STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145783	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Skilled Nur & Rehab	333 South Wrightsman Street Virden, IL 62690

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the Facility failed to prevent pressure ulcer development, implement preventative measures and follow physicians orders for 1 of 2 residents (R8) reviewed for skin integrity, in the sample of 41. Findings include: R8's Face Sheet dated 7/24/2024 documents R8 has a diagnosis of Dementia and disturbances of skin sensation. R8's Minimum Data Set (MDS) dated [DATE] documents R8 is severely cognitively impaired, always incontinent of urine, frequently incontinent of bowel, requires assistance for turning/bed mobility, and has one unstageable pressure area. R8's Care Plan dated 2/22/2021 documents R8 is at risk for impaired skin integrity due to cognitive deficits, impaired mobility, and requires assist with turning and repositioning. R8's Skin Inspection assessment dated [DATE] documents, Current skin concerns. It further documents R8 had an open area to her coccyx. R8's Skin and Wound Evaluation dated 6/18/2024 documents R8 had an unstagable pressure wound that was acquired in house (at the facility) that began on 4/25/2024. On 7/22/2024 at 9:57 AM, there was an odor in R8's room. V6, Certified Nursing Assistant (CNA) and V7, CNA, began providing incontinent care to R8. V7 stated R8 did not have any open areas on her skin. R8's pants, bottom of her shirt, and the mechanical lift sling were soiled with a wet substance. After removing R8's pants it was verified R8 had a large bowel movement. V7 began cleaning/wiping the feces from R8's backside. R8's right and left upper buttocks had quarter sized reddened areas. At this time V6 stated the reddened areas were caused by R8 sitting in her poop. It really hurts her. She's up (out of bed) about 6:30 (AM). V6 further stated breakfast trays come about 8 (AM) or after. On 7/24/2024 at 11:30 AM, V3, Assistant Director of Nursing (ADON) stated R8 did develop a pressure sore to her coccyx/sacrum (buttocks) area while at the facility on 4/25/2024 but they had healed on 6/18/2024. V3 stated she completed a skin check on R8 last week and she did not have any open areas. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/2024 at approximately 9:00 AM, R8 was located in her room, sitting in her wheelchair. On 7/24/2024 at 11:24 AM, R8 was located in her wheelchair in the dining area of the unit. At this time V18, CNA stated she will lay R8 down (in bed) after lunch. V18 stated she last checked R8 for incontinence after breakfast but wasn't sure what exact time it was. On 7/24/24 at 1:40 PM, R8 was observed laying on her back in bed with both heels laying flat on bed. R8's Progress Notes dated 7/21/2024 documents a CNA reported R8's right heel was soft and mushy; the area was assessed with no open area noted. R8's Skin Inspection assessment dated [DATE] documents, Right heel: apply skin prep every shift for 14 days then reassess. Float heels while in bed as preventative. The Facility's Pressure Ulcer policy dated 8/31/2023 documents, To provide guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview and record review, the facility failed to ensure care plan interventions were followed, assess resident smoking risk to prevent injury and provide appropriate supervision to prevent falls for 3 of 6 residents (R17, R46, R64) reviewed for safety and supervision in the sample of 41. Findings include: 1.R17's face sheet, dated 7/24/24, documented R17 was admitted to the facility on [DATE]. R17's face sheet documented R17 has diagnoses of left femur fracture, dementia, Alzheimer's disease, atherosclerotic heart disease, hypertension, and history of urinary tract infections. R17's MDS (Minimum Data Set), dated 4/26/24, documented that R17 is severely cognitively impaired and requires substantial/maximum assistance from staff with mobility. R17's fall risk assessment, dated 7/17/24, documented that R17 is high risk for falls. R17's care plan, undated, documented that R17 is to have the following fall interventions in place; dycem to wheelchair initiated 3/22/24, offer to toilet before meals initiated 5/22/24, drop wheelchair seat initiated 7/2/24, keep environment clutter free initiated 3/21/24, mat at bedside when in bed initiated 4/26/24, pressure alarm to bed initiated on 6/21/24, proper footwear at all times initiated 6/16/24, and provide adequate lighting initiated 3/21/24. The facility's incident log, dated 7/23/24, documented that R17 had falls on 5/22/24, 6/15/24, and 7/2/24. On 7/23/24 at 9:30 am R17 was transferred from her wheelchair onto her bed. R17 did not have dycem placed in her wheelchair as care planned to help reduce the risk of falls. On 7/23/24 at 2:53 pm R17 was observed resting in bed. R17 did not have a pressure alarm on as care planned. On 7/23/24 V11 CNA (Certified Nurse Assistant) stated that R17 does not have a pressure pad, nor has she ever been told she is supposed to have one. V11 stated that she was aware that R17 did not have the dycem in her wheelchair earlier in the day, but she now has it placed. On 7/24/24 at 12:28 pm V1 Administrator stated that she would expect fall interventions to be in place as care planned. 