STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145611	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Wellness Rehab Villas	1251 East Richton Road Crete, IL 60417

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on interview and record review, the facility failed to provide a resident and/or their family/POA (POA/Power of Attorney) in writing of the reason for transfer to the hospital. The facility also failed to notify the ombudsman of the transfer. This applies to 6 of 6 residents (R26, R35, R50, R68, R72, and R73) reviewed for discharge in a sample of 30. The findings include: 1. R26's Face Sheet showed R26 was admitted to the facility on [DATE]. R26 had multiple diagnoses which included multiple sclerosis, dementia, diabetes, emphysema, hypertension, and major depressive disorder. R26's MDS (Minimum Data Set) dated 11/04/24 showed R26 had severe cognitive impairment. R26's Progress Notes showed the following: 08/20/24 at 6:45 PM Writer called to resident room by CNA'S (Certified Nursing Assistant). Resident noted slow to respond to verbal stimuli, as her normal baseline is AOX4, ashen color to skin noted, skin diaphoretic warm to touch. Noted for bloody (dark red) stool or urine, unable to determine which orifice blood is coming from. Writer notified NP (Nurse Practitioner) on call, received T.O (Telephone Order) to transfer to (Hospital) for evaluation. Daughter notified of change of condition and new orders for transfer. 08/20/24 at 7:34 PM Report given to (Hospital), daughter notified of the hospital being transferred to. 08/24/24 at 8:50 PM Resident is [AGE] years old was admitted to (Hospital) for sepsis and GI bleed, she is a full code has NKA (No Known Allergies), regular diet with thin liquids, and oriented times one to two fall risk. Resident came with a foley due to excoriation, skin is intact. Resident has a history of heart failure, stroke, dementia, diabetes, hypertension, multiple scoliosis contracted. Resident was readmitted back to room [ROOM NUMBER]-2. Resident came back with the same medications treated for sepsis in the hospital. NP notified, orders carried out, family POA (Power of Attorney) notified, will be here tomorrow to visit resident. R26's After Visit Summary from the hospital showed R26's dates of admission to the hospital were 08/20/24 through 08/24/24. The electronic medical record showed no documentation of written notice of reason for transfer or discharge to the hospital given to the resident or POA. The electronic medical record showed no notification to the Ombudsman for transfer or discharge to hospital. Facility unable to provide written documentation to the resident, POA, and Ombudsman. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R50's Face Sheet showed R50 was admitted to the facility on [DATE]. R50 had multiple diagnoses which included benign neoplasm of right bronchus and lung, anemia, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. R50's MDS dated [DATE] showed R50 had sever cognitive impairment. R50's After Visit Summary from the hospital showed R50's dates of admission to the hospital were 02/05/24 through 02/07/24. R50's Progress Notes showed the following: 02/05/24 at 11:20 AM Resident in bed, HOB (Head of Bed) elevated, alert and oriented, verbally communicates needs. On oxygen as needed, respirations are regular, even, and unlabored. Skin is warm and dry to the touch. No s/s (signs and symptoms) of distress or discomfort noted at this time. Incontinence care provided by staff. Resident was in the dining room noted not responsive but breathing. Resident was brought to the room assisted to bed. Resident started responding. (Ambulance) was called. Resident assessed by the NP. Resident was transferred to the ER (emergency room) for evaluation. Family called, no answer. Call light within reach will continue to monitor. 02/07/24 at 10:51 AM Received resident in bed, alert and verbally responsive. Resident was admitted to facility from (Hospital) for syncope. Resident was brought to facility in a stretcher by (Ambulance), was readmitted back to room [ROOM NUMBER] bed two. Resident according to report had a dressing on her bottom. Upon assessment resident skin was dry but intact. Family and NP made aware. NP gave an order to continue the medications from the hospital. Orders carried out. The electronic medical record showed no documentation of written notice of reason for transfer or discharge to the hospital given to the resident or POA. The electronic medical record showed no notification to the Ombudsman for transfer or discharge to hospital. Facility unable to provide written documentation to the resident, POA, and Ombudsman. 3. R72's Face Sheet showed R72 was admitted to the facility on [DATE]. R72 had multiple diagnoses which included dementia, atherosclerotic heart disease, anxiety disorder, cognitive communication deficit, need for assistance with personal care, and hypertension. R72's MDS dated [DATE] showed R72 had moderately impaired cognition. R72's hospital records showed on 07/14/24 R72 had an emergency room to hospital admission. R72's After Visit Summary from the hospital showed she was discharged back to the facility on [DATE]. R72's Progress Notes showed the following: 07/14/24 at 6:10 PM Nurse was called to the room that resident was complaining of chest pain. Writer came, assessed resident, stated she was having pain to the left breast. Resident was assisted into a w/c (wheelchair) then to her bed. Resident complained of chest pain, Nitro given, 911 called. Saturation was in the 80's, a non-rebreather was administered. Saturation came up to 100%. 911 arrived. Resident was taken to (Hospital). 07/14/24 at 6:44 PM Resident was taken on a stretcher by 911 crew. NP on call was notified and POA by voicemail. 07/15/24 at 7:00 PM 88y (year) old female returned from hospital visit. Resident assist off the ambulance gurneyx2 assist. Resident refused to transfer to bed and chair. Resident up ambulating in room, gait unsteady. Staff attempts to assist resident with ambulating, resident very resistive. Staff stays at bedside for now, will continue to monitor. 07/15/24 at 7:25 PM POA notified of resident return to facility. The electronic medical record showed no documentation of written notice of reason for transfer or discharge to the hospital given to the resident or POA. The electronic medical record showed no notification to the Ombudsman for transfer or discharge to hospital. Facility unable to provide written documentation to the resident, POA, and Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44387 4. R73's Hospital Admission Face sheet shows that R73 was admitted to the hospital on 10/3/24 due to worsening confusion. R73 was found to have acute catheter associated UTI (Urinary Tract Infection). R73's progress notes of 10/3/24 at 11:06 PM states that resident was transported to the hospital. 5. R35's After Visit Summary shows that R35 was admitted to the hospital on 10/10/24 to 10/14/24 with the diagnoses of acute and chronic respiratory failure with hypercapnia. R35's progress notes of 10/10/24 at 3:06 PM states that resident was admitted at hospital for respiratory failure. 6. R68's After Visit Summary shows that R68 was admitted to the hospital on 10/17/24 to 10/24/24 with the diagnoses of complicated Urinary Tract Infection. On 12/5/24, V1 (Administrator) and V2 (Director of Nursing/DON) said they are not providing written documentation of the bed hold policy to the residents, family, or the ombudsman when the residents are sent to the hospital. The facility's Bed Hold and Readmission policy (effective 11/2016) states that residents, or their designated representative, shall be informed of this policy at time of admission, and the time of transfer to a hospital or therapeutic leave which extends beyond 24 hours. The facility provides written notification at the time of transfers as included in the designated state form. A specific bed may be held for 10 days for the recipient of Medicaid benefits in accordance with State Plan.