STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146133	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandwich Living & Rehab Center	902 East Arnold Street Sandwich, IL 60548

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36186 Based on observation, interview and record review the facility failed to provide a comfortable home like dining experience for two of three residents (R21 and R7) reviewed for clean, comfortable homelike in the sample of 13. The findings include: On 12/4/2024 at 8:20 AM R21 and R7 were observed eating their breakfast in the small dining room near the sliding glass doors leading to the patio. R5 came and opened the patio doors to go outside to fill the bird feeders, leaving the doors open and cold air was blowing into the dining room. R21 was observed pushing himself away from his breakfast and saying,It's too cold to sit here anymore. R21 had over half his breakfast left. R7 was observed glancing over his shoulder several times to look at the open doors. R7 then left the dining room with food still on his plate. Several facility staff were observed walking past the small dining room and the open door and some were heard saying how cold it was. At 8:28 AM, V6 (Registered Nurse/RN) went and got R21 who had wheeled himself around the corner to get away from the cold, and brought him to the medication cart placed in line of the cold draft blowing into the facility. R21 said,It's too cold to sit here and V6 said she just had to give him his medications and then she would move him to another area. On 12/5/24 at 9:25 AM, R7 said it was getting too cold to sit in the dining room with the door open for that long, but he was done eating anyway. R7 said he doesn't know why the door had to be left open for so long. On 12/5/24 at 9:15 AM, R5 said he fills the bird feeders whenever they need to be filled. R5 said he can do it by himself and does it when he wants to. R5 said no staff have ever helped him or asked him to keep the doors closed. The weather on 12/5/24 at 8:30 AM was in the 20's with wind per accu weather. On 12/5/24 at 9:30 AM, V6 said she was so busy with passing medications that she did not notice the residents leaving the dining room. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 9:35 AM, V1 (Administrator) said he was not aware R5 was filling the bird feeders outside and he had concerns for his safety doing this. V1 said the staff should have intervened in the situation and closed the door to prevent the cold air from coming in and should have assisted R5 for his safety. The facility policy for resident rights (Residents' Right for People in Long-term Care Facilities) shows you have the right to safety and good care. Your facility must provide services to keep your physical and mental health and sense of satisfaction. Your facility must make reasonable arrangements to meet your needs and choices.

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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 - 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** 34891 Based on observation, interview, and record review the facility failed to identify a wound prior to becoming a deep tissue injury (DTI), failed to ensure pressure ulcer interventions were in place, and failed to ensure weekly wound assessments were done for 2 of 5 residents (R11, R19) reviewed for pressure ulcers in the sample of 13. These failures resulted in R11 being at an increased risk of infection and delayed wound healing. The findings include: 1. R11's face sheet printed on 12/4/24 showed an admitted [DATE] and diagnoses including but not limited to fracture of right lower leg, urinary tract infection, pneumonia, and peripheral vascular disease. R11's facility assessment dated [DATE] showed no cognitive impairment and staff assistance required for transfers and toileting hygiene. The same assessment showed R11 is always incontinent of urine and bowel. R11's pressure ulcer risk assessment dated [DATE] showed a moderate risk for pressure ulcer development. R11's December 2024 physician orders report showed an order start dated 10/6/24 for: Check lower leg, with CAM (controlled ankle movement) boot on for increased edema or complications. Notify MD if changes/occur, every day and night shift. The report showed a second order start dated 11/10/24 for: Right heel: cleanse, paint right side of heel with betadine, wrap with kerlex, apply heel boot, every day and night shift. On 12/3/24 at 9:22 AM, R11 was lying in bed and complained of pain to her right foot, which was wrapped in a white gauze bandage (kerlix) from the ankle to the toes. Her right heel was lying directly on the bed and the left heel had a blue heel boot on it. A sign was posted above the bed showing heel boots to be on at all times. R11 said she has a sore on her right foot but was not able to explain the cause. A black medical boot (CAM boot) was lying on the floor at the foot of the bed. On 12/3/24 at 11:47 AM, V11 and V12 (Certified Nurse Aides) stated R11 has a sore on her right heel. It was caused by the medical boot she wears when she is out of bed. Her heels need to