STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185316	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Nursing & Rehabilitation	1333 West Main Street Princeton, KY 42445

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observation, interview, record review and review of facility policy, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, with measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment for two (2) of three (3) sampled residents. (Resident (R)38), and R26. The facility care planned R38 for alteration in nutritional status related to receiving enteral (tube) feedings, with interventions that included elevating the head of bed (HOB) during feedings, and maintaining the resident in an upright posture to decrease aspiration risk. However, observation on 09/10/24 at 5:00 PM, revealed R38 lying on the bed with the HOB flat and the bed elevated while the resident's enteral tube feeding was hanging and infusing. The findings include: Review of the facility policy titled, Comprehensive Care Plans, revised 02/01/2024 revealed it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident to meet their medical, physical, mental, and psychosocial needs. Review of the facility policy titled, Resident Rights, revised 03/22/2022, revealed residents had the right to receive the items and/or services included in their plan of care. Review of the facility policy titled, Nursing Services and Sufficient Staff , revised 02/20/2024, revealed the facility must ensure the nursing assistants were able to demonstrate competency in skills and techniques necessary to care for residents' needs as identified through their assessments and as described in the plan of care. Review of the facility's Face Sheet for R38 revealed the resident was admitted on [DATE], with diagnoses which included Malignant Neoplasm of the bladder, Alzheimer's Disease, Stage 3 Chronic Kidney Disease and a history of gastrostomy tube (g-tube) placement with enteral feedings. Review of R38's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/08/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) of zero (00) out of fifteen (15), which indicated she was severely cognitively impaired. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R38's Comprehensive Care Plan dated 11/23/2022, revealed the facility care planned the resident for alterations with nutritional status related to protein calorie malnutrition, requiring feeding tube with oral food intake diet, and failure to thrive. Continued review revealed the goal was for lessening potential signs of complications from bolus feedings or enteral feeding solution. Review further revealed interventions that included maintaining R38 in an upright posture and elevating the head of bed (HOB) 30-45 degrees during feedings to decrease the risk for aspiration. Observation on 09/10/2024 at 5:00 PM, of R38 revealed the resident's tube feeding was hanging and infusing. Continued observation revealed R38 was lying flat on the bed and the bed was elevated. In interview on 09/12/2024 at 10:42 AM, Certified Nursing Assistant (CNA) 16 stated she typically got information on the residents in her care from the night shift CNA's. She said depending on who's working, they would update them with information. CNA 16 stated if nightshift staff did not tell them they just usually had to figure it out. She said she could access residents' care plan in Matrix (facility's electronic charting system) to get the information on how to care for her residents if she needed to do that. The CNA stated however, most times she got information in report from the off-going shift. She further stated after assisting CNA 17 with R38's care she had left the resident's room where CNA 17 was still with the resident. CNA 16 also stated she assumed CNA 17 was going to raise the head of R38's bed back up. In interview on 09/12/2024 at 3:31 PM, CNA 5 stated she got residents' care information from the care plan on the computer. She further stated if she could not find information on the resident in the computer she would look at the Kardex or Binder. In interview on 09/10/2024 at 5:00 PM, Licensed Practical Nurse (LPN) 1 stated R38 needed to have the head of her bed raised and bed lowered for her safety. The LPN stated R38 could potentially aspirate if left in a lying flat position. She stated she had two new CNA's working that had provided care for R38 and they must have forgotten to place the resident back into the appropriate position. LPN 1 said she had last checked on R38 around 3:00 PM or so and the resident had been sitting in the correct position at that time. She additionally stated she did not know why the CNA's had not implemented R38's care plan interventions; however, would educate the two CNA's on the proper positioning for R38. In interview on 09/12/2024 at 3:32 PM, Registered Nurse (RN) 1 stated nurses had books they could go to for reference if needed. She stated when she was working she had morning huddles with her nursing staff and discussed care expectations and tasks. The RN said she had the staff members sign off that they attended huddle, and she did walking rounds and checked on residents on the hall to ensure they were being cared for (as per their care plan). In interview on 09/12/2024 at 3:24 PM, RN 2 stated she looked at a resident's care plan and admit information to find out what care staff needed to provide for the resident. She stated she checked up on the CNA's by looking over their charting and different things to ensure they were providing resident care according to the residents' care plans. The RN further stated the MDS Nurse, and Social Services Director (SSD) were responsible for updating residents' care plans. She additionally stated facility staff should implement residents' care plan interventions as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 09/12/2024 at 2:13 PM, the MDS Coordinator stated care plans were updated after an MDS Assessment had been performed. She stated she also updated residents' care plans daily as she got new orders. The MDS Coordinator stated usually information was attached to the care profile (CNA Care Plan/Kardex) and nurses' care plan. She stated they verified residents' care plan were implemented by staff by visually observing resident care and confirmed staff were following the residents' care profile or were implementing residents' care plans. The MDS Coordinator also stated floor nurses could update residents' care plans when they got a new order for something. She further stated she went back over residents' care plans and checked them to make sure that it had been updated. In interview on 09/12/2024 at 3:15 PM, the Director of Nursing (DON) stated her expectations was for her staff to follow R38's care plan interventions. In interview on 09/13/2024 at 10:19 AM, the Administrator stated she was a member of the facility's Interdisciplinary Team (IDT) team, who confirmed interventions were in place by going to check after the IDT meeting to make sure interventions were done. She stated she expected staff to follow residents' care plans, and a potential outcome for not following the care plan was a resident might not receive the care they were supposed to be getting. The Administrator further stated, regarding R38, that staff should have followed the resident's care plan