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to provide in writing to the residents and/or their POA (POA/Power of Attorney) regarding bed hold and return at the time of discharge to the hospital. This applies to 6 of 6 residents (R26, R35, R50, R68, R72, and R73) reviewed for discharge in a sample of 30. The findings include: 1. R26's Face Sheet showed R26 was admitted to the facility on [DATE]. R26 had multiple diagnoses which included multiple sclerosis, dementia, diabetes, emphysema, hypertension, and major depressive disorder. R26's MDS (Minimum Data Set) dated 11/04/24 showed R26 had severe cognitive impairment. R26's Progress Notes showed the following: 08/20/24 at 6:45 PM Writer called to resident room by CNA'S (Certified Nursing Assistant). Resident noted slow to respond to verbal stimuli, as her normal baseline is AOX4, ashen color to skin noted, skin diaphoretic warm to touch. Noted for bloody (dark red) stool or urine, unable to determine which orifice blood is coming from. Writer notified NP (Nurse Practitioner) on call, received T.O (Telephone Order) to transfer to (Hospital) for evaluation. Daughter notified of change of condition and new orders for transfer. 08/20/24 at 7:34 PM Report given to (Hospital), daughter notified of the hospital being transferred to. 08/24/24 at 8:50 PM Resident is [AGE] years old was admitted to (Hospital) for sepsis and GI bleed, she is a full code has NKA (No Known Allergies), regular diet with thin liquids, and oriented times one to two fall risk. Resident came with a foley due to excoriation, skin is intact. Resident has a history of heart failure, stroke, dementia, diabetes, hypertension, multiple scoliosis contracted. Resident was readmitted back to room [ROOM NUMBER]-2. Resident came back with the same medications treated for sepsis in the hospital. NP notified, orders carried out, family POA (Power of Attorney) notified, will be here tomorrow to visit resident. R26's After Visit Summary from the hospital showed R26's dates of admission to the hospital were 08/20/24 through 08/24/24. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. 2. R50's Face Sheet showed R50 was admitted to the facility on [DATE]. R50 had multiple diagnoses which included benign neoplasm of right bronchus and lung, anemia, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. R50's MDS dated [DATE] showed R50 had sever cognitive impairment. R50's After Visit Summary from the hospital showed R50's dates of admission to the hospital were 02/05/24 through 02/07/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R50's Progress Notes showed the following: 02/05/24 at 11:20 AM Resident in bed, HOB (Head of Bed) elevated, alert and oriented, verbally communicates needs. On oxygen as needed, respirations are regular, even, and unlabored. Skin is warm and dry to the touch. No s/s (signs and symptoms) of distress or discomfort noted at this time. Incontinence care provided by staff. Resident was in the dining room noted not responsive but breathing. Resident was brought to the room assisted to bed. Resident started responding. (Ambulance) was called. Resident assessed by the NP. Resident was transferred to the ER (emergency room) for evaluation. Family called, no answer. Call light within reach will continue to monitor. 02/07/24 at 10:51 AM Received resident in bed, alert and verbally responsive. Resident was admitted to facility from (Hospital) for syncope. Resident was brought to facility in a stretcher by (Ambulance), was readmitted back to room [ROOM NUMBER] bed two. Resident according to report had a dressing on her bottom. Upon assessment resident skin was dry but intact. Family and NP made aware. NP gave an order to continue the medications from the hospital. Orders carried out. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. 3. R72's Face Sheet showed R72 was admitted to the facility on [DATE]. R72 had multiple diagnoses which included dementia, atherosclerotic heart disease, anxiety disorder, cognitive communication deficit, need for assistance with personal care, and hypertension. R72's MDS dated [DATE] showed R72 had moderately impaired cognition. R72's hospital records showed on 07/14/24 R72 had an emergency room to hospital admission. R72's After Visit Summary from the hospital showed she was discharged back to the facility on [DATE]. R72's Progress Notes showed the following: 07/14/24 at 6:10 PM Nurse was called to the room that resident was complaining of chest pain. Writer came, assessed resident, stated she was having pain to the left breast. Resident was assisted into a w/c (wheelchair) then to her bed. Resident complained of chest pain, Nitro given, 911 called. Saturation was in the 80's, a non-rebreather was administered. Saturation came up to 100%. 911 arrived. Resident was taken to (Hospital). 07/14/24 at 6:44 PM Resident was taken on a stretcher by 911 crew. NP on call was notified and POA by voicemail. 07/15/24 at 7:00 PM 88y (year) old female returned from hospital visit. Resident assist off the ambulance gurneyx2 assist. Resident refused to transfer to bed and chair. Resident up ambulating in room, gait unsteady. Staff attempts to assist resident with ambulating, resident very resistive. Staff stays at bedside for now, will continue to monitor. 07/15/24 at 7:25 PM POA notified of resident return to facility. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Bed Hold and Readmission Policy dated November 2016 showed- Policy: It is the policy of this facility to readmit residents after hospitalization s or temporary therapeutic leave when the resident requires services which can be provided by the facility. This may be accomplished by holding a specific bed or by making available the next semi-private accommodations in the event a resident does not desire to hold the specific bed. Standards: 1. Residents, or their designated representative, shall be informed of this policy at the time of admission and at the time of transfer to a hospital, or for therapeutic leave which extends beyond 24 hours. The facility provides written notification at the time of transfer as included in the designated stated form. The notice to the resident or their representative will specify the facility's policy, the duration of the state bed hold policy and the reserve bed payment policy. 2. In the event of an emergency hospitalization the resident or their representative shall be notified by telephone or in person of this policy, within 24 hours, and asked to provide the facility with their decision. The staff member making the call or explaining the policy may accept verbal determination as to whether the resident desires bed hold or having their name placed on the reservations/waiting list and shall document same in the medical record and in the progress notes. Follow up written confirmation may be required. 44387 4. R73's Hospital Admission Face sheet shows that R73 was admitted to the hospital on 10/3/24 due to worsening confusion. R73 was found to have acute catheter associated UTI (Urinary Tract Infection). R73's progress notes of 10/3/24 at 11:06 PM states that resident was transported to the hospital. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. 5. R35's After Visit Summary shows that R35 was admitted to the hospital on 10/10/24 to 10/14/24 with the diagnoses of acute and chronic respiratory failure with hypercapnia. R35's progress notes of 10/10/24 at 3:06 PM states that resident was admitted at hospital for respiratory failure. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. 6. R68's After Visit Summary shows that R68 was admitted to the hospital on 10/17/24 to 10/24/24 with the diagnoses of complicated Urinary Tract Infection. No bed hold documentation uploaded into the medical record. The facility was unable to provide documentation of bed hold given to the resident and/or the POA. On 12/5/24, V1 (Administrator) and V2 (Director of Nursing/DON) said they are not providing written documentation of the bed hold policy to the residents, family or the ombudsman when the residents are sent to the hospital.