2. R46's face sheet, dated 7/24/24, documented that R46 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of supraglottis, esophageal obstruction, emphysema, dysphagia, and osteoarthritis. R46's MDS, dated [DATE], documented R46 is cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's care plan, undated, documented R46 requires supervision to moderate assistance with ADLS (Activities of Daily Living). R46's Safe Smoking Screening, dated 6/24/24, is incomplete and does not document the level of supervision that is required for R46 when she is smoking. R46's Safe Smoking Screening, dated 7/24/24, is incomplete and does not document the level of supervision that is required for R46 when she is smoking. R46's care plan, undated, documented R46 has recently exhibited unsafe smoking practices on 7/18/24. This care plan has a revision date of 7/23/24. R46's incident report, dated 7/18/24, documented CNA reported that resident was outside smoking and fell asleep and burnt small amount of hair on L (left) side of head. CNA asked resident to give her the cigarette so she wouldn't cause injury and resident refused. Writer went to speak with resident, and she stated I am not giving up my cigarette. This incident report also documented, IDT (Interdisciplinary Team) note: resident put cigarette too close to her hair and singed a piece of her hair. Root cause: Resident not paying attention where she placed her cigarette as she got distracted. New intervention: will continue supervised smoking and use a smoke apron. On 7/22/24 at 8:55 am R46 was observed outside in front of the facility smoking a cigarette. R46 was unsupervised. No facility staff were observed outside nor near the front entrance. R46 did not have a smoke apron on her. On 7/23/24 at 11:00 am R46 stated that she singed her hair a little bit while she was smoking a cigarette and that it did not burn her skin. On 7/23/24 11:18 am V14 Regional Director stated that there was already an incident completed on R46 when she burned a small amount of her hair from smoking on 7/18/24. V14 stated that there was not another smoking assessment completed after the 7/18/24 until today (7/23/24) and after the surveyor requested the incident for the 7/18/24. Surveyor informed V14 that R46 was out smoking unsupervised when surveyors entered on 7/22/24 and V14 replied you caught me, she shouldn't have been unsupervised after she burned her hair. The Facility's Smoking Policy, dated 9/1/19 and date revised 3/11/24, documented 1. Smoking is only allowed in designated areas, during designated smoking times established by management. 2. Residents who smoke will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials. The facility shall complete Smoking Safety Assessments upon admission, a quarterly basis, and as needed. 3. Desire to smoke, as well as supervision required for smoking, shall be included in the resident's individualized care plan. It continues, the facility recognizes the potential harm that may result from careless, hazardous smoking and has implemented this policy to maintain a safe living environment. 44967 3. R64's Face Sheet, undated, documents R64 was admitted to the facility on [DATE] with diagnosis of Neurocognitive disorder with Lewy Bodies, Dementia, Malignant neoplasm of prostate, Hemangioma, and Anxiety disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's Care Plan, dated 6/30/24, documents R64 is at risk for falls and injuries related to Parkinson's Diagnosis, impaired cognition, and antidepressant use. Interventions: 6/13/24 Trial with motion sensor in room, 1/9/24 Wear shower shoes when taking shower, 3/3/24 low bed when in bed, 5/23/24 Wear proper footwear at all times, 5/7/24 grabber/reacher, encourage use of call light, keep call light within reach, keep environment clutter free, keep personal belongings within reach, observe for unsteady gait and balance, provide adequate lighting, provide/reinforce use of non-skid footwear. R64's MDS, dated [DATE], documents R64 has a severe cognitive impairment and requires supervision/touching assistance for all Activities of Daily Living (ADLs). R64 is occasionally incontinent of both bowel and bladder. On 7/23/24 at 8:45 AM, R64's door was closed