STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185408	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Care and Rehabilitation Center	616 S Wallace Wilkinson Blvd Liberty, KY 42539

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442 Based on observation, interview, and review of the facility's documents and policies, the facility failed to provide a clean and homelike environment for residents. Observations on 06/10/2024 and 06/11/2024, revealed the facility failed to ensure the interior of the building including residents' room walls and residents' room doors were in good repair. The observations revealed peeling paint or missing paint on the walls and some areas had wood missing from the doors leaving rough edges or gouges. Additionally, residents' rooms and bathrooms had a strong odor of urine. This affected the rooms and/or bathrooms for rooms 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, and 226. Additionally, the shared bathroom between rooms [ROOM NUMBERS] had two (2) open urinals containing urine, hung on the handrail which were not bagged. One (1) of the urinals was not labeled for identification. The findings include: Review of the facility's policy titled, Resident Rights, revised March 2017, revealed the resident had a right to be treated in a manner and live in an environment that promoted enhancement of quality of life. Review of the facility's policy titled, Environmental Services, revised 06/21/2023, revealed the facility was to utilize best practice guidelines in manners pertaining to environmental services. However, the policy did not list the best practice guidelines. Review of the facility's document titled, Quality Control Inspection-Housekeeping, revealed random daily spot checks of 34 residents' bathrooms over a three (3) week period from 05/23/2024 through 06/12/2024. The spot checks showed nine (9) of the inspected bathrooms had to be re-cleaned. Observation on 06/10/2024 at 2:26 PM, revealed the bathroom shared between rooms [ROOM NUMBERS] smelled strongly of urine. Two (2) open urinals containing urine, hung on the handrail and were not bagged. One was labeled with a resident's name and one was not labeled to show identification. Additionally, room [ROOM NUMBER] had peeling paint on the walls and the door had chunks of wood missing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview with the Director of Nursing (DON), on 06/14/2024 at 8:51 AM, revealed the facility did not have a written policy related to storage of urinals after use. Observation on 06/10/2024 at 2:34 PM, revealed room [ROOM NUMBER]'s door had gouges and rough edges. The walls inside the room had peeling paint. Observation on 06/10/2024 at 2:41 PM, revealed room [ROOM NUMBER]'s walls had peeling paint, and a large, patched area that had not been repainted. The door had chunks of wood missing on its edges. The bathroom smelled strongly of urine. Observation on 06/10/2024 at 2:45 PM, revealed room [ROOM NUMBER]'s walls had chipped paint and gouged marks on the door. Additionally, the bathroom smelled like urine. Observation on 06/10/2024 at 2:47 PM, revealed room [ROOM NUMBER]'s walls had paint that was peeling and the door had chunks of wood missing on the edges. Additionally, the bathroom had a strong odor of urine. Observation on 06/10/2024 at 2:54 PM, revealed room [ROOM NUMBER] had a door with chunks missing out of the edges down to the splintered wood. There were also deep gouges and holes in the front of the bottoms of the door. The walls had chipped paint. There was a place on the wall that had been repaired, but not repainted. The bathroom smelled strongly of urine. Observation on 06/10/2024 at 3:00 PM, revealed room [ROOM NUMBER] and the bathroom both smelled strongly of urine. The walls had peeling paint and the door had missing pieces of wood on the edge. Observation on 06/10/2024 at 3:06 PM, revealed room [ROOM NUMBER] had paint scraped off the walls and peeling paint. The door was missing chunks of wood on the edge. The bathroom smelled like urine. Observation on 06/10/2024 at 3:11 PM, revealed rooms 225's and 226's walls had peeling paint. There was wood chipped out of the door, and a bathroom that smelled like urine. Observation on 06/11/2024 at 8:23 AM revealed both the room and bathroom for room [ROOM NUMBER] smelled strongly of urine. room [ROOM NUMBER] also had peeling paint and missing chunks of wood on the edge of the door. In an interview with Housekeeper (HK) 2, on 06/12/2024 at 10:44 AM, he stated the first thing he did when he cleaned a resident's room was to spray the bathroom and sink to let them soak. He stated he cleaned each room front to back and cleaned the walls and the baseboards. He then wiped down all surfaces such as bedside tables and dressers. During further interview he stated cleaning residents' rooms included taking out the trash, sweeping, and mopping. HK2 stated his training on how and what to clean was provided in his orientation. In an interview with HK1, on 06/12/2024 at 10:51 AM, she stated her supervisor did hands on training with her upon hire. She stated first she cleaned the communal areas, and the offices and resident rooms were done later in the day. She further stated for each resident room she scrubbed the bathroom, dusted, swept, mopped and took out the trash. Further, she stated they also did a deep cleaning on one (1) room per day which consisted of changing out the curtains, wiping down all surfaces including bed and mattress, and moving the furniture and cleaning underneath. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Housekeeping Director, on 06/13/2024 at 1:25 PM, she stated resident bathrooms were cleaned daily. She stated she checked the bathrooms multiple times a day to make sure they were clean. She further stated she picked three (3) rooms per day to spot check and she would have her housekeeper go back and reclean anything in a room that was not cleaned properly. The Housekeeping Director stated her staff did not fill out cleaning documentation forms for each room they cleaned. In continued interview, she confirmed that some of the resident rooms and bathrooms smelled of urine and it was difficult to get rid of the urine smell. She stated, for these rooms she had to use bleach-based cleaning products. Further, she stated all her staff were trained on how to clean during their orientation and used a check list to go by when cleaning. In an interview with the Plant Operations Director, on 06/13/2024 at 1:07 PM, he stated he had worked at the facility for several years as the Assistant Maintenance Director and had been in his present position for one (1) year. He stated the vents in the bathroom were attached to a motor that pulled the air from the bathroom. He further stated that many of them had stopped working because maintenance had not been performed properly on them in the past which may contribute to the urine odor. The Plant Operations Director stated he was in the process of replacing the motors and planned to have a preventative maintenance schedule for the new fans. When interviewed related to the peeling paint, and missing wood chunks on the doors, he stated they were in the process of repainting resident rooms and the painting and repair of the doors was on the to do list. In an interview with Licensed Practical Nurse (LPN) 3, on 06/13/2024 at 3:39 PM, she stated housekeeping cleaned the bathrooms daily. She stated it was her expectation nursing staff was to clean the bathrooms if they smelled or were dirty when housekeeping was not there. She stated urinals should be labeled with the resident's name and date and should be placed in a bag after use. In an interview with the Director of Nursing (DON), on 06/14/2024 at 8:51 AM, she stated bathrooms were cleaned daily. Further, she stated nursing staff was expected to let housekeeping know of any bathrooms that were dirty or if it was after hours they were to clean the bathrooms themselves. In further interview, she stated urinals should be emptied, cleaned, and stored in bags when not in use and should always be labeled with the resident's name. In an interview with the Administrator, on 06/14/2024 at 9:10 AM, she stated housekeeping cleaned the residents' bathrooms daily and if there was an odor or someone made a mess in the bathroom, housekeeping was to be notified. She further stated urinals should be labeled, cleaned and stored in a bag either in the bathroom or on the resident's bedside table. In further interview she stated the maintenance staff would be checking resident rooms and making repairs as necessary.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49267 Based on interview, record review, and review of the facility's policy, the facility failed to make the appropriate Level II Preadmission Screening and Resident Review (PASARR) referral based on the positive Level 1 PASARR screening results for one (1) of two (2) sampled residents reviewed for PASARR Screening (Resident (R)19) out of a total sample of forty-two residents. The facility assessed R19 to have a positive Level I PASARR screen at admission on 06/15/2023. This screening indicated the resident required a Level II Screening; however, the facility failed to ensure a Level II Screening was completed in the required timeframe. The findings include: Review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASARR), revised 09/15/2023, revealed a positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. PASARR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitation services the individual needs. Further review of the facility's policy, revealed the PASARR evaluation should be placed in the resident's Electronic Health Record. Review of R19's Face Sheet in the electronic medical record (EMR), revealed the facility admitted the resident on 06/15/2023 with diagnoses including dementia with psychotic disturbance and Alzheimer's disease. Review of R19's Quarterly Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 04/18/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine (9) out of 15, which indicated moderate cognitive impairment. Review of R19's EMR, revealed a positive Level I PASARR screening with a 06/15/2023 admitted , which indicated the need for referral for a Level II PASARR due to a diagnosis of psychotic disorder. Further review revealed as of 06/11/2024, the facility had not referred R19 for a Level II screening. Review of the Summary received from The Kentucky Level of Care System (KLOCS), revealed R19 failed to meet criteria for Level II; however, the facility failed to follow their policy of necessary Level II evaluations prior to admission. The facility referred R19 for a PASARR Level II screening on 06/12/2024, which was after the required time frame of 30 days after admission or a significant change. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Social Services Director (SSD), on 06/14/2024 at 10:21, she stated Level II PASARR referrals had to be completed within 30 days of admission unless a 30-day exemption was received from the physician. She stated referrals were submitted through the state system and a state community health representative made the determination for Level II. The SSD further stated if residents were not referred appropriately, necessary services and/or medication were potentially missed. In further interview, the SSD was unsure of how she missed ensuring the Level II PASARR referral was completed timely for R19. During an interview with the Administrator, on 06/14/2024 at 3:18 PM, she stated it was her expectation Level II PASARR referrals were submitted as soon as possible unless a physician's order for a 30-day exemption was received.

