STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145944	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Aurora	400 West Sullivan Road Aurora, IL 60506

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview, and record review, the facility failed to assist residents identified as needing assistance with personal hygiene. This applies to 3 of 3 residents (R12, R60 and R61) reviewed for ADLs (activities of daily living) in the sample of 20. The findings include: 1. R12 had multiple diagnoses including Parkinson's disease with dyskinesia without mention of fluctuations and altered mental status, based on the face sheet. R12's quarterly MDS (minimum data set) dated February 27, 2024 showed that the resident was moderately impaired with cognition and required assistance from the staff with regards to personal hygiene. On April 8, 2024 at 11:43 AM, R12 was inside his room, sitting in his wheelchair. R12 was alert and verbally responsive. R12 had accumulation of long facial hair (beard and mustache). R12 stated that he needed assistance from the staff to shave his beard and trim his mustache. V9 (Licensed Practical Nurse/LPN) was made aware of R12's request to have his beard shaven and mustache trimmed. R12's active care plan initiated on June 6, 2023 showed that the resident required assistance with ADLs including personal hygiene. 2. R60 had multiple diagnoses including unspecified nontraumatic intracerebral hemorrhage in hemisphere, based on the face sheet. R60's admission MDS dated [DATE] showed that the resident was cognitively intact and required maximum assistance from the staff with personal hygiene. On April 8, 2024 at 11:02 AM, R60 was in bed, alert, oriented and verbally responsive. R60's fingernails were long, jagged and with black substances underneath. R60 stated that she wanted the staff to trim and clean her fingernails. V5 (Certified Nursing Assistant/CNA) was informed of R60's request to have her fingernails trimmed and cleaned. R60's active care plan initiated on February 27, 2024 showed that the resident had ADL self-care performance deficit related to decreased in functional mobility, decrease in strength and increase need for assistance from others. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 10, 2024 at 12:40 PM, in the presence of V4 (Assistant Director of Nursing/Infection Preventionist), V2 (Director of Nursing) stated that she expects the nursing staff to remove resident's unwanted facial hair, and to trim and clean resident's fingernails, specially to those residents needing assistance with ADLs to maintain good hygiene and grooming. 50501 3. R61 has multiple diagnoses including hemiplegia and hemiparesis, following cerebral infarction affecting right dominant side due to thrombosis of left anterior artery and diabetes insipidus, based on the face sheet. On April 8, 2024 at 10:26 AM, R61 was sitting in the wheelchair, alert and verbally responsive. R61 had accumulation of long facial hair (beard and mustache). R61's fingernails were long with black substance underneath. R61 stated that it has been two weeks since he was last shaved. R61 stated that he would like to have his fingernails trimmed and cleaned. R61 also stated he would like to have his beard shaven. V10 (Licensed Practical Nurse) was made aware of R61's request. R61's active care plan initiated on June 29, 2023, showed that the resident has ADL self-care performance deficit and impaired mobility. R61's care plan showed he is dependent on staff for ADL care. R61's quarterly MDS dated [DATE] showed that the resident has moderately impaired cognition and required assistance from staff for personal hygiene.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on observation, interview, and record review, the facility failed to follow physician's orders and weigh a resident weekly. The facility also failed to implement interventions for residents with weight loss. This failure resulted in R76 having a significant weight loss. This applies to 5 of 7 residents (R76, R40, R13, R10, and R53) reviewed for weight loss in the sample of 20. The findings include: 1. The EMR (Electronic Medical Record) showed R76 was admitted to the facility on [DATE], with multiple diagnoses including stroke, type 2 diabetes, protein-calorie malnutrition, dysphagia, and gastrostomy status. R76's MDS (Minimum Data Set) dated March 23, 2024, showed R76 had moderate cognitive impairment. R76's nutrition care plan dated March 28, 2024, showed, Resident is at risk for alteration in nutritional status related to tube feeding, dysphagia. The care plan continued to show multiple interventions dated March 