and upon entrance to his room, R64 was seen on the floor next to his bed. R64's fall mat was seen folded up and against the wall and his call light was on his roommate's side of the room underneath an oxygen concentrator and not within reach or eyesight of R64. A large white bed/pad alarm was seen sitting on top of the bed and was not on. Staff was notified of R64's fall. On 7/23/24 at 8:50 AM, R64's Roommate, R42 witnessed R64's fall and stated, 'He tried to get up on his own and just plopped down on his butt. On 7/23/24 at 8:53 AM, V4, CNA, was asked how R64 can call for help if needed, V4 stated We just keep a close eye on him. The facility's fall log for the past 3 months, documents R64 has had falls on 5/7/24, 5/23/24, and 6/12/24. R64's Admission Fall Risk Assessment, dated 7/5/23, documents R64 as a Low Fall Risk. R64's Nursing Note, dated 5/7/24 at 1:17 PM, documents Resident was noted to be sitting upright on the floor leaning against his recliner with an abrasion above his right eyebrow and a swollen lip. He had one shoe on and one shoe off. His roommate said he had fallen and hit his head on the floor. ROM (Range of Motion) done without difficulty and assessed for further injuries. Resident assisted up and was sitting on his bed and then laid back to rest. Administrator, ADON (Assistant Director of Nursing), Wife and Dr. (doctor) notified. Neuro checks WNL (within normal limits). R64's Fall Risk Assessment, dated 5/7/24, documents R64 as a Low Fall Risk. The facility's fall investigation, dated 5/7/24, documents Incident Description: Writer was called to the resident's room, and he was noted to be sitting upright leaning on his recliner with blood above his right eyebrow and a swollen lip. It appears that resident was leaning over while sitting on his bed to put his shoes on because he only had one shoe on and when he leaned over to put the other shoe on his sheet slipped causing him to fall forward. He did say he hit his head on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's Nursing Note, dated 5/23/24 at 8:15 AM, documents 0500 Writer was called to room by CNA informed nurse that when she answered call light resident's roommate informed her that client fell and hit his face. Client placed self back in bed. Bleeding noted from mouth, Asked resident what happened he stated I stopped floor with my face. Nurse assessed client - a/o (alert and oriented) times 3, PERRLA (pupils are equal, round and reactive to light and accommodation), able to move all extremities passively without c/o (complaint of) pain, laceration to right elbow, lacerations to lower lip and right cheek inside mouth, face cleansed, ice applied, VS (vital signs) WNL (within normal limit), Nuero checks started per protocol. 0530 lips still bleeding Dr informed, recommended ER (emergency room) eval for continued bleeding to mouth and unwitnessed fall with facial injury. 0540 Wife called informed of above and agreed, Ambulance called for transfer to (Local Hospital). 0610 client transferred to (Local Hospital) via ambulance. There was no fall risk assessment completed after the fall on 5/23/24. The facility's fall investigation, dated 5/23/24, documents Incident Description: CNA informed nurse that when she answered call light resident's roommate informed her that client fell and hit his face. Client placed self back in bed. IDT Note: CNA informed nurse that when she answered call light resident's roommate informed her that client fell and hit his face. Client placed self back in bed. Nurse assessed client - a/o times 3, PERRLA able to move all extremities passively without c/o pain. Laceration to right elbow, lacerations to lower lip and right cheek inside mouth, face cleansed, ice applied, VS WNL, Dr. informed, recommended ER eval for continued bleeding to mouth and unwitnessed fall and facial injury. Wife called informed of above and agreed, ambulance called for transfer to hospital. BIMS: 6. Root cause: resident having increased shuffling of feet. New intervention: proper footwear at all times. R64's Fall Risk Assessment, dated 5/31/24, documents R64 as a High Fall Risk R64's Nursing Note, dated 6/12/24 at 4:35 PM, documents Summoned to room by staff. (R64) seen sitting on the side of bed with staff at side. Assessment finds dark purplish area with small abrasion to right elbow. No other injuries seen. DON (Director of Nursing) aware. Call placed to POA (Power of Attorney) and updated on (R64). Communication sent to Dr. and hospice with update on res. R64's Fall Risk Assessment, dated 6/12/24, documents R64 as a High Fall Risk. The facility's fall investigation, dated 6/12/24, documents Incident Description: Summoned to room [ROOM NUMBER] by staff. (R64) seen sitting on the side of bed with