interventions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50153 Based on observation, interview, record review, and review of the facility policies, the facility failed to ensure the comprehensive care plan was reviewed and revised by its Interdisciplinary Team (IDT following a fall with major injury for 1 of 22 sampled residents, Resident (R)26. On 06/23/2024 a perimeter defining mattress (PDM) was recommended as an intervention by the IDT for R26, and a PDM was placed on the resident's bed. The PDM was removed at R26's request; however, was not added to the resident's falls care plan to accurately reflect the resident's plan of care. In addition, R26's falls care plan noted a high rise mattress r/t fall from bed remained as an active intervention, but was not observed to be in use. The findings include: Review of the facility policy titled, Comprehensive Care Plans revised 02/2024, revealed it was the policy of the facility to develop and implement a comprehensive, patient-centered care plan for each resident to meet the resident's medical, physical, mental, and psychosocial needs. Further policy review revealed the care plan was to include resident specific interventions that reflected the resident's needs and preferences and was to include factors identified by the IDT. Review of the facility policy titled, Falls revised 03/22/2022, revealed care plan interventions should be implemented that address the resident's risk factors. Continued review revealed the care plan interventions were to reduce risk of repeat episode. Further review revealed any orders received from the Physician were to be noted and the resident care plan should be updated to reflect any new or change in interventions. Review of the facility's medical record for R26 revealed the facility admitted the resident on 05/31/2016, with diagnoses of history of malignant neoplasm of the breast, primary generalized (osteo)arthritis, and hypertensive chronic kidney disease (CKD). Review of R26's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident cognition was intact. Per MDS review, the facility assessed R26's functional abilities as requiring substantial to maximal assistance for rolling left to right. Further review revealed the facility further assessed R26 as dependent for all transfers and wheelchair mobility. Review of R26's Significant Change in Status MDS assessment dated [DATE], revealed the facility assessed the resident as having a BIMS score of 6/15, which indicated severe cognitive impairment. Per MDS review, the facility also assessed R26 to be dependent for rolling left and right; and dependent for chair/bed and bed/chair transfers and wheelchair mobility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's comprehensive care plan developed for R26 revealed a falls care plan with start date of 11/15/2022, for the resident's risk for falls due to incontinence of bowel and bladder, psychoactive drug use, and impaired functional status and mobility. Continued review revealed the falls care plan goal was to lessen R26's potential for falls/injury through the review date, and a target goal date of 10/18/2024. Per care plan review, there were three discontinued interventions that included an intervention for an x-ray of R26's right leg and send out to the emergency room (ER) for evaluation which had a start and end date of 06/25/2024. Review also revealed a discontinued intervention for a body pillow to provide R26 an extra reminder of bed edges with a start date of 6/24/2024 and end date of 7/02/2024. Care plan review revealed an additional discontinued intervention for a urinalysis (U/A) to be obtained due to R26's confusion related to fall and for therapy to evaluate and treat that had a start and end date of 6/24/2024. Further review of the falls care plan revealed it included active interventions for assuring R26's glasses were clean and in good repair and making sure she wore the glasses; encouraging use of 1/2 side rails for bed mobility and transfers dated 6/28/2023; and keeping personal and frequently used items in reach. Additionally, review of the falls care plan revealed however, no current or historical/resolved interventions related to a specialized mattress or for the resident's bed to be in a low position. Review of R26's comprehensive care plan additionally revealed a care plan for pressure ulcer/injury related to the resident being at risk for skin integrity alterations due to impaired mobility. Further review revealed interventions which included a pressure reduction high rise mattress with a start date of 06/28/2023, which had not been discontinued and was still an active intervention. Review of the Physician's orders dated 03/29/2023, revealed a high rise mattress related to falls from bed, which had a discontinued date of 09/11/2024. Review of the facility's investigation titled, Incident Fall with Major Injury with a date of 06/23/2024, for R26's fall which revealed a brief review of the incident. Continued review revealed the investigation noted What was the new intervention placed on the care plan/Kardex at time of incident? with a response for R26's bed to be in low position, perimeter defined mattress. Review of the IDT's review in the progress notes dated 06/27/2024 at 12:22 PM, revealed, Care plan revision perimeter defined mattress. Observation on 09/10/2024 at 5:04 PM ,and on 09/11/2024 at 10:51 AM and at 11:05 AM, of R26's mattress, revealed a standard pressure reduction mattress in place on the resident's bed. In interview on 09/11/2024 at 2:03 PM, Certified Nursing Assistant (CNA) 11 stated the CNA's accessed residents' care plans on Matrix (facility's electronic health record) all day every day. She stated that was where the CNA knew to find information on residents' transfer status; whether they were continent or incontinent; their behaviors; and how to bathe the resident. CNA 11 stated sometimes it did say if a resident had an intervention like bed low to the ground. She said she was not able to see the full nursing care plan in Matrix, but received report from the previous shift CNA and got any new information that report. In interview on 09/11/2024 at 2:20 PM, the CCN stated the CNA care plan in Matrix showed the level of assistance a resident required. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 09/11/2024 at 10:51 AM, Registered Nurse (RN) 2 stated she did not participate in residents' care plan meetings. She further stated however, she had been asked for updates on residents for their care plans. In interview on 09/12/2024 at 2:14 PM, MDS Coordinator 10 stated the MDS Coordinators were responsible to update residents' care plans when doing their MDS Assessment and daily with any new orders. MDS Coordinator 10 stated the floor nurses were supposed to assist in updating residents' care plans. She stated she checked the care plans to make sure interventions were there (on the care plan). The MDS Coordinator stated once the care plan was updated staff could see the updates. She said interventions were attached to the care profile for the CNA's and everyone could see residents' care plans. The MDS Coordinator stated she was not really sure what a high rise mattress but thought it was like a perimeter mattress that was used to keep the body in the bed. In interview on 9/12/2024 at 9:31 AM, the Director of Nursing (DON) stated the nurses should put interventions