28, 2024, including Obtain weight as ordered. R76's order summary report dated April 10, 2024, showed an order dated March 20, 2024, for weight upon admission/readmission, weekly times four, then monthly, every day shift every Monday for 28 days weekly times four. R76's Weight and Vitals Summary dated April 10, 2024, at 10:15 AM, showed on March 20, 2024, at 2:12 PM and 4:37 PM, R76 weighed 141.1 pounds. The facility does not have documentation to show R76 was weighed weekly times four weeks. On April 10, 2024, at 2:21 PM, V4 (ADON/Assistant Director of Nursing) and V8 (CNA/Certified Nursing Assistant) weighed R76 in her wheelchair on the scale. R76's weight, including the weight of her wheelchair was 196.8 pounds. V4 said R76's wheelchair weighed 64.6 pounds and R76 weighed 132.6 pounds. On March 20, 2024, R76 weighed 141.1 pounds, on April 10, 2024, R76 weighed 132.6 pounds which is a 6. 02% (percent) weight loss. On April 10, 2024, at 1:22 PM, V17 (Physician) said R76's weight loss could have been prevented if facility staff followed physician's orders and weighed R76 weekly as ordered. V17 continued to say interventions could have been put in place to prevent R76's significant weight loss. On April 10, 2024, at 11:26 AM, V13 (Registered Dietician) stated R76 is on tube feeding and an oral diet. V13 continued to say she assessed R76 on March 21, 2024, and has not seen R76 since March 21, 2024. V13 said R76 only has a weight from admission and should have been weighed weekly times four weeks. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On April 10, 2023, at 2:19 PM, V2 (DON/Director of Nursing) said the expectation is facility staff follow physician orders for weighing a resident weekly. R76's Dietary Evaluation dated March 21, 2024, by V13 showed R76 at risk for malnutrition. 2. R10's EMR showed R10 was admitted to the facility on [DATE], with multiple diagnoses including right femur fracture, type 2 diabetes, dementia, and multiple pressure ulcers. R10's MDS dated [DATE], showed R10 was cognitively intact. R10's nutrition care plan dated March 5, 2024, showed, Resident is at risk for alteration in nutritional status related to therapeutic diet. The care plan continued to show multiple interventions dated March 5, 2024, including Obtain weight as ordered. R10's Weights and Vitals Summary dated April 10, 2024, at 10:14 AM, showed on February 26, 2024, R10 weighed 140 pounds. On March 19, 2024, R10 weighed 121 pounds which is a 13.57 % weight loss. A progress note dated March 19, 2024, at 2:17 PM, by V13 showed Noted resident had emesis after hip surgery- fluid shifts could also be the cause of weight loss. Variable oral intake also noted. Suggest [nutritional supplement] 237 mL (milliliter) three times a day. Notes labs, KUB (Kidney, Ureter, Bladder X-Ray) ordered. RD (Registered Dietician) to follow up with resident March 21, 2024, when in facility. A progress note dated March 21, 2024, at 7:32 PM, by V13 showed Please start weekly weights time four weeks to monitor. R10's Order Summary Report dated April 10, 2024, showed an order dated March 26, 2024, for Weights weekly times three weeks, one time a day every Monday for three weeks. R10's Weights and Vitals Summary dated April 10, 2024, at 10:14 AM, showed R10's last weight was obtained on March 26, 2024. The facility does not have documentation to show R10 was weighed after March 26, 2024. On April 10, 2024, at 11:23 AM, V13 said she was notified of R10's significant weight loss on March 19, 2024. V13 continued to say one of R10's interventions in response to the significant weight loss was weekly weights for four weeks. V13 said the facility did not obtain R10's weekly weights as ordered. 3. R53's EMR showed R53 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure, chronic obstructive pulmonary disease, severe protein-calorie malnutrition, and dysphagia. R53's MDS dated [DATE], showed R53 was cognitively intact. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R53's weight loss care plan dated March 28, 2024, showed Unintended weight loss/gain, [R53] has the following conditions and risk factors that put him at risk for unintended weight loss/gain: COPD (Chronic Obstructive Pulmonary Disease), malnutrition/failure to thrive. The care plan continued to show multiple interventions date March 28, 2024, including Provide regular diet to meet the nutritional needs of the resident by: 1. Liberalize the diet; 2. Providing supplements. R53's order summary report dated April 10, 2024, showed an order dated August 24, 2023, for [Nutritional supplement] three times a day, [nutritional supplement] or equivalent, 