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F 0657 Level of Harm - 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** 44001 Based on interview, record review, and review of the facility's policies, the facility failed to review and revise the comprehensive care plan (CCP) for three (3) of 42 sampled residents, (Residents (R), R29, R37, and R49). Although staff was aware R37 had a history of grabbing onto the wheelchair wheels of her Evolution Mobility wheelchair when she did not want to be transported by staff, the facility did not revise her Comprehensive Care Plan (CCP) with safety interventions to prevent injury related to this behavior. On 06/09/2024, R37 was being transported by staff to her room when her hand was caught in the wheel spokes of her wheelchair, causing her to sustain a fracture and lacerations to her left index finger. Additionally, R29 sustained a fall on 06/10/2024 when searching for something in his closet, causing a skin tear to his right forearm (RFA). However, there was no documented evidence the resident's CCP was revised to prevent recurrence. Furthermore, R49's CCP, dated 12/07/2023, revised 04/17/2024, revealed the resident exhibited behaviors of entering other residents' rooms and had removed personal belongings from those rooms. Also, the Progress Note, dated 05/28/2024, revealed the resident was trying to enter the room of another resident. Observation on 06/11/2024 revealed the resident was trying to enter R4's room and on 06/12/2024 the resident was trying to enter the locked soiled utility room. Although resident interviews revealed the resident continued to enter their rooms, and staff interviews revealed they were aware of the resident's behaviors of attempting to enter other residents' rooms; there was no documented evidence the resident's CCP was revised, in an attempt to prevent recurrence. Refer to F689 The findings include: Review of the facility's policy titled, Comprehensive Care Plans, revised 02/09/2024, revealed each resident's care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and were to be revised as necessary with changes. 1. Review of R37's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 12/09/2022, with diagnoses which included Alzheimer's disease, severe dementia with agitation, mood disturbances, psychotic disturbances, and cognitive communication deficit. Review of R37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/24/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen, indicating severe cognitive impairment. Additional review revealed the facility assessed the resident as requiring substantial/maximal assist of two (2) for chair to bed, and bed to chair transfers and as independent with locomotion in a specialized wheelchair. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R37's Comprehensive Care Plan (CCP), revised 05/24/2024, revealed a focus of Activities of Daily Living (ADL) with a goal stating the resident will regain ability for locomotion on and off the unit. Interventions related to locomotion included following Physical Therapy's (PT) and Occupational Therapy's (OT) recommendations related to ADLs and the correct use of the resident's mobility chair; and to allow the resident extra time to complete ADLs. However, the care plan interventions did not list PT and OT recommendations for the correct use of the mobility chair. Additional review of R37's CCP, revised 05/24/2024, revealed a focus on behaviors, including demonstrates non-compliance with Physician's Orders and/or plan of care. The long term goal revealed the resident's preferences will be honored to the extent that non- compliance with the plan of care will not result in injury to self or others. Interventions created on 02/11/2024 included encourage resident to actively participate in the care plan and decision making; and encourage the resident's participation with care. Additional review of the CCP revealed the facility did not address the resident's habit of grabbing onto the wheelchair wheels and not moving her feet when being transported by staff in her specialized wheelchair. There were no safety interventions to prevent injury related to this behavior. Review of the facility's Event Report - Change in Condition, dated 06/09/2024 at 12:52 AM, signed by Licensed Practical Nurse (LPN) 5, revealed while staff assisted R37 to her room for routine care, the resident's finger was caught in the wheel spokes of the mobility chair causing injury to her left index finger. LPN5 assessed R37 as having a skin tear with moderate blood noted. The resident's responsible party and physician were notified and the resident was transferred by emergency medical services (EMS) to the Hospital for further evaluation. Review of R37's local Hospital Emergency Department's Progress Note, dated 06/09/2024 at 1:38 AM, revealed physicians found (1) laceration, measuring 2.0 centimeters (cm) which exposed the bone in the proximal region of the finger, and another measuring 1.5 cm which was located at the medial joint. Per the Note, the resident was subsequently transferred to the University Hospital Emergency Department to seek evaluation by a hand specialist. Review of R37's University Hospital Physician Progress Notes, dated 06/09/2024 at 1:38 AM, revealed the patient (resident) presented to the emergency department for a higher level of care from an outside hospital to evaluate the left finger injury. The patient sustained an open fracture to her left index finger, with an approximate 2.0 cm laceration to the metacarpophalangeal joint, with deformity of the left hand noted. Review of R37's University Hospital X-ray findings, dated 06/09/2024, revealed the resident had a significantly displaced comminuted angulated fracture (when the bone is broken at an angle and into several pieces) of the proximal index finger with associated soft tissue swelling and significant soft tissue irregularity which is suggestive of an open fracture (a broken bone that causes an open wound). Continued review of R37's University Hospital's Emergency Department Progress Note, dated 06/09/2024, revealed the emergency department physician applied a bandage and short arm splint to the resident's left hand/arm for stabilization of the fracture. Per the Note, the University Hospital referred the patient to an orthopedic surgeon for follow-up care. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	On 06/11/2024, after the incident, the facility revised R37's CCP to include an intervention to provide spoke covers to her wheelchair. During an interview with State Registered Nurse Aide (SRNA) 4, on 06/12/2024 at 3:16 PM, she stated she was agency staff and did not directly care for R37 during her shift on 06/09/2024, but noticed the resident needed incontinence care. She stated she informed SRNA10 of this and offered to help. SRNA4 stated SRNA10 initially took hold of the wheelchair handles and began to push the wheelchair forward, and then SRNA10 instructed R37 to remove her hands from the wheel spokes after she tried to push the wheelchair. SRNA4 stated after R37 was instructed to do so, she placed her hands in her lap. SRNA #4 stated R37 tended to grab the spokes part of the wheelchair when she did not want staff to move her. SRNA4 stated it was not until she and SRNA10 had transferred R37 to her bed that she noticed R37's finger was crooked and they called LPN5 to the resident's room. Per interview, R37 was transferred out of the facility per Emergency Medical Services (EMS). During follow up interview with SRNA4, on 06/14/2024 at 1:30 PM, SRNA4 was interviewed about SRNA10's handling of the specialty wheelchair while transporting R37. SRNA4 stated SRNA10 initially pulled the chair backwards toward the resident's room at an angle and then pushed the chair into R37's room. During a telephone interview, with SRNA10, on 06/13/2024 at 4:12 PM, she stated she had worked at the facility for two (2) months as an agency SRNA and did not know R37 well at the time of the incident. SRNA10 stated R37 was sitting in her specialty wheelchair facing the day room, when SRNA4 informed her the resident needed to be changed. SRNA10 stated she saw R37's hands holding on to the wheelchair wheels and asked her to move her hands to her lap, which she did. SRNA10 stated there were no cuts on the resident's hand when R37 placed her arms in her lap. She then stated she pulled the wheelchair backwards toward room [ROOM NUMBER]. SRNA10 stated once she and SRNA4 transferred R37 to her bed, she noticed the resident's finger did not look normal and called for the nurse, who immediately came to the room. She further stated she stayed in the room until EMS left with the resident. In continued telephone interview, on 06/13/2024 at 4:12 PM, with SRNA10, she was interviewed as to why she pulled the chair backward. She explained the chair was hard to push forward, R37 had a boot on her foot, and it was easier for her to pull the wheelchair backward the short distance from room [ROOM NUMBER] to 211. SRNA10 further explained she was afraid the resident would not move her foot, and there were no foot rests on the chair. During an interview with LPN5, on 06/13/2024 at 8:52 AM, she stated after SRNA4 and SRNA10 took R37 to her room on 06/09/2024, she heard them yell, Oh my gosh. Oh my gosh. She explained when she arrived at the resident's room, she observed R37's finger was turned and it looked as though there was one (1) laceration. She further stated she applied a pressure dressing and informed the resident's physician, Hospice, and Family Member (F)1 of the injury. Further, she stated the physician gave an order to send the resident to the hospital by EMS transport for evaluation. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	In continued interview with LPN5, on 06/13/2024 at 8:52 AM, she stated she was uncertain how the resident's finger was injured, but stated the resident's hand might have been caught in the spokes of the wheelchair. LPN5 stated, before the incident, R37 had been sitting in her specialty wheelchair in the day room. Further, LPN5 stated R37 tended to grip the wheels of her chair tightly when she did not want to move. LPN5 further stated when R37 exhibited the behavior of gripping the wheels, she would get down on her level and encourage her to put her hands in her lap. LPN5 further stated she was unsure if the resident was care planned for this pattern of behavior prior to the incident. However, she stated it would be important for staff to be aware of this behavior in order to ensure the resident did not have her hands in the wheel spokes prior to moving the resident in the chair. LPN5 stated changes to a resident's care plan were automatically updated in the system, and staff communicated changes verbally. She stated as soon as nursing made changes to a care plan, those changes appeared in the computer system used by the SRNAs. During an interview with LPN3/Unit Manager (UM), on 06/13/2024 at 3:43 PM, she stated R37 was often non-verbal and could be very non-compliant due to decreased cognition, especially when staff tried to provide care or transport her in her wheelchair. She stated when R37 did not want to move, staff found it challenging to transport her as she would grab the wheels of the chair to resist being moved. She further stated staff had to encourage R37 to place her hands in her lap. LPN3/UM stated R37 should have been care planned for this behavior of grabbing the wheels, and interventions should have been in place to prevent injury related to this prior to the incident that occurred on 06/09/2024. Additionally, she stated nurses should update care plans immediately with new interventions if increased behaviors were noted that could lead to injury. She stated the MDS Nurse was primarily responsible for making revisions. During an interview with the MDS Nurse, on 06/14/2024 at 1:27 PM, she stated resident care plans reviewed and revisions made with each MDS assessment and as needed, such as when there was an incident such as a resident fall, injury or a change in behavior. The MDS Nurse stated all nurses updated care plans, but she typically completed most care plan revisions. She stated she was made aware of behaviors, falls, injuries, and changes in resident's condition as this was discussed daily at their interdisciplinary meetings. She further stated she was not made aware of R37's tendency to grab the wheels and spokes of her wheelchair and therefore she did not revise the resident's care plan to address this prior to the resident sustaining the injury on 06/09/2024. During an interview with the Director of Nursing (DON), on 06/14/2024 at 9:06 AM, she stated R37 preferred to be in control and could sometimes be non-compliant due to decreased cognition. She stated staff was aware of R37's behaviors as any non-compliance was reported during shift changes. The DON stated she was not aware of the resident's tendency to grip the wheels, place her hands in the spokes, or not move her feet when staff attempted to ambulate her. She stated if a resident exhibited these behaviors, this should be addressed in the care plan. The DON stated it was important for the nurses to ensure care plans included necessary safety interventions and were revised as needed in order to ensure a safe and comfortable environment for the residents. In further interview, she stated this was important to prevent accidents and injury to residents and staff. During an interview with the Administrator, on 06/14/2024 at 3:18 PM, she stated she expected staff to update care plans as needed as this was important in providing resident centered care. The Administrator further stated it was her expectation staff ensure care plans included important safety measures in order to provide a safe and comfortable environment for residents. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	49267 2. Review of R29's electronic medical record (EMR) Face Sheet, revealed the facility admitted the resident on 04/10/2022 with diagnoses to include dementia, Alzheimer's disease, and a history of falls. Review of R29's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2024, revealed the facility assessed the resident to have a BIMS score of six (6) out of 15, indicating severe cognitive impairment. Continued review revealed the facility assessed the resident as requiring partial/moderate assistance for tub and shower transfers, toileting, chair to bed transfers, and sit to stand transfers. Additional review revealed R29 wheeled himself in a manual wheelchair after help being seated and had a history of falls. Review of R29's Comprehensive Care Plan (CCP), revised 05/10/2024, revealed the resident was identified as a fall risk with poor safety awareness. The goal revealed the resident would not sustain an injury related to falling. Interventions included safety checks, bathroom light left on at night, non-slip socks as resident allowed, assistance to toilet as needed and limited/partial assistance with transfers. Review of the Progress Note, dated 06/10/2024, revealed Licensed Practical Nurse (LPN) 6 found R29 on his knees beside the closet door. R29 told LPN6 he fell to his knees when searching for something in his closet. Continued review revealed LPN6 noted a skin tear to the resident's right forearm (RFA) with no pain complaints. LPN6 cleaned and covered the skin tear, notified the physician, and notified R29's family. Review of the facility's Event Report, dated 06/10/2024, entered by Licensed Practical Nurse (LPN) 6, revealed R29 sustained an unwitnessed fall. Further review revealed nursing performed an assessment and completed neurological checks; both with no significant findings. Review of R29's Physician's orders, dated 06/10/2024, revealed orders to cleanse skin tear to RFA (right forearm) with normal saline, pat dry. Apply triple antibiotic ointment (TAO) and cover with abdominal (ABD) pad. Wrap area with kerlex daily until healed. However, review of R29's CCP, revealed no updates with new interventions following R29's 06/10/2024 documented fall, in an attempt to reduce the resident's risk of recurrence. Observation of R29 on 06/12/2024 at 10:43 AM, revealed the resident was resting in bed and his right forearm was wrapped with gauze. (continued on next page)

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Liberty Care and Rehabilitation Center	616 S Wallace Wilkinson Blvd Liberty, KY 42539

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F 0657 Level of Harm - Actual harm Residents Affected - Few	In an interview with LPN6, on 06/13/2024 at 4:01 PM, she stated she found R29 on the floor by his closet on 06/10/2024. She further stated he was on his knees banging on a drawer. LPN6 stated the resident told her he was trying to get something from his closet. LPN6 further stated the resident sustained a skin tear to the right forearm (RFA), and she notified the physician and R29's family. In continued interview, LPN6 stated she did not know if R29's care plan was updated after the 06/10/2024 fall with new interventions, but if there was a fall, there should be a new intervention placed on the care plan in order to prevent the resident from falling again. She stated changes to a resident's care plan automatically showed in the system, but staff communicated changes verbally. She further stated as soon as nursing made changes to a care plan, those changes showed in the computer system the Certified Nursing Assistants (CNAs) utilized. During an interview with the MDS Nurse, on 06/14/2024 at 1:27 PM, she stated resident care plans received updates with MDS assessments or as needed, such as with resident falls, changes in behavior, or incidents. She further stated care plans were to be updated immediately following a fall in order to prevent recurrence. The MDS Nurse stated all nurses updated care plans, but she typically completed most care plan revisions. She was unaware R29's 06/10/2024 had not been care planned for a new intervention to prevent recurrence. During an interview with the Unit Manager (UM), on 06/13/2024 at 1:55 PM, she stated care plans should be updated immediately with new interventions after a fall in order to prevent recurrence. The UM stated all nurses updated care plans, but the MDS Nurse primarily made revisions. In an interview with the Director of Nursing (DON), on 06/14/2024 at 1:32 PM, she stated the MDS Nurse as well as other nurses could update the care plans and it was her expectation care plans were updated with changes in condition or behavior, or events such as falls. The DON further stated she performed random reviews to ensure staff revised care plans when changes or events occurred. Additionally, she stated she provided education as needed to staff based on concerns identified with the reviews. During an interview with the Administrator on 06/14/2024 at 3:18 PM, she stated it was her expectation nursing staff updated care plans after a fall. 50442 3. Review of R49's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 09/28/2023 with diagnoses to include dementia and cognitive communication deficit. Review of R49's Comprehensive Care Plan, dated 12/07/2023, revised 04/17/2024, revealed the resident exhibited behaviors of entering other residents' rooms and had removed personal belongings from those rooms. The goal stated the resident will have decreased episodes of entering others room. Interventions included: resident will become involved in activities; remind resident not to enter others rooms and take their belongings; remind resident where her room is located; and Social work/psych evaluation. All interventions were initiated on 12/07/2023. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R49's most recent Quarterly MDS dated [DATE], with an ARD of 10/01/2023 revealed the facility assessed the resident as having a BIMS' score of two (2) out of 15 indicating severe cognitive impairment. Further review revealed the resident could only understand simple, direct phrases and could not recall any of the three (3) words given in the short term memory test. Continued review revealed the facility assessed the resident as not exhibiting wandering behaviors. Review of R49's Progress Note, dated 05/28/2024 at 10:00 AM, revealed she was seen trying to enter the room of another resident. However, review of R49's EMR in the Point of Care (POC) section, revealed the resident had no charted behaviors for the previous month (05/13/2024 through 06/13/2024) Review of R49's Progress Note, dated 05/29/2024 at 9:54 AM, revealed the Interdisciplinary Team met and discussed the event of 05/28/2024. No new orders were implemented. Review of R49's care plan revealed the last conference was on 04/24/2024 and the next care conference was projected for 07/23/2024. No revisions were made to the CCP related to the resident's behaviors of entering other residents' rooms since the initial problem was care planned on 12/07/2023. Observation of R49 on 06/11/2024 at 10:22 AM, revealed the resident was trying to enter R4's room. R49 was redirected away from the entrance of R4's door by staff. Observation of R49 on 06/12/2024 at 2:18 PM, revealed the resident was trying to enter the locked soiled utility room. She was rolling down the hallway in her wheelchair and stopped and tried to push open the door. In an interview with R26, on 06/10/2024 at 2:43 PM, she stated R49 wandered into her room several times per week and would go through her belongings. R26 stated R49 opened a box of cookies and touched them, but did not take or eat them. R26 further stated she threw them away afterwards. In an interview with R4, on 06/12/2024 at 9:44 AM, she stated R49 frequently came in her room, and the last time this occurred was the prior week. She stated she had to hide away her perfumes because R49 was seen trying to take them. In an interview with State Registered Nurse Aide (SRNA) 6, on 06/12/2024 at 11:13 AM, she stated R49 did try to enter other resident rooms, and when she observed this, she would stop and redirect the resident to another area. In an interview with SRNA7, on 06/12/2024 at 11:17 AM, she stated R49 did try to wander into other residents' rooms, and when she observed this she would redirect the resident to another area or activity and sometimes offer the resident food. She stated when she saw R49 repeatedly trying to enter other residents' rooms, she reported the behavior to her nurse. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	In an interview with Licensed Practical Nurse #1 (LPN1), on 06/12/2024 at 11:29 AM, she stated when R49 was wandering in the hallway, she tried to keep a close eye on her. LPN1 stated when R49 tried to enter another resident's room, she would redirect her and find a diversionary activity. She stated she was unsure what interventions were care planned for R49. Further, she stated R49 had behaviors of wandering and entering other residents' rooms because she had a need that was not met, and she was looking for something that she needed. She stated, for example, after lunch, R49 would sometimes enter someone else's room, and it was most likely because she was looking for a bathroom. During continued interview with LPN1, on 06/12/2024 at 11:29 AM, she stated she watched R49 and then would try and anticipate what needs were not being met and meet those needs to prevent the wandering behavior from increasing. LPN1 stated if R49's behaviors were escalating, she would inform the Unit Manager. In further interview, LPN1 stated it would be up to the Interdisciplinary Team (IDT) and the facility's Medical Director to modify interventions to prevent behaviors. The nurse stated there was one (1) resident who had a stop sign on his door and R49 was not observed trying to enter his room. LPN1 stated the stop sign deterred R49; however, other residents did not like the stop sign on their doors. In an interview with Registered Nurse (RN)1, on 06/12/2024 at 2:28 PM, she stated R49 had to be diverted away from other residents' rooms. RN1 stated R49 wandered into other resident rooms in search of something that she needed. She stated she tried to prevent this wandering behavior when she noted it by trying to find out what R49 needed. In an interview with LPN3/Unit Manager, on 06/13/2024 at 3:37 PM, she stated she had offered the stop signs to residents when R49 entered their rooms, but the residents refused them. She stated current interventions in place to prevent R49 from wandering into the rooms of others and getting into their possessions was to watch R49 and prevent her from entering other residents' rooms, and then redirect her to another area and engage her with a diversionary activity. In an interview with the MDS Nurse, on 06/13/2024 at 2:45 PM, she stated she was not aware R49 was still wandering and entering the rooms of other residents and this was why the resident's CCP had not been revised with new interventions. She stated when she looked in R49's EMR in the Point of Care (POC) section, no behaviors were documented by staff. She stated if she had known R49 was still exhibiting behaviors of entering other residents' rooms she would have had staff do a stop and watch. Per interview, that was when a resident was placed one (1) on one (1) with a staff member to see if and when the behaviors were occurring. She further stated the Administrator, Social Services, and the Psychology Nurse Practitioner along with the IDT would need to work on interventions to prevent R49's behaviors. She stated the stop sign was a deterrent for R49 and offering stop signs to other residents might be an intervention to help prevent R49 from entering their rooms. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	In an interview with the DON, on 06/14/2024 at 8:41 AM, she stated the facility had tried to get R49 involved in activities to prevent her from wandering, but due to her dementia she had a short attention span, and it was difficult. She further stated if getting R49 to participate in activities was not conducive to keeping her out of other residents' rooms, then she may need to be placed one (1) on one (1) with someone. That individual would watch her and keep her out of other residents' rooms. In continued interview, she stated the facility had spoken with her son to see what things R49 enjoyed, and they had tried to incorporate those into her activities. She further stated the care plan needed to be revised to include other interventions such as new activities in an attempt to prevent the resident from wandering into other residents' rooms. She stated R49 did not enter the room with the stop sign. She said they may have to offer it to residents such as R4 and R 26. In an interview with the Administrator, on 06/14/2024 at 9:08 AM, she stated it was unfair for other residents to have their room entered and their belongings gone through or taken. She stated when the care planned interventions did not work for preventing a resident from entering the rooms of others, the IDT needed to get involved and revise the care plan to address the behavior. She stated R49 would be placed on one (1) on one (1) supervision with a staff member.