be floated or a heel protector on them to take any pressure off the areas. At 11:50 AM, V14 (Registered Nurse) entered the room and said R11 had surgery on her right leg due to a fall at home. She wears the medical boot daily and it has caused a sore on her foot. V14 stated she was not sure if the boot rubbing has been addressed with the physician or family yet. V14 was unable to provide any specifics related to the stage or characteristics of the wound. R11's progress note dated 11/10/24 at showed: .Writer observed a circular, non-blanchable purple discolored area measuring 3x3 (centimeters). Skin intact, no drainage or odor observed. No (complaint) pain or discomfort. Area cleansed with wound cleanser, betadine applied along with kerlix dressing. Resident tolerated dressing change. MD faxed and made aware. Return orders pending. Will endorse to oncoming shift to follow up. POA make aware and was happy that she was informed. Treatment in place. Will continue with current care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R11's November TAR (Treatment Administration Record) showed an order start dated 7/16/24 for weekly skin checks every Tuesday. The TAR was documented every Tuesday with no skin changes for the entire month, including the three Tuesdays after the 11/10/24 progress note showed a wound. R11's electronic and paper medical records were reviewed by this surveyor. No documentation could be located related to any heel wound assessments after the 11/10/24 progress note. R11's care plan was reviewed by this surveyor. There was no focus area or interventions in place related to the wound. On 12/4/24 at 11:51 AM, V4 (Nurse Consultant) stated there are no wound assessments for R11 after the day it was identified on 11/10/24. V4 said there are no wound rounds or weekly assessments available. Nothing is in the progress notes either. On 12/4/24 at 2:35 PM, R11's right heel was observed during the dressing change with V6 (Registered Nurse/RN). A dark purple, half-dollar size pressure ulcer was still located on her right heel. On 12/5/24 at 8:39 AM, V3 (Director of Nursing) stated wounds should be found before reaching an advanced stage. Residents can get more skin break down and have the risk for infection. V3 said a deep, dark purple area would be an unstageable pressure ulcer. That is an advanced stage wound. Any resident with a pressure ulcer should be followed by the wound physician. A wound assessment should be done immediately by the nurse on duty. A full physician wound assessment should be done within a day or two after that and then on a weekly basis. The weekly assessments are important to be sure that the treatment is working. There is no way of knowing if the wound is getting better or worse if there are no assessments. Interventions need to be in place right away. The care plan shows how to direct the wound care being provided. Interventions explain from shift to shift what is needed for good wound healing. R11's Wound and Skin Record dated 12/5/24 at 9:34 AM (only performed after this surveyor requested the wound to be assessed) showed a right heel deep tissue injury, dry with cracks around it, black color on both sides and purple/redness within the wound. The facility Pressure Ulcer Prevention and Guidelines policy reviewed dated 9/2024 states under the procedure section: 3. The skin check assessment tool will be used with new onset and referred to the treatment nurse for follow-up with the Physicians as indicated. The facility Wound Assessment policy review dated 9/2024 states: It is the policy of this facility to do a systemic ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities. The policy states: 2. A complete wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairment in the skin integrity. 3. The weekly wound assessment documentation will be recorded weekly on the weekly pressure sore log and/or other skin condition log. 31615 2. R19's order summary sheet documents his diagnoses to include multiple sclerosis and pressure ulcer of unspecified buttock, stage 4. The current orders include dressing orders for the left buttock and sacrum, and the right buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/3/24 at 10:37 AM, R19 said he has wounds to his buttocks. The nurses change the dressings twice a day. On 12/4/24 at 3:02 PM, V6 (RN) performed the dressing change for R19, and he was observed to have a large and deep Stage 4 pressure injury to his left buttock and sacral area. He had an additional wound to his right buttock. The last 3 months of wound assessments were requested from the facility. The last assessment was dated 11/15/24. The previous assessments were dated 10/25/24, 10/4/24 and 9/27/24. The facility Wound Assessment policy review dated 9/2024 states: It is the policy of this facility to do a systemic ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities. The policy states: 2. A complete wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairment in the skin integrity. 3. The weekly wound assessment documentation will be recorded weekly on the weekly pressure sore log and/or other skin condition log.