237 mL, three times a day. R53's April 2024 MAR (Medication Administration Record) showed V6 (RN/Registered Nurse) documented R53 did not received his nutritional supplement on: April 3, 2024, at 9:00 AM and 1:00 PM due to the supplement being unavailable. April 4, 2024, at 9:00 AM and 1:00 PM due to the supplement being unavailable. April 8, 2024, at 9:00 AM and 1:00 PM due to the supplement being unavailable. April 9, 2024, at 9:00 AM and 1:00 PM due to the supplement being unavailable. On April 9, 2024, at 12:38 PM, V6 said sometimes [nutritional supplement] is out of stock. V6 continued to say if the [nutritional supplement] is unavailable then she just waits for more [nutritional supplement] to be restocked. On April 9, 2024, at 1:57 PM, V19 (RN) said the nutritional supplements are kept in the supply room. V19 opened the supply room and multiple nutritional supplements were stocked in the supply room. On April 10, 2024, at 11:30 AM, V13 said R53 has had ongoing weight loss while residing in the facility. V13 continued to say R53 should receive a nutritional supplement three times a day. V13 said if the facility does not have R53's ordered nutritional supplement, V13's expectation is R53 will receive an equivalent nutritional supplement. V13 continued to say the facility stocks a house supplement and R53 should have received the house supplement in place of the ordered supplement. V13 said the facility's house supplement has not been out of stock in the month of April. A progress note dated March 14, 2023, at 11:03 AM, by V13 showed BMI (Body Mass Index) 16.7 (Underweight) . Resident has [nutritional supplement] 237 mL three times a day, [mirtazapine] to increase appetite, food brought in by family. Encouraged resident to consume 75 to 100% of supplements . 35267 4. Face sheet, dated April 10, 2024, shows R13's diagnoses included malignant neoplasm of the pancreas, dysphagia, schizophrenia, bipolar disorder, cerebral infarction, and anxiety disorder. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Care plan initiated May 21, 2022 and resolved on February 22, 2024, showed R13 was at risk for alteration in nutritional status related to her tube feeding and oral diet. Care plan, initiated February 22, 2024, showed Actual weight loss: R13 has experienced weight loss and is at risk for continued weight loss. Has experienced progressive weight loss . Interventions, initiated March 9, 2024, included Determine food preferences through one-to-one interview and/or family interview. POS (Physician Order Sheet), printed April 9, 2024, showed R13 had physician orders for the following nutrition supplements: 1. (Nutritional supplement) to be provided twice daily since May 23, 2023 2. (Nutritional supplement) or equivalent to be provided twice daily since October 24, 2023 The POS also showed R13 had physician orders for her g-tube (gastrostomy tube) to be flushed with water daily. Review of R13's weights show the following: 151.6# (Pounds) August 1, 2023 146.2# September 21, 2023 137.2# October 9, 2023 131.4# November 3, 2023 - 13% weight loss in 3 months 128.4# November 20, 2023 132.0# December 11, 2023 134.2# January 4, 2024 126.8# February 5, 2024 116.6# March 7, 2024 125.9# April 3, 2024 MARs (Medication Administration Records), dated August 2023 to February 2024, showed R13 had an order for enteral nutrition g-tube feedings to supplement her oral nutritional intake. The MARs show R13 received the enteral nutrition feedings August 2023 until September 30, 2023 however R13 intermittently refused her supplemental enteral nutrition feedings during those months. The MARs show R13's enteral nutrition feedings were placed on hold from October 1 to November 16, 2023 and then resumed November 17, 2023 until February 11, 2024 when all g-tube feedings were discontinued and R13 was placed on hospice. Physician note, dated February 5, 2024, shows R13 lost significant weight in six months, was diagnosed with failure to thrive, and the physician instructed the dietitian to follow R13. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of R13's POS, nutrition assessments and progress notes, dated September 21, 2023 to April 10, 2024, showed no new nutrition interventions were recommended or implemented for R13 to prevent further weight loss. Nutrition assessment, dated October 12, 2023, shows R13 began refusing her enteral feedings. No new nutrition interventions were identified for R13 to prevent further weight loss. Nutrition note, dated January 31, 2024, showed R13's oral intake at meals was reported as good. Nutrition assessment, dated February 12, 2024, shows R13 had good oral intake and was consuming 75-100% of her meals and was continuing to refuse her enteral feedings. On April 9, 2024, at 11:15 AM, V14 (Licensed Practical Nurse) stated R13 formerly received enteral feedings via her g-tube but R13 began to refuse all enteral g-tube nutrition and wished to have her g-tube removed. V14 stated R13 was only receiving an oral diet for some time. V14 stated R13 did eat her meals but did not eat as much as she used to eat. V14 stated R13 needed staff assistance to eat and would sometimes refuse meals. At 11:50 AM, V14 stated R13 was not drinking the physician ordered nutritional supplements and some days refused the nutritional supplements. V14 stated R13 used to receive milkshakes from her POA (Power of Attorney) but the POA no longer brought milkshakes to R13. V14 stated she gives R13 chocolate or vanilla pudding as much as she is able because R13 likes pudding. On April 10, 2024, V13 (Dietitian) stated on August 12, 2023, she recommended weekly weights to monitor R13 for further weight loss. V13 reviewed R13's weights and stated the facility did not weigh R13 weekly. V13 stated when R13 began refusing her tube feedings, V13 did not implement any further interventions to prevent further weight loss. V13 stated she did not talk to R13 during the time R13 was losing weight and did not obtain any food preferences or discuss R13's menu with R13. V13 stated there were several different options for supplements the facility could offer if a resident did not like nutritional supplement. V13 stated she was unaware R13 was not drinking her nutritional supplement. V13 stated if R13 was not taking her nutritional supplement, the facility staff could offer a different supplement but was not aware if R13 was offered alternatives to the nutritional supplement. V13 also stated the facility had the option of placing resident food preferences on their meal trays to be given at each meal. V13 stated if the CNAs (Certified Nursing Assistants) fill out resident menus they should write in the resident food preferences or any extra items at each meal. On April 10, 2024 at 2:22 PM, V1 (Administrator) stated the facility had no policy regarding addressing residents at nutrition risk, residents with significant weight loss, or frequency of dietitian assessments of residents with tube feedings. On April 10, 2024 at 01:38 PM V1 (Administrator) and V2 (Director of Nursing) stated they conduct nutrition at risk meetings at the facility. V1 stated they discuss residents who had experienced significant weight loss. V1 stated the facility dietitian should be meeting with the residents to assess what foods they like to eat. V2 stated resident food preferences should be provided on the resident meal trays at meals and not be left to the CNAs (Certified Nursing Assistants) to write in on resident meal tickets when CNAs assist selecting the daily menus. 5. Face sheet, printed April 10, 2024, shows R40's diagnoses included depression and legally blind. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Care plan, August 19, 2023, showed R40 was assessed to be malnourished and interventions included, Monitor food and hydration intake/consumption. Monitor weight in accordance to policy and plan of care. Offer nutritional supplements as ordered and monitor compliance. Care plan, dated August 11, 2023, showed R40 was at high risk for development of skin breakdown. Care plan interventions includes Encourage good nutrition and hydration in order to promote healthier skin. POS, printed April 9, 2023, shows R40 had the following physician orders for nutrition supplements: Nutritional supplement three times a day since August 24, 2023 Nutritional supplement AWC (Advanced Wound Care) two times a day 30 milliliters since March 13, 2024 Review of R40's weights showed the following: 144.6# August 12, 2023 133.6# August 17, 2023 144.6# August 19, 2023 140.0# September 6, 2023 135.2# October 9, 2023 131.0# November 6, 2023- 9.4% weight loss in three months 131.0# November 11, 2023 131.9# November 20, 2023 131.9# November 27, 2023 132.4# December 13, 2023 134.2# January 5, 2024 120.8# February 4, 2024 - 16% weight loss in six months 122.0# February 12, 2024 121,0# March 7, 2024 120.2# April 3, 2024 On April 9, 2024 at 1:28 PM during lunch, R40 ate approximately 75% of her lunch and drank approximately half of her nutrition supplement. R40 stated she enjoyed her lunch that day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of R40's nutrition progress notes and POS, dated August 24, 2023 to March 13, 2024, showed no new nutrition interventions were recommended/implemented for R40 to prevent further