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 41384 Based on observation, interview, and record review, the facility failed to provide ADL care (Activities of Daily Living) for 5 residents (R20, R69, R10, R62, & R5) who are dependent on care for daily living in a sample of 30. The findings include: 1. On 12/3/24 at 10:51 am R10 was observed with long jagged nails, white flakes of skin on the right upper side of his gown next to his face and his face had dry flaking skin. R10's 11/12/24 MDS (minimum data set) section C showed that R10's cognition is severely impaired. R5's 11/12/24 MDS section GG showed that R10 is dependent on staff for personal hygiene. R10's 3/8/24 care plan showed that R10 is dependent on ADLs with approaches including provided assistance with ADLs as needed. On 12/05/24 11:02 AM V1 DON (Director of Nursing) said that nail care and skin care should be provided as needed. 2. On 12/03/24 at 10:10 AM R20 was observed with long jagged fingernails. R20's 11/24/24 MDS section GG showed that R2 needs partial/moderate assistance for hygiene from staff. On 12/05/24 at 10:15 AM V2 said R20 should not have long jagged nails because he could scratch himself. V2 looked at R20 EHR (Electronic Health Record) and said that she could not find any documentation showing that R20 has refused any ADL care. 3. On 12/03/24 at 10:36 AM R69 was observed with long jagged fingernails with a brown substance under the nails. R69's feet were observed with dry flaking skin. R69's 10/4/24 MDS section C showed that R69's cognition is severely impaired. R69's 10/4/24 MDS section GG showed that R69 needs setup or clean-up assistance from staff for personal hygiene. R69's 10/25/24 care plan showed that R60 is limited in his ability to perform his ADLs related to Alzheimer's and lack of coordination. On 12/05/24 at 10:26 AM V2 (DON) said that staff should provide nail care as needed because of hygiene, dignity, infection control and safety. V2 said that the resident can scratch themself and or others. V2 said that R69 does not refuse any ADL care and that there is no reason that his nails and skin were like that. V2 said that staff should provide lotion to the residents' skin every day and as needed. 4. On 12/03/24 at 10:19 AM R62 was observed with dry flaking skin on his feet and his fingernails were observed long, jagged and with a brown substance under the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/24 at 12:34 PM R62 was observed with long nails with a brown substance under the nails and V20 CNA (Certified Nurses' Assistant) brought his lunch tray into him, set up his tray but did not ask R62 if he would like to have his hands cleaned before he ate. At 12:36 PM V20 said that she did not ask R62 if he wanted his hands cleaned before he ate because she had given him a bath that morning between 730 AM and 8 AM. V20 said that she had seen the brown substance under his nails and that she should have offered to clean his hands before he ate. R62's 9/12/24 MDS section C showed that R62's mental cognition is moderately impaired. R62's 8/15/24 care plan showed that R62 has a decline in self-care related to cerebral palsy with approaches including providing assistance with ADLs as needed. On 12/05/24 at 11:06 AM V1 (DON) said that staff should provide nail and skin care as needed. 5. On 12/03/24 at 01:33 PM R5 was observed in her room with dry flaking skin on her forehead and scalp, hair oily, and her chin and upper lip was observed with long facial hair. R5 said that her hygiene bothers her and makes her frustrated. R5 said that she has not had a shower, or bed bath in over a month. R5 said that it has been weeks since her hair was washed because the facility does not have enough staff. R5's 9/11/24 MDS section C showed that R5's cognition is intact. R5's MDS section GG showed that R5 needs supervision or touching assistance with personal hygiene. On 12/05/24 at 11:08 AM V1 (DON) said that R5 does not refuse care and staff should be providing hygiene and shaving her. The facility's Activities of Daily Living (ADL) policy dated 2/2023 the policy shows that in accordance with the comprehensive assessment the facility will provide care and services including hygiene, bathing, dressing, grooming. and oral care.

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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** 41384 Based on observation, interview and record review, the facility failed to have fall interventions in place for 4 residents (R20, R51, R71, & R83) who are at risk for falls in a sample of 30. The findings include: 1. On 12/03/24 at 10:10 AM, R20 was standing up next to his bed, his wheelchair on the side of his bed, out of R20 reach. R20 was wearing only socks, and the socks were not non-skid or slip resistant. R20's electronic health record showed that R20 has a history of falls, 10/20/24 Fall report, and 12/12/23 Fall report, and 6/22/24 Quarterly fall report all show that R20 is a high risk for falls. R20's 10/21/24 care plan showed that R20 is at risk for falling related to nontraumatic intracranial hemorrhage, spastic hemiplegia with approaches including provide proper, well-maintained footwear. On 12/05/24 at 09:15 AM R20 was in his room sitting in his wheelchair, V2 (Director of Nursing) and the R20 without shoes and wearing socks that were not non-skid. V2 said that R20 should be wearing proper footwear. 2. On 12/3/24 at 10:36 AM R83 in his bed and no mats were observed on the floor next to his bed. On 12/5/24 at 12:04 PM R83 in his bed and no mats were observed on the floor next to his bed. R83's 7/31/24 care plan showed R83 is at risk for falls with approaches including apply fall mats to floor when R83 is in bed. On 12/05/24 at 10:02 AM V2 (Director of Nursing) said that R83 should have fall mats on the floor next to his bed for safety because he is a high risk for falls. The facility's Fall and Fall Risk, Managing policy dated August 2008 showed that staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and trying to minimize complications from falling. The policy shows that the staff with the input of the attending physician will identify appropriate interventions to reduce the risk of falls. The staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 46003 3. R51 diagnoses includes hemiplegia and hemiparesis following cerebral infarction, hydronephrosis, retention of urine, chronic obstructive pulmonary disease, abnormal posture, lack of coordination, dysphagia, cognitive communication deficit and atrial fibrillation. On 11/2/24 V6 LPN (Licensed Practical Nurse) completed a fall risk observation and identified R51 as high risk for falls. On 12/04/24 at 12:28 PM, R51observed at the dining room table wearing regular tube socks without skid protection and without shoes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/24 at 12:57 PM, V16 CNA (Certified Nursing Assistant) assigned to R51 did not know what fall interventions were in place for him. V16 CNA stated she did not have access to resources to inform her of interventions in place for R51. V16 stated the nurse communicates to the CNA's any changes in residents' care. On 12/05/24 at 01:01 PM, V6 LPN did not know what fall interventions were in place for R51 or where to look for them. On 12/05/24 at 2:08 PM, V2 DON (Director of Nursing) stated R51 is a fall risk, there are care cards in residents' closets to reference for the CNAs. R51 is impulsive at times and should have on non-slip footwear. 34410 4. R71 is a [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE]. On 12/03/24 at 10:42 AM, R71 was in his bed with the floor mat almost four feet away was from the bed. On 12/03/24 at 10:42 AM, V22 (CNA) stated that she moved floor mat to make the resident (R71) sit at the bedside to eat his breakfast, and then she forgot to move it back to the bedside. A review of the R71's fall risk assessment dated [DATE] document that R71 is at high risk for fall. A record review of the fall log indicates that R71 has had multiple falls within the last six months. On 12/04/24 at 12:10 PM, V2 (Director of Nursing / DON) stated that the floor mat should be close to the bed to prevent injury in case of a fall. A review of the facility provided Fall and Fall Risk, managing policy revised on August 2008 document: Staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Wellness Rehab Villas	1251 East Richton Road Crete, IL 60417

