STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145875	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Lincoln Park	2732 North Hampden Court Chicago, IL 60614

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45001 Based on interview and record review, the facility failed to accurately complete one residents (R29) comprehensive annual assessment. Findings include: On 10/30/24 at 3:58 PM, V24 (Regional Director of Clinical Data Quality and Performance Audits) stated, Someone is covering MDS (Minimum Data Set) from another facility. On 10/30/24 at 4:25 PM, V1 (Administrator) stated, We do not have a current MDS Coordinator. On 10/31/24 at 9:10 AM, V19 (MDS Consultant) stated, (R29's) Census, 5/18/2024, is an error. (R29) went to the hospital and was admitted and returned with qualifying nights at the hospital. (R29) came back to the facility as dual (Medicaid and Medicare payor). MDS is scheduled in sequence. The census line has an error. The submitted MDS on 10/17/24, was a quarterly assessment, modified to be inactivated. MDS annual created it to be finalized on 10/31/24, with the same ARD (Assessment Reference Date) of the submitted MDS (10/17/24). Census drives the MDS. Assessments are in sequence. A quarterly was sent. The type of assessment was an error. We inactivated the quarterly and made an annual. Today (10/31/2024) is the last day to complete the annual. Entry and admission assessment and comprehensive are done yearly. Quarterly is every 92 days. A quarterly does not suffice as an annual, it is not comprehensive. We submitted the quarterly in place of annual in error. According to document provided by facility on 10/31/24, R29's next full ARD is 10/23/2024; next quarterly ARD is 1/17/2025. A quarterly assessment was submitted 10/17/2024 and inactivated. Annual and inactivation of quarterly are in progress.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, the facility failed to initiate a new Level I screen for one (R70) resident reviewed for Pre-Admission Screening and Record Review (PASARR) in a total sample of 21. Findings include: R70's Facesheet documents R70 was admitted to the facility on [DATE]. R70's Level I PASARR outcome documents R70 has an exempted hospital discharge, with a 30-day length of stay that expired on [DATE]. On [DATE], at 2:19 PM, V1 (Administrator) states the facility checks to see if a resident has a PASARR screening upon admission. V1 states the PASARR indicates the determination of needs/DON score for the individual resident. V1 states based on the DON score, it is determined if a resident is appropriate for the nursing home setting or not. V1 states she is unaware of the DON score ranges or what the different DON score ranges are indicative of. V1 states a PASARR Level II is needed for a resident if it is determined that the resident has an SMI/severe mental illness. V1 states the determination for a Level II PASARR screening is based off of the results of the Level I PASARR screening. V1 states R70 has been admitted to the facility for longer than 30 days, therefore, R70's exemption status has expired. V1 states R70's PASSAR screening expired on [DATE]. V1 states once a resident's PASARR screening expires, a new Level I PASARR screening has to be submitted to the designated screening agency. V1 states the purpose of the PASARR screening is to determine if a resident have any significant mental illnesses and to ensure that the facility is an appropriate setting for the residents. Facility policy, dated [DATE], titled PASSAR Screening of Residents with Mental Disorder of Intellectual Disability documents, Policy: It is the facility's policy to ensure that resident's with Mental Disorder and those with Intellectual Disorder will receive PASSAR Screening within the timeframe allowed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on interview and record review, the facility failed to address a high blood sugar result for 1 out of 3 residents (R75) reviewed for blood sugar testing. Findings include: R75 was [AGE] years old, initially admitted on [DATE], in the facility with medical diagnosis that includes diabetes mellitus. V25 (Registered Nurse) progress notes, dated [DATE], reads R75 expired in the facility pronounced expired by EMS (Emergency Medical Service) at 3:15 PM. Also on the same progress notes, at 2:31 PM, R75's blood sugar was obtained, with 397 result. Per physician order, R75 was receiving Paxlovid medication for Covid-19 from [DATE] to [DATE]. There was an order to check R75's blood sugar before meals and at bedtime, and to call the MD (Medical Doctor) if blood sugar result is below 60 or above 300. R75's MAR (Medication Administration Record), dated [DATE], R75's blood sugar result was scheduled at 11:00 AM. R75's result was 33,3 which was above 300 that per physician order to call physician. Review of all documentation in R75's resident record does not reflect any documentation that any physician or nurse practitioner was informed of R75 blood sugar result. On [DATE] at 10:35 AM, V2 (Director of Nursing) stated during the time that R75 expired, she was not in the facility. V2 stated, I am not sure if the doctor was notified when blood sugar was 333. But I don't see any documentation that the doctor was aware. My expectation with my nurses is that they should follow doctor's order. A result of 333 was high blood sugar and the order was to notify the physician. Therefore, there should have been proper notification. V2 stated V25 is not employed by the facility anymore. On [DATE] at 11:13 AM, V13 (Restorative Director / Licensed Practical Nurse) stated she worked as nurse manager that day. V25 did not inform her R75's blood sugar was elevated. On [DATE], at 2:10 PM, V27 (Nurse Practitioner) stated R75's high blood sugar may be due to Covid-19, and may be due to non-complianace with diet. The first blood sugar result was more than 300. He was informed, but he did not get the next result until after 2:00 PM. V27 stated he instructed V25 to monitor R75. V27 stated he did not know R75's blood sugar further increased to 397 after 2:00 PM. V27 stated he should have been informed also about the other result which is 397. V27 stated normally he would order Hgb (Hemoglobin) A1C in this situation to address the problem, but did not. V27 stated he just ordered V25 to monitor R75. V27 stated he did some notes he saw R75 that day in the morning. V27 stated he did not document V25 informing him of R75's elevated blood sugar because the notes were done in the morning before he was informed by V25. Upon further review of V27's progress notes, it documents the progress notes were created on [DATE], contrary to R27's statement that he made his notes prior to R75's elevated blood sugar result. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V27 was asked why he failed to document R75's blood sugar was elevated, and what has he done to address the problem? V27 stated he was referring to his early encounter; that is why he did not include R75's elevated blood sugar result. V27 was asked if he was informed by V25 that R75 had an elevated blood sugar result of 333. Was it important enough to include what care that was provided in his progress notes? V27 responded he did not document regarding R75 elevated blood sugar. He understands there was no documentation to support his statement he was informed of R75's elevated blood sugar, or that he addressed R75's elevated blood sugar. V27 said, Well you cannot prove that I was informed by (V25). I understand that if it was not documented, then it was not done. Management of Diabetes in Long Term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association, dated 2016, reads: Glucose meter readings .250 mg/dL two or more times within 24-h period accompanied by a new or change in medical or functional status: - Call practitioner, - Increase frequency of glucose monitoring Glucose meter readings. Glucose meter readings .300 mg/dL during all or part of 2 consecutive days: - Confirm high glucose value by laboratory test, - Evaluate nutritional intake Any glucose reading too high to measure by glucose meter, - Adjust diabetes regimen as needed c If glucose levels are persistently high after changes to the diabetes regimen, consider medical evaluation for other causes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45001 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer preventative measures were accurately applied for two residents (R4 and R62) in a sample of 18 residents reviewed for pressure ulcer. Findings include: 1. R4's POS (Physician Order Summary) has active order, Patient to be on low air loss mattress at all times daily, afterrnoon, and every shift for pressure reduction, order date 8/27/24. On 10/29/24 at 12:40 PM, R62 was lying in bed on a low air loss. A fitted sheet was on the mattress, and a flat sheet folded two times was between R62 and the mattress. On 10/29/24 at 12:45 PM, V2 verified there was a fitted sheet, a flat sheet folded two times, and R62 was wearing a brief. 