weight loss. Nutrition progress note, dated August 12, 2023, shows V13 (Dietitian) recommended R40 to be weighed weekly. Review of R40's weights show R40 was not weighed weekly. Nutrition note, dated April 2, 2024, shows R40 was eating an average of 75% of her meals however R40's April 3, 2024 weight showed R40 continued to lose weight. On April 9, 2024 at 11:22 AM, V14 (Licensed Practical Nurse) stated R40 did not always drink her supplement and preferred them served on ice. R40 used to have a visitor who brought her outside food she liked, but no longer received the food from her visitor. V14 stated R40 was always fed by staff. Physician note, dated March 26, 2024, showed R40 was diagnosed with severe protein calorie malnutrition. On April 10, 2024 at 10:50 AM, V13 (Dietitian) stated R40 was receiving nutritional supplement as ordered during the course of her weight loss, but V13 did not recommend any new nutrition interventions for R40 to prevent further weight loss between August 2023 and February 2024. V13 stated she requested to have R13 reweighed during the time she was losing weight. V13 stated she had not discussed food preferences with R40 or R40's nurses recently.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35267 Based on observation, interview and record review, the facility failed to follow their planned menu/recipes resulting in lunch entrees being served to residents with inadequate protein. This applies to all 66 residents in the facility receiving General, Low Concentrated Sweets, No Added Salt, Pureed, and Mechanical Soft diets at the facility. The findings include: Long-Term Care Facility Application for Medicare and Medicaid, dated April 8, 2024, showed the facility census was 71 residents. Client List Report, printed April 9, 2024, showed all but five residents in the facility received either a General, Low Concentrated Sweets, No Added Salt, Pureed or Mechanical Soft diet. Facility Daily Spreadsheet, dated Week 2 Monday, shows residents with General, Mechanical Soft, Pureed, No Added Salt, Low Concentrated Sweets all received either regular, ground or pureed portions of Chicken Alfredo. The spread sheet shows each resident receiving the Chicken [NAME] were to be served the equivalent of a six fluid ounce portion of chicken with [NAME] sauce and a separate 1/2 cup equivalent of pasta. On April 8, 2024 at 12:15 PM during lunch service, with V12 (Food Service Manager) V11 (Cook) was serving portions of Chicken [NAME] from full steam table pan. The chicken, mushrooms, [NAME] sauce and noodles were all mixed in the pan and the mixture was being served to resident plates using a six fluid ounce spoodle. A six fluid ounce sample of the mixture was plated, and the chicken was removed from the mixture and weighed. The total amount of chicken in the six fluid ounce serving weighed 0.75 ounces. V12 reviewed the lunch spread sheet and stated the chicken should have weighed two ounces in one serving of Chicken Alfredo. Review of the facility Chicken [NAME] recipe shows the prepared menu item was to consist of pulled/diced chicken, mushrooms, [NAME] sauce and milk and was to provide a total of two ounces weight of chicken in each serving. The recipe does not show the noodles were to be added to the Chicken [NAME] prior to being served on resident plates. The recipe shows one serving of the Chicken [NAME] was to be served with a six-ounce spoodle and placed over cooked fettuccini or linguini noodles. Review of Ground and Pureed Chicken [NAME] recipes both show each serving of ground or pureed Chicken [NAME] was prepared using an initial six fluid ounce portion of Chicken Alfredo. The recipes showed each serving of Chicken [NAME] was to be prepared without the noodles added. On April 10, 2024 at 11:02 AM, V13 (Dietitian) stated she did not closely monitor the menus/food production in the kitchen and only performs a walk-through of the kitchen during her visits. V13 reviewed the menus and spreadsheets and stated the Chicken [NAME] should have been served in a six fluid ounce serving separately from the noodles at lunch on April 8, 2024. V13 stated the pureed and ground diets should also have received the Chicken [NAME] and the noodles separately when served to the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Kitchen Policy, reviewed July 23, 2023, showed, 8. Menu a. All food items in the menu and recipe will be followed. In the event that change is needed, the dietitian may be consulted first to approve the change and ensure that the change is appropriate.