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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** 44387 Based on observation, interview, and record review, the facility failed to properly position resident's indwelling catheter bag/drainage bag during wound care dressing change. The facility failed to provide incontinent care to residents in a timely manner. This applies of 6 of 6 residents (R14, R24, R29, R71, R73 and R83) reviewed for indwelling catheters and incontinent care in a sample of 30. The findings include: 1. On 12/4/24 at 9:54 AM, V13 (Registered Nurse/RN) was gathering supplies outside of R73's room for wound care dressing change. At 9:58 AM, V16 (Certified Nurse Aide/CNA) was already in R73's room providing care. R73's catheter drainage bag was on the right side of the bed, not below the bladder. V13 approached R73 and informed him of the wound dressing change, and instructed V16 to turn R73 on his left side so she could access the wounds on R73's back and sacral area. R73's catheter drainage bag was on the bed throughout the wound dressing change, backflow of urine was noted in the catheter tubing. R73 had a suprapubic indwelling catheter. Review of R73's Electronic Medical Records shows that R73 has the following diagnoses of spinal stenosis cervical region, pressure ulcer of sacral region stage 4, quadriplegia, neuromuscular dysfunction of bladder, sepsis, hematuria, urinary tract infection (UTI), retention of urine and resistance to multiple antibiotics. R73's Minimum Data Set (MDS) of 9/18/24 shows that R73's cognition is intact. R73 has a physician order for indwelling catheter. R73's care plan (start date 6/26/24) shows that he requires an indwelling suprapubic catheter related to urinary retention and neuro-bladder dysfunction with intervention to position bag below level of bladder. R73's Hospital Admission Face sheet shows that R73 was admitted to the hospital on 10/3/24 due to worsening confusion. R73 was found to have acute catheter associated UTI. On 12/5/24 at 12:19 PM, V10 (Infection Preventionist/Assistant Director of Nursing) said the catheter drainage bag should not be on the bed, should be below the bladder to prevent backflow of urine and to prevent UTI. V10 said has a history of UTIs, his late UTI was in September, and he had Acinetobacter Baumannii Complex/CRAB (gram negative bacteria) in his urine. V10 said they also collected urine sample on V10 today because he was confused, and they are waiting on the results of the urine sample. The facility's Catheter Care, Urinary (revised 9/2005) states that the urinary catheter drainage bag must be held or positioned lower than bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the urinary bladder. 41384 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 12/03/24 at 10:36 AM R83 observed in his bed with a heavily soiled brief with colored lines on the bottom of the brief indicating that the brief was wet. R83 said that he had been trying to get someone to change his brief since early that morning. R83 said that he had already turned on his call light to be changed earlier. At 10:47 AM R83 turned on his call light while the State Surveyor was present and at 10:48 AM V8 CNA (Certified Nurses' Assistant) came into the room to answer the call light and asked if the staff had changed his brief yet. R83 said they had not. V8 said that when the staff does come back, she will help. V8 then turned off the call light and left the room. At 11:20 AM R83 was observed in his bed naked and no staff around. At 11:21 AM V8 came into R83 room with an incontinence brief in her hand and then she put the brief on R83. On 12/05/24 at 10:22 AM V2 DON (Director of Nursing) said that if residents are not provided incontinence care timely it can possibly cause UTIs (urinary tract infections) and skin infections. R83's 10/18/24 MDS (Minimum Data Set) section GG showed that R83 need substantial/maximal assistance from staff for personal hygiene. R83's 7/9/24 care plan showed that R83 has alteration in skin integrity with approaches including for staff to provide ADL care as needed. 34410 3. R14 is a [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE]. The MDS also documents that R14 is dependent on toileting hygiene. On 12/3/24 at 11:20 AM, V23 (Certified Nursing Assistant / CNA) checked on R14, and R14 was observed with a urine-soaked, blackish-colored incontinent brief. On 12/3/24 at 11:20 AM, V23 stated that she is not his (R14) assigned CNA, and they are supposed to check on residents for incontinent care every two hours. A review of the care plan documents that R14 was care planned for incontinent bowel and bladder, with interventions including providing incontinent care after each incontinent episode. 4. R24 is a [AGE] year-old female with severely impaired cognition, as per the MDS dated [DATE]. The MDS also documented that R24 is dependent on toileting hygiene. On 12/03/24 at 11:45 AM, R24 was observed with a urine-soaked brief with mild brownish discoloration on the brief (outside). On 12/03/24 at 11:45 AM, V21 (CNA) stated that she had not changed R24 yet as she was busy with other residents. V21 added that the residents should get incontinent care every two hours and as needed. A review of the R24's ADL care plan documents interventions, including providing incontinent care after each incontinent episode. 5. R29 is an [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE]. MDS also documented that R29 requires substantial/maximal assistance for toileting/hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 10:16 AM, V21 (CNA) checked on R29, and R29 was observed to have a urine-soaked brief with brownish discoloration. On 12/03/24 at 10:16 AM, V21 stated that she started her shift at 6:30 AM, and she was giving care to other residents, but she didn't get a chance to change R29. V21 continued to say that they should check on residents every two hours. A review of the R29's incontinence care plan documents interventions, including providing incontinent care after each incontinent episode. 6. R71 is a [AGE] year-old male with severely impaired cognition as per the MDS dated [DATE]. MDS also documented that R71 requires supervision or touching assistance with toilet hygiene. On 12/03/24 at 10:42 AM, R71 was on his bed with a urine-soaked diaper (front) with brownish discoloration. On 12/03/24 at 10:42 AM, V22 (CNA) stated that she changed R71 before breakfast at 7:00 AM and she was planning to change him again before lunch at 11:30 AM. V22 continued to say that she was the only CNA in her hallway, and she was watching all the residents in her hallway. The second CNA just showed up now. V22 added that they are supposed to check on residents every two hours. A review of the R71's fall care plan documents interventions, including providing toileting assistance every two hours. On 12/04/24 at 12:10 PM, V2 (Director of Nursing / DON) stated that incontinent care should be offered to residents every two hours and as needed. A review of the facility presented Urinary Incontinence - Clinical Protocol document: Treatment/Management 4. As appropriate, based on an assessment of the category and cause of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's incontinent status.