2. R62's POS has active order, Patient on LAL (Low Air Loss) mattress at all times every shift for pressure reduction. Order date 9/23/24. On 10/29/24 at 1:00 PM, R4 was lying in bed on a low air loss mattress. A fitted sheet was on the mattress. On 10/29/24 at 1:05 PM, V22 verified there was a fitted sheet, a flat sheet folded two times used as a draw sheet, and R4 was wearing a brief. V22 stated, Wound care said a fitted sheet and a draw sheet can be used on the low air loss mattress. On 10/31/24 at 2:00 PM, V28 (Wound Care Manager) stated, I started here May 21, 2024. According to company protocol, the air loss mattress should have a flat or fitted sheet, not both. They (staff) cannot use a draw sheet. They cannot use the flat sheet folded twice. That is four layers. They can use a blue pad or a chuck in place of the draw sheet, and the resident can have a brief on. There can be nothing more, no more layers. (R4) and (R62) are on a low air loss mattress by weight. (R4) needs the mattress for preventative measures. (R62) needs the mattress because (R62) has active wounds. There should be only three layers between the mattress and the resident, a sheet, blue pad, and a diaper. It was not correct to have the flat sheet folded two times. Proactive Medical Products Operation Manual reads in part: Installation Instructions Step 2, you may place a thin cotton sheet over the quilted mattress to cover. Operating Instructions Step 5, Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the patient. Med-Aire 8 Alternating Pressure Mattress Replacement System With Low Air Loss User Manual, obtained from https://www.unitedmedsupply.com/drive-14027-drv14027 reads in part: Recommended Linen: Drive DeVilbiss Healthcare bed support surfaces are designed to be used with appropriate linens. Deep pocketed fitted or flat sheets are recommended. Multiple layering of linens or underpads beneath the patient should be avoided, when possible, for the prevention and treatment of pressure injuries.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on observation, interview, and record review, the facility failed to ensure narcotic medication or controlled substance were accounted correctly as to recording compared to the actual medication per policy; failed to separate each medication during gastronomy tube administration; and failed to ensure insulin is available per physician order to avoid delay of administration. These failures affect 6 residents (R23, R2, R53, R127, R69, and R11) reviewed for medication administration. These failures affect 6 residents (R2, R11 R23, R53, R69, R127) in receiving proper pharmaceutical services. On [DATE], at 10:25 AM, V10 (Registered Nurse / Agency) gave a folder that includes narcotic record documents. A document titled Shift Change Accountability Record for Controlled Substances, dated [DATE], was not signed/initialed. V10 stated, I forgot to sign that narcotic medications were counted as correct. The nurse that will be leaving and the nurse that is incoming (V10) during change of shift need to count all narcotics to make sure that the count is correct. V10 was asked if the counting was done. V10 did not answer. All narcotic medications inside the cart were counted with V10. After counting, R23's Pregabalin 75 MG was seen with discrepancy. Controlled Drug Administration Record documents from the pharmacy reads there is one (1) capsule left. The card for the same narcotic was seen without any medicine left. V10 said he forgot to sign, took out his pen and was about to sign the document. When V10 gave both copies after request, both documents were filled up to correct discrepancies. V10 stated when he went to the nurse station, he signed the documents. On [DATE] at 10:53 AM, with V11 (Licensed Practical Nurse) inside the medication carts two resident's narcotic medications did not tally to the records, and the actual count of medicines were: R53 Oxycodone 10 MG record has 4, actual count of tablets has 3. R127 Morphine Sulfate 15 MG record has 18, actual count of tablets has 17. V11 stated she was supposed to sign when giving narcotic medications, but forgot. On [DATE], at 9:34 AM, V12 (Licensed Practical Nurse) was preparing medications to administer via gastronomy tube to R69. The following medications in tablets form were prepared: - Senna Plus 8XXX,d+[DATE] MG 2 tablets - Amlodipine 10 MG 1 tablet - Carvedilol 25 MG 1 tablet - Modafinil 200 MG 1 tablet - Vitamin C 250 MG 2 tablets (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V12 popped each tablet out, putting it inside the medication cups. Each cup was stacked on top of each another. All four cups were exposed to high touch areas and made contact with the medicine. Not all medications were placed in individual medication cups. Amlodipine and Carvedilol medications were placed in a single cup. After V12 washed her hands and put on her gloves, V12 touched the bed surroundings, including the rails and bed remote control to elevate the head of the bed. V12 then administered each cup touching the enteral/gastronomy tube with one hand and the other hand inserting the syringe to the tube to administer the medication. V12 uses the same gloves that touched unclean surrounds/environment. V12 stated she placed two different medications in a single cup because they are both blood pressure medicines. V12 stated she should have separated those two medications since they need to be flushed independently with 10 ML of water in between. V12 stated she should refrain from touching high touched areas to maintain cleanliness including contacting the tubing, but she forgot. On [DATE] at 12:28 PM, V13 (Restorative Director / Licensed Practical Nurse) took the blood sugar of R11; the result was 243. After getting the result of blood sugar, V13 used an alcohol pad to apply to the open skin of R11's finger. V13 then put a tissue on the bed which was open and was sticking out of the box. V13 then wiped the blood off R11's finger. V13 returned to her medication cart and took the insulin out for R11, that read Humalog insulin. V13 was asked, Is this the insulin that you will give to (R11)? V13 stated, Yes. V13 was then asked, For how long does this insulin expire? V13 stated, 28 days. The insulin had a written open date of [DATE] and expiration date of [DATE]. The number 30 was written on top of the original number. V13 was asked if the calculation of 28 days after [DATE] is correct? V12 (Licensed Practical Nurse), sitting at the nurse station near V13, stated after checking her phone's calendar, It expired on [DATE]. It was corrected by V13 to [DATE] after rechecking. V13 then checked her medication cart and could not find R11's insulin that was not expired. V13 was not able to give R11's insulin until 2:20 PM. Per V13, she needed to call the physician to get a one-time dose, because the only available insulin is a pen, and not a vial. On [DATE] at 10:43 AM, V2 (Director of Nursing) stated, Insulin needs to have an open date and expiration date when first opened. Nurses who gave narcotic medication should sign on the eMAR (electronic Medication Administration Record) and pharmacy document in the narcotic book. When giving medication via G Tube (stomach tube), each medication needs to in separate cups to identify each medication in case the resident vomited when administering. It also needs to be flushed with 10 CC's of water per pill. Medication Pass policy dated [DATE], reads: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. Under medication labeling, all opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded within 28 days of opening except for Levemir insulin which can be discarded 42 days after opening and Xalatan eye drops which can be discarded 6 weeks after opening. Follow pharmacy recommendation as to when the medication should be discarded after opening. Insulin vials are to be discarded within 28 days after opening, except for Levemir insulin which are to be discarded 42 days after opening. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under controlled substances, all scheduled 2 controlled substances will be stored properly and double locked. Under procedure related to G - Tube medications, separate each medication in medication cup and flush in between each medicine with at least 5 ML of water. Can use the water to rinse the medication cup as flushing in between medicine. Under controlled substances, all scheduled 2 controlled substances will be stored properly and double locked. Controlled Medications Count policy dated [DATE], reads: It is the policy of the facility to maintain accurate count of Scheduled 2 controlled medications. Under procedure, after removing the controlled medication from the bingo card or individual packet, the nurse will sign off the accompanying controlled medication sheet indicating the medication is taken.