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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** 34891 Based on observation, interview, and record review the facility failed to ensure a resident was transferred in a safe manner (R8) and failed to ensure a resident was assessed for safe smoking (R18) for 2 of 4 residents reviewed for safety in the sample of 13. The findings include: 1. R8's face sheet printed on 12/4/24 showed diagnoses including but not limited to cerebral infarction, Parkinson's disease, depression, vomiting without nausea, and dysphagia (difficulty swallowing). R8's facility assessment dated [DATE] showed no cognitive impairment and partial to moderate staff assistance for eating. The same assessment showed full staff dependence for transfers. R8's December 2024 order summary report showed an order start dated on 9/30/24 for: Because of potential for injury please make this patient a Mechanical lift only . On 12/4/24 at 9:03 AM, V11 and V16 (Certified Nurse Aides) transferred R8 from her bed to the wheelchair. The aides sat R8 on the edge of the bed and held her underneath her arms. R8 appeared thin, weak, and fragile. R8 was unsteady and struggled to stand. R8's shoe fell off while she was attempting to pivot to the wheelchair. The aides did not apply a gait belt around R8's waist at any time. On 12/5/24 at 8:51 AM, V3 (Director of Nursing) stated the therapy department determines what method is needed to transfer a resident. Any physician order regarding the type of transfer should absolutely be followed. The MDS (facility assessment) also shows how to transfer a resident. The aides ask the nurse or look in the chart to determine which method to use. It is unsafe for the aides to transfer a resident incorrectly. There is a high risk of injury and falls, V3 stated R8 is a high fall risk and could seriously be injured if the mechanical lift is not used. On 12/5/24 at 8:59 AM, V11 and V12 (CNAs) stated they look at the banner in the electronic medical record for resident transfer types. If a resident needs a mechanical lift it will show there. The aides and this surveyor reviewed R8's banner page in the medical record. The banner showed a two person assist and did not state that a mechanical lift should be used. The aides stated the MDS nurse is the one that looks at the transfer orders and inputs it on the banner page. The aides said her banner needs to be updated if she has an order for a mechanical lift. The aides said they were not aware R8 needed a mechanical lift now. The facility's undated transfer policy states: Before the initiation of a transfer, you must know resident's weight bearing status (if appropriate) .medical precautions or contraindication .be knowledgeable of the amount/type of assistance required and any weight bearing precautions. 31615 2. The smoking/vaping safety screen of 12/6/23 shows R18 was admitted to the facility on [DATE]. He uses smoking tobacco, and requires minimal assist with his ability to smoke. The next assessment was completed on 5/16/24, and no further assessments were documented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24, R18 was lying in bed, alert and oriented. He had an unlit cigar in his hand. He said since it is so cold outside, now he only goes out at night time to have a couple of hits. On 12/4/24 at 12:39 PM, V15 (Social Services) said smokers are screened annually and quarterly for safety. She said (R18) should have had a quarterly assessment to determine if he is safe to go outside to smoke. The facility smoking safety policy documents it is to provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. 3. Smokers will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials. Residents requiring supervision shall receive this monitoring consistent with their assessment and plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview and record review the facility failed to ensure an indwelling catheter drainage bag was maintained in a manner to prevent contamination for 1 of 3 residents (R4) reviewed for catheters in the sample of 13. The findings include: R4's admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including multiple sclerosis, flaccid neuropathic bladder, acute kidney failure, history of UTI's (Urinary Tract Infections). The facility's 10/21/24 annual resident assessment for R4 shows he has an indwelling urinary catheter. The 10/31/24 care plan documents he is at risk for UTI's due to indwelling urinary catheter. On 12/03/24 at 10:02 AM, R4 was observed lying in bed. He had an indwelling catheter bag on the side of his bed, and it was resting on the floor. On 12/03/24 at 11:27 AM, V11 and V12 (Certified Nursing Assistants) said catheter drainage bags should not be on the floor, due to infection issues. The drainage bag should be in a dignity bag. V11 and V12 were advised of R4's catheter drainage bag being on the floor. On 12/04/24 at 10:00 AM, R4's catheter drainage bag was observed still on the floor and the drainage tube was not covered, and touching the floor. On 12/4/24 at 10:13 AM, V3 (Director of Nursing) the catheter drainage bag should not be on the floor, and the drainage tube should be covered and closed. The bag needs to be in a bag. When the bag is on the floor, it could cause infections if that is on the floor.