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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. 41384 Based on observation, interview, and record review, the facility failed to ensure that 2 residents (R5 & R10) received oxygen as their physician ordered in a sample of 30. The findings include: 1. On 12/03/24 at 01:33 PM, R5 observed in bed with oxygen on at 2 liters per minute through a nasal canula. On 12/05/24 at 11:22 AM R5 observed in her bed with oxygen on at 2 liters per minute through a nasal cannula. V2 DON (Director of Nursing) was present at the time. On 12/05/24 at 11:12 AM V2 said while looking at R5 EHR (Electronic Health Records), that R5's records showed that she is to be on 4 liters of oxygen continuously. R5's 11/26/24 Physician's Order showed, Oxygen: Nasal Cannula. Rate 4 liters/Min. Humidity 100 %. Continuous. 2. On 12/03/24 at 10:51 AM R10 observed in his bed with his nasal canula not in his nostrils but around his neck. At 10:56 AM to 11:03 AM V6 was in R10 room adjusting his bed and repositioning him in his bed but did not put his oxygen cannula in his nostrils. V6 did not put R10's oxygen on him until the State Surveyor brought it to her attention that R10 did not have the canula in his nostrils. V6 says My God, I don't know how long he has been without his oxygen. At 11:17 AM V6 was in R10's room with V9 (Nurse) raised the head of R10 bed and begins laughing about R10 not having his oxygen on. R10's 11/6/24 physician's order showed oxygen nasal cannula. Rate 2 liters oxygen per nasal cannula as needed for shortness of breath every shift. On 12/05/24 at 11:03 AM V2 DON (Director of Nursing said that she expects the nurse to check that the resident's oxygen is on, that it is at the right rate, and that the nasal canula is on. V2 said that this needs to be done to ensure that the resident is getting enough oxygen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44387 Based on observation, interview and record review, the facility failed to obtain physician orders for over-the-counter medications and to have medications stored in resident rooms. This applies to 6 of 6 residents (R13, R58, R66, R67, R72 and R73) reviewed for medications in the sample of 30. The findings include: 1. On 12/3/24 at 10:26 AM, R73 was observed in bed watching TV. R73 had a bottle of eye vitamin and mineral supplement on a dresser in his room. R73 said he has been using it for two years. On 12/4/24 at 9:42 AM, the bottle of eye vitamin and mineral supplement was still noted in R73's dresser. On 12/5/24 at 10:03 AM, the bottle of eye vitamin and mineral was still in R73's room. Review of R73's Electronic Medical Records (EMR) shows that R73 has the following diagnoses of glaucoma. R73's Minimum Data Set (MDS) of 9/18/24 shows that R73's cognition is intact. Review of R73's current physician order was done, R73 did not have an order for eye vitamin and mineral and did not have an order for medication to be stored in resident room. 2. On 12/3/24 at 10:35 AM, R13 was observed resting in bed in his room. There was a bottle of Nystatin topical powder 100,000 units per gram on his bedside table. R13 said he uses it on his groin area. On 12/5/24 at 9:55 AM, the bottle of Nystatin powder was still on R13's bedside table. Review of R13 EMR shows the following diagnoses of chronic obstructive pulmonary disease with acute exacerbation, muscle weakness, lack of coordination, and need for assistance with personal hygiene. R13's MDS of 8/29/24 shows that R13's cognition was intact. Review of R13's current physician order was done. R13 has an order for Nystatin Powder 100,000 units, apply to groin and scrotum twice a day. R13 does not have an order that states medications can be stored in residents' rooms. 3. On 12/3/24 at 10:56 AM, R67 was sitting in chair in her room doing a crossword puzzle. There were two bottles of eye drops on R67's bedside dresser. One bottle was Systane Complete lubricant eye drop and the other was Advanced eye drop. Surveyor asked R67 if the eyedrops were hers, she said, I don't think so. R67 shares the room with her husband. On 12/4/24 at 9:45 AM, the two bottle of eye drops were still on R67's bedside dresser. R67 said she uses the eyedrops daily for her eyes. Review of R67's EMR shows the following diagnoses of dementia, candidiasis of skin and nail, lack of coordination, need of assistance with personal care. R67's MDS of 9/12/24 shows that R67's cognition is moderately impaired. Review of 67's current physician was done, R67 has an order for Refresh Lacri-Lube ointment (Artificial Tear ointment) instill 0.25 inch in both eyes at bedtime for dry eye. R67 did not have an order the Systane Complete lubricant eye drop Advanced eye drop. R67 does not have an order that states medications can be stored in residents' rooms. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 12/3/24 at 11:05 AM, R66 was sitting in a chair in R67's room writing in a notepad. There was a bottle of Fluticasone Propionate nasal spray 50mcg (microgram) on a table next to R66, it had R66's name on the box. R66 said the nasal spray was his and he uses it. Review of R66's EMR shows the following diagnoses of Parkinson's disease without dyskinesia, other specified extrapyramidal and movement disorders, genetic related intellectual disabilities, weakness, and lack of coordination. R66's MDS of 9/13/24 shows that his cognition is intact. Review of R66's current physician was done; R66 has an order for Fluticasone 50mcg 1 spray in nostril two times a day for allergy. R66 does not have an order that states medications can be stored in residents' rooms. 