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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** 41356 Based on observation, interview, and record review, the facility failed to date and label insulins and eye drops per policy; failed to maintain medication carts free from insulin that were expired; failed to store controlled substances inside a double locked storage; and failed to maintain medication storage area free from controlled substance that was discontinued. These failures affect 6 residents (R19, R30, R2, R1, R53, and R3) reviewed for drug storage. Findings include: On [DATE] at 10:25 AM, with V10 (Registered Nurse / Agency), the following insulins were found: R19's Insulins Lispro had no date and Fiasp insulin had written as follows: date opened [DATE], and date expired was [DATE]. V10 stated it should not be in the medication cart because it was already expired. R30's insulins Lispro and Fiasp both had no date written. V10 stated, All of insulins are being used because it is inside the medication cart. It should have been dated when opened and the expiration date is 28 days after opening. R2's Lorazepam Injection Solution 2 MG per ML was not in the medication cart. V10 stated, It is in the refrigerator at the nurse station. All floors of the facility with residents does not have medication room. They have a cabinet with small refrigerator where medications are stored. At the nurse station, there is a cabinet that has a small refrigerator inside. The cabinet door has a lock and the refrigerator has a padlock.Both of them were not in a locked position. It could be opened without using a key. V10 opened the cabinet and padlock. Both of them were already opened and not locked. V10 was asked why both cabinet door and padlock was left unlock when there is narcotic inside the refrigerator. V10 stated it supposed to be locked, but he forgot. Inside the refrigerator, V2's Lorazepam vial was found. V10 stated, It needs to be locked because there is narcotic inside the refrigerator. Without locking either the cabinet door or the refrigerator anyone can access the narcotic medicine. Review of R2's Lorazepam order by the physician reads this medication was discontinued on [DATE], but ir still inside the refrigerator, with other medication was for general usage. On [DATE], at 10:53 AM, with V11 (Licensed Practical Nurse), the following insulins were found: R1's Novolog insulin vial has written as follows: date opened [DATE], and date expired [DATE]. R53's Humulin ,d+[DATE] insulins has written as follows: date opened [DATE], and date expired [DATE]. And Lantus insulin has no date. R3's insulins Lantus and Humulin ,d+[DATE] insulin has no date written. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 11:15 AM, R65's Latanoprost eye drop, inside the medication cart, has no date. On [DATE], at 10:43 AM, with V2 (Director of Nursing) stated, Insulin needs to have an open date and expiration date when first opened. When narcotic medication is discontinued, normally nursing staff brings it and be destroyed per Pharmacy guidelines.All narcotics should be stored in double lock storage. 10 CC's of water per pill. Medication Pass policy dated [DATE], reads: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. Under medication labeling, all opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded within 28 days of opening except for Levemir insulin which can be discarded 42 days after opening and Xalatan eye drops which can be discarded 6 weeks after opening. Follow pharmacy recommendation as to when the medication should be discarded after opening. Insulin vials are to be discarded within 28 days after opening, except for Levemir insulin which are to be discarded 42 days after opening. Under controlled substances, all scheduled 2 controlled substances will be stored properly and double locked.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 45000 Based on observation, interview, and record review, the facility failed to follow their policy on resident food preferences for one (R70) resident in a total sample of 21 residents reviewed. Findings include: R70's Nutrition Progress Note, dated 10/20/2024, documents in part, Review of diet tolerance, PO (by mouth) intakes, appetite changes, weights, labs, medications, skin conditions. Recommend: Continue current diet, provide food preferences, provide foods from alternative menu, provide assistance with meals as needed, closely monitor diet tolerance, PO intakes, labs, and weights. Continue Pro Stat three times daily to maintain skin integrity. Will continue to monitor and make changes as necessary. Facility menu documents eggs were served in the facility for breakfast on 10/27/24, and 10/28/24. On 10/29/2024, at 11:50 AM, R70 stated the facility staff continues to serve her eggs on her meal trays for breakfast although she has informed the facility that she does not like eggs to eat. R70 states she has informed the Dietary Manager (identified as V8) of her dislike for eggs, and the facility still serves them to her on her meal tray. On 10/30/2024, at 9:55 AM, R70 states the facility served her eggs again today for breakfast, so she refused her breakfast meal tray. On 10/30/2024 at 10:06 AM, V8 stated she is aware R70 does not like eggs as a food preference. V8 stated she completes a food preference interview form with all the residents who are admitted to the facility. V8 stated she usually tries to complete the form within 2 days of the resident being admitted to the facility. V8 stated she completed a food preference interview form for R70, but is unable to locate the form in her files in her file cabinet. V8 then observed looking inside of a dark colored tote bag sitting in a chair next to V8. V8 took out a storage clipboard from the bag. V8 opened the storage clipboard and located R70's food preference interview form. R70's food preference interview form documented no eggs written in ink on the form. V8 observed deploying R70's facility dietary meal ticket on the computer. V8 stated R70's no egg preference was not documented on R70's facility dietary meal ticket. V8 stated R70's no egg preference should be documented on R70's facility dietary meal ticket. On 10/31/2024 at 1:36 PM, V8 stated eggs were served for breakfast in the facility yesterday on 10/30/2024, but did not print on the facility's menu. Facility policy, dated 07/26/2024, titled Food Preference Policy documents, Purpose: The facility will provide food that accommodates allergies and preferences. Policy: 1) The facility will identify resident's allergies, intolerances, and preferences based on medical record and interviews.