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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 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** 34891 Based on observation, interview, and record review the facility failed to prevent an unplanned, significant weight loss for 1 of 2 residents (R8) reviewed for nutrition in the sample of 13. This failure resulted in R8 sustaining a 7.98% weight loss over 1 month. The findings include: R8's face sheet printed on 12/4/24 showed diagnoses including but not limited to cerebral infarction, Parkinson's disease, depression, vomiting without nausea, and dysphagia (difficulty swallowing). R8's facility assessment dated [DATE] showed no cognitive impairment and partial to moderate staff assistance for eating. The same assessment showed full staff dependence for transfers. On 12/3/24 at 12:23 PM, R8 was seated at the lunch table with a pureed texture meal in front of her. A magic cup nutritional supplement was next to her plate and R8 was using a sippy-type cup. R8's head was down, and she was not eating. R8 appeared thin and fragile. R8 was missing multiple teeth. Several staff members approached R8 throughout the meal but none offered assistance or cueing. At 12:48 PM, R8 wheeled herself out of the dining room. Her lunch meal was completely untouched. R8's electronic medical record was reviewed and showed on 10/23/24 she weighed 106.5 pounds. On 11/28/24 she weighed 98 pounds. (This is a 7.98% loss in one month). R8's nutrition/dietary note dated 10/18/24 showed resident is under weight for her age and dietary recommendations were given. Those recommendations included pudding 2 times daily, magic cup daily, mighty shake 3 times daily, benecalorie to be mixed with thickened cranberry 2 times daily, and medpass 90 mL (milliliters) mixed with food. The same 10/18/24 nutritional note recommended Remeron (medication) to increase R8's appetite. The note stated resident will continue on weekly weights. R8's November and December 2024 medication administration records and progress notes were reviewed. There was no documentation of any follow up or administration of the dietary recommendations, other than the medpass and pudding. R8's physician order report showed an order start dated 10/24/24 for weekly weights to be done every Wednesday morning. There were no weights done until 11/13/24 (two weeks later). On 12/5/24 at 12:06 PM, V6 (Registered Nurse) stated weights should be done as frequently as ordered. The dietary staff and dietitian reviews them. Any big gains or losses need to be addressed. The dietitian gives recommendations if someone is losing weight. The nurses are responsible for getting the suggestions to the doctor. New orders are put in after he approves the suggestions. It should be done in a couple of days, 1 to 3 max. It is important the recommendations get followed up on quickly for healthy weight gain, wound healing, and good health. V6 stated R8 has definitely lost weight recently. V14 (Registered Nurse) just dug into her chart two days ago and is looking into it. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 11:30 AM, V13 (Registered Dietitian) stated she just took over care for R8 three weeks ago. Residents should be seen by a dietician on at least a monthly basis. Weights are obtained from staff and group discussions take place as soon as any concerns are discovered. V13 said the staff should be getting weights recorded sooner. Any refusals to be weighed should be charted. V13 said she defines a significant weight loss based on the general standard of 5% loss over 30 days, 7.5% loss over 90 days, and 10% loss after that. V13 stated R8's weight loss of 7.98% over one month is a significant weight loss. V13 said she would expect staff to be implementing and following up on dietary recommendations within a few days. The physician should have been notified of the recommendations and all the approved recommendations started. V13 said there is the potential for more weight loss, poor skin integrity and overall decline of a resident when the dietary recommendations are not followed. R8's care plan showed a focus area related to weight loss. Interventions included give the resident supplements as ordered. Alert nurse/dietitian if not consuming on a routine basis. Monitor and evaluate any weight loss. Weight monitoring per facility protocol. The facility Unintended Weight Loss policy revision dated 9/2024 states: 1. Resident is weighed monthly after admission and/or weekly, as requested by the physician/dietician .5. Resident's physician will be informed of significant weight loss. 6. Dietician recommendation for weight gain will be referred to the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview and record review the facility failed to initiate an antibiotic when ordered for 1 of 1 residents (R19) reviewed for pharmacy services in the sample of 13. The findings include: R19's order summary sheet documents he was admitted on [DATE] with multiple diagnoses including multiple sclerosis, and neuromuscular dysfunction of bladder. The orders show he has long term use of a urinary catheter. The after visit summary of the local emergency room shows R19 was seen on 9/20/24 for a fever and abdominal pain. He had blood tests and a urine culture completed. He was given IV (intravenous) antibiotics, and discharged with an order for cefpodoxime 200 mg (milligrams) twice daily for 10 days. The medication was to start on 9/20/24 and end on 9/30/24. The facility order for cefpodoxime was input on 9/21/24 at 1:20 AM. The September MAR (Medication Administration Record) shows the medication was not started until 9/21/24. On 12/05/24 at 10:13 AM, V3 (Director of Nursing) said at that time the facility had a different pharmacy could not say if the medication was available. She said the medication should have been started the same day it was ordered, especially an antibiotic. The doctor should have been notified if there was any issue with obtaining the medication. It is very important to start the antibiotics for UTI's (Urinary Tract Infections). R19 is very susceptible to going septic when he gets sick. The facility's 9/2023 policy for medication administration documents 11. In the event a drug is unavailable, the charge nurse shall be responsible for notifying the pharmacy for delivery. R19's progress notes were reviewed and no pharmacy or physician notification was documented relating to the antibiotic not being available for administration on 9/21/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36186 Based on observation, interview and record review the facility failed to administer medications as ordered. There were 25 opportunities with two errors resulting in a 8% error rate. This applies to one of four residents (R23) observed in the medication pass. The findings include: On 12/4/2024 at 8:47 AM, V6 (Registered Nurse/RN) was observed giving R23 his morning medications during the medication pass observation task. The Physician Orders dated 12/2024 shows an order for pantoprazole 40 mg (milligrams) (medication for heartburn) to be given two times a day at 8:00 AM, and 5:00 PM and polyethylene glycol 17 grams (medication for constipation) at 8:00 AM. These two medications were not given to or offered to R23 during the medication pass on 12/4/24 by V6. On 12/5/24 at 9:00 AM, V4 (Nurse Consultant) and V3 (Director of Nursing) said a resident's medication should be given as ordered by the physician. The facility face sheet shows R23 was admitted to the facility with alcoholic hepatitis, alcoholic cirrhosis and esophageal varices. The facility policy updated on 9/2023 for medication administration shows the medication administration record will be verified against the Physician orders.

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36186 Based on observation, interview and record review the facility failed to use the current electronic health records (EHR) medication administration record (MAR) to administer medications to the residents. This applies to 3 of 3 residents (R21, R18 and R23) reviewed for medical records in the sample of 13. The findings include: On 12/3/24 at entrance into the facility at 8:30 AM, V1 (Administrator) said the facility had just gone live with the new EHR at midnight on 12/3/2024. On 12/4/24 between the hours of 8:20 AM to 8:47 AM, V6 (Registered Nurse/RN) was observed passing medications to R21, R18 and R23 and was using the past EHR's MAR. V6 said she had never been trained on how to pass medications and document in the facilities current EHR, so she was using what she knew how to do. V5 (Licensed Practical Nurse), who was in the facility to assist the staff on the use of the new EHR, observed V6 using the old EHR, asked V6 why was she using the old EHR and was told by V6 she did not know how to use the new system. V5 walked away from V6 and allowed her to continue using the old system to complete the AM medication pass. On 12/5/24 at 9:00AM, V4 (Nurse Consultant) and V3 (Director of Nursing) said all staff had been educated on the current EHR on 11/21/24 and the staff were expected to be using the new system for all care and documentation. V3 and V4 said if V6 had questions on how to document medication administration, she should have asked for help rather than using the old system. The old EHR's MAR may not have been up to date with the residents current medication orders. The MAR used for R23 on 12/4/24 at 8:47 AM by V6, did not show the medications pantoprazole (medication for heartburn) and polyethylene glycol (medication used for constipation) and R23 was not given these medications. The facilities current EHR's MAR dated