staff at side. IDT Note: Resident witnessed trying to ambulate independently in room. Root Cause: attempted to ambulate without assistance and lost balance and fell . New Intervention: Trial with motion sensor in room. The facility's fall investigation, dated 7/23/24, documents Incident Description: Resident on floor in his room sitting with back against side of bed. VSS (vital signs stable). Neuro check wnl (within normal limites). [NAME] (unknown). No injury. Denies pain. Roommate says he tried to get up and fell . IDT Note: Resident observed on floor next to his bed. Roommate stated he tried to get out of bed unassisted and fell . Root Cause: Resident attempted to self-transfer without assistance out of the bed. New Intervention: Bed alarm when in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall interventions were not in place to help prevent R64 from falling. This includes the call light on the floor and out of reach, the fall mat folded up and lying against the wall, bed alarm sitting on top of the bed and not on, and the resident's door was closed where staff was not able to put eyes on R64. On 7/24/24 at 2:50 PM, V3, Assistant Director of Nursing (ADON), stated I would expect all staff to ensure that the residents fall precautions/interventions are in place to help prevent resident falls. The facility's Fall Prevention/Safe Patient Handling Implementation Plan, undated, documents 'Fall Prevention Policy: 1. Audit medical records to be sure all residents have up to date Fall Risk Assessment completed. 2. Review MDS of residents to see who triggered Fall CAA for other at-risk residents. 3. All resident who scores 10 or higher on the Fall risk Assessment will be placed on the Fall Prevention Program. 4. All preventative measures will be put in place for at risk residents including: a. Identifier visual aide beside door to alert staff of fall risk. b. Identifier visual aide on wheelchair to alert staff if wheelchair bound. c. Notify family or responsible party of fall risk. d. Put in place all needed preventative interventions. Ensure proper facility environmental safety and transfer equipment inspection rounds are done at least weekly to ensure safety for all in the facility. Ensure that interventions relating to prevention of falls are communicated to line staff and followed through. Ensure new interventions are put in place with each new fall and communicated to the care plan. Ensure that the facility Safe patient handling program is implemented and utilized.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44967 Based on interviews, observations, and record reviews the facility failed to provide timely and complete incontinent care including improper glove changes and hand hygiene for 3 out of 6 residents, (R7, R8, R9) reviewed for incontinence care in a sample of 41. The findings include: 1. R9's Face Sheet, undated, documents R9 was admitted to the facility on [DATE] and has diagnosis of Metabolic Encephalopathy, Atrial Fibrillation, Hypertensive Chronic Kidney disease (CKD), Major depressive disorder, Bipolar, Dementia, Pacemaker, and Hypertension. R9's Care Plan, dated 6/28/24, documents R9 has Self-Care Deficits As Evidenced by: Needs moderate to dependent assistance with functional abilities. Interventions: Toilet Use - One-person physical assist required. It continues R9 is incontinent of Bowel/Bladder. Interventions: Assist with toileting: as needed. R9's Minimum Data Set (MDS), dated [DATE], documents R9 has a severe cognitive impairment and is dependent on staff for toileting, bathing, and personal hygiene. R9 is always incontinent of both bowel and bladder. On 7/23/24 at 11:45 AM, V4, Certified Nursing assistant (CNA), and V13, CNA, provided peri-care to R9. While wiping feces from R9's anal area, V4 used the same soiled gloves and put her hands into the basin of water to get another wet washcloth, squeezed the water from the washcloth, and used that cloth on R9. V4 did this same process three different times, each time using the same soiled gloves, contaminating the clean water that she was using to further clean R9. On 7/24/24 at 2:50 PM, V3, Assistant Director of Nursing (ADON), stated that I would expect the staff to perform timely and complete incontinence care including proper hand hygiene and gloves changes when appropriate. [NAME]: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 7/24/24 at 11:48 AM, V19, CNA, and V15, Health Information Management (HIM), enter R9's room for peri care. R9 is on contact precautions for Extended-Spectrum Beta-Lactamase (ESBL) of urine. V19 removed R9's bed sheets and rolled her to her left side while V15 helped hold R9's right thigh. R9 did not have a brief on, there was a slightly saturated bed pad under