 PM, R9 was in bed, being fed by staff. R9 stated staff placed a dressing on R9's left buttock pressure injury sometime after 10 AM that morning. When R9 was asked if she ever refused to allow staff to apply a dressing to her wound on the morning of 8/20/24, R9 stated, No I didn't. The facility's Prevention and Treatment of Pressure Injury and other Skin Alterations policy dated 3/2/21 showed it was the facility's policy to identify the presence of pressure injuries . implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan .

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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** 40798 Based on observation, interview, and record review, the facility failed to ensure residents were transferred and/or repositioned in a safe manner for 4 of 33 residents (R69, R66, R114, and R130) reviewed for safety and supervision in the sample of 33. The findings include: 1. On 8/19/24 at 10:50 AM, V10 (Certified Nursing Assistant/CNA) and V11 (CNA) finished changing R69. V10 was on one side of R69's bed and V11 was on the other side. V10 and V11 each hooked their respective arms under R69's underarms and pulled R69 up in bed. Then, V10 and V11 proceeded to pull R69 forward by R69's underarms using the same method described above to reposition R69's pillow. On 8/19/24 at 11:24 AM, V16 (CNA) said when boosting a resident in bed there should be a person on each side of the bed and they should use the bed pad or flat sheet to pull the resident up in bed. V16 said it is not safe to pull a resident up by their arms. R69's Admission Record shows she is a [AGE] year old female. R69's current care plan provided by the facility shows R69 has limitation in range of motion and is to receive passive range of motion to both upper and lower extremities. R69's current care plan provided by the facility shows R69 has the potential for hemorrhage or bruising and impaired skin integrity due to use of anticoagulant therapy and a history of decreased mobility. Staff are to instruct R69 to put her arms into a self-hugging position when being boosted up in bed and an assistive device is to be used to decrease friction to lift (do not slide) R69 for bed mobility. 2. On 8/19/24 at 11:02 AM, V16 was in the bathroom with R66. V16 assisted R66 off the commode and pulled up R66's pants and transferred R66 to her wheelchair without using a gait belt. R66's Admission Record dated 8/21/24 shows R66's diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R66's Minimum Data Set, dated dated dated [DATE] shows R66 has limitation that interfered with daily functions or placed resident at risk of injury to an upper extremity and a lower extremity, is dependent on staff for toileting hygiene, and requires substantial/maximal assistance with lower body dressing, sit to stand, and toilet transfers. The facility's Incidents by Incident Type list dated 8/20/24 shows R66 fell on [DATE] and again on 8/7/24. The facility's Transfer Techniques Policy dated 2/2022 shows the purpose is to safely transfer the resident from one location to another and staff are to place a gait belt around the resident's waist during the transfer. 34506 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R114's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including legal blindness, major depressive disorder, and depression. R114's Care Plan revised January 8, 2024 shows, [R114] has potential for alteration in skin integrity related to frequent falls, syncope and collapse, muscle weakness, unsteadiness on feet, cognitive communication deficit and bowel and bladder incontinence. On August 19, 2024 at 9:56 AM, R114 was asleep in someone else bed. V4 (CNA) transferred R114 from the bed to his wheel chair with no gait belt. R114 was unsteady on his feet and was hunched over during the transfer. V4 held R114 by the back of his pants while transferring him. 4. R130's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, abnormalities of gait and mobility, and muscle weakness. R130's Care Plan revised on August 1, 2024 shows R130 is at risk for falls due to diagnoses of dementia, high blood pressure, depression, and benign paroxysmal vertigo. On August 19, 2024 at 11:42 AM, R130 let V3 (CNA) know that R130 had to go to the bathroom. V3 wheeled R130 to the bathroom via her wheel chair. V3 pulled R130 up via the back of R130's pants. V3 had a transfer belt around V3's waist. V3 sat R130 onto the toilet. When R130 was done using the bathroom, V3 stood R130 up and wiped R130's peri area. V3 pulled R130's incontinence brief and pants up and then transferred R130 back into her wheel chair. R130 was unsteady on her feet. On August 20, 2024 at 1:32 PM, V14 (CNA) said staff should use a gait belt when transferring resident for the resident and staff safety. The facility's Transfer Techniques dated February 2022 shows, Purpose: To safely transfer the resident from bed to chair or from one location to another. Transfer from bed to wheel chair: Have resident