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	145875	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Lincoln Park	2732 North Hampden Court Chicago, IL 60614

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49666 Based on interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are accurately documented for eight (R8, R16, R26, R33, R53, R61, R127, R277) out of eight residents reviewed for resident records. Findings include: On 10/29/2024 at 11:30 AM, V14 (Certified Nursing Assistant/CNA) stated, I believe there are 10 residents I am responsible for. Surveyor questioned V14 what room numbers she was responsible for. V14 voiced the room numbers she was assigned to. V14 stated she works from 7:00 AM until 3:00 PM. Surveyor questioned V14 on what her next duties/tasks she was going to carry out. V14 stated, I was waiting on the other lady to come in, so she can chart under my name, lunch is about to come, she doesn't have a log in. V14 reported she is just helping the lady out with the charting. Surveyor questioned V14 for the name of the person that doesn't have log in. V14 stated the other CNA is V15 (CNA). V14 stated, If the resident received care and it is documented, that is what matters. On 10/29/2024 at 1:07 PM, V15 stated she works through an agency, and she works for the facility once in a blue moon. V15 stated she is documenting resident's care provided under another CNAs account. V15 stated she has not been able to log in the account she was given. On 10/29/2024 at 1:09 PM, V3 (Assistant Director of Nursing) stated all agency staff are provided with an individual electronic login access to document their work. On 10/30/24 at 3:48 PM, V32 (Certified Nursing Assistant) stated =she has worked for the facility for about 7 months. V32 stated she has her own individualized login to POC (Plan of Care) access. V32 stated POC is where the CNAs document what care they provided. V32 stated staff are not allowed to share login information. V32 stated, If I can't remember my password, I will request new one. It is private information. HIPAA (Health Insurance Portability and Accountability Act) law. Employees cannot share that information. It doesn't matter if I was assigned CNA yesterday. The facility's floor assignment, dated 10/29/2024, documents the assignments assigned to V14 and V15. V15 is assigned to R8, R16, R33, R52, R61, R127, and R277. R8's bowel task, dated 10/29/2024 at 11:24 AM, documents R8 had a bowel movement, and it was documented by V14 (CNA). R8's urinary/bladder task, dated 10/29/2024 at 11:24 AM, documents R8 is continent, and it was documented by V14. R16's urinary/bladder, dated 10/29/2024 at 1:21 PM, documents R16 is continent, and it was documented by V14. R16's bowel task, dated 10/29/2024 at 1:21 PM, documents none and it was documented by V14. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R26's bowel task, dated 10/29/2024 at 11:48 AM, documents none and it was documented by V14. R26's bladder task, dated 10/29/2024 at 11:48 AM, documents continent and it was documented by V14. R33's bowel task, dated 10/29/2024 at 1:24 PM, documents none and documented by V14. R33's bladder task, dated 10/29/2024 at 1:24 PM, documents incontinent and it was documented by V14. R52's urinary/bladder task, dated 10/29/2024 at 11:37 AM, documents incontinent and it was documented by V14. R52's behavior monitoring, and intervention task, dated 10/29/2024 at 11:28 AM, documents no behaviors observed, and it was documented by V14. R52's bowel task, dated 10/29/2024 at 11:37 AM, documents none and it was documented by V14. R61's urinary/bladder task, dated 10/29/2024 at 11:40 AM, documents incontinent and it was documented by V14. R127's urinary/bladder task, dated 10/29/2024 at 1:35 PM, documents incontinent and it was documented by V14. R127's behavior monitoring and intervention task, dated 10/29/2024 at 1:35 PM, documents no behaviors observed and documented by V14. R277's urinary/bladder, dated 10/29/2024 at 11:44 AM, documents continent and it was documented by V14. R277's bowel task, dated 10/29/24 at 11:44 AM, documents none and it was documented by V14. Facility document, dated 05/20/2022, titled Certified Nursing Assistant documents, in keeping with our organization's goal of improving the lives of the guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety and welfare of all guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Completes medical records documenting care provided and other information in accordance with nursing policies while maintaining strict confidentiality.