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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** 16746 Based on observation, interview, and record review the facility failed to perform hand hygiene before and after providing direct care to residents on EBP (enhanced barrier precaution). The facility also failed to implement EBP for residents with implanted medical devices, and during high-contact resident care. This applies to 4 of 20 residents (R18, R25, R60 and R76) reviewed for infection control in the sample of 20. The findings include: 1. R18 had multiple diagnoses including chronic respiratory failure with hypoxia, end stage renal failure and dependence on renal dialysis, based on the face sheet. On April 9, 2024 at 10:30 AM, V14 (LPN/Licensed Practical Nurse) was inside the unit nursing station. V14 was on her computer and stated that she was preparing R18's papers because the resident was going out for dialysis. V14 then walked towards R18's room and went inside. An EBP sign was posted on R18's front door. The EBP sign showed, to clean hands, including before entering and leaving the room, wear gloves and gown for high-contact resident care activities. Inside the room, R18 was in bed, alert and verbally responsive. R18's oxygen nasal cannula was on his chin area, instead of on his nostrils. V14 was informed that the resident's nasal cannula was not in place. V14 without performing hand hygiene (hand washing or use of the alcohol rub) and/or putting on gloves, placed the nasal cannula on R18's nostrils with her bare hands. R18 had an active care plan initiated on October 1, 2023 indicating that the resident was at risk for complications or adverse reactions related to EBP due to ESRD (end stage renal disease) with hemodialysis and wound. The same care plan had multiple interventions including, Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for those with central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs (Multidrug-Resistant Organisms) to staff hands and clothing. On April 4, 2024 at 12:26 PM, V2 (Director of Nursing) stated that R18 was on EBP because the resident was receiving dialysis and with a dialysis access site. V2 stated that since R18 was on EBP, V14 should have washed her hands, put on gloves and gown before handling/putting back the resident's nasal cannula, because V14's action was still considered direct care to a resident. According to V2, EBP should be followed to maintain infection control and prevent cross contamination. 2. R60 had multiple diagnoses including, unspecified nontraumatic intracerebral hemorrhage in hemisphere, based on the face sheet. R60's order summary report and active care plans showed that the resident had orders to receive pressure injury treatment on her sacrum and treatment on her right lateral lower leg wound. (continued on next page)

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	145944	A. Building B. Wing	04/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 9, 2024 at 10:34 AM, V14 (LPN) was inside the nursing station typing on the desk top computer. V14 was asked if R60's wound treatment had been completed that morning. V14 stated that she was not sure, but she will check. V14 then proceeded to R60's room. Inside R60's room, the resident was in the bathroom sitting on the toilet. V5 (Certified Nursing Assistant) was inside the bathroom with the resident. V5 stated that R60 had urinated. V14 (who just entered R60's room, coming from the nursing station, typing on the computer) stated that she will clean R60. V14 put on a pair of gloves without performing hand hygiene (hand washing or use of alcohol gel). After R60 was assisted by V5 to stand using a gait belt, the resident's sacral area was observed without any cover/dressing. According to V5, R60's sacral dressing came off when the resident sat on the toilet. R60's sacrum had an open wound. V14 stated that she will apply a new dressing on R60's sacrum after cleaning the resident. With her gloved hands, V14 started cleaning R60's perineal area. During the above observation, V5 and V14 were not wearing gown and no EBP sign was observed posted on R60's front door. After providing perineal care to R60, V14 removed her gloves and stated that she will check R60's orders for the sacral wound treatment. V14 did not perform hand hygiene after removing her gloves, even though a sink and a faucet was available in the resident's bathroom. V14 got out of R60's room, proceeded to her medication cart, touched the computer mouse and the computer keyboard, then went to the medication room, opened the treatment cart (that was inside the medication room) and was about to take out and prepare the needed treatment supplies for R60's sacral