5. On 12/3/24 at 11:50 AM, R58 observed in bed in her room. There was a bottle of Nystatin Powder 100, 000 units and a tube of Terconazole vaginal cream 0.4% on her bedside table. R58 said they were hers and she uses them. On 12/4/24 at 9:47 AM, the vaginal cream and Nystatin powder were still on R58's bedside table. Review of R58's EMR shows the following diagnoses of morbid obesity due to excess calories, major depressive disorder and personal history of urinary tract infection. R58's MDS of 10/22/24 shows that her cognition is intact. Upon review of R58's current physician order, R58 has an order for Nystatin 100, 000 units, apply toe perineal topically one time a day. R58 does not have an order that states medications can be stored in residents' rooms. On 12/5/24 at 12:57 PM, V2 (Director of Nursing/DON) said the residents have to be alert and oriented to have medications stored in the residents' rooms. V2 said there has to be an assessment done for residents to self-administer medications and there also has to be a physician order. The facility's Storage of Medications policy (revised 10/25/14) states that medications and biologicals are stored safely, securely and properly. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 48526 6. On 12/03/24 at 10:46 AM R72 was not in her room. One bottle of Fluticasone Propionate Nasal Spray USP (USP/United States Pharmacopeia) 50 mcg with an expiration date of 06/2025 on top of dresser drawer. On 12/03/24 at 11:19 AM R72 stated she did not know if the medication in her room on the dresser drawer was hers or not. On 12/03/24 at 2:39 PM V32 (Registered Nurse) went into R72's room with the surveyor. V32 removed the Fluticasone Nasal Spray from the room. V32 stated R72 is not able to self-administer medications and has not been assessed to self-administer medications. V32 stated R72 has dementia. V32 stated R72 does not have orders to self-administer medications, or an order for the nasal spray to be administered to her. V32 stated he does not know why the medication was in the R72's room. V32 stated the nasal spray should have been locked in the medication cart. V32 stated if R72 ingested the medication, she could become sick or die. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R72's Face Sheet showed R72 was admitted to the facility on [DATE] with multiple diagnoses which included dementia, anxiety disorder, chest pain, hypertension, disorientation, altered mental status, and cognitive communication deficit. R72's MDS dated [DATE] showed R72 had moderate cognitive impairment. R72's physician's orders for December 2024 showed no orders for R72 to self-administer medications or keep medications at the bedside. The same physician orders showed no order for Fluticasone. R72 did not have a care plan to self-administer medications or keep medications at bedside.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness. This applies to 80 residents in the facility receiving dietary services. Findings include: On [DATE] 10:55 AM, V26 (Dietary Manager) stated 80 residents were served from dietary services on [DATE]. On [DATE] at 10:01 AM, the kitchen tour was conducted with V26. The dry storage contained a facility contained labeled [NAME] powder was dated [DATE]. On [DATE] at 10:08 AM, the walk-in cooler contained a shelf labeled employee items included two personal lunch bags with food items, an 18 oz bottle of barbeque sauce, three unlabeled cups take sauce cups two with red sauce one with green sauce. Sliced Jalapenos 64 ounces dated [DATE]. An open 16-ounce bottle of water. A blue bottle with blue straw containing brown liquid was without a label or date. Two unlabeled pies dated ,d+[DATE]. Relish 128 ounces without a date. The facility policy Food Storage dated [DATE] states, food and non-food supplies are to be clearly labeled. Leftover foods are labeled, dated, immediately place under refrigeration, and used within 72 hours or discarded. On [DATE] at 10:30 AM, the one red sanitizing buckets sanitizer solution tested at 400 ppm (Parts Per Million). The facility policy Sanitation and Infection Control dated [DATE] states, sanitizer solution should read at 200 ppm (parts per million). On [DATE] at 10:33 AM, the vents over the stove were covered with grease and dust. The metal wall behind the stove was greasy with brown greasy grime drippings. Covered shelves containing neatly stacked dishware declared clean by V26 Dietary Manager and V27 Assistant Dietary Manager were caked with yellow crusts, dried food, and small dead black bugs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:46 AM, V27 Assistant Dietary Director was observed in the kitchen with her bangs exposed from under her hair net. The facility policy Sanitation and Infection Control dated [DATE] states, it is the facilities policy to store, prepare, distribute, and serve food in an acceptable manner as to prevent the growth of food borne pathogens. At all times, facilities shall be thoroughly cleaned and sanitized to protect against potential contamination including spoilage, unacceptable microbial growth, dust, unclean equipment or utensils, hair, flooding, drainage, chemicals, or other sources of contamination. On [DATE] at 12:08 PM, V33 Dietary Aide stated the temperature for the turkey sandwich should be 35 degrees or below. The turkey sandwich plate was taken from an open cart to be served during lunch was 64. 8 degrees F (Fahrenheit). The facility policy Food Storage dated [DATE] states, all readily perishable foods or beverages shall be maintained at temperatures of 41 degrees F or below. On [DATE] at 10:55 AM, V26 Dietary Manager stated food items should be labeled with delivery date. Open food products should have the open date and use by date written on them. The delivery date tells us when the food item was delivered. The open on and use by date lets everyone know when it expires. Eating expired foods can cause food borne illness. Anyone coming through the kitchen door should have their hair covered. The entire head should be covered. to keep hair from getting in the food and contaminating it. I was told we can keep employee food in the kitchen refrigerator if it's labeled as employee food on the shelf. My supervisor the regional director told me it was ok for employees to have a shelf in the refrigerator. Employees food being stored in the kitchen refrigerator is subject to the same standards of labeling and storage.

