STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Village	2233 W Jefferson St Kokomo, IN 46901

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36454 Based on interview and record review, the facility failed to notify the resident's representative of a psychotic disturbance and the start of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident 89). Finding includes: The clinical record for Resident 89 was reviewed on 3/13/24 at 4:44 p.m. The diagnoses included, but were not limited to, nondisplaced fracture of the right femur, major depressive disorder, generalized anxiety disorder, cognitive communication deficit and dementia with psychotic disturbance. A physician's order, dated 1/4/24, indicated to give Risperdal (an antipsychotic medication) 0.25 milligram (mg) at bedtime for dementia with psychotic disturbance. A physician's order, dated 1/25/24, indicated to give Risperdal 0.5 mg at bedtime for dementia with a psychotic disturbance. A physician's order, dated 2/7/24, indicated to give Risperdal 1 mg twice a day. A Pharmacy Consultation Report, dated 1/14/24, indicated the resident received Risperdal 0.25 mg at bedtime for dementia with psychotic disturbance. Antipsychotics had a boxed warning for an increased risk of mortality in older adults with psychosis related to dementia. The recommendation was to consider discontinuing the Risperdal. The prescriber response, dated 1/25/24, indicated the recommendation was declined due to the resident had delusions. A Psychiatric Nurse Practitioner (NP) note, dated 1/4/24 and recorded as a late entry on 1/5/24 at 7:57 a.m., indicated the resident was seen by staff request for a medication review due to increased falls. The resident continued to agree to feelings of sadness and reported she cries frequently. The resident continued to display delusional thinking and symptoms of depression. She had been getting up at night because she was afraid. The resident's delusional thinking continued to be distressing and was difficult to redirect. Risperdal 0. 25 mg at bedtime would be started for dementia with psychotic disturbance. The progress notes did not include notification to the resident's representative for the start of the antipsychotic medication. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/15/24 at 12:45 p.m., the Director of Nursing Services (DNS), indicated there was no documentation of the resident's representative being notified of the start of the antipsychotic medication and no documentation to indicate the representative had been informed of the risks of the antipsychotic medications versus the benefits. A current policy titled, Resident Change of Condition Policy, revised on 11/2018 and received from the DNS on 3/15/24 at 3:41 p.m., indicated, .It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party and appropriate, timely, and effective intervention takes place .Non-Urgent Medical Change .The nurse in charge is responsible for notification of physician and family/responsible party .Documentation will include time and family/physician response 3.1-5(a)(3)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 48525 Based on interview and record review, the facility failed to correctly code an annual Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for Preadmission Screening and Record Review (PASARR) (Resident 9). Finding include: The clinical record for Resident 9 was reviewed on 3/13/24 at 9:20 a.m. The diagnoses included, but were not limited to, unspecified dementia with mood disturbance, insomnia, bipolar disorder, major depressive disorder, and psychotic disorder with delusions. A notice of PASARR level 2 outcome, with a notice date of 12/23/22, indicated the resident had a long-term approval without specialized services based on the diagnoses of bipolar disorder NOS (not otherwise specified), unspecified depressive disorder, dementia NOS, unspecified insomnia disorder, and for treatment history, current symptoms, and service needs. An annual MDS assessment, dated 1/10/23, indicated the resident was not currently considered by the state level 2 PASARR process to have a serious mental illness and/or intellectual disability or related condition. During an interview, on 3/14/24 at 11:01 a.m., the SSD (Social Services Director) indicated the MDS assessment was marked in error and should have been marked as a yes on the assessment. During an interview, on 3/15/24 at 3:40 p.m., the DNS (Director of Nursing Services) indicated the facility used the RAI (resident assessment instrument) manual for the facility policy for MDS assessments. A CMS (Centers for Medicare and Medicaid Services) document titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 October 2023, indicated, .