STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155461	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Village Nursing and Rehabilitation	801 S Sr 57 Washington, IN 47501

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46882 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity and care was performed for each resident in a manner that protected and promoted the rights of the resident for 2 of 2 residents reviewed for dignity. Two female residents could not get their legs shaved on their shower day. (Resident 14, Resident 31) Findings include: 1. On 4/29/24 at 2:03 P.M., during the Resident Council Meeting, Resident 14 indicated staff won't shave her legs in the shower. She indicated she had asked several times, and she can't wear shorts because they won't shave her legs. During an interview on 4/30/24 at 10:01 A.M., Resident 14 indicated she had asked CNAs (Certified Nursing Assistant) to shave her legs when she got a shower and they told her they would be back but never show up. On 5/1/24 at 11:12 A.M., Resident 14's clinical record was reviewed. Diagnosis included but was not limited to chronic obstructive pulmonary disease, hemiplegia, unspecified affecting left nondominant side, and major depressive disorder. The most recent Admission MDS (Minimum Data Set) Assessment, dated 2/5/24, indicated Resident 14 was cognitively intact and required extensive assistance of two for bed mobility, transfers, and toilet use. Care Plan: Resident requires assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to: COPD (chronic obstructive pulmonary disease), DM 2 (diabetes mellitus Type II), hemiplegia on left nondominant side, dysphagia following cerebral infarct, vascular dementia, paranoid schizophrenia, major depressive disorder, hypertension, anemia, hypothyroidism, hyperlipidemia, convulsions, GERD (gastroesophageal reflux disease), rheumatoid arthritis, muscle weakness, pain in right shoulder, constipation. Start Date 1/29/2024 Interventions included, but were not limited to the following: (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start Date 1/29/2024 Assist with dressing/grooming/hygiene as needed. Encourage resident to do as much for self as possible. Start Date 1/29/2024 2. On 4/29/24 at 2:03 P.M., during the Resident Council Meeting, Resident 31 indicated staff didn't have time to shave her legs while they were standing at the desk talking. During an interview on 4/30/24 at 9:49 A.M., Resident 31 indicated she wanted her legs shaved, but staff told her they didn't have time on shower days. She indicated it didn't have to be done every time. On 4/30/24 at 11:09 A.M., Resident 31 clinical record's were reviewed. Diagnosis included, but were not limited to chronic obstructive pulmonary disease, asthma, diabetes mellitus with diabetic neuropathy, epilepsy, major depressive disorder, and generalized anxiety disorder. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 4/8/24, indicated Resident 31 was cognitively intact and required supervision of one for bed mobility, and transfers and extensive assistance of two for toilet use. Care Plan: Resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: COPD (chronic obstructive pulmonary disease), asthma, DM 2, epilepsy, atherosclerotic heart disease, hypertension, GERD, anemia, hyperlipidemia, major depressive disorder, obesity, poly osteoarthritis, chronic kidney disease, constipation, chronic embolism and thrombosis, chronic pain, allergic rhinitis, arthropy, chronic ischemic heart disease, chronic pain, ESBL (extended-spectrum beta-lactamase). Start Date 2/01/2024 Interventions included, but were not limited to the following: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start Date 2/01/2024 Assist with dressing/grooming/hygiene as needed. Encourage resident to do as much for self as possible. Start Date 2/01/2024 During an interview on 5/1/24 at 10:51 A.M., with QMA (Qualified Medication Aide) 31 and CNA (Certified Nursing Assistant) 23, both indicated they helped with showers and would shave residents if needed. They indicated they shave men and women who looked like they need shaved and would shave women's legs if they were asked. They indicated not all women wanted their legs shaved. On 5/3/24 at 8:58 A.M., a current Resident Rights Policy, revised on 1/06, provided by the DON (Director of Nursing), indicated .All Staff members recognize the rights of residents at all times and residents assure their responsibilities to enable personal dignity, well being, and proper delivery of care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(a)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46416 Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents observed with medications in their room. (Resident 13) Finding includes: On 4/29/24 at 10:50 A.M., Resident 13 was observed sitting on his bed and indicated he had a Ventolin inhaler on the nightstand that he kept with him at all times. A Ventolin inhaler was observed on the nightstand, not dated. An