on residents' care plans that they came up with, and the IDT added something else which the MDS Coordinator usually made the changes to on the care plan. She stated the IDT reviewed falls in the morning meetings where the fall event was discussed, and the care plan reviewed and updated. In an additional interview on 09/13/2024 at 10:18 AM, the DON stated she expected residents' care plans to be up to date and reflect the care being provided to the resident. When the State Survey Agency (SSA) Surveyor asked the DON if audits were completed to ensure the care plan interventions were in use, she stated audits were completed periodically; however, did not specify a frequency of the auditing. She stated she did not know when the last audit was completed and would have to look, then she stated maintenance did bed audits. The DON she told us it got done and the nurse and CNA would know in regards to care plan intervention implementation. She stated residents' care plan were reviewed in the IDT meetings to see if additional interventions needed to be added, with the additions usually made by the MDS Coordinator. In interview on 09/13/2024 at 10:20 AM, the Administrator stated she led a daily morning meeting with facility managers where incidents were discussed with the IDT at that time to review the incident report and resident's care plan. She stated it was her expectation for the care plan to be changed when an intervention was added or removed and, a progress note documented if needed to reflect the current care to be provided for a resident. The Administrator further stated, in regards to the PDM for R26, she expected the care plan intervention to be removed if it was discontinued.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50153 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure medical provider orders were entered upon receipt for 1 of 22 sampled residents, Resident (R)26. On 06/25/2024 at 11:11 AM, Registered Nurse (RN) 3 contacted the Advanced Practice Registered Nurse (APRN) 1 to report R26 had right leg pain, scattered bruising of the right leg and swelling of the right knee. RN 3 said APRN 1 ordered an x-ray of R26's right leg the previous night. Review of the medical record revealed no documented evidence of an x-ray order or documentation of the nurse's communication with APRN 1 on 06/24/2024. The findings include: Review of the facility policy titled, Verbal Orders, with a revision date of 03/23/2020 revealed Physician orders might be received by a licensed nurse or registered health care specialist who was legally authorized to do so. Per review, verbal orders were given to the nurse by the Physician or extender in person or by telephone. Further review of the policy revealed the orders were to be entered into the resident's medical record and were to be followed through with by making appropriate contact or notification (eg. lab or pharmacy). Review of R26's electronic health record (EHR), revealed the facility admitted the resident on 05/31/2016 with primary diagnoses of Hypertensive Chronic Kidney Disease (CKD), Unspecified Convulsions, personal history of malignant neoplasm of the breast, and primary generalized (osteo)arthritis. Review of R26's Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six out of 15 indicating the resident had severe cognitive impairment. Review of R26's comprehensive care plan revealed the facility developed a problem for Falls, with a start date of 11/15/2022. Review of the Falls care plan revealed R26 was at risk for falling related impaired mobility and functional status, incontinent of bowel and bladder (B&B), and psychoactive drug use. Per review, the target goal date was 10/18/2024, with the goal noted as to lessen potential for falls/injury through the review date. Review of the care plan approaches/interventions revealed three interventions had been discontinued that included one on 06/25/2024, with the same date as the end date, to x-ray R26's right leg, and send out to the emergency room (ER) for evaluation. Continued review revealed the second discontinued approach, with a start date of 06/24/2024 and an end date of 07/02/2024, which noted, Body pillow to provide resident extra reminder of bed edges. Care plan review revealed the third discontinued approach, with a start date of 06/24/2024, with the same end date, revealed therapy was to evaluate and treat, and a urinanalysis (U/A) was to be obtained related to confusion from a fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 06/23/2024 at 12:55 AM, revealed R26 experienced a fall from the bed on that date at 12:15 AM, with an abrasion identified at the time but no other injury identified. Per review of the note, the Physician was notified and no new orders were received at that time. Review of the nursing progress notes from 06/24/2024 through early on 06/25/2024, revealed the resident was monitored; however, there was no documented evidence of R26 reporting pain or other abnormalities. Review of a progress note 06/25/2024 at 9:30 AM, revealed RN 3 had contacted APRN 1 due to R26 having, Right leg pain and scattered bruising and Right knee Swollen. In addition, revealed APRN 1 ordered an x-ray of R26's right leg and foot. Review of the progress notes further revealed the x-ray was obtained and results reported to the APRN (APRN 2) on 06/25/2024 at 1:30 PM, with a new order received to send out the resident. Review of the x-ray report results received on 06/25/2024 revealed R26 had a Fracture of the distal femur. In an phone interview with RN 3 on 09/11/2024 at 2:52 PM, she stated she had received report and was told about R26 sustaining a fall. She stated she assessed R26 on 06/25/2024, during incontinence care and found bruising to the resident's leg down to her foot and the resident complained of pain in the right leg. RN 3 stated she contacted APRN 1 who said she gave an order the previous night to obtain an x-ray of R26's right lower extremity. She said however, no order had been entered for R26's x-ray and so she contacted the Unit Manager (UM) who had worked the day prior (06/24/2024) to ask about the order. The RN stated the UM reported an order was received the night before but the UM had not had a chance to enter the order into the computer yet. RN 3 stated she entered the x-ray order on 06/25/2024 at 9:30 AM, and the x-ray was completed at 11:11 AM. She stated the x-ray results were received at 1:30 PM, and reported to APRN 2 who gave an order to send the resident out to the ER for evaluation. In an interview with APRN 1 on 09/11/2024 at 3:12 PM, she stated she recalled the situation involving R26 and the x-ray. She said she gave an order for the x-ray the night before RN 3 contacted her (06/24/2024). APRN 1 stated the UM had contacted her on 06/24/2024, to report redness of R26's leg and so she gave the order for the x-ray. Per continued interview, APRN did not indicate the x-ray order was a stat (immediate) order. She stated she worked on Monday, Wednesday, and Friday and she had not examined the resident. APRN 1 stated staff probably entered the order into the Trident System, (a computerized order entry system used to enter Physician/provider orders for x-rays) and they don't come until the next day. In a phone interview with the UM on 09/12/2024 at 10:20 AM, she stated she recalled that R26 had experienced a fall. She said she