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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. 41384 Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene during provisions of bowel/bladder care and wound care, no signage for residents in EBP (Enhanced Barrier Precautions), improper disposal of PPE (Personal Protective Equipment), and improper practices for residents on transmission base precautions. This applies to 8 residents (R83, R54, R59, R62, R88, R13, R39, R73) reviewed for infection control in the sample of 30. The findings include: 1. On 12/3/24 at 11:21 am V8 (Certified Nurse's Assistant) was providing incontinence care for R83, V8 begins to attach a brief to R83 rolling him back and forth on the bed, then she removed his soiled gown, then V8 repositioned R83 in his bed, then she turns the volume down on his TV controller, returns to applying his brief, adjusts his sheet, adjust the bed height, then adjusts R83 again in his bed and touches the top of R83's bedside table. V8 did all of this without removing her gloves and cleaning her hands after removing the soiled gown. On 12/05/24 at 10:22 AM V2 (Director of Nursing) said that her expectations are that staff change their gloves and clean their hands when going from dirty to clean. 2 On 12/03/24 at 11:31 AM V6 (Nurse) went into R59's room to check her blood sugar. R59's 11/25/24 physician's order showed, contact with and suspected exposure to COVID-19, the facility's 12/3/24 10:04 Midnight Census report showed that R59 was PUI (Person Under Investigation) for COVID-19 and there were contact and droplet precautions signs on the wall outside of R59's room. V6 went into R59's room with a surgical mask on that she had been wearing previously to entering the room, gown, and gloves. V6 did not put on the required face shield/eye protector or N95. After V6 finished she came out of R59's room and said that there was no garbage container in the room and then V6 removed her gown and gloves in the hallway and disposed of them in the garbage container on the medication cart. V6 did not remove her surgical mask, she continued wearing it while providing care for the next resident. 3. V6 then continued to R88's room at 11:39 AM. R88 too had droplet and contact precaution signs on the wall next to her door. R88's electronic health records showed a diagnosis on 12/2/24 of COVID-19, a 12/2/24 physician's order for transmission-based precautions Contact and droplet precautions, and the facility's Midnight Census report dated 12/3/24 showed that R88 is COVID+. V6 put on a gown, pulled out an N95 mask out of her pocket (did not cover the N95 with another mask), and put on gloves. V6 did not put on a face shield or eye protector. V6 then went into R88's room to check her blood sugar. V6 removed her gloves and gown before leaving the room but kept the N95 mask on and continued to the next resident's room for their blood sugar sample. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 12/3/24 at 10:35 AM, R13 was observed resting in bed in his room. There were two bed pans on the floor, one bed pan was in a clear plastic bag, the other was not. There were three dirty towels on the floor and two blankets on top of R13 oxygen concentrator. R13 said he uses the bed pan because he is unable to walk. Review of R13 EMR shows the following diagnoses of chronic obstructive pulmonary disease with acute exacerbation, muscle weakness, lack of coordination, and need for assistance with personal hygiene. R13's MDS of 8/29/24 shows that R13's cognition was intact; needs substantial/maximal assistance with toileting hygiene and personal hygiene. 8. On 12/4/24 at 9:54 AM, V13 (Registered Nurse/RN) was gathering supplies outside of R73's room for wound care dressing change from the treatment cart. R73 was on Enhanced Based Precautions (EBP), signage was outside the door, had PPE (Personal Protective Equipment) supplies outside his room. V13 put on gown, gloves and mask and entered R73's room at 9:58 AM. V16 (Certified Nurse Aide/CNA) was already in R73's room providing care. V16 had full PPE on, gown, gloves, masks, and face shield. V13 set the wound care supplies on R73's bedside table, did not use a barrier and did not sanitize the table. V13 had V16 position R73 on his left side facing the window, so she could access the wounds on his back and sacral area. V13 removes the two dressings on R73's back; there was no drainage. V13 said the first wound was a stage 3 and the second wound was a stage 2. After removing the old, soiled dressing, V13 changes her gloves, did not perform hand hygiene with the glove change. V13 cleanses both wounds on the back with normal saline and gauze, applies Medihoney to the wounds and applies bordered dressing to each wound. V13 then removes old dressing on R73's sacral area, there was minimal light pink, serosanguineous drainage to the wound. V13 cleanses the wound with saline, packs the wound with gauze and Medihoney and applies bordered dressing. V13 said R73's sacral wound has improved, it used to have a lot of drainage. After completing the dressing change, V13 gathers a garbage and places it in clear garbage bag. V13 and V16 repositions R73 in bed. They needed an extra pillow to put under R73's leg, V16 removes her gown and gloves and leaves the room to get the pillow. There was no isolation bin in the room, there was a trash can with no trash bag in it, trash can was overflowing with gowns and gloves. Prior to leaving R73's room, V13 removes gown and gloves and puts in clear garbage bag. V13 said there should be an isolation bin in the room for disposal of used PPE. Review of R73's Electronic Medical Records shows that R73 has the following diagnoses of spinal stenosis cervical region, pressure ulcer of sacral region stage 4, quadriplegia, neuromuscular dysfunction of bladder, sepsis, hematuria, urinary tract infection (UTI), retention of urine and resistance to multiple antibiotics. R73's Minimum Data Set (MDS) of 9/18/24 shows that R73's cognition is intact. R73 has an order for Medihoney wound and urn dressing external past (wound dressing) apply to skin topically every day for skin. 9. On 12/5/24 at 12:19 PM, V10 (Infection Preventionist/Assistant Director of Nursing) said the nurse should have placed the wound dressing supplies on a foam tray/plate to prevent contamination. V10 said the nurse should perform hand hygiene with each glove change and should not move from dirty to clean during dressing changes. V10 said there should be trash bags in the trash cans to reduce contamination and to contain infections. V10 said they do can use regular trash cans for isolation rooms, there's no need for isolation bins as long as staff are disposing trash properly into the soiled utility room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 10:18 AM, V13 (RN) informed R39 of the wound dressing change. V13 said R39 has a venous ulcer wound on her left leg. V13 gathered wound dressing supplies and put on two sets of gloves and set the supplies on R39's bed. V13 then removes the old dressing, the date on the old dressing was 11/29/24. There was light yellowish/brownish drainage noted, wound on left lower leg had open areas. After removing the old dressing, V13 cleanses the wound with saline; V13 rolls up the old dressing, and then places R39's leg back on the bed and on top of the old dressing. V13 removes one set of gloves to dispose it, but there was no garbage can next to her. V13 returns to her treatment cart and gets a trash bag, and removes the second set of gloves, sanitizes her hands, and wears clean gloves. V13 applies treatment to the wound, Xeroform dressing/petroleum dressing on ABD pad and wraps the wound with gauze dressing. At 10:30 AM, V13 said R39's dressing are to be done daily and as needed. Review of R39's Electronic Medical Record shows that R39 has the following diagnoses of metabolic encephalopathy, dementia, convulsions, peripheral vascular disease, and non-pressure chronic ulcer of unspecified part of left lower leg. R39's Minimum Date Set of 9/25/24 shows that R39's cognition is moderately impaired. R39 has order to cleanse left lower leg wound with normal saline or wound cleanser, pat peri wound dry. Apply Xeroform, ABD pad, cover with roll gauze every 3 days and as needed if loose/soiled. On 12/4/24 at 11:53 AM, V10 (Infection Preventionist/Assistant Director of Nursing) said R39 has a chronic vascular wound