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50442 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for two (2) of 42 sampled residents, Resident #55 and #55 (R55 and R58). R55 complained on 06/12/2024, staff had not brushed her teeth or swabbed her mouth, and she did not receive assistance with mouth care very often. R55 further complained she was given a bed bath twice a week and her privates were washed only when she had a bowel movement. Additionally, observation of R58, on 06/10/2024 and 06/11/2024, revealed his fingernails were long and dirty and he had not been shaved. R58 was wearing the same dark gray shirt both days. The findings include: Review of the facility's policy titled, Activities of Daily Living (ADLs), created on 09/15/2023, revealed ADL assistance would be provided on a level appropriate to the resident's level of functioning and learning and/or the responsible party's level of support and contribution to resident care. For residents who were unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of care. Review of the facility's policy titled, Oral Care, last reviewed on 07/05/2018, gave guidelines for oral and denture care. The policy did not mention the frequency of oral care. 1. Review of R55's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 12/27/2023 with diagnoses including essential primary hypertension, depression, and generalized muscle weakness. Review of R55's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/18/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. Further review of the MDS, revealed the facility assessed the resident to be dependent for eating, oral hygiene, toileting hygiene, showering/bathing, dressing her lower body, putting on/taking off footwear, and personal hygiene. Continued review revealed the resident required substantial/maximal assistance for dressing her upper body. Review of R55's Comprehensive Care Plan, dated 05/22/2024, revealed a focus of requiring assistance with ADLs. The goal stated the resident will not further deteriorate related to ADL ability as evidenced by maintaining current ability with potential for improvement. The interventions included: provide extensive assistance with dining and bed mobility; use mechanical lift for transfers; provide total assistance with locomotion in wheelchair; and total assistance with personal hygiene/grooming. R55's Comprehensive Care Plan did not indicate there was a problem of refusing assistance with ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R55's EMR, under the Point of Care (POC) History section, revealed from 05/12/2024 to 06/09/2024, R55 received eight (8) complete bed baths; and two (2) partial bed baths. One (1) refusal for assistance with ADLs was documented on the Non-Compliance-Informed Refusal and Non-Compliance Event Report, during this time. Observation on 06/11/2024 at 8:38 AM, revealed R55 had white crust on her lips and mouth. She smelled of urine and was dressed in a white long-sleeved shirt and a brief only. R55's hair was greasy, tangled and matted. Observation on 06/12/2024 at 10:03 AM, revealed R55 was still dressed in the same white shirt as the day before. She smelled like urine. Her hair was still greasy, tangled, and matted and did not look like it had been combed. Her lips and mouth still had patches of white crust. In an interview with R55, on 06/12/2024 at 10:03 AM, she stated staff had not brushed her teeth or swabbed her mouth, and she did not receive assistance with mouth care very often. R55 stated she was given a bed bath twice a week and her privates were washed only when she had a bowel movement. R55 stated she was bed bound and staff did not take her to the shower. 2. Review of R58's electronic medical record (EMR) Face Sheet revealed the facility readmitted the resident on 05/24/2024 with diagnoses including congestive heart failure, dementia, and benign prostatic hyperplasia (BPH). Review of R58's Admission Minimum Data Set (MDS) with an ARD date of 05/13/2024, revealed the facility assessed the resident as having a BIMS' score of 12 out of 15, indicating moderate cognitive impairment. Further review of the MDS revealed the facility assessed the resident as dependent for transfers from bed to chair and in and out of the shower. Continued review revealed the facility assessed the resident as always incontinent of bowel and bladder. Review of R58's Comprehensive Care Plan, dated 05/24/2024 revealed a focus of requiring assistance with ADLs. The goal stated the resident will not experience any adverse outcomes related to requiring assistance with ADL care through next review. Interventions included: have resident perform as much of his own care as he could, but provide the amount of assistance needed to complete ADLs; total assistance with the mechanical lift for transfers; and assist with showers and incontinence care. Review of R 58's EMR, under the Point of Care (POC) History, revealed from 05/12/2024 to 06/09/2024, the resident received five (5) complete bed baths; and one (1) partial bed bath approximately every three (3) to five (5) days. No refusals were documented. Observation of R58, on 06/10/2024 at 3:02 PM, revealed he had long, dirty fingernails. The resident was wearing a dark gray shirt. Observation of R58 on 06/11/2024 at 9:07 AM, revealed he was still wearing the same shirt as the day before. He was still not shaved, his teeth were covered with a gray film, and his fingernails were still long and dirty. In an interview with R58, on 06/10/2024 at 3:02 PM, he stated he was unable to answer questions related to his care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with State Registered Nurse Aide (SRNA)5, on 06/12/2024 at 10:32 AM, revealed residents were showered twice per week and received bed baths on days they were not showered. Further, oral care was to be performed daily. If a resident refused help or performance of ADLs, she would let the nurse know, and then would try again later or ask another staff member to perform the care. If the resident still refused, she charted the refusal. In an interview with SRNA7, on 06/12/2024 at 11:07 AM, she stated she assisted her assigned residents with a shower according to the daily shower schedule, which she received in the morning report from her nurse. She stated she was not sure how many times per week residents were showered. She further stated she helped residents with their ADLs who wanted to go to breakfast in the dining room first in the morning, and then afterwards moved on to assist residents who ate in their room. In continued interview she stated she ensured residents received oral care daily, and assisted residents with getting dressed and combed their hair every morning. Further, she stated she did rounds on residents every two (2) hours checking for anyone who was incontinent and needed care. In an interview with Licensed Practical Nurse (LPN)1, on 06/12/2024 at 11:29 AM she stated if residents were able to perform some of their ADLs, she allowed them to do as much as they could and would assist with what they were unable to do. She stated residents were to receive showers twice a week unless it was in their care plan for more frequent showers or to only give them a bed bath. Per interview, it was her expectation SRNAs give bed baths on days showers were not performed. She further stated it was her expectation oral care be performed a minimum of once per day, but ideally should be done in the morning, after meals, and at night. In an interview with Registered Nurse #1(RN1)1, on 06/12/2024 at 2:28 PM, she stated each day she gave her SRNAs a printed census of which residents were to be assisted out of bed in the mornings first, because they wanted to go to breakfast in the dining room. She stated the census list also showed which residents were due for a shower that day. Per interview, residents who ate breakfast in their rooms received help with their ADLs later in the morning. Further, she stated residents were to receive two (2) showers a week, and partial baths in between. RN1 stated she assured residents received oral care at least daily, and more frequently if needed. She stated she did now know how often SRNAs did rounds on their residents to check for incontinence, but stated it was frequently. In an interview with LPN3/Unit Manager, on 06/13/2024 at 3:31 PM, she stated the residents' shower schedules were set up upon admission. Showers were to be completed twice a week, but could also be given upon request. She stated residents received bed baths daily or upon request; oral care was performed each shift; nail care was performed every Sunday; and male residents received shaves on shower day or upon request. LPN3/Unit Manager stated refusal of care such as bathing, shaving, or oral care was documented. She further stated it was her expectation SRNAs made rounds on residents every two (2) hours to check for incontinence. Additionally, she stated any refusals of care were charted on a noncompliance form and followed for three (3) days afterwards. LPN3/Unit Manager stated she was unaware R55 and R58 were not receiving assistance needed with ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Directive of Nursing (DON), on 06/14/2024 at 8:22 AM, revealed residents were expected to perform as much of their ADLs as they were able and nursing staff would assist with the rest of the care. She stated residents were to receive showers or baths at least twice a week, but the shower/bath schedule was individualized for each resident. She stated staff was to help residents wash up in between showers. In interview, she stated oral care was to be performed every shift and residents were to have their clothes changed daily, and their hair should be brushed at least daily. Further, she stated male residents should be shaved daily as they would allow. She stated staff was to check on the residents at least every two (2) hours to check for incontinence. In an interview with the Administrator, on 06/14/2024 at 8:58 AM, she stated complete baths or showers were to be given at least twice a week, and residents were to receive partial baths in between their total baths/showers. Further, she stated staff was to assist residents with oral care after each meal, and nail care was to be performed on shower day and as needed. She further stated shaving for male residents depended on the wishes of the resident as some residents preferred not to be shaved every day. The Administrator stated nursing staff was to round on the residents every two (2) hours or more frequently to check to see if incontinence care was needed. Further, she stated residents were to have their hair combed daily and their clothes changed daily unless the resident refused. Any care that was refused was documented on a noncompliance form.

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F 0689 Level of Harm - 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** 44001 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for two (2) of eight (8) sampled residents reviewed for accidents out of a total sample of 42 residents, Resident (R), R29 and R37. On 06/09/2024, during transfer back to R37's room, staff allowed the resident's left hand to become entangled in the Evolution Mobility (brand of wheelchair) wheelchair's wheel spokes. The resident was transferred to the local Hospital Emergency Department and was noted to have two (2) lacerations on the left second finger. One (1) laceration, measured 2.0 centimeters (cm), with exposed bone in the proximal region of the finger, while the other, measured 1.5 cm, and was located at the medial joint. R37 was subsequently transferred to the University Hospital Emergency Department to seek evaluation by a hand specialist where the resident was diagnosed with an open fracture to her left index finger, with an approximate 2.0 cm laceration to the metacarpophalangeal joint. Additionally, R29 sustained a fall on 06/10/2024, while searching for something in his closet, and was found on his knees beside the closet door. The resident sustained a skin tear to the right forearm (RFA). However, there was no documented evidence the facility initiated new interventions to prevent recurrence. Refer to F657 The findings include: Review of the facility's policy titled, Accidents and Incidents, revised 09/15/2023, revealed the facility would provide an environment that was safe free from accidents and incidents that were avoidable. Review of the facility's policy titled, Resident Rights, revised 09/15/2023, revealed all residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. 1. Review of the Instruction Manual, undated, for the Evolution Mobility Chair, Model S-250 (specialty wheelchair), revealed to avoid injury during transfers be sure the patient's (resident's) arms were inside the armrests during transfer. It is important to observe resident's behavior while moving to ensure they do not pose a risk to themselves or others. Following safety measures is necessary for the safety of both the patient and the caregiver. Before using the chair, caregivers must receive adequate training from an Evolution Mobility Chair medical representative or a trained third party. Additionally, for the patient's safety, the manual stated that anyone who has not received adequate training should not be allowed to use the chair. Review of R37's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 12/09/2022, with diagnoses including Alzheimer's disease, severe dementia with agitation, mood disturbances, psychotic disturbances, and cognitive communication deficit. (continued on next page)