albuterol inhaler was also observed sitting on the nightstand that was empty. At that time, Resident 13 indicated staff had given him the blue one (Ventolin) when the other ran out. On 4/30/24 at 12:05 P.M., Resident 13's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/24/24, indicated Resident 13 was cognitively intact, a limited assistance of 1 staff for bed mobility and transfers, and extensive assistance of 1 staff for toileting. Current Physician's Orders included, but were not limited to: Ventolin (respiratory inhaler) 90 mcg/actuation HFA (hydrofluoroalkane) aerosol inhaler, 2 puffs every 4 hours as needed, dated 4/19/24. Resident 13 lacked a current order to self administer medications. Resident 13 lacked a care plan related to self administration of medications. Resident 13 lacked a self administration of medications assessment. On 5/2/24 at 7:37 A.M., Resident 13 was observed lying in bed asleep. The two inhalers were observed on the nightstand. On 5/2/24 at 10:00 A.M., Licensed Practical Nurse (LPN) 5 indicated Resident 13 had a current order for as needed Ventolin, but the order did not say it could be kept at the bedside. She also indicated Resident 13 did not have a self administration assessment for that medication and should not have it at the bedside. At that time, LPN 5 observed 2 inhalers on the resident's nightstand and Resident 13 indicated he used the inhaler twice a day around the same time each day. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/24 at 8:58 A.M., a current Self Administration of Medications policy, dated 1/2015, was provided by the Director of Nursing and indicated If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation . A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan . Storage of self-administered medications will comply with state and federal regulations. All bedside medications will be maintained in a secured location in the resident's room 3.1-11(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46416 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans for 2 of 5 residents reviewed for unnecessary medications and 1 of 3 residents reviewed for falls. Antiplatelet care plans were not developed for 2 residents on antiplatelet medications. An oxygen concentrator filter was not cleaned and oxygen tubing was not changed as ordered. A resident was not wearing non skid socks. (Resident 13, Resident 2, Resident 16) Findings include: 1. On 4/29/24 at 11:00 A.M., Resident 13 was observed sitting bedside in his room wearing oxygen per nasal cannula at 4 LPM (liters per minute). The oxygen tubing and empty humidifier bottle were dated 3/21 and the concentrator filter was gray instead of black from the accumulated dust. On 4/30/24 at 11:18 A.M., Resident 13 indicated staff changed his humidifier bottle yesterday but it was observed with a date of 4/24/24 but the oxygen tubing was observed dated 3/21 and the filter was observed gray instead of black from the accumulated dust. On 4/30/24 at 12:05 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and atherosclerotic heart disease The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/24/24, indicated Resident 13 was cognitively intact, a limited assist of 1 staff for bed mobility and transfers, and an extensive assist of 1 staff for toileting. Resident 13 was on oxygen and administered an AP, AA, and antiplatelet during the 7 day look back period. Current Physician's Orders included, but were not limited to, the following: aspirin (antiplatelet) 81 milligram (mg) tablet,delayed release, give 1 by mouth daily, ordered 4/19/24 Change oxygen tubing, humidifier bottle,clean concentrator, and filter once a day on Wednesdays, ordered 04/19/2024 A current Respiratory Care Plan, dated 9/19/18 included, but was not limited to, the following interventions: resident uses oxygen, 9/19/18 The clinical record lacked a care plan for an antiplatelet medication. The Medication Administration Record (MAR) for April 20-30, 2024 was reviewed and indicated Resident 13 was administered the antiplatelet aspirin. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record (TAR) for April 2024 was reviewed and indicated the tubing and humidifier bottle was changed and the concentrator filter was cleaned on 4/24/24 and 4/30/24. During an interview on 5/1/24 at 3:10 P.M., Licensed Practical Nurse (LPN) 29 indicated she was responsible for developing nursing care plans. At that time, she indicated there was not an antiplatelet care plan in Resident 13's clinical record but there should have been. During an interview on 5/2/24 at 9:58 A.M., LPN 5 indicated night shift was responsible for changing the oxygen tubing and humidifier bottle and cleaning the oxygen concentrator filter every Wednesday night and otherwise it was changed as needed by whoever would observe it being dirty or empty. At that time, she indicated it was recorded in the TAR when it was completed and the date on the humidifier bottle and tubing was the date it was changed. She