recalled contacting APRN 1 due to the resident having complaints of pain, but did not recall if the UM reported whether the pain was constant or intermittent. The UM stated APRN 1 gave an order for an x-ray; however, she could not recall if she entered the order into the system or not. She stated the x-ray order was received at shift change, and she might have passed it on in report to the next nurse to enter the order. The UM said she would have to look at R26's record to see. The UM further stated there was no guarantee the mobile x-ray provider would come and do the x-ray on the same day if the order had been entered on 06/24/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with a Representative from the mobile x-ray provider on 09/12/2024 at 10:49 AM, she stated if an order was entered at 7:00 PM, and was entered as a stat order, the mobile x-ray provider's policy was to complete the order within four to six hours from the time the order was received. She stated the policy was to include a report of the results of the x-ray within the required timeframe. The mobile x-ray Representative said if the x-ray order was entered as a routine order, the provider had eight to 24 hours to complete and result the x-ray. She stated depending upon the volume of x-rays to be completed, the test might be done the following day. The Representative said a call was to be placed to the facility to notify them the x-ray would not be completed the same day. In addition, she said she had been unable to locate an order in their electronic system requesting an x-ray for R26 on 06/24/2024. She further stated the only x-ray that had been obtained was on 06/25/2024, with the results reported on 06/25/2024. In an interview with the Director of Nursing (DON) on 09/12/2024 at 9:31 AM, she stated it was her expectation that orders were entered into the facility's system before the nurse left their shift. The DON stated she did not think the mobile x-ray provider would have completed the x-ray until probably the next morning, unless it was a stat order. She further stated if there was any delay in receiving the x-ray, she would expect the delay to only be one to two at most to get the x-ray In an interview with the Administrator on 09/13/2024 at 10:20 AM, she stated an order was to be noted in the system when it was obtained. She stated any negative outcomes for a resident would depend on what the order was for, in determining the negative outcome. The Administrator stated that had the x-ray order been entered as a stat order, she did not think it still would have been completed on the same day by the mobile x-ray provider. She further stated if we thought a resident needed a stat order we would send that resident to the ER for evaluation.

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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** 50153 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the use of assistive devices to prevent injury for 1 of 3 sampled residents, Resident (R)26. Review of the Physician's Order History revealed an order with a start date of 03/29/2023 and a discontinue date of 9/11/2024 for High rise mattress as intervention r/t falls from bed. However, observation of R26's bed mattress revealed a standard mattress was in place, not the ordered high rise mattress. Therefore, on 6/23/2024 R26 sustained a fall from the bed that resulted in a comminuted impacted extra-articular (bone broken into multiple pieces with the ends driven into each other) right distal femur fracture with lateral displacement that required surgical repair. The findings include: Review of the facility policy titled, Falls with a revised date of 03/22/2022, revealed the purpose of the policy was to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. Per review, care plan interventions were to be implemented that addressed the resident's risk factors with interventions to reduce risk of repeated episodes. Continued review revealed any orders received from the Physician should be noted and carried out. Further review revealed the resident's care plan should be updated to reflect any new or change in interventions. Review of the facility policy titled, Accidents and Supervision, revised 02/21/2024, revealed each resident was to receive adequate supervision and assistive devices to prevent accidents. Continued review of the policy revealed Fall as a potential accident with a definition of a fall. Further review revealed a section titled, Policy Explanation and Compliance Guidelines which noted ensuring interventions are put into action. Review of R26's record revealed the facility admitted the resident on 05/31/2016 with primary diagnoses of primary generalized (osteo)arthritis, hypertensive chronic kidney disease (CKD), unspecified convulsions, and history of malignant neoplasm of the breast. Review of the Quarterly Minimum Data Set (MDS) Assessment for R26 dated 04/04/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. Continued review of the MDS revealed for R26's functional abilities and goals, the facility assessed the resident to require substantial/maximal assistance for rolling left to right; as dependent for all transfers; and as dependent for wheelchair mobility. Review of the Significant Change in Status MDS Assessment for R26 dated 07/05/2024, revealed the resident with a BIMS score of six out of 15, indicating the resident had severe cognitive impairment. Further review of the MDS revealed for R26's functional abilities and goals, the facility assessed the resident as: dependent for rolling left and right; dependent for chair to bed and bed to chair transfers; and dependent for wheelchair mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order History for R26 revealed an order with a start date of 03/29/2023 and a discontinue date of 9/11/2024, for a high rise mattress as an intervention related to falls from bed. Review of R26's comprehensive care plan revealed the facility developed a care plan for falls with a problem start date of 11/15/2022, related to the resident being at risk for falls due to impaired functional status and mobility, incontinence of bowel and bladder (B&B), and psychoactive drug use. Per review, the falls care plan target goal date was 10/18/2024, and the goal was to lessen potential for falls/injury through the review date. Continued review revealed the interventions included three discontinued interventions which x-ray of right leg and send out to the emergency room (ER) for evaluation with a start and end date of 6/25/2024. The falls care plan review also revealed a second discontinued intervention with a start date of 6/24/2024 and end date of 7/02/2024, for R26 to have a body pillow to provide the resident extra reminder of bed edges. Further review revealed a third discontinued approach with a start and end date of 6/24/2024, noting therapy was to evaluate and treat R26 and for a urinalysis (U/A) to be obtained due to confusion related to fall. Additionally, review revealed active intervention included: keeping personal and frequently used items in reach dated 3/10/2024; assuring R26 wore her glasses, and ensuring the glasses were clean and in good repair; and encouraging use of 1/2 side rails for bed mobility and transfers dated 6/28/2023. Further review of R26's comprehensive care plan revealed the facility developed a care plan