December 2024 showed the medications pantoprazole and polyethylene glycol. The Physician's Order Sheet (POS) for R23 dated December 2024 showed orders for these same two medications should have been given at 8:00 AM medication pass. A medication error occurred for R23. The old EHR's MAR for R21 did not show the following medications that are listed on the new and current EHR's MAR: divalproex and levothyroxine. Both medications are listed as current on R21's POS dated December 2024. The facility policy updated on 9/2023 for medication administration shows the medication administration record (MAR) will be verified against the Physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146133	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 31615 Based on observation, interview and record review the facility failed to implement EBP (enhanced barrier precautions) for 3 of 6 residents (R4, R11, R19) reviewed for infection control in the sample of 13. The findings include: 1. R19's December 4, 2024 order summary sheet documents him to have a stage 4 pressure injury, and an indwelling urinary catheter. On 12/2/24 at 9:30 AM, R19's door did not have a sign to indicate he was on EBP, and no PPE (personal protective equipment) including gowns, were readily available. On 12/03/24 at 10:36 AM, R19 was observed to have a urinary drainage bag on the frame of his bed. V11 and V12 (Certified Nursing Assistants/CNAs) were observed entering R19's room without donning gowns. V11 put on gloves. V12 did not have gloves on when she transferred the urinary drainage bag from the bed to the wheelchair during the mechanical lift transfer. V11 and V12 both said they did not know of any EBP, and no residents in the facility had any such isolation. R19's 9/17/24 care plans show Implementation of Enhanced Barrier Precaution due to 3 wounds (pressure injuries) and an indwelling catheter. The interventions show the use EBP during high contact care activities such as transferring, proving hygiene urinary catheter care and wound care. The care plan was revised on 10/2/24. 2. R4's admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including multiple sclerosis, flaccid neuropathic bladder, acute kidney failure, history of UTIs (Urinary Tract Infections). The facility's 10/21/24 annual resident assessment for R4 shows he has an indwelling urinary catheter. The 10/31/24 care plan documents he is at risk for UTIs due to indwelling urinary catheter. On 12/03/24 at 10:02 AM, R4 was observed lying in bed. He had an indwelling catheter bag on the side of his bed. R4's door did not have any signs indicating EBP, and no PPE near his room. R4's care plan shows on 5/9/24 Enhanced Barrier Precautions were to be in place due to R4 having an indwelling urinary catheter. On 12/04/24 at 10:13 AM, V3 (Director of Nursing) said she was not aware residents with catheters had to be on EBP, she thought it was only for residents with open wounds. She said that was why R4 was not on EBP. She did not know R19 was not on EBP (due to wounds and a catheter) and both should have PPE available and signs on their doors. She said the staff should be educated on the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 3/1/23 policy for EBP shows 1. EBP signs must be posted on the door. 3. Gloves and gowns must be worn for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. It applies to residents with devices such as urinary catheters, and residents with any skin opening requiring dressing. 34891 3. R11's face sheet printed on 12/4/24 showed an admitted [DATE] and diagnoses including but not limited to fracture of right lower leg, urinary tract infection, pneumonia, and peripheral vascular disease. R11's facility assessment dated [DATE] showed no cognitive impairment and staff assistance required for transfers and toileting hygiene. The same assessment showed R11 is always incontinent of urine and bowel. On 12/3/24 at 11:47 AM, V11 and V12 (CNAs) entered R11's room to provide care. There was no signage posted on the door to indicate any type of isolation concerns and no PPE bin (personal protective equipment) nearby. The CNAs performed pericare wearing only gloves. A white gauze dressing was on R11's right foot. The aides stated she has a wound on her heel from a surgical boot. V11 and V12 transferred R11 from the bed to the wheelchair using a mechanical lift. On 12/3/24 at 12:10 PM, the aides and this surveyor exited R11's room. A PPE bin had been placed next to the door and a sign showing she was on enhanced barrier precautions was posted on the door. The sign showed gowns and gloves are needed while providing direct resident care, including transferring, changing briefs, and any wound care. V12 stated the bin and sign just got put there. V12 said if the signs are not posted, we have no way of knowing when to wear PPE.