sit on the edge of the bed with feet uncrossed and resting on the floor. He/she may use this as an opportunity to practice sitting balance. Put on gait belt and shoes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to perform peri care in a manner to prevent urinary tract infection and failed to maintain the catheter bag below the level of the bladder to prevent infection for three of three residents (R33, R19, R9) reviewed for incontinence care and catheter care in the sample of 33. The findings include: 1. R19's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including hemiplegia, dementia, anxiety disorder, and heart failure. R19's Care Plan revised on July 8, 2024 shows R19 experiences bowel and bladder incontinence due to dementia, chronic kidney disease stage three, diabetes, atrial fibrillation, and anxiety. R19's Medication Administration Record shows she has been treated for a urinary tract infection in the past. On August 19, 2024 at 10:56 AM, V6 (Certified Nursing Assistant/CNA) and V4 (CNA) provided incontinence care on R19. R19 had a large amount of stool in her incontinence brief. R19 was turned on her side and V6 wiped the stool from R19's buttocks. R19 was then laid back onto her back. There was a moderate amount of stool noted to R19's front peri area. V6 wiped the stool from R19's peri area from back to front multiple times. 2. R33's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including malnutrition, palliative care, morbid obesity, depression, anxiety disorder, and dementia. R33's Medication Administration Record shows she has been treated with antibiotics for a urinary tract infection in the past. On August 19, 2024 at 10:11 AM, V4 (CNA) performed incontinence care on R33. There was stool noted in R33's buttocks. V4 wiped R33's buttocks then laid her onto her back to perform peri care to R33's front. There was a large amount of stool noted to R33 front peri area. R33 had an urinary catheter in place. V4 wiped the stool in R33's front peri area from back to front multiple times, using the same wet wipe. On August 20, 2024 at 1:32 PM, V14 (CNA) said stool should be wiped from front to back on residents to prevent infection. The facility's Perineal Care policy dated September 2020 shows, Purpose: To prevent infection and odor. Female Perineal Care: Separate the labia. Clean downward from front to back with one stroke. 35541 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R9's current care plan showed R9 required the use of a supra-pubic urinary catheter due to her diagnosis of obstructive and reflux uropathy. The plan showed, keep (catheter) tubing free of kinks and monitor (tubing) for patency . On 8/20/24 at 8:45 AM, R9 was lying in bed, covered with a blanket. No urinary catheter collection bag was noted hanging off either side of R9's bed. At 8:47 AM, V10 (CNA) and V11 (CNA) entered R9's room to provide cares. As V10 (CNA) removed the blanket off R9, R9's urinary catheter collection bag lay next to R9's left leg, on the bed. Urine was noted in the tubing of R9's catheter tubing. As V10 and V11 repositioned R9 in bed, a back-flow of urine was noted in the tubing of R9's catheter. Once cares were completed on R9, V10 (CNA) hung R9's urinary catheter collection bag off the side of R9's bed, allowing the urine in the catheter tubing to drain into the collection bag. On 8/20/24 at 8:54 AM, V9 (Registered Nurse) stated a resident's urinary catheter collection bag should be hanging below the level of the resident's bladder to make sure the urine is able to drain out. If the urine can't drain out, it can cause pain or infection.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 40798 Based on observation and interview, the facility failed to ensure a resident's tube feeding bag was labeled with the time it was initiated for 1 of 4 residents (R60) reviewed for tube feeding in the sample of 33. The findings include: On 8/19/24 at 9:49 AM, R60 was lying in bed with her tube feeding infusing. R60's tube feeding formula bag was dated 8/18/24, however, no time was documented. On 8/20/24 at 10:56 AM, V17, (Registered Nurse), said the G-tube bags should be labeled with the formula, dose, date and time since the bag and the tubing are good for 24 hours before they need to be changed. On 8/21/24 at 11:07 AM, V2, (Director of Nursing), said the tube feeding bag is good for 24 hours once hung; it needs to be labeled with the date and time it was started. R60's Order Summary Report dated 8/19/24 shows an order to infuse tube feeding at 60 ml (milliliters)/hour for 24 hours.