R9. V19 took a wet towel and sprayed it with peri wash then wiped starting in R9's vaginal region back to her anal region, then placed the dirty towel on the dirty pad and grabbed a new wet towel. V19 took the new wet towel, sprayed it with peri wash and wiped to the left of R9's vaginal fold back to her left buttock and placed the dirty towel on top of the other dirty towel and rolled the pad over them. V19 took another wet towel, sprayed it with peri wash and wiped to the right of R9's vaginal fold back to her right buttock and placed the dirty towel with the other dirty towels in the rolled up dirty pad. V19 then took a dry towel to R9s vaginal region back to her buttock padding it dry. V19 tucked a clean brief and pad under R9's old pad then V19 and V15 rolled R9 onto her back. V19 took a wet towel, sprayed it with peri wash and wiped R9's midline vaginal region front to back, placed the dirty towel in the dirty rolled up pad and grabbed another wet towel. V19 sprayed the new wet towel with peri wash and wiped R9's left groin top to bottom. V19 repeated the same process and wiped R9's right groin. No hand hygiene or glove changes between wipes. V19 and V15 rolled R9's to her right side. V19 removed the dirty pad and unrolled the new brief and pad under R9. V19 helped V15 secure R9's brief and cleaned up the dirty linen. 3. R7 was admitted to the facility on [DATE] with diagnosis of, in part, encephalopathy, and benign prostatic hyperplasia with lower urinary tract symptoms. R7's MDS completed on 6/6/2024 documents R7 as being severely cognitively impaired. R7 MDS further documents R7 is dependent on toileting hygiene: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement, shower/bathe self: the ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) and toilet transfer: the ability to get on and off a toilet or commode. R7 was admitted to the hospital on 5/27/24 with a diagnosis of Sepsis tachycardia with leukocytosis and a right foot and thigh cellulitis. R7 was discharged back to the facility 6/1/24. On 7/1/24 a wound culture was collected and resulted on 7/10/24 with heavy growth of Escherichia Coli - Extended Sprectrum Beta Lactamase (ESBL). R7's current care plan with a completion date of 6/12/2024, documents R7 needs moderate to total assistance with functional abilities related to a history of Cerebral Vascular Accident (CVA), hemiparesis with right side weakness with interventions as follow: Personal Hygiene-One-person physical assist required. R7's care plan further documents R7 has potential for impaired skin integrity related to urinary and bowel incontinence with intervention to monitor incontinence. R7's Physician Orders, it documents to apply Triad paste to scrotum due to maceration, to be completed on every shift, from 6/12/24-7/9/24 and on 7/9/2024 with no end date. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/24 at 1:50 PM, R7 was heard from hallway stating, please help me, someone please help me. V13, CNA, responds to R7 at 1:53 PM and asked him what was wrong. R7 stated he has been trying to get help from someone to go take a poop for an hour. V13 stated she will have to get someone to help her transfer him to the toilet and will return. At 1:59 PM, V13 and V4, CNA, arrive to R7's room with a sit-to-stand transfer device. V13 and V4 attached R7's sling to the sit-to-stand. Once R7 was attached to the transfer device, both V13 and V4 move R7 over to the toilet. V4 removed R7's pants and a urine saturated brief before lowering him down to sit on the toilet. V4 removed R7's pants and stated they were wet. V13 and V4 detached the sling from the device while R7 had a bowel movement. When R7 finished his bowel movement, V13 and V4 hook him back up to the transfer device, put a new brief and new pants on his legs and raised him up. While R7 was raised up, V4 takes a wet towel with peri wash and wiped R7's buttock. As V4 wiped R7, R7 yelled out load and grimaced in pain. R7 stated that it hurt. V4 then took another wet towel and wiped his midline anal region, R7 yelled again and continued to grimace with his face. V13 stated R7 has had issues with his peri skin rubbing creating some irritation. V4 took a tube of antifungal cream and applied it to his buttock and scrotum. V4 and V13 transfer R7 to his bed for a skin check. Once R7 was lying in his bed turned on his left side, his peri region was seen. Red, raised, fragile skin was located on his scrotum, in between his scrotum and thighs, on his penis and in his anal region. A skin tear to his left buttock and two skin tears to his anal region were present. Stool was still present. V4 takes another wet towel and wiped the stool off R7's anus. R7 yelled and grimaced again. V4 took another wet towel and