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	185408	A. Building B. Wing	06/14/2024

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Liberty Care and Rehabilitation Center	616 S Wallace Wilkinson Blvd Liberty, KY 42539

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R37's Occupational Therapy Treatment Encounter Note, dated 03/13/2024 at 4:06 PM, revealed the Occupational Therapist (OT) transferred R37 from a conventional wheelchair to the Evolution specialty wheelchair. The resident required maximum assistance to transfer to the chair, but was independent in self-propelling the Evolution wheelchair throughout the facility using bilateral upper extremities and lower extremities. According to the note, the therapist left R37 with the Evolution wheelchair after the resident demonstrated her ability to use the chair and navigate around other patients and obstacles. Review of R37's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen, indicating severe cognitive impairment. Further review revealed the facility assessed R37 as requiring substantial/maximal assist of two (2) for chair to bed, and bed to chair transfers. Per the MDS, the resident was independent with locomotion in the specialized wheelchair. Review of R37's Comprehensive Care Plan (CCP), revised 05/24/2024, revealed a focus of Activities of Daily Living (ADL). The goal stated the resident will regain ability for locomotion on and off the unit. Interventions included to follow Physical Therapy (PT) and Occupational Therapy's (OT) recommendations related to ADLs and the correct use of the resident's mobility chair. However, the care plan interventions did not list PT's and OT's recommendations for the correct use of the mobility chair. Further review of R37's CCP, revised 05/24/2024, revealed a focus on behaviors, including demonstrates non-compliance with physician's orders and/or plan of care. The long term goal stated the resident's preferences will be honored to the extent that non- compliance with the plan of care will not result in injury to self or others. Interventions created on 02/11/2024 included: encourage resident to actively participate in the care plan and decision making; and encourage resident participation with care. Further review of the CCP, revealed the facility did not address the resident's habit of grabbing onto the wheels or wheel spokes and not moving her feet when being transported by staff in her specialized wheelchair. (Refer to F657) Review of the facility's Event Report - Change in Condition, dated 06/09/2024 at 12:52 AM, completed by Licensed Practical Nurse (LPN) 5, revealed while staff assisted R37 to her room for routine care, the resident's finger was caught in the wheel spokes of the mobility chair causing injury to her left index finger. Per the report, LPN5 assessed R37 as having a skin tear with moderate blood noted. The resident's responsible party and physician were notified. The resident was transferred by emergency medical services (EMS) to the Hospital for further evaluation. Review of the facility's Event Report - Skin Integrity, dated 06/09/2024 at 1:53 AM, (documented after the resident was transferred to the hospital) completed by LPN5, revealed R37 was assessed as having one (1) laceration with smooth edges on her left index finger, which resulted in moderate bleeding. The resident's pain was rated at a seven (7) out of 10, indicating severe pain, using the Glasgow Pain Scale, with a rating of 10 being the worst. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the local Hospital Emergency Department's Progress Note, dated 06/09/2024 at 1:38 AM, revealed physicians assessed R37 and found two (2) lacerations on the left second finger. One (1) laceration, measuring 2.0 centimeters (cm), exposed the bone in the proximal region of the finger, while the other, measuring 1.5 cm, was located at the medial joint. The resident was subsequently transferred to the University Hospital Emergency Department to seek evaluation by a hand specialist. Review of the University Hospital Physician's Progress Note, dated 06/09/2024 at 1:38 AM, revealed R37 presented to the emergency department for a higher level of care from an outside hospital to evaluate the left finger injury. The patient sustained an open fracture to her left index finger, with an approximate 2.0 cm laceration to the metacarpophalangeal joint, with deformity of the left hand noted. The physician could not assess R37's motor and sensation, given the resident's dementia. emergency room (ER) staff administered two (2) milligrams (mg) of intravenous (IV) morphine (narcotic analgesic) to R37 for pain control. Review of the University Hospital X-ray findings, dated 06/09/2024, revealed R37 had a significantly displaced comminuted angulated fracture (when the bone is broken at an angle and into several pieces) of the proximal index finger with associated soft tissue swelling and significant soft tissue irregularity which is suggestive of an open fracture (a broken bone that causes an open wound). Continued review of the University Hospital's Emergency Department Progress Note, dated 06/09/2024, revealed the emergency department physician applied a bandage and short arm splint to R37's left hand/arm for stabilization of the fracture. Per the Note, the University Hospital referred her to an orthopedic surgeon for follow-up care. Review of State Registered Nurse Aide (SRNA) 4's Witness Statement, dated 06/19/2024, revealed R37 was sitting in the hallway in front of the nurse's station. The resident needed to be changed, so she and SRNA10 took R37 back to her room. SRNA10 took hold of the chair and started pulling it backward toward R37's room. Further review revealed after SRNA4 and SRNA10 transferred R37 from the specialty wheelchair to her bed, she observed R37's index finger bleeding and dangling. During an interview with SRNA4, on 06/12/2024 at 3:16 PM, she stated she was agency staff and did not take a report on R37 and did not directly care for her during her shift on 06/09/2024. However, she stated she noticed R37, who was sitting in her wheelchair across from the nurse's station, needed incontinence care. She informed SRNA10 of this and told her she would help. SRNA4 further stated, SRNA10 took hold of the wheelchair handles and began to push the wheelchair. She stated SRNA10 instructed R37 to remove her hands from the wheel spokes after she tried to push the wheelchair. SRNA4 stated after being instructed to do so, R37 placed her hands in her lap. She stated R37 tended to grab the spokes part of the wheelchair when she did not want staff to move her, as the resident did not vocalize her needs. During continued interview with SRNA4, on 06/12/2024 at 3:16 PM, she stated it was not until she and SRNA10 had transferred R37 to her bed that she noticed R37's finger was crooked. She stated R37 did not express pain or cry out. She further stated she did not notice signs of blood on the floor, in the wheelchair, or the hallway. Although SRNA4 stated she did not see any blood initially, she stated she did observe a small amount of blood on R37's shirt. In continued interview, SRNA4 stated R37 did not appear to be in any pain, but when LPN5 arrived in the room, R37 verbally stated it was the worst pain she had ever felt. Further, SRNA4 stated SRNA10 was never abusive toward R37 and she did not know how the injury occurred. She stated SRNA10 did not act in a hateful manner at any point. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with SRNA4, on 06/14/2024 at 1:30 PM, she was interviewed about SRNA10's handling of the specialty wheelchair while transporting resident R37. SRNA4 stated SRNA10 initially pulled the chair backwards toward the resident's room at an angle and then pushed it into R37's room. SRNA4 further stated she stayed in the room with SRNA10 until EMS left the facility with R37. Per interview, SRNA4 stated she provided a written statement about the incident at the request of LPN5. Additionally, she stated the Administrator interviewed her by phone the following day, and she provided a verbal statement. SRNA4 stated LPN5 asked SRNA10 to leave the facility after the incident, but did not ask her (SRNA4) to leave. She stated she completed her shift and clocked out at 7:00 AM. Review of SRNA10's Witness Statement, dated 06/19/2024, revealed she and SRNA4 transferred R37 to her room. SRNA10 wrote in her statement, [I started to push her to her room I seen her hand beside the chair I told her to move her hands and raise her feet so she wouldn't flip out of the chair or hurt her hands she moved them and I started pushing her while talking to the nurse.] Per her statement, once R37 was in her bed, she noticed her finger was broken. During a telephone interview, with SRNA10, on 06/13/2024 at 4:12 PM, she stated she had worked at the facility for two (2) months as an agency SRNA and did not know R37 well prior to the incident. SRNA10 stated R37 was sitting in her specialty wheelchair across from room [ROOM NUMBER] facing the day room, and parallel to the nurse's station when SRNA4 informed her the resident needed to be changed. She stated she saw R37's hands holding on to the wheels, and she asked the resident to move her hands to her lap, which she did. SRNA10 stated there were no cuts on the resident's hand when R37 placed her hands in her lap. She then stated she pulled the wheelchair backwards toward room [ROOM NUMBER]. During continued telephone interview, on 06/13/2024 at 4:12 PM, with SRNA10, she stated nothing seemed out of the ordinary, and while both SRNAs were transporting R37, LPN5 was talking to them and asking why they were taking the resident back to her room. SRNA10 stated once she and SRNA4 transferred R37 to her bed, she noticed her finger did not look normal. She stated she called for the nurse, who immediately came to the room. She further stated she stayed in the room until EMS left with the resident. In continued interview, she stated she took a lunch break, and continued working on the hall until around 5:00 AM, when LPN5 told her she had to leave. SRNA10 stated LPN5 told her, You were the one pushing the chair. During continued telephone interview, on 06/13/2024 at 4:12 PM, with SRNA10, she was asked why she pulled the chair backward. She stated the chair was hard to push forward, the resident had a boot on her foot, and it was easier for her to pull the wheelchair backward the short distance from room [ROOM NUMBER] to 211. SRNA10 further stated she was afraid R37 would not move her foot, and there were no foot rests on the chair. In continued interview, SRNA10 stated she was employed by an outside staffing agency and received education and training on abuse from the agency before working at the facility. She stated she would report any suspected abuse or injuries to her supervisor immediately. Additionally, she stated she was taught in school how to safely transfer residents by wheelchair. However, she stated the facility did not in-service her on how to transfer R37 in her specialty wheelchair. Review of SRNA10's Timesheet, dated 06/08/2024, revealed the SRNA clocked in at 6:34 PM, punched out for lunch at 1:00 AM, punched back in from lunch at 1:30 AM, and clocked out at 5:04 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of LPN5's Witness Statement, dated 06/19/2024, revealed she was sitting at the nurse's station labeling syringes when she noticed the SRNAs were moving R37 to her room. Per her statement, she heard one of the aides say, [OMG, OMG, we need to get the nurse.] LPN5 then got up and went to R37's room. Per LPN5's statement, when she entered the room, R37 was lying in bed and she noticed her left finger had a laceration and deformity. During an interview with LPN5, on 06/13/2024 at 8:52 AM, she stated she was on the 200 Hall nurse's station when she looked up and saw SRNA4 and SRNA10 taking R37 back to her room. She stated she talked to the aides as they went to get the resident and asked them why they were taking the resident to bed. LPN5 stated SRNA4 replied they were only taking R37 to her room to change her brief. She stated after the aides transported the resident to her room, she heard them yell, Oh my gosh. Oh my gosh. She further stated when she arrived in the room, she observed R37's finger was turned and it looked as though there was one (1)laceration. LPN5 described the laceration as a pretty good size cut. She stated she applied a pressure dressing to the injury. LPN5 further stated the resident was quiet and did not make any sounds, but she appeared to be grimacing. She stated at 1:20 AM, she administered an ordered dose of oral morphine. LPN5 stated she informed the resident's physician, Hospice, and Family Member (F)1 about the incident. Further, the physician gave an order to send the resident to the hospital by Emergency Medical Services (EMS) transport for evaluation. In continued interview with LPN5, on 06/13/2024 at 8:52 AM, she stated she was uncertain about how the resident's finger was injured, but suggested that her hand might have been caught in the spokes of the wheelchair. LPN5 