indicated the filter would not have been that dirty if it was changed 1 week or 1 day ago. 2. On 4/29/24 at 10:16 A.M., Resident 2 was observed sitting in his room in a recliner and was barefooted. On 4/30/24 at 11:16 A.M., Resident 2 was observed sitting in his room in a recliner, barefooted and asleep On 5/1/24 at 11:09 A.M., Resident 2 was sitting in his room. He was observed to stand up without the assistance of staff. On 5/1/24 at 9:06 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus type II, and blindness. The most recent Annual MDS Assessment, dated 2/21/24, indicated Resident 2's cognition was unable to be assessed and he was an extensive assist of 2 staff for bed mobility, transfers, and toileting. A current Falls Care Plan, dated 3/18/85, included, but was not limited to, the following intervention: Non skid footwear, initiated 3/18/85 On 4/29/24 at 9:55 A.M., a current, daily Certified Nurse Aide (CNA) Assignment Sheet was provided by LPN 34 and indicated non skid footwear as an intervention for Resident 2. During an interview on 5/1/24 at 11:09 A.M., LPN 15 indicated that she was shocked the resident had non skid socks on but it was probably because state was in the building. At that time, she indicated Resident 2 was constantly standing up without staff's assistance and needed to wear them, but usually wouldn't let them on. 46882 3. On 4/30/24 at 2:34 P.M., Resident 16's clinical records were reviewed. Diagnosis included, but was not limited to chronic diastolic (congestive) heart failure, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, dementia, anxiety disorder, and bipolar disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most current Significant Change in Condition MDS (Minimum Data Set) Assessment, dated 3/11/24, indicated Resident 16 had severe cognitive impairment and needed extensive assistance of two for bed mobility, extensive assistance of one for eating, and total dependence of two for transfers and toilet use. Physician orders included, but were not limited to the following: aspirin 81 mg tablet,chewable Once a day Indication: Heart Health, Atherosclerotic heart disease of native coronary artery without angina pectoris, dated 3/5/2024 The clinical record lacked a care plan for anti-platelet use. On 5/2/24 at 10:13 A.M., the MAR (Medication Administration Record) was reviewed from 3/5/24 through 3/11/24. Resident 16 was in the hospital from 3/2/24 through 3/5/24. Aspirin 81 mg (milligram) one daily was given for heart health from 3/6/24 through 3/11/24. During an interview on 5/2/24 at 12:41 P.M., the DON (Director of Nursing) indicated they didn't have a policy for following the care plan interventions or provider orders, but it was their policy to follow the interventions and orders. On 5/2/24 at 12:41 P.M., a Comprehensive Care Plan Policy, revised 8/23, was provided by the DON which indicated, It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process . 3.1-35(b)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview and record review, the facility failed to ensure quarterly care plan conferences were completed for 3 of 5 residents reviewed for unnecessary medications and 1 of 3 residents reviewed for falls. (Resident 22, Resident 2, Resident 13, Resident 1) Findings include: 1. On 5/2/24 at 6:22 A.M., Resident 22's clinical record was reviewed. Diagnosis included, but was not limited to, epilepsy. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/28/24, indicated Resident 22 was cognitively intact. The most recent care plan conference was completed 9/6/23. 2. On 5/1/24 at 9:06 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but was not limited to, blindness. The most recent Annual MDS Assessment, dated 2/21/24, indicated Resident 2's cognition status could not be assessed. The most recent care plan conference was completed 9/20/23. 3. On 4/30/24 at 12:05 P.M., Resident 13's clinical record was reviewed. Diagnosis included, but was not limited to, schizophrenia. The most recent Annual MDS Assessment, dated 4/24/24, indicated Resident 13 was cognitively intact. The most recent care plan conference was completed 8/28/23. During an interview on 4/29/24 at 10:50 A.M., Resident 13 indicated he was unsure if he was having care plan confrences. On 5/1/24 at 3:01 P.M., the SSD (Social Services Director) indicated she was responsible for completing care plan conferences, but had been out and unable to complete them. She indicated care plan conferences should be done at least quarterly. 45933 4. On 4/30/24 at 11:09 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, anemia, thyroid disorder, and schizophrenia. The most recent Significant Change MDS, dated [DATE], indicated a moderate cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked any care plans before or after 9/20/23. During an interview on 5/1/24 at 1:54 P.M., the Social Services Director (SSD) indicated care plan conferences should be completed quarterly. On 5/3/24 at 8:58 A.M., the Director of Nursing (DON) provided a IDT (Inter Disciplinary Team) Comprehensive Care Plan Policy, revised 8/2023, that indicated, It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-center care plan developed and implemented based on Resident Assessment Instrument (RAI) process . 