wiped the left back side of his scrotum front to back, and then took another wet towel and wiped his right back scrotum front to back. No hand hygiene completed or glove changes between wipes. V4 then took antifungal cream and applied it to R7's scrotum and buttock. V4 and V13 help R7 pull is new brief and pants up in place. Both V4 and V13 hook R7 back up to the sit-to-stand to transfer him into his recliner. No peri care was completed to R7's penis or front groin after having a urine saturated brief. On 7/24/24 at 10:50 AM, V19, CNA, stated peri care is supposed to be done anytime a resident needs to be changed, or technically every 2 hours. V19 stated gloves are supposed to be changed after every swipe from dirty to clean and hand hygiene when changing from dirty to clean areas. On 7/24/24 at 3:14 PM, V22, Licensed Practical Nurse (LPN), stated she was not aware of R7 having any skin issues, she did not have to complete any peri care on him, she was running around all day, and was not aware of any special orders in place for creams to be applied other than what the CNA's do. On 7/24/24 at 3:15 PM, V19 stated she noticed R7's peri region was red and blotchy. V19 stated when she did peri care on R7 earlier that day, he yelled in pain when she wiped the area. V19 stated she applied barrier cream to the irritated peri region on R7 but did not notify anyone of the situation because the nurse should already know. 40701 4. R8's Face Sheet dated 7/24/2024 documents R8 has a diagnosis of bladder disorder. (continued on next page)

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	145783	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/2024 at 9:57 AM, there was an odor. V6, Certified Nursing Assistant (CNA) and V7, CNA, began providing incontinent care to R8. V7 stated R8 did not have any open areas on her skin. R8's pants, bottom of her shirt, and the mechanical lift sling were soiled with a wet substance. After removing R8's pants it was verified R8 had a large bowel movement. V7 began cleaning/wiping the feces from R8's backside. R8's right and left upper buttocks had quarter sized reddened areas. At this time V6 stated the reddened areas were caused by R8 sitting in her poop. It really hurts her. She got up (out of bed) about 6:30 (AM). V6 further stated breakfast trays come about 8 (AM) or after. On 7/24/2024 at 11:24 AM, R8 was located in her wheelchair in the dining area of the unit. At this time V18, CNA stated she will lay R8 down (in bed) after lunch to check her for incontinence. V18 stated she last checked R8 for incontinence after breakfast but wasn't sure what exact time it was. R8's Minimum Data Set (MDS) dated [DATE] documents R8 is severely cognitively impaired, always incontinent of urine, and frequently incontinent of bowel. R8's Care Plan dated 3/3/2021documents R8 is incontinent of bowel and bladder. It further documents, Toilet upon rising and before or after meals. The Facility's Incontinent Care Policy, dated 5/16/22, documents All incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/or odor. Incontinence care will be provided as required. Procedure: 1. Assemble Equipment. 5. Perform hand hygiene, apply gloves. 8. Wash all soiled skin areas and dry very well, especially between skin folds: changing gloves and performing hand hygiene as required to prevent cross-contamination.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 49494 Based on interview, observation, and record review, the facility failed to store medications at an appropriate temperature and dispose of expired multi-dose/stock medications. This failure has the potential to affect all 83 residents in the facility. Findings include: On [DATE] at 12:05 pm the South-East medication room was entered with V8 LPN (Licensed Practical Nurse). The medication refrigerator contained two thermometers that read 50 degrees Fahrenheit . The temperature log for [DATE] was posted on the front of the refrigerator. This temperature log did not have temperatures recorded on the following dates [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. This form documented a temperature of 48 degrees Fahrenheit on [DATE]. The refrigerator contained the following medications: 11 basaglar 100 u/ml (units per milliliter) insulin kwikpens for R12, 4 basaglar 100 u/ml insulin kwikpens for R19, 3 trulicity .75 mg insulin pens for R22, 5 lantus insulin pens 100 u/ml for R54, 2 lantus 100 u/ml for R57, 1 bottle of liquid vancomycin 2mg/ml for R179, and 3 IV (intravenous) bags of daptomycin 500 mg/100 ml for R180. This refrigerator had an open vial of TB solution (tuberculin purified protein derivative) with an open date of [DATE]. On [DATE] at 12:22 pm the South medication cart was inspected. This medication cart