stated, before the incident, R37 had been sitting in her specialty wheelchair in the day room. She stated it was usual for the resident to be awake at night. Additionally, LPN5 stated R37 tended to grip the wheels of her chair tightly when she did not want to move, but stated she had not seen R37 with her hands holding onto the wheel spokes. LPN5 stated when she exhibited the behavior of gripping the wheels, she would get down on her level and encourage her to put her hands in her lap. Observation on 06/12/2024 at 3:57 PM, revealed R37 sitting in her specialty wheelchair and independently propelling the wheelchair in the day room on the 200 Hall. The resident had a large, padded dressing covered by an ace wrap covering her entire hand and forearm. The specialty wheelchair had a cover over the spokes of the wheel. When LPN3 attempted to move the resident out of the way of another resident, R37 grabbed the wheel to prevent herself from being moved. During a telephone interview with Family member (F)1, on 06/12/2024 at 10:04 AM, she stated the facility promptly informed her about R37's s injury. According to F1, a nurse on duty informed her R37 was being pulled in her wheelchair by a staff member to return to her room when she was injured. She stated R37 was taken to the local County Hospital by EMS, and later transferred to the University Emergency Department to see a hand specialist. F1 explained R37 tended to resist staff attempts to move her and preferred to control her wheelchair herself, as she enjoyed self-propelling throughout the facility. Furthermore, she stated R37's nighttime activity was not unusual, considering her 24-year history of working night shifts as a nurse. She stated F1 typically stayed awake during the night for long periods before sleeping for 24 to 36 hours at a time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with F2, on 06/12/2024 at 10:16 AM, she stated the aides caused a severe injury to R37's left index finger. She further stated staff pushed the wheelchair while R37's hand was between the wheels as she was holding on to the spokes of the wheel, resulting in a significant fracture and laceration to the finger. In continued interview, she stated F1 had informed her the physician stated they had to be going pretty fast with a lot of force to cause the injury. An interview was attempted with R37, on 06/13/2024 at 2:00 PM, but the resident did not respond to questions when asked. During an interview with the Rehabilitation Services Manager (RSM), on 06/14/2024 at 11:09 AM, she stated R37 had been on and off the caseload since her admission to the facility due to issues with positioning and cognition. She stated the facility provided R37 with an Evolution Chair (a specialty wheelchair) due to her decreased cognition and difficulty with posture and positioning. The RSM stated this chair was safer and lower to the ground and the specialty wheelchair had been a good fit for her, improving her mobility around the facility while providing more support, comfort, and preventing falls. In continued interview, the RSM explained R37 tended to put her hands on the wheels when staff tried to move her due to her desire for control with self-ambulation. She stated she was not aware the resident held onto the spokes. The RSM stated if she had been aware of this behavior she would have evaluated the resident and provided spoke covers. When asked if the Rehabilitation Department provided direct care staff with in-service training on specialty wheelchairs, she stated, there was no difference between the Evolution chair and a regular wheelchair, and added, I don't think our staff needs training on wheelchairs. Furthermore, the RSM stated the rehabilitation department assessed all residents who used similar wheelchairs and maintenance placed spoke covers on all three (3) chairs which were similar to R37's wheelchair after the incident. Additionally, she stated after R37's accident, referrals had been made to evaluate the positioning and safety of all residents using wheelchairs. During an interview with the Occupational Therapist, (OT), on 06/14/2024 at 11:25 AM, she stated she evaluated R37 due to her fall risk, mobility issues, and decreased safety awareness. She stated she recommended placing R37 in an Evolution specialty wheelchair and provided staff with an in-service on the safe usage and transfer of residents in wheelchairs. The OT could not state when and to whom she provided the in-service, nor could she provide documentation related to the in-service, but stated it was provided to clinical staff prior to R37's incident. The OT stated before R37's injury she was not aware of any issue with R37's hands going down into the spokes, but stated she was aware R37 tended to put her hands on the wheels when propelled by staff. Additionally, the OT stated after R37's accident, a spoke cover was placed on her chair to prevent her from placing her hands between the wheels and the spokes. Further, the OT stated she evaluated the positioning and safety of all residents using wheelchairs, and maintenance placed spoke covers on wheelchairs similar to R37's after the incident. During an interview with LPN3/Unit Manager, on 06/13/2024 at 3:43 PM, she stated R37 enjoyed self-locomotion throughout the facility. She stated the resident could be very non-compliant due to her decreased cognition, especially when staff tried to provide care or transport her in her wheelchair. LPN3 further stated she was not aware of any issue with R37's hands going down into the spokes, but stated she was aware R37 tended to put her hands on the wheels when propelled by staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the MDS Nurse, on 06/14/2024 at 1:27 PM, she stated resident care plans received updates with MDS assessments or as needed, such as when there was an incident such as a resident fall or a change in behavior. The MDS Nurse stated all nurses updated care plans, but she typically completed most care plan revisions. In further interview, she stated she was not made aware of R37's tendency to grab the wheels and spokes of her wheelchair and therefore she did not revise the resident's care plan to address this prior to the resident sustaining the injury on 06/09/2024. (Refer to F657) During an interview with the Director of Nursing (DON), on 06/14/2024 at 9:06 AM, she stated she was notified of R37's injury by LPN5. The DON stated after the resident was transferred to her bed, staff observed her finger was lacerated and injured, and the injury was caused by the wheelchair. The DON further stated prior to R37's incident staff was trained on the use of all equipment in the facility, including all makes of wheelchairs, and to pay attention to the residents during transport and transfer. However, the DON could not provide any documented evidence staff was trained on the Evolution chair prior to R37's accident. In further interview, the DON stated R37 liked to be in control and was non-compliant at times due to decreased cognition. She further stated staff was aware of this, as behaviors and non-compliance were reported at shift change and were in the resident's care plan. She further stated after the incident, R37's wheelchair spokes were covered by maintenance to prevent her hands from getting caught in the spokes; and maintenance placed spoke covers on all specialty wheelchairs. Additionally, she stated the facility evaluated all residents who used wheelchairs for positioning and safety after the incident. During an interview with the Corporate Nurse Consultant (CNC), on 06/14/2024 at 9:24 AM, she stated she was notified the morning of the incident regarding R37's injury. The CNC stated the resident's finger was injured at some point during her transport to her room to provide care. She stated R37 should have been care planned for grabbing the wheels during transport in order for staff to watch for this. She further stated she expected staff to follow all safety procedures, and watch residents during transport and transfers to avoid injuries. The CNC stated it was important to provide a safe and comfortable environment for residents and to prevent accidents and injury to residents and staff. The State Survey Agency Surveyor attempted to contact the Provider at the University Hospital on 06/14/2024 at 7:55 AM. During a conversation with the emergency department's Case Manager, she stated she would have the Provider call. No return call was received. During an interview with the Administrator, on 06/14/2024 at 9:24 AM, she stated she was notified of R37's injury by the DON. The Administrator stated the injury was caused by the wheelchair. She further stated after the incident the facility assessed all residents in wheelchairs for positioning and safety; and spoke covers had been placed on all specialty wheelchairs. The Administrator stated it was her expectation staff ensure important safety measures were in place in order to provide a safe and comfortable environment for residents. She stated this was important to prevent accidents and injury to residents and staff. During an interview with the Medical Director, on 06/14/2024 at 1:10 PM, he stated he was informed about the incident regarding R37. He stated he was told the aide pulled the wheelchair in the opposite direction and the resident's fingers were caught in the wheelchair spokes. He further stated he ordered the resident to be transferred to the ER. The Medical Director stated it was his expectation staff provide for the safety and well-being of the residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	49267 2. Record review revealed the facility admitted Resident #29 (R29) on 04/10/2022 with diagnoses including dementia, Alzheimer's disease, and a history of falls. Review of R29's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2024, revealed the facility assessed the resident as having a BIMS score of six (6) out of 15, indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring partial/moderate assistance for tub and shower transfers, toileting, chair to bed transfers, and sit to stand transfers. Additionally, the facility assessed R29 for wheeling himself in a manual wheelchair after help being seated. Continued review revealed the facility assessed the resident as having a history of falls. Review of R29's Comprehensive Care Plan (CCP), revised on 05/10/2024, revealed the resident was identified as a fall risk with poor safety awareness on 04/10/2022. The goal stated the resident would not sustain an injury related to falls. An intervention for safety checks was initiated on 02/06/2024. Additional interventions in place included: bathroom light left on at night, non-slip socks as resident allowed, assistance to toilet as needed and limited/partial assistance with transfers. Review of R29's Progress Note, dated 06/10/2024, revealed Licensed Practical Nurse (LPN) 6 found the resident on his knees beside the closet door. Per the Note, R29 told LPN6 he fell to his knees when searching for something in his closet. Further review revealed LPN6 noted a skin tear to the resident's right forearm (RFA) with no pain complaints. LPN6 cleaned and covered the skin tear, notified the physician, and notified R29's family. Review of the facility's Event Report, dated 06/10/2024, signed by Licensed Practical Nurse (LPN) 6, revealed R29 sustained an unwitnessed fall. Further review revealed nursing performed an assessment and completed neurological checks; both with no significant findings. Review of R29's Physician's orders, dated 06/10/2024, revealed orders to cleanse skin tear to right forearm with normal saline, pat dry. Apply triple antibiotic ointment (TAO) and cover with abdominal (ABD) pad. Wrap area with kerlex daily until healed. However, review of R29's CCP, revealed no documented evidence of new interventions following R29's 06/10/2024 documented fall in an attempt to reduce the resident's risk of recurrence. Observation on 06/12/2024 at 10:43 AM revealed R29 was resting in bed. The resident's right forearm was wrapped with gauze. An interview was attempted with R29 on 06/13/2024 at 2:00 PM, but the resident did not respond to questions. During an interview with LPN6, on 06/13/2024 at 4:01 PM, she stated she was familiar with R29's care and found him on the floor by his closet on 06/10/2024. LPN6 stated R29 told her he was trying to get something from his closet. She stated she observed a skin tear to the resident's right forearm (RFA), so she notified the physician and R29's family. The nurse stated she cleaned the area with normal saline, repositioned the skin back into place, and covered it with a dressing. She was unaware of any new interventions to prevent recurrence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the MDS Nurse, on 06/14/2024 at 1:27 PM, she stated resident care plans received updates with ARD assessments or as needed, such as with resident falls or changes in behavior. She further stated care plans were to be updated immediately following a fall with new interventions in order to prevent recurrence. During an interview with the Unit Manager (UM), on 06/13/2024 at 1:55 PM, she stated R29 often displayed confusion. She stated the resident constantly asked staff, Why am I here? The UM stated resident falls were communicated during shift change to oncoming staff. The UM stated the MDS Nurse or any nurse could update the CCP when resident falls occurred. She stated care plans should be