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment 3.1-31(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48525 Based on observation, interview, and record review, the facility failed to ensure a resident's oxygen was on the correct liter flow per the physician's orders for 1 of 1 residents reviewed for respiratory care (Resident 60). Findings include: During an observation, on 3/13/24 at 11:03 a.m., Resident 60's oxygen was at 1 liter flow. The clinical record was reviewed on 3/13/24 at 11:17 a.m. The diagnoses included, but were not limited to COPD, chronic respiratory failure with hypoxia, and influenza due to novel influenza A virus. A physician's order, with a start date of 2/21/24 and an end date of 3/13/24, indicated the resident was to wear oxygen at 2 liters per nasal canula continuously. A physician's order, started on 3/13/24 at 9:17 a.m., indicated the resident was to wear 2 liters of oxygen per nasal canula at bedtime. During an observation and interview, on 3/13/24 at 2:20 p.m., the DNS (director of nursing services) saw and indicated the resident's oxygen was on 1 liter. During an interview, on 3/13/24 at 2:21 p.m., the DNS indicated the resident had a continuous oxygen order at 2 liters to be worn at bedtime. The order was changed last night. A history of oxygen saturation results indicated the following: a. 3/10/24 at 10:06 p.m.- oxygen was on at 3 liters. b. 3/11/24 at 9:25 a.m.- oxygen was not used. c. 3/11/24 at 2:19 p.m.- oxygen was not used. d. 3/12/24 at 6:17 a.m.- oxygen was not on. During an interview, on 3/14/24 at 2:39 p.m., Resident 60 indicated she did not touch her oxygen concentrator. Resident 60's record lacked documentation she had ever adjusted her oxygen concentrator before. A policy, titled, Oxygen Concentrator, not dated and received from the DON on 3/15/24 at 3:40 p.m., indicated .1) Verify and understand the physician's orders. 2) know the flow rate and duration of use . 3.1-47(a)(6)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 36454 Based on observation, interview, and record review, the facility failed to ensure staff were documenting resident behaviors, implementing and documenting nonpharmacological interventions for behaviors, and failed to ensure potential side effects of an antipsychotic medication were documented and assessed for a resident with dementia for 1 of 5 residents reviewed for dementia care (Resident 75). Findings include: During an observation, on 3/12/24 at 10:31 a.m., the resident was sitting up in her wheelchair in the activity room. The resident was continuously rocking herself back and forth in the wheelchair. The resident was very fidgety and pulling at a blanket while continuously moving her hands. During an observation, on 3/12/24 at 10:57 a.m., the resident was still in the dining area and was fidgeting with a napkin on the table and the blanket on her lap and making constant movements with her body. During an observation, on 3/13/24 at 1:58 p.m., the resident was sitting up in her wheelchair in the common area at a table by herself. The resident was constantly touching a piece of paper and a plastic cup and rolling them back and forth across the tablecloth. During an observation, on 3/13/24 at 2:22 p.m., the resident was sitting up in her wheelchair in the dining area and was constantly rocking back and forth in her wheelchair. The clinical record for Resident 75 was reviewed on 3/13/24 at 4:19 p.m. The diagnoses included, but were not limited to, unspecified dementia, Alzheimer's disease, severe recurrent major depressive disorder with psychotic symptoms, anxiety disorder, delusional disorder, a cognitive communication deficit, and unspecified psychosis not due to a substance or known physiological condition. A care plan, dated 2/24/23, indicated the resident was at risk for adverse side effects related to the use of psychotropic medications and the resident was on an antipsychotic medication. The goal was for the resident to have no adverse side effects. The approaches included, but were not limited to, AIMS assessment two times a year, observe for tremors and for abnormal involuntary movements. A care plan, dated 4/27/23, indicated the resident had a history of becoming verbally and physically combative with care. The approaches included, but were not limited to, redirect the resident to sit on the recliner by the television for a quieter space, offer the resident a snack and drink, provide personal space, staff to offer care at a later time and/or with a different staff member. A physician's order, dated 9/1/23, indicated to give Risperdal (an antipsychotic medication) 0.5 milligram (mg) daily for anxiety disorder due to a known physiological condition. An annual Minimum Data Set (MDS) assessment, dated 11/1/23, indicated the resident's Brief Interview for Mental Status (BIMS) was a 3 which indicated severe cognitive impairment. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment, dated 12/28/23, indicated the resident's BIMS was 2 which indicated severe cognitive impairment. A pharmacy Consultation Report, dated 1/14/24, indicated the resident had experienced more than one fall in the last 30 days and received the following psychotropic medications which could increase the risk of falls. The psychotropic medications included buspirone (an antianxiety medication), Cymbalta (an antidepressant) and Risperdal 1 mg at bedtime. The recommendation indicated to consider decreasing the Risperdal to 0.5 mg at bedtime. The Psychiatric Nurse Practitioner (NP) response, dated 2/7/24, indicated to accept the recommendations. A monthly behavioral report, dated 2/2/24, indicated the resident did not display any new or worsening behaviors. A physician's order, dated 2/7/24, indicated Risperdal 0.5 mg at bedtime for depression. The nursing progress notes, dated 2/8/24 through 2/20/24, indicated there were no changes in the resident's mood or behaviors, the resident was sleeping at night and there were no adverse drug reactions related to the decrease in the dose of Risperdal except for 2/15/24 at 5:10 a.m. A nursing progress note, dated 2/15/24 at 5;10 a.m., indicated there were no adverse effects noted from the decrease in Risperdal. The resident had slept well all night with no behaviors. During the last bed check, the resident scratched the Certified Nursing Assistant's (CNA) arm with care. The CNA stopped and then continued the care without problems. A nursing progress note, dated 2/21/24 at 9:08 p.m., indicated the resident had episodes of crying this evening and talking to unseen stimuli. The resident was getting upset because the unseen stimuli was not responding. The progress note did not include non-pharmacological interventions utilized for the behaviors. There were no more progress notes documented in the EHR and no documented behaviors between 2/21/24 at 9:08 p.m. and 2/22/24 at 8:31 a.m. An NP progress note, dated 2/22/24 at 8:31 a.m. and recorded as a late entry on 2/23/24 at 8:31 a.m., indicated the resident had a failed gradual dose reduction (GDR) for Risperdal. The resident was seen for follow up after a GDR of Risperdal. The resident was taking the medication for management of symptoms of a delusional disorder. The staff had reported the resident had been yelling out and had an increase of distressing hallucinations since the decrease of the Risperdal. The resident had been observed crying and talking to an unseen stimuli. The resident had an increase in aggression with care. The resident was asleep upon entering her room and did not engage in the NP visit when she awakened. The staff reported there were no changes in the resident's appetite or sleep since the last visit. The symptoms of aggression, agitation, delusions and hallucinations had increased since the GDR of the Risperdal. The Risperdal 1 mg at bedtime would be resumed due to the failed GDR. A physician's order, dated 2/22/24, indicated to give Risperdal 1 mg at bedtime for a delusional disorder. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abnormal Involuntary Movement Scale (AIMS) assessment, dated 2/23/24 at 10:06 a.m., completed by the Dementia Unit Manager (UM), indicated a full examination was conducted and scored. The total score was a zero. The resident had no facial or oral movements, had no movements of the extremities and had no rocking, twisting, squirming or pelvic gyrations. During an interview, on 3/14/24 at 2:35 p.m., the Director of Nursing Services (DNS) indicated the staff would talk about the residents behaviors during the behavior meetings although they did not document all the behaviors reviewed during the meeting in the electronic health record (EHR). During an interview, on 3/14/24 at 3:13 p.m., Licensed Practical Nurse (LPN) 2 indicated she was working the evening of 2/21/24 on the dementia unit. The resident was crying and was upset because of the unseen stimuli was not responding to her. LPN 2 had the resident sit at the nurses desk with her, had her listen to music and had a snack. The resident accepted the snack. The resident would be crying and upset, then would be fine and would ask why he was not responding to her. LPN 2 indicated usually she would document the interventions in the EHR although she was busy and did not document them. During an interview, on 3/14/24 at 3:23 p.m., the Social Services Director (SSD) indicated she talked to the LPN 3 who had worked the night shift from 10:00 p.m. on 2/21/24 through 10:00 a.m. on 2/22/24 and LPN 3 indicated the resident did go to bed and did not have any further problems for the shift. During an interview, on 3/14/24 at 3:39 p.m., the Psychiatric NP indicated when she saw the resident on 2/22/24, the resident was asleep. The resident did not want to talk to the NP when she woke up. The staff told the NP the resident was more aggressive and had been yelling out. The NP saw one nursing progress note with the information the resident was tearful, had hallucinations and was distressed. The staff had verbally told the NP the resident was having more behaviors. The failed GDR was based on what the staff had told the NP. The NP went by what the staff had told her even though there was only one documented behavior in the EHR. During an observation, on 3/14/24 at 4:24 p.m., with the dementia unit manager (UM), the resident was in her room while the UM was completing an AIMS assessment. The resident was constantly moving in her wheelchair while the UM was attempting to complete the evaluation. The resident stood up in her chair and tried to ambulate on her own. The UM indicated she could not complete the AIMS assessment since the resident was too fidgety. The resident was not able to follow the directions of the UM. The UM indicated while completing an AIMS assessment she would ask the resident if she experienced abnormal movements and would ask to see the resident's tongue. The UM was not aware of the instructions on the AIMS assessment on how to complete the assessment or the modifications for a resident who could not cooperate with the assessment. She indicated she was trained to do the assessment by other staff including the previous UM. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/14/24 at 4:52 p.m., the DNS indicated the staff should have documented the resident's behaviors from the previous week in the EHR to show if it was new or worsening behaviors. The EHR only had one note of behaviors documented on 2/21/24. The instructions for the AIMS were on the AIMS assessment form. The staff were not given training on how to complete an AIMS assessment. Resident 75 was not capable of having a full AIMS assessment. The staff should not have marked the full AIMS assessment was completed. There was a difference in a full AIMS assessment and the options to include the resident was uncooperative or non ambulatory. The DNS was not aware if the resident's constant movements were related to side effects of the psychotropic medication. The current Nursing Drug Handbook, indicated the adverse reactions of Risperdal included, but were not limited to, extrapyramidal movement dysfunction symptoms including akathisia (a combination of feelings of restlessness/agitation and a compelling need to move including uncontrollable rocking, pacing and shifting weight). The nursing considerations included, but were not limited to, watch for evidence of extrapyramidal effects. A current policy, titled, Behavior Management, revised on 8/22 and received from the DNS on 3/15/24 at 9:48 a.m., indicated, .It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions .When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix[the electronic health record] .If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT [interdisciplinary team] for assessment and preventative actions. New/Worsening Behaviors include .Behaviors that are new for the resident .Behaviors that are directed at another resident . Behaviors that are increasing in either frequency or severity .Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care .The IDT review is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentation of new interventions if applicable and an assessment of underlying causes of the behavior .The root cause and preventative interventions will be included in the resident's plan of care .If the behavioral expression is not new, worsening or high risk .the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT Behavior Review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective interventions A current policy, titled, Psychotropic Management, revised on 7/22 and received from the DNS on 3/15/24 at 12:30 p.m., indicated, .It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment .Potential adverse side effects to psychotropic medications will be observed each shift by a licensed nurse. An AIMS assessment will be completed for residents who are taking antipsychotic medication as a tool to monitor for adverse side effects. The assessment should be completed within 72 hours of new order to initiate an antipsychotic, within 72 hours of an increase in antipsychotic medication and then every six months (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The instructions for the AIMS assessment included, but were not limited to, before or after completing the Examination Procedure, observe the resident unobtrusively at rest. The chair used in the examination should be a hard, firm one without arms, ask the resident if he/she notices any movements in the mouth, face, hands or feet. If yes, ask the resident to describe and to what extent the movements bother the resident or interferes with their activities. As the resident to sit with their hands hanging unsupported. Have the resident sit in the chair with their hands on their knees with their legs slightly apart and their feet flat on the floor. Ask the resident to open their mouth and observe their tongue at rest. Ask the resident to protrude their tongue and observe for abnormal mouth movements. Ask the resident to tap their thumb with each finger as rapidly as possible for 10-15 seconds with the right hand and then with the left hand while observing for facial and leg movements. Flex and extend the resident's left and right arms and note any rigidity. Have the resident walk a few paces, turn and walk back to the chair. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44598 Based on observation, interview, and record review, the facility failed to ensure medication carts were free of loose pills and opened medications were dated for 1 of 3 medication carts reviewed for medication storage (The Walnut Unit and a combined medication cart for the [NAME] and Magnolia Units). Findings include: During a medication storage observation with the Qualified Medical Assistant (QMA) 4 on 3/14/24 at 11:10 a.m., the Walnut unit cart was observed to have the following: a. The second left large drawer had 17 loose pills on the bottom. b. The third left large drawer had 33 loose pills and 13 half tablets on the bottom of the drawer c. The third right drawer had a bottle of opened Milk of Magnisium (MOM) for Resident 89 opened and not dated. The record for Resident 89 was reviewed on 03/14/23 at 11:40 a.m. A physician order, dated 12/28/23, indicated to give MOM 400 Milligram(mg)/5 Milliliter(ml) daily when needed. During an interview, on 3/14/23 at 11:23 a.m., QMA 4 indicated the pills should not be in the bottom of the cart. The pills should be destroyed in a jug in the medication room. During an interview, on 3/14/24 at 11:48 a.m., the Dementia Facilitator 5 indicated the loose pills probably should not be in the bottom of the drawers. During a medication cart observation with QMA 7 on 3/14/24 at 10:38 a.m., the [NAME] and Magnolia unit cart was observed to have the following: a. The first large drawer had 12 loose pills on the bottom of the drawer. b. The second large drawer had 11 loose pills on the bottom of the drawer. During an interview, on 3/14/24 at 10:30 a.m., QMA 7 indicated there were a lot of pills and the pills should not be on the bottom of the cart. The pills should be taken out and destroyed. During an interview, on 3/15/24 at 12:16 p.m., Unit Manager(UM) 9 indicated she did not know who was assigned to clean the medication carts. The nurses on any shift could clean the cart. During an interview, on 3/15/24 at 12:19 p.m., Licensed Practical Nurse (LPN) 6 indicated the nurse on night shift usually cleaned out the carts. There was a cleaning list in a binder on the Walnut unit and had a cleaning schedule. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/15/24 at 2:09 p.m., UM 9 indicated they do have a cleaning list and the nurse on night shift was responsible to clean the carts. A current policy, titled, LTC [long term care] Facility's Pharmacy Services and Procedure Manual, revised on 8/07/2023 and received from the Director of Nursing (DON) on 3/14/24 at 4:47 p.m., indicated, .Facility should ensure that medications and biological's are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding .Facility staff may record the calculated expiration date based on date opened on the primary medication container .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis 3.1-25(j) 3.1-25(0)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Village	2233 W Jefferson St Kokomo, IN 46901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49891 Based on observation, interview, and record review, the facility failed to store clean clothing or resident personal care items in a clean environment for 4 of 117 residents (Residents 2, 14, 52, and 76). Findings include: 1. During an observation on 03/11/24 at 01:15 p.m., clean clothes were hanging from one end of the shower curtain rod to the other over the bathtub in the bathroom of Residents 2 and 52. Blankets and a large black trash bag of items were in the bathtub. The toilet had armrests attached, no lid, and was positioned immediately beside the bathtub. Multiple items of clean hanging clothes were touching the armrest of the toilet. At least half of the hanging items were within the contamination splash zone of the flushing toilet of less than 3 feet. During an observation on 03/12/24 at 09:37 a.m., clean clothes continued to hang from one end of the shower curtain rod to the other over the bathtub, were touching the armrest of the toilet, and were within the splash zone of the flushing toilet. During an observation on 03/13/24 at 10:40 a.m., clean clothes continued to hang from one end of the shower curtain rod to the other over the bathtub, were touching the armrest of the toilet, and were within the splash zone of the flushing toilet. During an interview on 03/12/24 at 10:39 a.m., Resident 2 indicated she used the bathroom in the room. During an interview on 03/13/24 at 11:30 a.m., the Assistant Director of Nursing Services (ADNS) indicated she thought the hanging clothes were Resident 52's from the room move and she did not know why clean clothes were hanging in the bathroom on the shower curtain rod instead of in the closet. During an interview on 03/13/24 at 11:53 a.m., the Executive Director (ED) indicated clean clothing was not to be stored in bathrooms or bathtubs and she would have all clothing removed from the bathroom and placed in linen closets for Residents 2 and 52. During an interview on 03/13/24 at 2:06 p.m., the ED indicated the clothes were removed from the bathroom of Residents 2 and 52. The ED indicated the bag of clothes in the tub were from the previous resident who had discharged and should have been put in overflow and not left in the room. During an interview on 03/12/24 at 03:12 p.m., the Infection Preventionist (RN 10) indicated clean laundry and linens were covered while transported from laundry to the units and then stored in closets. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record for Resident 52 was reviewed on 03/15/24 at 09:52 a.m. The diagnoses included, but were not limited to, cellulitis (skin infection), chronic ulcer of the skin, chronic pain, edema, rheumatoid arthritis, type 2 diabetes mellitus without complications, hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure, contracture of muscle, stage 4 pressure ulcer of left buttock, and chronic obstructive pulmonary disease. The electronic medical record indicated Resident 52 was transferred to room [ROOM NUMBER]A on 12/22/2023 at 03:38 p.m. A Progress Note, dated 02/13/2024 at 07:22 a.m., stated, Patient has a wound on their bottom, with redness initially observed on the left side of their hip and pelvis. The redness has now spread to the right side of their pelvis and peri area. Patient started taking Keflex 500 milligrams over the weekend and began the medication today. Patient has a history of rheumatoid arthritis, congestive heart failure, COPD, and diabetes. and they have swelling in their right leg and foot. There is slight redness and warmth in their left foot, which is the side with the majority of the wound on their coccyx and buttocks. An IDT Weekly Wound Review Note, dated 02/15/2024 at 02:42 p.m., indicated an overall decline in the resident's condition with worsening of Resident 52's pressure ulcer and signs and symptoms of infection. Redness, swelling, and warmth were noted in the Resident's torso and thigh. A care plan, initiated on 02/19/24, stated Resident 52 had impaired skin integrity: pressure ulcer noted to left posterior thigh. A MDS (Minimum Date Set) assessment, dated 02/28/24, indicated Resident 52 was fully dependent on staff for toileting and was always incontinent of bowel and bladder. The clinical record for Resident 2 was reviewed on 03/15/24 at 03:15 p.m. The diagnoses included, but were not limited to, cerebral infarction (stroke), hemiplegia (paralysis of body parts on one side of the body) and hemiparesis (muscle weakness or partial paralysis of parts of the body on one side) following cerebral infarction affecting left non-dominant side, weakness, legal blindness, and type 2 diabetes mellitus without complications. An annual MDS (Minimum Data Set) assessment, dated 01/15/24, for Resident 2 indicated resident was continent of bowel and bladder and required partial to moderate assistance for toilet transfers. The electronic medical record contained the toileting record for Resident 2. It listed multiple urine outputs and bowel movements for Resident 2 on the survey dates of 03/11/24, 03/12/24, and 03/13/2024 when the clean clothing was observed hanging in the bathroom and touching the toilet arm. 2. During an observation on 03/11/24 at 02:02 p.m., the bathroom for Resident 14 and Resident 76 had a strong odor of urine and bowel movement. The sink handles were dirty and rusty. The bathtub had plywood over it and was being used for storage of the residents' clean personal care supplies. During an interview on 03/13/24 at 11:53 a.m., the ED indicated she was not sure why the plywood was over the tub in bathroom for Residents 14 and 76. The ED indicated she did not know why the bathtub was being used for clean storage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/24 at 2:06 p.m., the ED indicated the plywood was removed from the bathtub and clean items were no longer stored in the bathtub. A current policy, titled, Laundry/Linen revised on 12/2021 and received from the DON on 03/15/24 at 02:30 p. m., indicated The laundry and nursing staff shall handle, store, .linen appropriately to prevent the spread of infection in resident-care areas.Clean linen must be protected from soiling or contamination. Splash Zone Information Sheet (April 20, 2023) was retrieved on 03/18/24 at 09:10 a.m. from the Health Quality Innovation Network at https://hqin.org/wp-content/uploads/2023/04/Splash-Zone-Infosheet.pdf. The Centers for Medicare & Medicaid Services (CMS) uses 3 feet as their guide for determining the splash zone because Studies have shown that splashing can occur up to 3 feet from the sink, (toilet) or drain.Evidence indicates sinks and other drains, such as toilets or hoppers, in healthcare facilities can become contaminated with multidrug-resistant organisms (MDROs). These microorganisms can stick to the pipes to form biofilms, which allow the organisms to persist in drains for long periods of time. In addition, microorganisms can multiply in moist conditions and are often difficult to impossible to fully remove. How are Patients/Residents Exposed? Splashes may occur when flowing water hits the drain or when a toilet or hopper is flushed. Splashes can lead to dissemination of MDRO-containing droplets, which in turn may contaminate the environment, equipment, and skin or clothing of healthcare personnel and patients/resident. Avoid storing supplies within 3 feet of splashing water. 3.1-18(b)(1)