without drainage and does not need to be placed on Enhanced Barrier Precautions (EBP). On 12/5/24 at 12:31 PM, V10 said R39's dressing changes should be done on Monday, Wednesday and Fridays, and the nurse should not have double gloves, nor should she have put clean supplies on the resident's bed because the bed is not clean. The nurse should have had staff assist her with the dressing change and should not have placed clean supplies on the bed. V10 said she placed on R39 on EBP because she as a vascular wound with drainage. The facility's Hand Washing/Hand Hygiene Policy (revised 3/2020) states that hand washing/hand hygiene procedures are a means to prevent the spread of infections amongst residents, personnel, and visitors. The use of gloves does not replace compliance with hand washing/hand hygiene procedures. The facility's Dressings Non-Sterile policy (effective 01/2017) states to prepare a clean, dry work area at bedside. Bring supplies into resident's room. Individual resident supplies maybe placed on the over bed table after it has been disinfected and protected barrier placed on the table (clean towel, plastic bag, small chux, foam tray). The facility's Enhanced Barrier Precautions policy (effective date 1/20/2024) states to implement EBP for residents with wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers. EBP refers to the use of gown and gloves for using high contact resident care activities for residents.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 46003 Based on observation, interview, and record review the facility failed to maintain the kitchen dishwasher and sink in good repair. This applies to 80 residents in the facility receiving dietary services. Findings include: On 12/05/24 10:55 AM, V26 (Dietary Manager) stated 80 residents were served from dietary services on 12/3/24. On 12/03/24 at 10:33 AM, V26 was unable to run the dishwasher stating it is currently not working. The trough like sink near the dishwasher was filled with dirty water. Covered shelves containing neatly stacked dishware declared clean by V26 Dietary Manager and V27 Assistant Dietary Manager were caked with yellow crusts, dried food, and small dead black bugs. On 12/03/24 at 10:42 AM, V27 Assistant Dietary Manager stated the dishwasher and sink have been backing up and not working since June. A shop vac is used to remove the water from the sink when it backs up. Dishes are either washed in the three-compartment sink for resident use or we use paper / disposable plates. On 12/04/24 at 12:08 PM, V33 Dietary Aide states residents' meals are served on Styrofoam when the dishwasher is not working. V33 stated the dishwasher works off and on and is not currently draining. On 12/05/24 at 10:46 AM, V18 Maintenance Director stated he has been in the facility for a month and has called twice for the sink / dishwasher repair. V18 stated the recommendation was the floor needs to be dug up to repair the drainage problem. The dishwasher has been repaired but not the drainage problem so the dishwasher still cannot be used. On 12/05/24 at 10:53 AM, Kitchen sink for dishwasher was filled with dirty standing water. On 12/05/24 at 10:55 AM, V26 Dietary Manager stated her employment in the facility began in August and there have been issues with the sink and dishwasher ever since she started. On 12/05/24 02:47 PM, V1 Administrator stated he did not have quotes or work order repairs going back to June. V1 stated he approved repairs for the floor to be dug up and pipes replaced on 12/04/24 and corporate submitted the approval for repairs. On November 26, 2024, a service request was created by V1 Administrator for Drain cleaning. Comment-request V1 request for pipes in dietary kitchen underground piping leading from the sink drain is clogged or broken. Needs to be pumped out, and camera line and fix pipe 11/29. 12/3 timeline - the work for job is not yet completed -not approved. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An August 23, 2024, work request was placed for the dishwasher broken wash gauge. On 10/8 timeline for repair quoted pending approval. On October 16, 2024, V1 submitted a request for repair of broken drainpipe. On 10/18 the quote was accepted. On 10/29 Repair technician comments the kitchen sink line is open to the pit, however the pit is full and needs to be pumped out. Coordination with a pump truck is needed. Will return when the pit is cleared and rod/ jet/ camera if needed from the pit out to the main. Customer is not approving further work. On November 5, 2024, V26 Dietary Manager submitted a work order for appliance in the kitchen that included the garbage disposal in the dishwasher. On 11/27 the repair timeline entry by V18 Maintenance Director update - set to complete. The facility policy Equipment Maintenance dated June 2023 states all food service equipment will be operated, maintained, serviced, and cleaned according to manufactures directions. The facility policy Sanitation and Infection Control dated June 2023 states, it is the facilities policy to store, prepare, distribute, and serve food in an acceptable manner as to prevent the growth of food borne pathogens. At all times, facilities shall be thoroughly cleaned and sanitized to protect against potential contamination including spoilage, unacceptable microbial growth, dust, unclean equipment or utensils, hair, flooding, drainage, chemicals, or other sources of contamination.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 44387 Based on observation, interview and record review, the facility failed to ensure the residents' call light system was functioning properly. This applies to 2 of 2 residents (R39 and R42) reviewed for functioning call lights in a sample of 30. The findings include: On 12/3/24 at 12:06 PM, R39 in bed. R39's sister was also at her bedside. R39 said her call light has not been working for a while. R39 said she either yells out for help or asks her roommate to use her call light when she needs help. R58 (R39's roommate) said she does use her call light to call for staff assistance when R39 needs help. R58 said they have told staff about the call light not working. At 12:07 PM, surveyor pushed R39's call light, the light did not come on in her room or outside her room. Review of R39's Electronic Medical Record shows that R39 has the following diagnoses of metabolic encephalopathy, dementia, convulsions, shortness of breath and delusional disorders. R39's Minimum Date Set of 9/25/24 shows that R39's cognition is moderately impaired and is dependent on staff for toileting hygiene, shower/bathe self and personal hygiene. R39's care plan (initiated on 12/3/24) shows that she is high risk for falls with intervention to have a call light. On 12/3/24 at 12:19 PM, surveyor informed V24 (Licensed Practical Nurse/LPN) about R39's call light not working. V24 checked the call light, pulled it out of the outlet, call light still was not working. V24 said resident's call light should be working and if it is not working, they should provide either a bell or doorbell for residents to use so they can call for assistance. On 12/5/24 at 11:43 AM, V1 (Administrator) said resident's call light should be working so that residents can call for help. V1 said if the call light is not working, they should transfer the resident to a room with a working call light or have staff round on the residents more frequently. The facility's Answering the Call Light policy (revised 8/2008) states the call system should be accessible to all residents. 46003 2. R42 diagnoses includes diabetes mellitus, acquired absence of right leg below the knee, dysphagia, anemia autistic disorder and hypertension. R42's care plan states he is limited in functional status regarding the ability to transfer self. Interventions include to keep the call light in reach. On 12/03/24 at 11:53 AM, R42's call light was cut short and not available for resident's use. On 12/05/24 at 12:45 PM, R42's call light was still cut short and not available for his use. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 12:48 PM, V22 CNA (Certified Nursing Assistant) stated R42 understands questions and follows directions. She did not know R42 did not have a working call light. When he needs assistance, he gets up and comes down the hallway to staff. On 12/05/24 at 02:08 PM, V2 DON (Director of Nursing) stated R42 should have a call light available to him. He is competent enough to use it.