titled, Category: Pressure Ulcer/Injury related to the resident being at risk for alterations in skin integrity due to impaired mobility. Per care plan review, the interventions included an approach for a pressure reduction high rise mattress with a start date of 6/28/2023, that was still an active intervention and had not been discontinued. Review of the Matrix Care (an electronic medical records [EMR] system used for charting) Resident Profile (the care guide utilized for the Certified Nursing Assistants [CNA's] with no print date), provided after request on 09/11/2024, revealed a Last Updated Date of 08/27/2024 at 8:53 AM. Further review revealed no documentation noting a mattress specified for R26's use. Review of the facility's progress note dated 06/23/2024 at 12:55 AM, revealed R26 had been found lying on the floor at 12:15 AM. Per review, R26 was assessed and found to have an abrasion to the right lower extremity with wound care provided. Ongoing review of the progress note revealed documentation noting R26's range of motion (ROM on the bilateral lower extremities (BLE) was decreased per norm. Review of the facility's progress notes dated 06/23/2024 through 06/25/2024, revealed documentation noting R26 was being monitored, had no complaints of pain, and indicated no problems until the resident was assessed by Registered Nurse (RN) 3 on 06/25/2024 at 11:11 AM. Review of the 06/25/2024 at 11:11 AM, progress note documented by RN 2, revealed R26 had right leg pain and scattered bruising, with a swollen right knee. Per review, RN 3 contacted Advanced Practice Registered Nurse (APRN) 1 who ordered an x-ray of R26's right leg and foot. Further review of the progress notes revealed the x-ray was obtained and resulted on 06/25/2024 at 1:30 PM, and was shown to APRN 2 with a new order received to send R26 out to the ER. Additionally progress note review revealed R26 left the facility at 1:55 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the x-ray report results dated 06/25/2024, revealed R26 had a fracture of the distal femur. Review of the After Visit Summary from the hospital revealed R26 was hospitalized on [DATE] related to injury sustained from a fall from her bed. Review of the After Visit Summary with dates of 06/25/2024 through 06/29/2024, revealed R26 had been hospitalized with a comminuted impacted extra-articular right distal femur fracture with lateral displacement. Further review revealed R26 underwent surgery for repair of the fracture. Review of the facility's Interdisciplinary Team (IDT) documentation for review of R26's fall dated 06/27/2024 at 12:12 PM, revealed the possible root cause of the resident's fall was poor safety awareness and thinks she can walk. Continued review revealed the IDT referral section noted the team would look at after R26's return from the hospital. Further review revealed the IDT's recommended interventions included a care plan revision for R26 to have a perimeter defined mattress and noted the resident's care plan was reviewed and updated. Review of the facility's monthly bed audits dated May 2024; June 2024; July, 2024; and August 16, 2024, revealed R26's mattress was documented as a regular mattress in May 2024, June 2024, July 2024 and August 2024. In an interview with RN 2 on 09/11/2024 at 10:51 AM, the RN stated a high rise mattress was higher on the edges which was the same as a perimeter mattress. In additional interview on 09/11/2024 at 11:05 AM, RN 2 stated that neither a high rise mattress or perimeter mattress was on R26's bed. The RN further stated maintenance was responsible to change out residents' mattresses and maintenance would be notified by a phone call or a work order. In an interview with the Director of Maintenance (DOM) on 09/11/2024 at 2:51 PM, he stated he was responsible for replacing mattresses. He stated a high rise mattress had bolsters built into an overlay that was zipped over the mattress. The DOM said staff placed work orders for maintenance requests/issues into the facility's, TELS, electronic system (used for communicating day-to-day maintenance requests). He stated if staff verbally reported a request for a resident's mattress change, that request was verified with the Director of Nursing (DON) to ensure the request was valid and had been care planned before placement of the mattress. The DOM stated there was a record of completed work orders through the facility's TELS system. The DOM provided a work order requesting placement of a perimeter mattress for R26, with a created date of 06/27/2024 and completion date of 6/28/2024. No further work orders regarding R26 were provided by the facility. In an interview with the MDS Coordinator on 09/12/2024 at 2:13 PM, she stated she and two other MDS Nurses were responsible for updating residents' care plans with all new Physician's orders from the previous day. She said they also updated residents' care plans when reviewing the MDS. The State Survey Agency (SSA) Surveyor asked the MDS Coordinator to define the high rise mattress intervention on R26's care plan. The MDS Coordinator stated she was not really sure, but thought a high rise mattress was like a perimeter mattress, to keep the resident's body in the bed. She stated if there was a Physician's order a specialty mattress would be noted on the resident's care plan, and if there was not an order the specialty mattress wound not be on the care plan. The MDS Coordinator further stated to ensure staff were following a resident's care plan, visualization, observation and review of what was checked off were all items reviewed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 09/12/2024 at 9:31 AM, she stated the nurse on duty at the time of a resident's fall was to look for root cause of the fall and put an immediate intervention in place. She said the fall would then be reviewed in the morning meeting that was attended by the IDT members which included: herself, the Administrator, Assistant Director of Nursing (ADON), Unit Manager (UM), MDS Coordinator, Therapy Manager, Business Office Manager (BOM), Social Services Director (SSD), Housekeeping Manager, and Dietary Manager. The DON also stated at that time of a fall care plans were reviewed and revised based on discussion of the fall and the MDS Coordinator usually made the changes needed in the resident's care plan. In continued interview on 09/12/2024 at 9:31 AM, the DON stated a high rise mattress was raised up on the sides a little, but was not full sides, like a perimeter mattress. She stated she was not sure why the Physician's order for the high rise mattress was discontinued on 9/11/2024, but would wonder if it was not on the bed. The DON stated periodic audits were done to ensure the residents' interventions in place matched their care plans. She stated however, she did not know when the last time that audit occurred. The DON said maintenance audited residents' beds for the type of bed, type of mattress, type of rail, gap assessment of the side rails, and a general safety assessment to ensure the appropriate bed and mattress were in use for the weight of the resident, the mattress was affixed to the bed, bed rails were firmly attached, and the bed rails latched appropriately. She further stated if an intervention was added to a resident's care plan and was implemented, the nurses and CNA's would know and would tell us it had