wound. During this time, V14 was asked if she had washed her hands or sanitized her hands after providing perineal care to the resident and after removing her gloves. V14 acknowledged that she did not perform any hand hygiene and stated that she should have washed her hands or used a sanitizer after removing her gloves post perineal care of the resident. While inside the medication room, V14 was prompted to wash her hands because a sink and a faucet were available in the room. On April 9, 2024 at 10:53 AM, V5 with her gloved hands, assisted R60 to stand up from sitting on the toilet to allow V14 to administer treatment on the resident's sacrum. V14 cleaned and applied treatment/dressing on R60's sacral pressure injury while wearing gloves. However, V14 and V5 were not wearing gown during the pressure injury treatment. R60 had an active care plan in place, initiated on March 15, 2024 indicating that the resident was at risk for complications or adverse reactions related to enhanced barrier precaution due to wound. The same care plan had multiple interventions including, Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for those with central line, urinary catheter, feeding tube, tracheostomy/ ventilator, and wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs to staff hands and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 10, 2024 at 12:26 PM, in the presence of V4 (Assistant Director of Nursing/Infection Preventionist), V2 (Director of Nursing) stated that residents are placed on EBP (enhanced barrier precaution) when the resident have tracheostomy, urinary catheter, PICC (peripherally inserted central catheter) line, gastrostomy tube, and wounds or pressure injury. V4 stated that for residents on EBP a gown and gloves should be worn during provision of direct care like, toileting, transferring and wound or pressure injury care and treatment. V4 stated that V5 and V14 should have worn a gown when R60 was being toileted, during the perineal care and during the treatment of the sacral wound. According to V4, V14 should have washed her hands before putting on gloves to clean/provide perineal care to R60 and V14 should have washed her hands after removing her gloves post perineal care to R60, and before performing any other task including touching the computer and keyboard and before opening the medication door and the treatment cart. During the same interview, V2 added that V5 and V14 should have put on a gown before toileting and before providing pressure injury treatment to R60. V2 stated that V14 should have washed her hands (preferred method by V2) before putting on gloves to provide perineal care and after removing gloves post perineal care of R60. According to V2, the wearing of the gown, gloves and performing hand hygiene (hand washing or use of alcohol) before and after a direct care/task to a resident on EBP should always be implemented by the nursing staff to prevent cross contamination and to maintain infection control. Both V2 and V4 stated that an EBP sign should have been posted on R60's door to ensure that the staff who comes in the room to provide a direct care to the resident was aware to wear gloves and gown, and to wash hands. The facility's policy and procedure regarding EBP (enhanced barrier precaution) last revised by the facility on October 23, 2023 showed, The facility will use Enhanced Barrier Precautions (EBP) to reduce transmission of (MDRO) multi-drug resistant organisms in the nursing home. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDROs as well as residents with wounds and/or indwelling medical devices. The same policy showed in-part under procedure, 1. EBP will be used for any resident in the facility: With open wound/s (pressure ulcer, diabetic ulcer, venous ulcer, arterial ulcer, unhealed surgical wounds, etc.) whose drainage can be contained by dressing. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing 3. The EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include : .c) Transferring, d) Providing hygiene, .f) Changing briefs or assisting with toileting, .h) Wound care: any skin opening requiring a dressing.7. An EBP sign should be posted on the doors of each resident on EBP. The facility's hand hygiene policy and procedure last reviewed by the facility on July 28, 2023 showed in-part, Hand hygiene is important in controlling infections. Hand hygiene consists of either hand washing or the use of alcohol gel. The same policy under procedure showed in-part under the procedure, 1. Hand hygiene using alcohol-based hand rub is recommended during the following situations: a. Before and after direct resident contact. The facility's gloves usage policy and procedure last revised by the facility on March 23, 2020 showed, Wash hands after removing gloves (Note: Gloves do not replace handwashing). The same policy showed in-part, under when to use gloves, 1. When touching excretions, secretions, blood, body fluids, mucus membranes or non-intact skin, . 