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to ensure medications were dispensed according to standards of practice. The facility failed to ensure residents were assessed to self-administer medications. These failures apply to 3 of 33 residents (R9, R65, R158) reviewed for medication administration in the sample of 33. The findings include: 1 .On 8/20/24 at 8:45 AM, R9 was lying in bed. A medication cup, containing sixteen different pills of size and color, was on the table directly in front of R9. When R9 was asked about the pills, R9 stated, I think those are my morning medications. No nursing staff were noted in R9's room. On 8/20/24 at 8:54 AM, V9 (Registered Nurse/RN) stated, No residents on the second floor (R9's floor) can self-administer their medications or have meds in their room. We must watch them take their medications to make sure they take them or don't choke. We would need a physician order to let a resident administer their own medications. On 8/20/24 at 1:38 PM, V1 (Administrator) stated, R9 had never been assessed to self-administer her medications. R9's August 2024 Order Summary Report showed no physician order to allow R9 to self-administer her medications or to keep medications in her room. The facility's Medication Administration: General Guidelines policy dated 1/2022 showed, All medications shall be administered as prescribed by licensed personnel authorized to do so in accordance with standard nursing practice and current regulations. Residents are permitted to self-administer medications when specifically authorized by the physician and if determined able in accordance with policies and procedures for self-administration of medication. 35174 2. R65's Facesheet printed on 8/21/24 showed R65 to be an [AGE] year old male resident readmitted to the facility on [DATE] with diagnoses which include: acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, and pneumonitis due to inhalation of food and vomit. On 8/19/24 at 11:00 AM, R65 was in his room completing a nebulizer treatment. R65 had a mediation package with 2 DuoNeb doses, 1 dose of Budesonide suspension, and 1 Fluticasone aerosol dispenser which R65 placed in the middle drawer of his nightstand. R65 stated he had made a deal to take the medications himself since he takes 4 DuoNeb and 2 Budesonide treatments a day. R65 stated the nurse will sometimes listen to my lungs in the morning, but they don't do it with every treatment. I have been doing these myself just after I was in the hospital with pneumonia. (continued on next page)

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	145379	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Valley Ridge Rehab & Hcc	275 East Army Trail Road Bloomingdale, IL 60108

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's Order Summary printed on 8/21/24 showed an order for Budesonide Inhalation Suspension 1 milligram/milliliter (mg/ml) inhale orally two times daily, DuoNeb Solution 0.5-2.5 (3) mg/3ml inhale orally via nebulizer four times daily (and as needed), and Fluticasone Furoate Aerosol Powder Breath Activated 200 micrograms per activation inhaled orally one time a day. On 8/20/24 at 9:35 AM, V21 (RN) stated if a resident is able to give themselves medications they need to be assessed. R65 has been doing his own nebulizer treatments for a while. R65's medical record showed no Self Administration Assessments prior to 8/20/24, and no Care Plan entries for Self administration of medications prior to 8/21/24. 3. R158's Facility assessment dated [DATE] showed R158 is a cognitive [AGE] year old female who was readmitted to the facility on [DATE] with diagnoses which included: chronic obstructive pulmonary disease with acute exacerbation and acute and chronic respiratory failure with hypoxia. On 8/19/24 at 11:20 AM, R158 was sitting on her bed self administering a nebulizer treatment. R158 had 3 unopened nebulizer medication vials (Albuterol) on the night stand. R158 stated I am very independent. It is just easier to have a few of these (treatments) in my room to just do them instead of tracking down a nurse to get one. Since restarting them I usually need 3 or 4 treatments a day. I knew how to use a nebulizer from before, but no one has ever came to teach me how to use it or had me sign anything saying I knew how. R158's Order Summary printed on 8/21/24 showed R158 has an order for Albuterol Sulfate Inhalation Nebulization Solution 2.5mg/3ml. Inhale orally every 4 hours as needed for wheezing or shortness of breath. R158's medical record showed no Self Administration Assessments prior to 8/20/24, and no Care Plan entries for Self administration of medications prior to 8/21/24. On 8/21/24 at 1:20 PM, V2 (Director of Nursing) stated a resident needs to be assessed to be able to self administer medications. The facility's Self-Administration of Medications Policy dated 9/2020 showed a resident will not be permitted to administer or retain medications in their rooms unless so ordered by the attending physician, assessed for their cognitive, physical, and visual ability to self-medicate, and approved by the care planning team. This Policy also showed a resident able to self-administer medications will be placed on a training program which includes: Self-medication assessments completed initially and quarterly, a plan of care with quarterly documentation, and the completion of a Self-Medication Daily Flow Sheet.