updated immediately with new interventions after a fall in order to attempt to prevent recurrence. During an interview with the Director of Nursing (DON), on 06/14/2024 at 1:32 PM, she stated she performed random reviews to ensure staff revised care plans when changes or events such as falls occurred. She further stated she provided education as needed to staff based on concerns identified with the reviews. In an interview with the Administrator, on 06/14/2024 at 3:18 PM, she stated she expected staff to ensure necessary interventions were in place to ensure resident safety in an attempt to prevent falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50442 Based on observation, interview, and review of the facility's policy, the facility failed to ensure residents requiring respiratory care received care consistent with professional standards of practice for one (1) resident reviewed for respiratory care out of a total of 42 sampled residents, Resident #58 (R58). Observation on 06/10/2024 and 06/11/2024, revealed R58 was receiving oxygen at two (2) liters per minute per nasal cannula as per Physician's Orders. However, the oxygen tubing was not dated. The findings include: Review of the facility's policy titled, Oxygen Administration Policy, revised 05/30/2024, revealed oxygen tubing was to be changed monthly or as needed. Review of R58's electronic medical record (EMR) Face Sheet, revealed the facility admitted the resident on 05/06/2024 with diagnoses including congestive heart failure, dementia, benign prostatic hyperplasia, and atherosclerotic heart disease. Review of R58's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2024, revealed the resident required continuous oxygen therapy. Review of R58's Physician's Orders, dated 06/11/2024, revealed orders for oxygen at two (2) liters per minute per nasal cannula; and oxygen tubing to be changed monthly. Observation on 06/10/2024 at 3:13 PM; and 06/11/2024 at 9:13 AM, revealed R58 receiving oxygen at two (2) liters per minute per nasal cannula. However, the oxygen tubing was not dated. In an interview with Registered Nurse 1 (RN1), on 06/12/2024 at 2:23 PM, she stated nurse management changed the oxygen tubing. She stated the oxygen tubing should be dated. In an interview with Licensed Practical Nurse (LPN) 3, on 06/13/2024 at 3:36 PM. she stated oxygen tubing was only changed by nursing management once a month. She further stated when the oxygen tubing was changed it should be dated. In an interview with the Director of Nursing (DON), on 06/14/2024 at 8:45 AM, she stated oxygen tubing was changed by nursing management and was changed monthly. She further stated the tubing should be dated with the date it was changed. In continued interview, she stated she had noticed when new admissions were ordered oxygen, the nursing staff set up the oxygen and did not date the tubing. In an interview with the Administrator, on 06/14/2024 at 9:21 AM, she stated nursing management changed the oxygen tubing monthly. She stated oxygen tubing should be dated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50442 Based on interview, record review, and review of facility policy, the facility failed to have prescribed medications available to administer for one (1) of 42 sampled residents, Resident #332 (R322). R322's Physician's Orders, dated 06/07/2024, untimed, revealed orders for rifampin 300 milligrams (mg), two (2) tablets, to be administered daily between 7:00 AM and 11:00 AM. However, the medication was not delivered to the facility until 06/10/2024 at 8:15 PM, four (4) days after it was ordered. Refer to F761. The findings include: Review of the facility's policy titled, Medication Administration, General Guidelines, revealed medications were to be prepared only by licensed medical or pharmacy personnel authorized by state regulations to prepare medicine. Review of R322's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 06/07/2024 with a diagnosis of latent tuberculosis (TB). Review of R322's Physician's Orders, dated 06/07/2024, untimed, revealed orders for rifampin 300 milligrams (mg), two (2) tablets, to be administered daily between 7:00 AM and 11:00 AM. Review of the Shipping Manifest from the pharmacy, dated 06/07/2024, revealed it did not list the rifampin. Review of the Shipping Manifest from the pharmacy, dated 06/10/2024, revealed thirty (30) rifampin 300 mg tablets, arrived at the facility on that date at 8:15 PM, which was after the scheduled administration time for the medication. Review of 322's Medication Administration Record (MAR), dated June 2024, revealed the resident did not receive the medication on 06/08/2024, 06/09/2024, or 06/10/2024 as the medication was unavailable. In an interview with Registered Nurse (RN)1, on 06/13/2024 at 9:53 AM, revealed R322 did not receive the rifampin on 06/08/2024, 06/09/2024, or 06/10/2024, because the pharmacy was out of the medication. In an interview with the Staff Development/Infection Control RN, on 06/13/2024 at 10:29 AM, she stated the facility was unable to obtain the rifampin medication for R322, until four (4) days after it was ordered. Further interview revealed it would be important to ensure rifampin was administered as ordered for the resident's diagnosis of latent TB. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON), on 06/14/2024 at 8:49 AM, and the Administrator on 06/14/2024 at 9:14 AM, they both stated they were unaware of the delay in receiving the prescribed rifampin from their pharmacy for R322.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50442 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents were free of significant medication errors for one (1) of 42 sampled residents, Resident 332 (R322). On 06/07/2024, R322 was prescribed two (2), 300 milligram (mg) tablets of rifampin (antibiotic to treat Tuberculosis) to be given once daily. However, R322 received half the dose (1 table, 300 mg) on 06/11/2024, and 06/12/2024. The findings include: Review of the facility's policy titled, Medication Administration General Guidelines, revealed medications were to be administered in accordance with written orders of the prescriber. Further review revealed those giving a medication should verify the medication is correct three (3) times before administering: when pulling the medication package from the medication cart, when the dose was prepared, and before the dose was administered. Review of R322's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 06/07/2024 with a diagnosis of latent tuberculosis (TB). Review of R322's Physician's orders, dated 06/07/2024, revealed orders for rifampin 300 milligrams (mg), two (2) tablets, to be given daily between 7:00 AM and 11:00 AM. Review of the Shipping Manifest from the pharmacy, dated 06/10/2024 at 8:15 PM, revealed thirty (30) rifampin tablets, each 300 mg were received on that day. Observation of the medication pass on 06/13/2024 at 9:00 AM with Registered Nurse (RN)1, revealed the nurse only administered R322 one (1) 300 mg rifampin tablet. Observation of the rifampin tablets count on 06/13/2024 at 10:45 AM with the Staff Development/Infection Control RN and RN1, revealed there were twenty-six tablets left. The Medication Administration Record (MAR), dated June 2024, revealed R 322 had been administered his daily dose of rifampin for three (3) days, including 06/11/2024, 06/12/2024, and 06/13/2024. Therefore, the bottle of rifampin should have had six (6) tablets missing to account for the three (3) days of medication administration. However, instead the count was observed to have only four (4) tablets missing. Review of Registered Nurse (RN) 1's employee personnel file, revealed she was an agency nurse and had passed a written medication administration test upon hire as a part of her orientation on 05/23/2024, and also passed a skills check off on medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Staff Development/Infection Control RN, and RN1 on 06/13/2024 at 10:29 AM, they were asked to review R322's orders with the State Survey Agency (SSA) Surveyor. Both nurses verbalized the resident was to receive two (2) of the 300 mg rifampin tablets per day. The Staff Development/Infection Control RN stated if an incorrect dosage of rifampin was administered to R322, the dose might not be therapeutic for treatment of the resident's latent TB. The Staff Development/Infection Control RN stated she would give the second pill of today's dose and contact the physician to notify him of the medication error. In further interview, both nurses verbalized the reason the medication was not sent from pharmacy until 06/10/2024, even though it was ordered on 06/07/2024, was because their pharmacy/supplier was out of the medication. In an interview with the Director of Nursing (DON), on 06/14/2024 at 8:49 AM, she stated medication administration training for new nurses and agency nurses was completed prior to the nurse administering medication at the facility. She stated this included a written medication administration test; and then another staff member observed them on medication pass to make sure they were competent. The DON stated medication errors were to be reported to the Medical Director and the resident observed for any signs of complications. In an interview with the Administrator, on 06/14/2024 at 9:14 AM, she stated newly hired nurses were given a written test for medication administration and then they had to pass a check off competency for medication administration. During further interview she stated medications errors such as this error related to the resident not receiving the scheduled rifampin as ordered was to be reported to the physician and the resident monitored.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, and review of the facility's policy, the facility failed to ensure drugs and biological's used in the facility were labeled, dated, and stored in accordance with currently accepted professional principles for one (1) of four (4) medication carts. Observation of the North Wing's A-C Medication Cart, on [DATE] at 10:15 AM, revealed two (2) opened vials of Insulin Glargine U100 with no opened date. The findings include: Review of the facility's policy titled, Medication Storage, dated 2007, revealed the purpose of the policy was to ensure medications and biological's were stored properly, following the manufacturer's or the provider's pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. Per the policy, medications should remain in packaging provided by the pharmacy. Observation of the North Wing's A-C Medication Cart, on [DATE] at 10:15 AM, revealed two (2) opened vials of Insulin Glargine U100 which were not marked with the opened date. During an interview with Licensed Practical Nurse #1 (LPN1), on [DATE] at 12:30 PM, revealed the nursing staff was responsible for managing the medication carts and storage rooms. LPN1 stated nursing staff should record the date medication was opened on the insulin vial and box in which in was packaged. The LPN stated if staff find opened medications without an open date or expired medicines, they should dispose of them according to policy. She stated properly labeling and storing medication was essential for the safety of the residents. During interview with LPN3/Unit Manager (UM), on [DATE] at 10:35 AM, she stated the nursing staff was responsible for making sure medications were labeled according to the facility's process, which included recording the opened date on the medication. According to LPN/UM3, the pharmacy provided resources regarding the proper storage of insulin. She stated if a medication was found to be expired, or improperly labeled, the nursing staff should dispose of it according to policy. LPN3/UM stated she routinely conducted audits of all medication carts. Additionally, she stated the importance of storing all medications according to the manufacturer's guidelines was to ensure the safety of the residents. During an interview with the Director of Nursing (DON) on [DATE] at 9:06 AM, she stated the nurses were responsible for stocking the medication carts and ensuring appropriate storage of medications. Per interview, nurses should store all medicines in their original packaging and date them when opened. She stated solutions were to have an opened date and an expiration date on the packaging and the bottle or vial. The DON stated if staff found any medication labeled, stored improperly, or expired, they should discard it. She stated it was important to ensure nurses labeled medications according to facility policy, which included recording the date opened on the packaging and medication container to prevent medication errors, wasting medications, and using potentially expired medicine. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Registered Pharmacist (RPH), on [DATE] at 3:16 PM, he stated medications should be stored in their original packaging from pharmacy and according to the manufacturer's guidelines. He further stated nursing staff should follow facility policies regarding dating opened containers to ensure the efficacy of the medications and biological's. During an interview with the Administrator, on [DATE] at 3:18 PM, she stated it was her expectation for medications to be stored and labeled appropriately per the directives from the manufacturer's guidelines and the facility's policies. She further stated it was important to follow guidelines and policies to ensure the safety of the residents.