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 45000 Based on observation, interview, and record review, the facility failed to ensure appropriate use of personal protective equipment (PPE) worn by staff caring for a resident with a known infectious disease (R50), and failed to ensure staff maintains clean technique/infection control practice while performing a bed bath (R3) for one resident. These failures affect 2 residents (R3 and R50) reviewed for infection prevention and control in a total sample of 21 residents reviewed. Findings include: 1. R50's physician order sheet/POS, dated 10/21/2024, documents R50 is on contact isolation precautions for shingles. On 10/29/2024, at 11:41 AM, V5 (Registered Nurse/RN) stated R50 is on contact isolation in the facility due to R50 being diagnosed with shingles. On 10/29/2024, at 11:48 PM, surveyor observed a sign posted on R50's door that reads, Contact Precautions Everyone Must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. On 10/29/2024 at 12:39 PM, V6 (Certified Nursing Assistant/CNA Supervisor) entered R50's room with a meal tray, without donning any personal protective equipment/PPE. V6 observed moving items on R50's bedside table and placing the meal tray on R50's bedside table. V6 then observed exiting R50's room. V6 stated she was aware R50 has shingles. V6 stated she is aware staff only need to wear PPE inside of R50's room whenever staff are providing direct patient care. After reading the sign on the door, V6 stated she should have worn a gown and gloves prior to entering R50's room. V6 stated she did not really read the sign posted on R50's door. V6 stated she could potentially cross contaminate and spread R50's infectious disease to another resident if the appropriate PPE is not worn while inside of R50's room. On 10/29/2024 at 1:16 PM, V7 (Certified Nursing Assistant/CNA) was observed entering R50's room without donning any personal protective equipment/PPE. V7 was observed grabbing R50's meal tray located on R50's bedside table. V7 then exited R50's room and placed the meal tray onto a meal cart located outside of R50's room. V7 stated she is aware R50 has shingles. V7 stated she was made aware by management, the nursing department, and the infection preventionist that staff does not have to wear PPE inside of R50's room if staff are only passing meal trays. V7 stated she was made aware she only needs to wear PPE inside of R50's room if she has contact with R50. After reading the sign, V7 stated she should have worn a gown and gloves prior to entering R50's room. V7 stated she is not the only staff member who enters R50's room without wearing PPE. V7 stated she could potentially spread R50's infectious disease to another resident if the appropriate PPE is not worn while inside of R50's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 2:28 PM, V4 (Infection Preventionist/RN) stated he expects staff to perform hand hygiene prior to entering a resident's room who is on contact isolation. V4 stated staff should also wear a gown and gloves prior to entering a contact isolation room regardless of what services are being provided, including passing meal trays. V4 stated if the appropriate PPE is not worn while inside of a contact isolation room, there is potential for transmission of the infection by the staff members. Facility policy, dated 07/31/2024, titled Infection Prevention and Control documents in part, 2. Contact Precaution- Intended to prevent transmission of infectious agents spread by direct or indirect contact with a patient or the environment. b. Use of gown and gloves is necessary prior to room entry. 49666 2. R3's Face sheet documents R3 is a [AGE] year-old female admitted to the facility on [DATE], who has diagnoses not limited to: morbid (severe) obesity due to excess calories, chronic diastolic (congestive) heart failure, hemiplegia and hemiparesis following cerebral infarction, neuromuscular dysfunction of bladder. R3's Minimum Data Set (MDS), dated [DATE], documents R3 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R3 is cognitively intact. R3's Minimum Data Set (MDS), section GG dated 08/23/2024, documents in part R3 requires Substantial/maximal assistance for shower/bathe self. On 10/29/2024 at 11:09 AM, R3 was lying on her bed, alert and responsive, and in no apparent distress. R3 stated there are certain CNAs (certified nursing assistants) that don't give her adequate bed baths, and R3 stated they just dab and don't clean her perineal area well. R3 stated staff don't clean certain