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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** 35174 Based on observation, interview, and record review the facility failed to ensure a COVID-19 positive resident remained in isolation, failed to ensure a resident identified as a close contact with COVID-19 symptoms was wearing a mask, failed to ensure staff donned personal protective equipment (PPE) when providing care for a resident on enhanced barrier precautions (EBP), failed to ensure residents with feeding tubes were placed on EBP, and failed to perform hand hygiene and change gloves during pericare to prevent cross contamination. These failures apply to 8 of 33 residents (R44, R91, R9, R60, R57, R33, R17, R19) reviewed for infection control in the sample of 33. The findings include: 1. R44's Facesheet printed on 8/21/24 showed R44 to be a [AGE] year old female resident readmitted to the facility on [DATE]. This document showed a new diagnosis of COVID-19 on 8/12/24. R44's COVID-19 Results Worksheet showed R44 being COVID-19 positive on 8/12/24. R44's Order Summary printed on 8/21/24 showed an order for Isolation: contact and droplet precautions due to positive COVID-19 times 10 days ending on 8/22/24. On 8/19/24 at 11:45 AM, R44's room doorway had a contact/droplet isolation sign on it and a PPE cart next to the doorway. R44's room is near the opposite end of the hallway from the nurses station. On 8/19/24 at 1:30 PM, R44 was in her wheelchair near the nurses station area raising her voice to the staff, she was looking for her ranch dressing. R44 had several staff members pass her while she was in the hallway waiting. None of the staff members attempted to redirect R44 back down the hall toward her room until they had found the salad dressing bottle. On 8/19/24 at 2:00 PM, R44 was in her room. During the interview, R44 had a repeated cough and congestion symptoms. On 8/20/24 at 1:40 PM, V2 (Director of Nursing) stated if a COVID-19 positive resident is out of their room the staff should attempt to redirect the resident back to their room as soon as possible. The first positive resident we had was on 7/21/24, and we had the 3 new positives on 8/4/24. The facility's undated COVID-19 policy showed residents COVID-19 transmission based precautions should have transport and movement outside their room limited to medically essential purposes. 35541 2. A facility roster dated 8/19/24 showed R40 and R91 resided in the same room in the facility. R40's Communication Form and physician orders dated 8/20/24 showed R40 was placed on strict contact/droplet isolation for possible COVID exposure as R40 had developed COVID-like symptoms of a congested, productive cough. The form showed R40 refused to be tested for COVID. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/24 at 9:11 AM, a droplet/contact isolation sign hung on the door of R40 and R91's room. V9 (Registered Nurse/RN) entered the room to administer medications to R91 but R91 was not in his room. R40 was in bed, actively coughing. When V9 was asked about R40's cough, V9 stated R40 had developed a cough and COVID-like symptoms overnight so was placed on droplet/contact isolation. V9 stated R40 had refused any COVID testing. At 9:14 AM, V9 (RN) found R91 seated in the second floor dining room, eating breakfast with thirteen other residents noted in the room. R91 wore no protective mask. V9 administered medications to R91. On 8/21/24 at 9:52 AM, V2 (Director of Nursing) stated, (R91) should be wearing a mask when he is out of his room. Any resident that has had close contact with someone exhibiting COVID symptoms are tested but don't need to be isolated if negative with no symptoms. They do need to wear a mask when out of their room for ten days post-exposure. The facility's COVID-19 policy (undated) showed residents who are not symptomatic but have had close contact with someone who has COVID-19 do not need to be isolated but do need to wear source control (masks) when out of their rooms for ten days post-exposure. 