gotten done. In addition, the DON said maintenance would notify staff when a request was completed. In an interview with the Administrator on 09/13/2024 at 10:20 AM, she stated that a morning meeting was held daily and falls and interventions were reviewed. She stated if changes were needed it was her expectation that the care plan was changed (updated) during the morning meeting and a note made in the resident's record if needed. The Administrator stated she was trying to put in the work orders because verbal requests got forgotten and there was no record that a request had been completed. She stated after the morning meeting we check to ensure (necessary) interventions were in place and maintenance will let her know a task had been completed. The Administrator additionally stated they would follow up. In continued interview on 09/13/2024 at 10:20 AM, the Administrator stated a high rise mattress could be an overlay or perimeter mattress. Per interview, the Administrator described the edges of the high rise or perimeter mattress as raised. She stated she recalled at some point after the perimeter mattress was placed on R26's bed, following the resident's fall in June 2024, R26 complained she did not like the mattress and did not want it on her bed anymore, so the mattress was changed out. The Administrator stated however, no work order was entered but she knew it was changed out and said it just was not in black and white that they had done that. She further stated if an intervention was discontinued, she expected it to be removed from the resident's care plan.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47567 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure a resident who was fed by enteral (tube) feedings, received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia for 1 of ?? sampled residents, Resident (R)38. 1. Review of the manufacturer's instruction manual for R38's feeding system revealed the feeding set should be replaced after 24 hours from initiation of the feeding to prevent bacterial growth that could be a hazard to the patient. However, observation on 09/09/2024 at 12:49 PM, revealed R38's enteral (tube) feeding bottle had been hanging for greater than 24 hours, and included a 4 hour holding of the feeding solution. 2. Review of R38's care plan revealed the head of the resident's bed was to be elevated during enteral feedings. Observation on 09/10/2024 at 5:00 PM and on 09/11/2024 at 5:00 PM, revealed R38 lying flat on the bed while her enteral feeding was infusing. The findings include: Review of the facility policy titled, Assisted Nutrition and Hydration, revised 02/21/2024, revealed the facility was to ensure each resident fed by enteral means received appropriate treatment and services to prevent complications of enteral feeding. Further review revealed the complications included, but were not limited to, aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Review of the facility policy titled, Appropriate Use of Feeding Tubes, revised 05/31/2023, revealed feeding tubes were to be utilized in accordance with current clinical standards of practice with interventions to prevent complications to the extent possible. 1. Review of the manufacturer's instruction manual titled, Kangaroo OMNI Enteral Feeding Pump, revealed the feeding set should be replaced after 24 hours from initiation of the feeding. Continued review revealed replacing the feeding set ensured the enteral feeding pump was operating within the specified parameters and prevented bacterial growth that could be a hazard to the patient. Review of the facility's Face Sheet for R38, revealed the facility admitted the resident on 05/07/2021, with diagnoses to include Alzheimer's Disease, Stage 3 Chronic Kidney Disease, and Malignant Neoplasm of the bladder. Review of R38's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/08/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (00) out of 15, indicating R38 had severe cognitive impairment. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's Comprehensive Care Plan dated 11/23/2022, revealed the facility care planned the resident for alteration with nutritional status related to failure to thrive and protein calorie malnutrition. Continued review revealed R38 required a feeding tube along with an oral food intake diet with a goal of lessening potential signs of complications from bolus feedings or enteral feeding solution. Further review revealed interventions which included elevating the head of bed (HOB) 30-45 degrees during (tube) feedings, and maintaining an upright posture to decrease aspiration risk. Observation on 09/09/2024 at 12:49 PM, of R38's enteral feeding bottle revealed it was dated 09/08/2024 at 8:18 AM, indicating the feeding had been hanging for 27 hours, and contained a 4 hour holding of the feeding solution. In an interview with Licensed Practical Nurse (LPN) 1 on 09/09/2024 at 1:00 PM, she stated enteral tube feeding was good for 48 hours. She further stated to her knowledge that was the facility's standard of practice. In an interview with Registered Nurse (RN) 1 on 09/12/2024 at 3:32 PM, she stated tube feeding systems should be changed every 24 hours. In an interview with the Director of Nursing (DON) on 09/09/2024 at 5:36 PM, she stated she thought tube feedings were good for 24 hours, but she was going to check on the facility's policy. In an additional interview on 09/12/2024 at 9:31 AM, the DON stated the (standard of) practice was to change the entire enteral feeding system every 24 hours. She additionally stated that was the protocol she expected all the nurses to follow. In an interview with the Administrator on 09/13/2024 at 10:19 AM, she stated the tube feeding systems needed to be changed every 24 hours. She stated it used to be changed every 48 hours, but with the new feeding system they had been using for the last few months it was to be done every 24 hours. The Administrator further stated they were starting to educate staff on that information now. 2. Review of the facility policy titled, Nursing Services and Sufficient Staff, revised 02/20/2024, revealed the facility must ensure nursing assistants were able to demonstrate competency in skills and techniques necessary to care for residents needs as identified through resident assessments and as described in the plan of care. Observation on 09/11/2024 at 5:00 PM revealed Resident 38 lying on her bed with her head of bed (HOB) flat while the resident's enteral tube feeding was hanging and infusing. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Certified Nursing Assistant (CNA) 16 on 09/12/2024 at 10:42 AM, she stated she helped CNA 17 change Resident 38's brief earlier, but did not recall what position the resident was in when being changed. She stated she left R38's room where CNA 17 remained and assumed they had left the resident lying flat. CNA 16 said she assumed that because afterwards the nurse came and got her and talked to both her and CNA 17 about how R38 had been lying and she assumed there must have been an issue with how the resident had been left lying. She stated they were both educated about positioning of R38, but were never told anything specifically about the resident's need for sitting up. The CNA stated she was taught how to clean the feeding tube, but not much else. She further stated now, if she saw a resident on tube feeding, she would raise the HOB to make sure the resident did not aspirate. In additional interview on 09/10/2024 at 5:00 PM, LPN 1 stated R38 needed to have her HOB raised as the resident could potentially aspirate if left in the lying flat position. She stated she last checked on R38 around 3:00 PM or so, and the resident had been sitting up in the correct position. LPN 1 stated she had two new CNA's caring for residents, that came in and provided care for R38 and they must have forgotten to put the resident back into the appropriate position. She further stated she would educate the CNA's on the proper positioning for R38. In an interview with Registered Nurse (RN) 1 on 09/12/2024 at 3:32 PM, she stated R38 should have had the head of her bed elevated to prevent aspiration, pneumonia, or an anxiety attack. In a follow-up interview on 09/12/2024 at 9:31 AM, the DON stated a potential negative outcome that could occur for R38 being left lying flat would be that the feeding could back up and the resident could aspirate it. In additional interview on 09/13/2024 at 10:19 AM, the Administrator stated a resident on tube feeding should have the head of their bed elevated, because they could potentially aspirate the feeding solution.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44370 Based on observation, interview, and review of facility policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Observation on 09/08/2024 of the reach-in cooler revealed multiple food items which had been opened; however, were not labeled and undated. The facility's failure had the potential to affect 96 of the facility's 98 residents who consumed food from the kitchen. The findings include: Review of the facility documents titled,Safe Standards and Procedures, Food Handling, dated 03/08/2024, from the facility's contracted kitchen services provider, revealed, foods, intended for storage beyond 24 hours, must be labeled. Further review revealed the food labels were to include: the item name; the preparation date and a use by date within seven days of preparation or opening; and the employees initials. Review of the facility policy, Food Storage - Cold, dated 10/2019, revealed it was the facility's policy to ensure all time and temperature control for safety (TCS), frozen and refrigerated food items be appropriately stored in accordance with the guidelines of the FDA Food Code. Further review revealed the Dining Services Director or cook were to ensure all food items were stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Review of the United States Department of Agricultural Food Safety and Inspection Services for Food Safety Information Basics for Handling Food Safely, revealed safe steps in food handling, cooking, and storage were essential to prevent food borne illness. Continued review revealed leftover food was to be used within four days. Observation, with the Dietary Manager (DM), during the initial tour of the kitchen on 09/08/2024 at 11:30 AM, of the reach-in cooler, revealed a large container of breakfast gravy 3/4 full not labeled or dated; 2 large containers of sausage patties dated 09/09/2024; a plastic bag containing 5 dinner rolls dated 9/05/2024. Continued observation of the reach-in cooler revealed a small bowl of yogurt, not labeled or dated; 17 prepared sandwiches of various types, dated 09/06-09/13; a small bowl of chicken soup, not labeled or dated; and packaged flour tortillas with an expiration date of 08/10/2024. Further observation revealed packaged ham slices containing six slices dated 08/26/2024. In addition, observation of the walk-in freezer contained 1 pint of ice cream with an expiration date of 06/30/2024. In an interview with the Dietary Manager on 09/08/2024 at 11:47 AM, during the initial kitchen tour, she stated food products were good for seven days after being opened. She stated she expected dietary staff to label and date all items as required. The Dietary Manager further stated food items should contain two dates, the date the item was placed in the cooler and the date it should be removed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Director of Nursing (DON) on 09/12/2024 at 10:15 AM, she stated she would expect the kitchen staff, from a contracted company, to follow their polices and procedures related to food storage. During an interview with the Administrator on 09/13/2024 at 10:35 AM, she stated the dietary department was a contract company and had their own policies. She stated she expected the dietary staff to follow their policies and ensure all items placed in the coolers were labeled and dated.

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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** 37031 Based on observation, interview, record review, and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 sampled residents, Resident (R)2. Observation revealed staff failed to follow infection control guidelines related to catheter care, clean linen placement, and hand hygiene for R2. Additionally, staff failed to perform proper hand hygiene while passing residents' meal trays. The findings include: Review of the facility policy titled, Hand Hygiene, revised 03/22/2024, revealed all staff were to perform proper hand hygiene procedures to prevent the spread of infection to residents, other personnel, and visitors. Per policy review, that applied to all staff working in all locations within the facility. Continued review revealed hand hygiene was a term for cleaning your hands by handwashing with soap and water or through use of an antiseptic hand rub. Review revealed hand hygiene was indicated and was to be performed under the following conditions: when hands were visibly dirty; soiled with blood or other body fluids; before and after eating; after using a restroom; and between resident contacts. Further policy review revealed hand hygiene was additionally to be performed: after handling contaminated objects; before and after applying personal protective equipment (PPE) including use of gloves; before performing resident care procedures; and when during resident care, moving from a contaminated body site to a clean body site. 1. Review of the facility policy titled, Catheter Care revised 02/20/2024, revealed it was the policy of the facility to ensure residents with indwelling catheters received appropriate catheter care and their dignity and privacy was maintained when indwelling catheters were in use. The policy review revealed for catheter care of a female resident, the cleansing was to include gently separating the labia to expose the urinary meatus, using a new part of the cloth or different cloth for each side. Further review revealed the process for female residents' catheter care also included cleansing of the catheter included using a new moistened cloth and starting at the urinary meatus moving out and making sure to hold the catheter in place so the catheter would not pull on the meatus. Review of R2's medical record revealed the facility admitted the resident on 03/08/2022, with diagnoses which included obstructive and reflux uropathy, retention of urine, and neuromuscular dysfunction of bladder. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R2 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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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 - Few	Observation on 09/11/2024 at 10:42 AM, of Certified Nursing Assistant (CNA) 11 and CNA 12 conducting indwelling catheter care for R2, revealed clean linens sitting at end of the roommate's bed. Per observation, CNA 12 pulled the overbed table with R2's belongings on it over, pushing the belongings to one side and placing a towel over the table without cleaning the table first. Observation revealed CNA 12 obtained a bath basin, ran water in it and placed it on the overbed table, and then picked up washcloths from the roommate's bed and placed them in the water. Continued observation revealed the two CNA's washed their hands, donned gloves and removed R2's soiled brief then initiated the resident's catheter care. Observation revealed neither CNA washed their hands after removing the soiled brief and prior to beginning the catheter care. In continued observation on 09/11/2024 at 10:42 AM, of CNA 11 and CNA 12 providing R2's catheter care, revealed during the cleansing of the catheter tubing the CNA's started at the resident's pubis and cleaned down; however, the CNA did not reposition the cloth to clean areas. Per observation, the CNA did the separate the labia to cleanse the meatus, and only cleaned down the catheter tubing approximately four inches from meatus. Continued observation revealed when R2 was turned to the side, stool was observed at the anus, and the CNA's started cleaning the stool off the resident. Observation revealed the CNA did not have cleansing wipes, so she used wash cloths and began cleaning R2's anal area contaminating the sleeve of her barrier/gown with stool. Further observation revealed after completing the catheter care and cleansing R2, the CNA's did not remove their dirty gloves prior to placing a clean brief on the resident. In addition, they were observed to reposition R2 up in the bed, touching the resident's bed clothes and overbed table with their contaminated gloves. Observation further revealed after ensuring R2 was comfortable, the CNA's placed the soiled laundry in bags, removed their gloves, washed their hands, picked up the dirty laundry and trash and left the room. During an interview on 09/11/2024 at 9:48 AM, CNA 12 stated she should have done a better job of cleaning R2, but since the resident had stool, it had caused some issues. CNA 12 stated she should have used a different technique when cleaning R2's catheter tubing by changing the site of the wash cloth to ensure it was clean each time. She further stated she should have washed her hands and changed gloves more frequently during the catheter care and when cleaning the stool from R2. During an interview with the Director of Nursing (DON) on 09/12/2024 at 10:05 AM, she stated she expected staff to use a clean technique procedure when providing catheter care. She also stated she expected staff to follow the facility's policy as written for indwelling catheter care and hand washing. The DON further stated the CNA was a new CNA who had just passed her test, who would need more education which was an ongoing process. During an interview on 09/11/2024 at 11:18 AM with the facility's Infection Preventionist, she stated there were skills fair during which certain areas were taught and check offs were completed for competency. She stated education was ongoing with staff. The IP also stated she made rounds to ensure staff were washing their hands appropriately and using proper infection control practices. She further stated she expected staff to follow the facility policy. 45914 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185316	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Nursing & Rehabilitation	1333 West Main Street Princeton, KY 42445

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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 - Few	2. Observation of meal tray pass on Wing 100, on 09/08/2024 at 12:50 PM, revealed CNA 1 serving meal trays to residents. CNA 1 was observed to exit room [ROOM NUMBER] and retrieve a meal tray from the food cart without using hand sanitizer or washing her hands. Per observation, CNA 1 then re-entered room [ROOM NUMBER] with another meal tray, returning to the food cart and pulled another meal tray again without sanitizing her hands prior to removing the tray and entering room [ROOM NUMBER] to serve the next tray. Further observation revealed CNA 1 delivered the tray, exited room [ROOM NUMBER] and went into room [ROOM NUMBER] to assist another CNA with readjusting a resident in the bed for dining without using hand sanitizer or washing her hands to prevent the spread of germs. In an interview with CNA 1 on 09/08/2024 at 1:10 PM, she stated she had worked in the facility for about 2-3 weeks. She stated she was aware she was required to sanitize her hands in between each resident's room when delivering meal trays and was to wash her hands after after every third resident room. CNA 1 further stated she was aware she was not practicing proper hand hygiene when going in and out of residents' rooms without following the guidelines which could be potentially harmful to residents. In an interview with CNA 6 working on Wing 200, on 09/13/2024 at 9:00 AM, she stated the facility's policy on hand hygiene required handwashing with soap and water before serving meal trays. She stated hand sanitizing was to occur between residents' rooms and handwashing required after entering every third room. CNA 6 further stated if staff had not followed the facility's policy and procedures for hand hygiene there was potential for harm of a resident if germs were carried into other residents' rooms. In an interview with CNA 16, working on Wing 300, on 09/13/2024 at 9:15 AM, she stated when passing meal trays staff were to use hand sanitizer between residents; rooms, and wash their hands with soap and water after entering the third room. She further stated there was always a potential to spread germs from resident to resident if staff did not followed the facility's policy and procedures for proper hand hygiene to prevent harm to residents. In an interview with Licensed Practical Nurse (LPN) 1 on 09/08/2024 at 1:20 PM, she stated she was Unit Manager (UM) of Wing 100, and had worked in the facility for [AGE] years. She stated she had not observed CNA 1 not using proper hand hygiene. LPN 1 stated CNA 1 was a good worker and new to her position, but she would use the incident as a teachable moment to re-educate CNA 1 on infection control procedures. In an interview with the Assistant Director of Nursing (ADON) on 09/08/2024 at 1:25 PM, she stated expectations were that all staff were to practice proper hand hygiene by sanitizing between residents' rooms and residents. She further stated staff should practice proper hand hygiene whenever a situation required it. During an interview with the DON on 09/12/2024 at 10:06 AM, she stated expectations for direct care staff were for them to follow facility policy and procedures when assisting with distribution of meal trays in resident rooms. She further stated all staff should be sanitizing their hands in between residents' rooms and handwashing after the third room to prevent the spread of germs. In interview with the Administrator on 09/12/2024 at 11:20 AM, she stated she expected all staff to follow the facility policies regarding hand washing and indwelling catheter care.