5. Whenever in doubt. 45303 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The EMR (Electronic Medical Record) showed R76 was admitted to the facility on [DATE], with multiple diagnoses including stroke, type 2 diabetes, protein-calorie malnutrition, dysphagia, and gastrostomy status. R76's MDS (Minimum Data Set) dated March 23, 2024, showed R76 had moderate cognitive impairment. The MDS continued to show R76 was dependent on facility staff for transfers from the bed to the chair. On April 8, 2024, at 11:58 AM, R76 was in her room, lying in bed. R76's door did not have a sign for EBP (Enhanced Barrier Precautions). On April 9, 2024, at 12:05 PM, R76's door did not have a sign for EBP. On April 10, 2024, at 9:12 AM, R76's door did not have a sign for EBP. On April 10, 2024, at 10:35 AM, V8 (CNA) said she was caring for R76. V8 did not identify R76 as having EBP. V8 said if a resident is not in EBP, V8 does not wear a gown while providing care to the resident. On April 10, 2024, at 11:58 AM, R76 was lying in bed with enteral feeding infusing into R76's gastrostomy tube. V15 (CNA) and V16 (CNA) transferred R76 from the bed to wheelchair. V15 and V16 were not wearing gowns. R76's door did not have a sign for EBP. On April 10, 2024, at 12:26 PM, V2 (Director of Nursing) said R76 should have EBP sign on the door because R76 has a gastrostomy tube. V2 said V15 and V16 should have worn gowns when transferring R76 from the bed to the wheelchair. 4. R25's EMR showed R25 was admitted to the facility on [DATE], with multiple diagnoses including congestive heart failure, end stage renal disease, and dependence on renal dialysis. R25's MDS dated [DATE], showed R25 had moderate cognitive impairment. The MDS continued to show R25 was dependent on facility staff for transfers from bed to chair and required maximal assistance from facility staff for bed mobility. R25's dialysis care plan dated February 10, 2024, showed [R25] requires in house hemodialysis three times a week related to end stage renal disease. Dialysis site: [dialysis catheter], location: right upper chest. On April 9, 2024, at 1:10 PM, R25's door did not have a sign for EBP. On April 9, 2024, at 1:12 PM, R25 was lying in bed with a meal tray in front of her on a bedside table. R25 had a dialysis catheter on her right chest. V7 (Guest Services) entered R25's room, did not perform hand hygiene, took R25's meal tray out of R25's room, placed it on a rack. V7 did not perform hand hygiene, V7 then took water from another facility staff member and brought it into another resident's room (R57's room). V7 did not perform hand hygiene before entering R57's 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 April 10, 2024, at 12:26 PM, V2 said R25 should have EBP because R25 has a dialysis catheter. V2 continued to say facility staff should perform hand hygiene when entering a resident's room with EBP and perform hand hygiene when leaving the resident's room. V2 said V7 should have performed hand hygiene when entering and exiting R25's room.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. 35267 Based on observation, interview, and record review, the facility failed to maintain the kitchen floor to ensure cleanability. This applies to all 70 residents in the facility receiving oral diets at the facility. The findings include: Long-Term Care Facility Application for Medicare and Medicaid, dated April 8, 2024, showed the facility census was 71 residents. Client List Report, printed April 9, 2024, showed only one resident did not receive an oral diet at the facility. On April 8, 2024 at 10:29 AM with V12 (Food Service Manager) during the initial kitchen tour, the kitchen floor under the dish machine, in the janitor area, under the cooking hood and cooking equipment, and near the cooler was in poor repair and had a large amount of loose, chipped and crumbled floor debris, as well as food debris, in the areas of disrepair. On April 10, 2024 at 2:24 PM, V18 (Maintenance Director) stated he was aware that the kitchen floor was chipping, crumbling, and in poor repair. V18 stated he was in discussions with the corporate office on how to repair the kitchen floor. Facility policy Maintenance, reviewed July 28, 2023, showed It is the facility's policy to maintain equipment and the building environment.