3. R9's physician order dated 8/22/23 showed R9 was on Enhanced Barrier Precautions (EBP) do to the placement of her urinary catheter. On 8/20/24 at 8:47 AM, an EBP isolation sign hung on the door to R9's room. V10 (Certified Nursing Assistant/CNA) and V11 (CNA) entered R9's room without donning protective gowns, only masks and gloves. V10 and V11 provided incontinence care to R9 which included cleansing R9's left buttock pressure injury and the handling of R9's urinary catheter. On 8/21/24 at 11:01 AM, V2 (Director of Nursing) stated any resident with a urinary catheter, gastrostomy tube, or wounds are to be placed on Enhanced Barrier Precautions (EBP). V2 stated staff are to wear gowns, gloves, and masks when providing cares to residents on EBP. 40798 4. R57's Order Summary Report dated 8/19/24 shows an active order for EBP for device care or use of feeding tube. On 8/19/24 at 9:43 AM, R57 was lying in his bed with tube feeding infusing. There were no signs on his door or in his room regarding enhanced barrier precautions and no PPE was located outside of his room. R60's Order Summary Report dated 8/19/24 shows an active order for EBP for device care or use of feeding tube. On 8/19/24 at 9:53 AM, R60 was lying in her bed with tube feeding infusing. There were no signs on her door or in her room regarding enhanced barrier precautions and no PPE was located outside of her room. On 8/21/24 at 10:50 AM, V2, Director of Nursing, said they follow the CDC guidelines for infection prevention/isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the CDC (Centers for Disease Control and Prevention) website dated 6/28/24 https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/faqs.html Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of Precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure Precautions are followed. According to the CDC website (updated 7/12/22) https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, residents with an indwelling medical device (including a feeding tube) are to be placed on EBP, regardless of MDRO colonization status. 34506 5. R33's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including malnutrition, palliative care, morbid obesity, depression, anxiety disorder, and dementia. R33's Order Summary Report dated August 19, 2024 shows an order for indwelling urinary catheter and EBP (Enhanced Barrier Precautions) for device care or use of urinary catheter. R33's Care Plan initiated March 5, 2024 shows, Enhanced barrier Precautions will be implemented during high contact resident care activities. On August 19, 2024 at 10:11 AM, there was a sign outside of R33's door that showed, Enhanced Barrier Precautions Everyone Must: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, changing linens, providing hygiene, and changing briefs or assisting with toileting. V4 (Certified Nursing Assistant/CNA) provided incontinence care to R33. V4 did not wear a gown while she changed R33's linens or changing her incontinence brief. The facility's Enhanced Barrier Precautions dated December 14, 2023 shows, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug resistant organism acquisition of those with an increased risk of acquiring MDROs including resident with a chronic wound or an indwelling medical device. 6. R17's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including dementia, non pressure chronic ulcer of skin, depressive episodes, and kidney disease. On August 19, 2024 at 9:56 AM, V4 (CNA) and V5 (CNA) provided incontinence care for R17. There was a large amount of urine and stool in R17's incontinence brief. V5 wiped R17's front peri area, then turned R17 onto his side. V5 then wiped R17's buttocks, applied cream to R17's buttocks. V5 turned R17 back onto his back and then touched R17's pillow under his head. V5 did not change her gloves or perform hand hygiene. 7. R19's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including hemiplegia, dementia, anxiety disorder, and heart failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's Care Plan revised on July 8, 2024 shows R19 experiences bowel and bladder incontinence due to dementia, chronic kidney disease stage three, diabetes, atrial fibrillation, and anxiety. On August 19, 2024 at 10:56 AM, V6 (CNA) and V4 (CNA) provided incontinence care on R19. V6 folded down R19's incontinence brief in between R19's legs while she was laying on her back. V6 then helped R19 turn onto her left side. V6 wiped the stool from R19's buttocks, placed a new incontinence brief underneath R19, then turned R19 back onto her back. V6 then wiped the stool from R19's front peri area, removed R19's gown, placed clean pants and a clean blouse onto R19. V6 did not change her gloves or perform hand hygiene. On August 20, 2024 at 1:32 PM, V14 (CNA) said gloves should be changed after touching dirty items and before touching clean items to prevent infection. The facility's Hand Washing and Hand Hygiene policy dated June 4, 2020 shows, Appropriate hand hygiene is essential in preventing the spread of infectious organisms in healthcare settings. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items.