3.1-35(c)(2)(C)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46882 Based on interview and record review, the facility failed to ensure services of an RN (Registered Nurse) were available at least 8 consecutive hours a day, seven days a week for one of seven days reviewed. (Facility) Findings include: On 5/1/24 at 3:30 P.M., the review of nurse staffing from 4/20/24 through 4/26/24 indicated there was no RN coverage for 8 consecutive hours on 4/21/24. During an interview on 5/2/24 at 9:03 A.M., the DON (Director of Nursing) indicated he had an RN scheduled for 4/21/24 but she called in sick and was replaced with an LPN (Licensed Practical Nurse). He indicated there should be an RN in the building at least 8 hours a day, seven days a week. During an interview on 5/2/24 at 12:41 P.M., the DON indicated they did not have a policy for RN coverage but it was their policy to follow the state regulations. 3.1-17(b)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46416 Based on observation, interview, and record review the facility failed to ensure proper storage of medications in 1 of 2 medication carts and 1 of 1 medication storage rooms. The narcotic box was not locked in a medication cart, unlabeled and expired medications where in the treatment cart. (100/400 Hall medication cart, treatment cart in E wing medication storage room) Finding includes: On 5/1/24 at 2:27 P.M., the narcotic box of the 100/400 Hall medication cart was observed unlocked. On 5/1/24 at 2:38 P.M., the following was found in the treatment cart in the medication storage room on the E Hall: -two unlabeled 15 gram (g) bottles of nystatin topical powder (anti-fungal) with expiration dates of 11/30/23 -two bottles of ammonium lactate lotion (lotion for dry skin) 12%, opened but not dated when opened -three 45 g tubes of clotrim betameth cream (anti-fungal) 1-0.5% with expiration dates of 5/30/23, 11/30/23, and 12/30/23 -one 1.5 fluid ounce (fl oz) tube of medihoney (medicated honey for wound care) gel from a resident that passed away 3/24/24 -one 1.5 fl oz tube of medihoney gel from a resident that passed away 4/10/24 During an interview on 5/1/24 at 2:30 P.M., Registered Nurse (RN) 26 observed the narcotic cart unlocked and indicated it should be locked when nurse wasn't using it. On 5/1/24 at 2:43 P.M., Licensed Practical Nurse (LPN) 5 indicated when residents pass away or medications expire, the nurses take the medications out of the carts and the Director of Nursing (DON) would contact the pharmacy to take the medications back or dispose of them. The carts should be checked by the night shift nurses periodically for expired medications or medications of residents that have passed away. The medications should be labeled properly and dated when opened. On 5/1/24 at 6:00 A.M., a current Medication Storage Policy, revised 8/7/23, was provided by the DON and indicated . Facility should store Schedule II-V Controlled Substances in a separate compartment within the locked medication carts . Facility should ensure that medications and biologicals that 1) have an expired date on the label; 2) have been retained longer than recommended by manufacturer or supplier guidelines; or 3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier . Facility staff should record the date opened on the primary medication container . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-25(m) 3.1-25(r)

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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** 45933 Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment to help prevent the development and transmission of diseases and infections for 3 random observations and 1 of 2 residents reviewed for pressure ulcers. Staff did not don personal protective equipment (PPE) before care was performed. Wash basins, urinals, and a plunger were uncovered. A urinal hung on a used trashcan. Linens were uncovered in a bathroom. (Resident 1, Resident 34, Resident 41, Resident 45, room [ROOM NUMBER]) Findings include: 1. During an observation on 4/29/24 at 11:40 A.M., an uncovered easy shampoo wash basin with an uncovered urinal was placed on the floor in Resident 34's bathroom. During an observation on 5/2/24 at 11:22 A.M., an uncovered eash shampoo wash basin continued to be on the floor in the bathroom. 2. During an observation on 4/29/24 at 11:43 A.M., an uncovered gray wash basin was on the floor in Resident 41's bathroom and a urinal was hung on the side of the trashcan. During an observation on 5/2/24 at 1:27 P.M., an uncovered gray wash basin with an uncovered urinal was on the floor in the bathroom. 