contained one bottle of expired thiamin vitamin b-1 100mg tablets with an expiration date of ,d+[DATE]. On [DATE] at 12:28 pm V8 stated that the tuberculin solution and the vitamin b-1 are stock medications that are used for all residents if needed or they have an order. On [DATE] at 12:27 pm V1 Administrator stated that she replaced the refrigerator in the South-East medication room because it wasn't staying cool enough. V1 stated that she would expect the medication refrigerator temperature to be below 40 degrees. V1 also stated that an open vial of TB solution is considered expired after 30 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Storage of Medications policy, dated ,d+[DATE], documented medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. It continues, Temperature 1. All medications are maintained within the temperature ranges noted in the United States Pharmacopeia. It continues, c. Refrigerated: 36 degrees Fahrenheit to 46 degrees Fahrenheit with a thermometer to allow temperature monitoring. It continues, 4. b. drugs dispensed in the manufacturer's original container will carry the manufacturer's original expiration date. Once opened, these products will be acceptable to use until the manufacturer's expiration date is reached. It continues, 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a date opened sticker on the medication and record the date opened and the new date expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating.

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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** 44967 Based on interview, observation, and record review, the facility failed to change gloves and perform hand hygiene during resident care and to wear appropriate Personal Protectant Equipment (PPE) for a resident on isolation for 5 of 24 residents (R7, R9, R17, R18, R179) reviewed for infection control in the sample of 41. The findings include: 1. R179's Face Sheet, undated, documents R179 was admitted to the facility on [DATE] with diagnosis of Sepsis, Urinary Tract Infection (UTI), Methicillin Resistant Staphylococcus Aureus (MRSA), and Enterocolitis due to Clostridium Difficile (C-DIFF). R179's Care Plan, dated 7/14/24, documents R179 has C. Difficile related to loose stools. Interventions: Contact Isolation: Wear gloves and gown and PRN (as needed) masks when coming into contact with body fluids and when changing contaminated linens, bag linens and close bag tightly before taking to laundry, disinfect all equipment used before it leaves the room, educate resident/family/staff regarding preventive measures to contain the infection, place in private room with contact isolation precautions. It continues R179 has a Potential for Weight Loss and Dehydration related to positive Stool Culture - C. Difficile with abdominal pain, abdominal tenderness, appetite loss, watery diarrhea. Interventions: Contact Isolation-Wear minimum of gown and gloves when providing care that comes in contact with body fluids, ensure hands and clothes do not touch surfaces potentially contaminated; ex. Bedrails, table, door knobs, faucets, etc. R179's Minimum Data Set (MDS), dated [DATE], documents R179 is cognitively intact and is dependent on staff for toileting, bathing, and transfers. R179 is always incontinent of both bowel and bladder. R179's Lab Result, dated 7/10/24, documents R179 was positive for C-Diff. On 7/22/24 at 11:08 AM, V4, Certified Nursing Assistant (CNA), was seen in R179's, room with no PPE on. V4 walked out of the room, used hand sanitizer from wall and did not wash her hands. V4 stated that R179 is on contact isolation for C-Diff and that she was supposed to wear a gown when going into the room, but R179 dropped something on the floor so she just went in and picked it up for him and forgot to put the gown or gloves on. V4 was then seen going in and out of other resident rooms. On 7/25/24 at 9:28 AM, V20, CNA, stated There are several types of isolation, but we should at least wear a gown, gloves, mask, and face shield if required to enter a isolation room. If it is a C-Diff room, we have to put a gown and gloves on to enter the room. After we do resident care and before we leave the room, we need to take our gown and gloves off and wash our hands with soap and water in the sink. On 7/24/24 at 2:50 PM, V3, Assistant Director of Nursing (ADON), stated I would expect all staff to don appropriate PPE upon entering any resident room and providing care for that resident while on isolation. If it is an isolation room with a resident with C-Diff, staff should be washing their hands with soap and water and not just use hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R9's Face Sheet, undated, documents R9 was admitted