areas on the body, and they need to clean between the buttocks. R3 stated the CNAs tell her that they are told they can't go that far, and they won't clean between her buttocks, by her rectum. R3 stated she last had a bed bath on Friday and is due for today. R3 stated she has had times where her skin is irritated and feels itchy under her breasts. R3 stated she once thought she had a bowel movement and when the CNA checked her, R3 didn't have a bowel movement, but the smell was coming from R3's right under arm. On 10/29/2024 at 11:30 AM V14 (Certified Nursing Assistant/CNA) stated that she has one resident's bed bath to complete. V14 stated that R3's bed bath is scheduled today. V14 stated she just started working on October 15, 2024. V14 stated that she has been a CNA for a long time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/2024at 1:39 PM, V14 gathered supplies for R3's bed bath. V14 was approached by V29 (CNA/Wound Tech) to ask V14 if she needed her assistance. V14 agreed for V29 to assist her. CDC (Centers for Disease Control and Prevention) enhanced barrier precaution sign outside of R3's bedroom door. Both V14 and V29 applied disposable gowns, gloves, and entered R3's room. V14 grabbed R3's basin, filled it with R3's body wash and water. V14 handed R3 a wet washcloth and R3 washed her face and then arms. V14 was standing watching television. V29 was standing too. V14 proceeded to remove soiled linen and applied new gloves. R3 stated, Can you get under my breast, it's really itchy. V14 lifted R3's breast and cleaned under it. V14 washed both of R3's under arms, rinsed the same washcloth with the same water. V14 proceeded to dry R3's under breast and under arms and threw the drying towel on the floor. V29 covered R3's breast for privacy. Surveyor observed bin with unclean water/murky appearance water. V14 questioned R3 if she would like for her to change the water, and R3 responded no. V14 did not verbalize any words to R3, and V14 then proceeded to use the same washcloth and clean R3's perineal area. V14 cleaned area around urinal catheter. R3 requested for V14 to clean her perineal area again. V14 cleaned area and proceeded to assist R3 to turn to her right side. V29 standing next to R3's right side for support. V14 cleansed R3's upper, mid, and lower back with the same washcloth that V14 cleaned R3's perineal area. V14 proceeded to wash R3's buttocks and rectal area. R3 noted with light brown stool between R3's buttocks. V14 used a clean new dry towel to dry R3's back. V14 looked at surveyor and stated, Just so you know this is not how I give bed baths. V14 continued to use the large dry towel to wipe R3's stool and V14 wiped all R3's stool. V29 applied body lotion onto R3's back. V14 changed her gloves and proceeded to apply new flat linen sheet, new yellow disposable brief, and assisted R3 to turn and lay on her back. R3 turned to her left side with assistance. R3's linen and brief were straightened out under her. R3 turned and laid on her back. V14 applied a clean hospital gown onto R3. R3's call light placed within reach. R3 placed in a comfortable position. V14 stated that he has completed the bed bath for R3. On 10/30/2024 at 10:36 AM, V4 (Infection Preventionist/Registered Nurse) stated, If they want to clean the perineal area, they should have one washcloth, and then they must change the gloves and the washcloth to prevent infection. The best practice is start from head to toes and clean from the cleanest area of the body to the dirtiest area the body. V4 stated once the nurse aid finishes washing the perineal area with the washcloth, they should grab a new washcloth to clean another part of the area. On 10/30/2024 at 2:12 PM, V30 (Regional Nurse Consultant) stated there is no bed bath procedure policy. V30 stated, The facility hosts skills fair; you have staff go over skills that were trained to reiterate on how to do the procedure, we do have those. Facility documen,t dated 08/19/24, titled Shower and Hygiene documents in part, it is the policy of this facility to ensure that resident shower/hygienic care is provided by the nursing staff to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin. Maintain clean techniques and isolation precautions as indicated. Facility document, dated 7/31/24, titled Infection Prevention and Control documents in part, the facility has established a policy to identify, record, investigate, control, test, and prevent infections in the facility. Staff will be educated about current infection control practices and procedures at least annually.