3. During a random observation on 5/03/24 9:21 A.M., Certified Nurse Aide (CNA) 3 placed a urinal on Resident 1's trashcan by his bed that had used gloves and used white tissues in it. At that time, she indicated that his urinal should always be placed on his trashcan. During an interview on 5/2/24 at 1:55 P.M., the Housekeeping Supervisor indicated she was unsure how the easy shampoo wash basins should be stored, but the gray wash basins and urinals should both be covered with a bag and not placed directly on the ground. 46416 4. On 5/1/24 at 10:16 A.M. Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus type II with bilateral foot ulcers, and pressure ulcers on left foot. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/9/24, indicated Resident 45's cognition was severely impaired, an extensive assist of 2 staff for bed mobility, totally dependent on 2 staff for transfers and toileting, had diabetic foot ulcer, and did not have pressure ulcers at that time. Current Physician's Orders included, but were not limited to, the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155461	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Village Nursing and Rehabilitation	801 S Sr 57 Washington, IN 47501

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleanse right and left foot wounds with normal saline, pat dry, apply/paint with Betadine, cover with 2 Abdominal Gauze (ABD) pads, wrap with Kerlix gauze and secure with tape. Change daily, ordered 5/1/24 A current EBP Care Plan, dated 4/6/24, included the following interventions: Identify resident as needing EBP through signage and medical record, initiated 4/6/24 Use standard precautions including hand hygiene in addition to EBP, initiated 4/6/24 Enhanced Barrier Precautions, initiated 4/6/24 On 4/29/24 at 9:55 A.M., a current, daily Certified Nurse Aide (CNA) Assignment Sheet was provided by LPN 34 and indicated Wear gown and gloves prior to high contact resident care activities and Enhanced Barrier Precautions as interventions for Resident 45. On 5/2/24 from 8:56 A.M. to 9:30 A.M., Licensed Practical Nurse (LPN) 9 was observed changing Resident 45's wound dressings with Certified Nurse Aide (CNA) 7 assisting. Neither staff wore gowns as the wound dressings were changed. An Enhanced Barrier Precautions (EBP) sign was hanging above his bed indicating a gown and gloves should be worn for high contact resident care which included wound care. During an interview on 5/2/24 at 9:25 A.M., LPN 9 indicated she was not sure if EBP should be used when doing wound care on Resident 45. On 5/3/24 at 8:58 A.M., a current Standard and Transmission-Based Precautions (Isolation) Policy was provided by the Director of Nursing (DON) and indicated . An intervention designed to reduce the transmission of resistant organisms that employs targeted use of gown and glove use during high contact resident care activities . it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multidrug-Resistant Organisms (MDROs) to staff hands and clothing . used for residents with chronic wounds . examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers . 5. During an observation on 4/29/24 at 11:12 A.M. of room [ROOM NUMBER], the following was observed: A female urinal uncovered, with brown stains on the inside and a strong urine odor was hanging from the bedside cabinet and in the bathroom, the call light cord was stained brown, an uncovered plunger was on the right side of the toilet, the was a hole on the inside of the bathroom door, and a wheelchair cushion on the shower floor with 3 uncovered bunches of bed linens on it. During an observation on 5/1/24 at 10:19 A.M., the same uncovered, brown stained female urinal with a strong urine odor was hanging on the trash can and in the bathroom, two uncovered bunches of bed linens were stuck between the wall and the hand rail in the shower, and the hole on the inside of the bathroom door and call light cord were the same. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 10:12 A.M., CNA 7 indicated urinals were replaced for residents. she was not sure how often but it should be changed out if soiled, stained, or it had an odor. At that time, CNA 7 replaced the urinal with a new one. During an interview on 5/2/24 at 11:02 A.M., the Infection Preventionist (IP) indicated linens were supposed to be covered if they were kept in resident rooms in the top of the closet and should be placed straight on the bed. Usually clean linens were stored in a covered cart. At that time, she indicated Resident 45 was on EBP and staff should follow it for any prolonged resident contact as the signage indicated. On 5/3/24 at 8:58 A.M., a current Laundry/Linen Policy, revised 12/2021, was provided by the DON and indicated . to ensure the proper care and handling of linen and laundry to prevent the spread of infection . clean linen should not be stored in resident rooms, drawers, or shower rooms . During an interview on 5/3/24 9:33 A.M., the Infection Preventionist (IP) indicated urinals should never be stored on a trashcan and the facility's policy is to store urinals on the bed rail or uncovered in the bathroom. 3.1-18(b)(1)