to the facility on [DATE] and has diagnosis of Metabolic Encephalopathy, Atrial Fibrillation, Hypertensive Chronic Kidney disease (CKD), Major depressive disorder, Bipolar, Dementia, Pacemaker, and Hypertension. R9's Care Plan, dated 6/28/24, documents R9 has Self-Care Deficits As Evidenced by: Needs moderate to dependent assistance with functional abilities. Interventions: Toilet Use - One-person physical assist required. It continues R9 is incontinent of Bowel/Bladder. Interventions: Assist with toileting: as needed. R9's MDS, dated [DATE], documents R9 has a severe cognitive impairment and is dependent on staff for toileting, bathing, and personal hygiene. R9 is always incontinent of both bowel and bladder. On 7/23/24 at 11:45 AM, V4, CNA, and V13, CNA, provided peri-care to R9. While wiping feces from R9's anal area, V4 used the same soiled gloves and put her hands into the basin of clean water to get another wet washcloth, squeezed the water from the washcloth, and used that cloth on R9. V4 did this same process three different times, each time using the same soiled gloves, contaminating the clean water that she was using to further clean R9. 49494 3. R18's face sheet, dated 7/25/24, documented R18 has diagnoses of glaucoma, myasthenia gravis, COPD (Chronic Obstructive Pulmonary Disease), type 2 diabetes mellitus, trigeminal neuralgia, hypertension, heart disease, and diplopia. On 7/23/24 at 8:53 am V9 RN (Registered Nurse) was administering medications to R18. V9 did not perform hand hygiene prior to dispensing R18's medication. V9 handed R18 his cup of medications and R18 dropped a pill on his lap. V9 then got down on her knees and was touching R18's lap and the floor as she was looking for the missing pill. V9 then touched the pill with her bare hands that was on R18's lap and placed it in his medication cup. V9 then retrieved R18's bottle of Brimonidine Tartrate Ophthalmic Solution 0.2% eye drops and pushed R18 to his room. V9 then instilled 1 eye drop into R18's left eye without the benefit of hand hygiene nor glove use. V9 then left R18's room without performing hand hygiene. 4. R17's face sheet, print date 7/24/24, documented R17 was admitted [DATE]. R17's face sheet documented diagnoses of left femur fracture, dementia, Alzheimer's disease, atherosclerotic heart disease, hypertension, and history of urinary tract infections. R17's MDS (Minimum Data Set), dated 4/26/24, documented that R17 is severely cognitively impaired and requires substantial/maximum assistance from staff with mobility. On 7/23/24 at 9:30 AM, V11, CNA (Certified Nurse Assistant) and V12, COTA (Certified Occupational Therapy Assistant) entered R17's room with a mechanical lift and transferred R17 from her wheelchair and into her bed. V11 and V12 did not perform hand hygiene upon entering R17's room nor prior to transferring R17 into her bed. V11 and V12 then repositioned R17 three times to ensure R17 was in a comfortable position and then pulled R17's blankets up over her. V11 and V12 then left R17's room without the benefit of hand hygiene and proceeded to care for other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 12:30 PM, V1, Administrator stated that she would expect the staff to perform hand hygiene before, during if needed, and after providing care for the residents. The facility's Handwashing/Hand Hygiene policy, undated, documented the facility considers hand hygiene the primary means to prevent the spread of infection. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. It continues, 6. Wash hands with soap and water for the following situations: a. When hands are visibly soiled, and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. 7. Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures, it continues h. Before moving from a contaminated body site to a clean body site during resident care. It continues, the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hygiene is recognized as the best practice for preventing healthcare-associated infections. The Facility's Incontinent Care Policy, dated 5/16/22, documents All incontinent residents will receive incontinence care in order to keep skin clean, dry, and free of irritation and/or odor. Incontinence care will be provided as required. Procedure: 5. Perform Hand Hygiene, apply gloves. 8. Wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and performing hand hygiene as required to prevent cross-contamination. The Facility's Initiating Isolation Precautions, dated 12/6/21, documents 3. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): d. Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions. e. Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment. f. Ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room.