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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** 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of the Manufacturer's Instructions for use of the Assure Platinum Blood Glucose Monitoring System and review of the facility's policies, the facility failed to develop and implement an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible. The facility failed to develop a water management program based on nationally accepted standards, specific to their building description, in order to prevent, detect and control water-borne contaminants and reduce Legionella growth. This had the potential to affect the entire population of the facility. Observation of a fingersick revealed staff failed to clean the glucometer according to facility policy and the Manufacturer's Instructions. Observation of medication pass revealed that staff failed to clean the shared blood pressure cuff and the shared pulse oximeter after each patient use. Observation of resident care revealed staff failed to don (put on) Personal Protective Equipment (PPE) before entering the room of a resident under contact precautions for shingles and a resident with enhanced barrier precautions. Observation of staff revealed that staff failed to perform hand hygiene prior to resident care and passing out food. Observation of resident care revealed that staff failed to empty a resident's indwelling catheter in a manner to prevent contamination of the catheter spigot and possible infection. The findings include: 1. Review of the facility's policy titled, Water Management Plan, reviewed 01/2020, revealed the facility would have a water management program in place to prevent, detect and control water-borne contaminants. Furthermore, documentation for all aspects of the water management program will be maintained within the maintenance logs. Per policy, the facility would review the Water Management Plan annually. Review of the CDC's Guidelines titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, reviewed 06/2021, revealed facilities should develop a water management program to reduce Legionella growth and spread that was specific to their building description. Per the guidelines, the facility's plan should include details such as where the building connects to the municipal water supply, how water was distributed throughout the building, to include if applicable, where pools and hot tubs, cooling towers, and water heaters or boilers are located. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's document titled, Legionella Water Plan Management, revealed the flow diagram provided by the Plant Operation Director (POD) only depicted the water flow from the building's front entry to the North Wing and South Wing mechanical rooms, but did not include the source of the water (e.g., municipal water company). Furthermore, the plan and flow diagram did not address the distribution of cold water, including ice machines, sinks, or showers, and how hot water flowed through the system to reach sinks and showers throughout the building. Further, the documentation stated Legionella growth was only possible in the water heaters located in the North and South Wings, but did not consider other potential locations such as low use sinks, showers, eye wash stations, kitchen appliances, or ice machines. Additionally, the facility did not outline in the plan how it would address situations where control limits were not met, stating only the Tels Program would be used to intervene. During an interview with the Plant Operations Director (POD), on 06/11/2024 at 1:10 PM, the State Survey Agency (SSA) Surveyor requested a water system process flow diagram. The POD stated the facility did not have a detailed water flow diagram. He further stated he was not aware of the requirement for the facility water plan or the assessment to include the building's water systems flow diagram for identification of Legionella. Furthermore, he stated he was not familiar with the CDC's tool kit to assist facilities to develop and implement a water management program. According to the POD, the Tels Program was a building management system, which tracked preventive maintenance tasks, and kept records of water temperature testing and when to test the water, but it did not identify hazardous conditions. During an interview with the Administrator, on 06/14/2023 at 9:12 AM, she stated it was her expectation the facility followed the CDC's recommendations and guidelines related to infection prevention and control practices. Further, she stated it was important to have a facility water management plan as part of the overall infection control plan, in order to reduce the risk of Legionnaire's disease and to identify potential areas where Legionella could grow and spread. 2. Review of the facility's policy titled, Glucometer Cleaning and Disinfecting, revised 01/2024, revealed the purpose of the policy is to minimize the risk of transmitting blood-borne pathogens. Per policy, licensed staff will follow the manufacturer's guidelines and recommendations for the cleaning and disinfecting of the glucose monitor. Licensed staff will receive education on cleaning and disinfecting the glucose monitors per the manufacturer's guidelines upon hire, and as needed. Furthermore, license staff should always wear the appropriate personal protective equipment (PPE). A review of the Manufacturer's Instructions for the Assure Platinum Blood Glucose Monitoring System, undated, revealed to minimize the risk of transmitting bloodborne pathogens the exterior of the glucometer should be cleaned of all dirt, blood, and bodily fluids before performing the disinfection procedure, which will prevent the transmission of bloodborne pathogens. Per the instructions, the exterior of the glucometer should remain wet for the appropriate contact time according to the disinfectant's instructions. Review of the cleaning and disinfecting instructions for Clorox Healthcare Bleach Germicidal Wipes, undated, revealed to clean and disinfect non-porous surfaces, the user would use disposable gloves and thoroughly clean the surface. Then, wrap the item with wipes, allow surfaces to remain wet for one (1) minute, and let air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Competency Performing A Blood Glucose Test, revealed to properly clean and disinfect the glucometer, the nurse should wear disposable gloves. First, wipe the surface of the glucometer to remove any blood or body fluids. Then use a new wipe to clean the entire surface horizontally and vertically, ensuring the entire surface remains wet for three (3) minutes. Finally, let the glucometer air dry. Review of R30's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 02/23/2019, with diagnoses to include type 2 diabetes mellitus, and long-term (current) use of anticoagulants. Observation on 06/11/2024 at 4:17 PM, revealed RN1 was observed at the foot of R30's bed holding a glucometer (blood glucose monitoring device) with a used bloody test strip in her bare hands. RN1 then exited the room and placed the contaminated glucometer on top of a towel on the medication cart, on which sat a water pitcher. She then with her bare hands, disposed of the bloody test strip in the trash container on the medication cart. RN 1 did not perform hand hygiene after disposing of the bloody test strip. Further observation on 06/11/2024 at 4:17 PM revealed RN1 picked up the contaminated glucometer with ungloved hands, walked back into room [ROOM NUMBER], and obtained a pair of gloves from inside the room. The SSA Surveyor could see RN1 from the hallway, and observed she wiped the glucometer, but did not allow for it to dry before putting it in a case and placing it inside the bedside drawer. She then performed hand hygiene. During an interview, on 06/11/2024 at 4:25 PM, RN1 stated she was an agency nurse and had just performed a fingersick (a minimally invasive procedure using a lancet to draw blood from a finger) on R30. She stated she had worn gloves when she performed the fingersick. RN1 stated she should have had gloves on when she disposed of the contaminated test strip. She stated she should not have placed the contaminated glucometer on the medication cart, as she had not yet cleaned/disinfected the glucometer when she placed it there. In further interview with RN1, on 06/11/2024 at 4:25 PM, she stated she cleaned the glucometer and put it in its container, and stored it in the nightstand in R30's room. RN1 stated residents requiring glucose monitoring had individual glucometer's. When interviewed about how she cleaned the glucometer, she showed the State Survey Agency (SSA) Surveyor a bag of Premium Adult Wet Wipes (non-germicidal personal cleaning cloths). She stated per the facility's policy, nurses should wipe the glucometer with the wipe and place it in the case. Additionally, RN1 stated she received online training, literature, and in-person instruction upon hire related to obtaining fingersticks and glucometer cleaning. She further stated she completed a competency checklist for fingersick and disinfection of the glucometer with a return demonstration during orientation. Review of RN1's personnel file, revealed there was no documented evidence she had passed a blood glucose monitoring competency test upon hire or as part of her orientation testing on 05/23/2024. During an interview with Licensed Practical Nurse (LPN) 3/Unit Manager, on 06/13/2024 at 3:41 PM, she stated all staff (agency and in-house) had been trained on how to perform a fingersick and how to clean and disinfect glucometer's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the Infection Preventionist (IP), on 06/12/2024 at 2:37 PM, she stated staff was to perform hand hygiene prior to and after a procedure and gloves should always be worn when performing a fingersick. Further, she stated the nurses stored glucometer's in an individual storage container in each resident's room and there were no shared glucometer's. She further stated it was facility policy to clean/disinfect the glucometer before and after use with Clorox bleach wipes. The IP stated all nursing staff should have been educated on the use of glucometer's which included obtaining a fingersick, and cleaning and disinfecting the glucometer before and after use. She stated that she and nursing leadership, the Director of Nursing (DON), and the Unit Manager, provided education and training, which required teach-back demonstration related to obtaining fingersticks and disinfecting the glucometer's. She stated this education was documented in the staff's orientation paperwork. During an interview with the Director of Nursing (DON), on 06/14/2024 at 9:06 AM, she stated nurses should adhere to the facility's policies and guidelines related to performing point-of-care finger sticks and cleaning and disinfecting glucometer's. Additionally, she stated proper cleaning and disinfection of glucometer's per manufacturer's instructions was crucial. Further, she stated it was her expectation all staff perform hand hygiene prior to and after performing a procedure such as a fingersick. 3. Review of the CDC's Guidelines provided by the facility titled, Core Infection Prevention and Control Practices for Safe Health Care Delivery in all Settings, reviewed 11/2022, revealed reusable medical equipment should be cleaned and disinfected before use or when soiled. Further review of the guidelines revealed the personnel should be trained in the correct steps for cleaning and disinfection of shared equipment and competencies should be assessed. Review of the facility's policy titled, Infection Control, dated 01/2024, revealed the purpose of the policy is to maintain a safe, sanitary, and comfortable environment to help prevent and manage the transmission of diseases and infection. According to the policy, department heads and managers are responsible for ensuring the implementation and adherence to infection control practices, which includes ensuring the safe cleaning and reprocessing of reusable resident care equipment. In addition, all personnel will receive training on infection prevention and control practices (IPCP) during their hiring process and periodically thereafter. Observation of medication pass, on 06/13/2024 at 9:00 AM, with RN1, revealed she obtained vital signs and then obtained an oxygen saturation using a pulse oxygen monitor on R323. She then without sanitizing the shared blood pressure cuff and pulse oxygen monitor, obtained vital signs and oxygen saturation level for R233. In an interview with RN1, on 06/13/2024 at 9:12 AM, she stated she was to clean the blood pressure cuff and the pulse oxygen monitor between taking vital signs for each resident with a disinfecting wipe. She further stated the dwell (time needed for the solution to remain on the device) time for the disinfection solution was three (3) minutes. In an interview with the Staff Development/Infection Control RN, on 06/13/2024 at 9:30 AM, she stated communal equipment should be cleaned after each use. She further stated the dwell time was three (3) minutes and could be found on the disinfecting wipe package. (continued on next page)

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	185408	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Care and Rehabilitation Center	616 S Wallace Wilkinson Blvd Liberty, KY 42539

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON, on 06/14/2024 at 8:49 AM, she stated it was facility policy for staff to clean shared equipment after each use. In an interview with the Administrator, on 06/14/2024 at 9:14 AM, she stated all shared equipment should be cleaned after each use. 4a. Review of the facility's policy titled, Transmission-Based Precautions, dated 09/15/2023, revealed transmission-based precautions were initiated when a resident developed signs and symptoms of a transmissible infection or when the laboratory confirmed infection. Review of R55's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 12/27/2023 with diagnoses including shingles, essential primary hypertension, and chronic kidney disease. Review of R55's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 05/18/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognition. Review of R55's Physician's orders dated 06/06/2024, revealed orders for contact precautions for localized shingles. Review of R55's Comprehensive Care Plan, dated 06/10/2024, revealed a focus of infection control measures and contact isolation related to shingles. The goal stated the resident's isolation will reduce the spread of the infectious agent and minimize the transmission of the infection. Interventions included: adequate PPE available for staff and visitors, practice good handwashing, and use principles of infection control and universal/standard precautions. Observation of SRNA6, on 06/12/2024 at 9:59 AM, revealed she entered R55's room without performing hand hygiene and donning PPE; although the resident's door had a sign posted stating contact precautions. SRNA5 was then observed exiting R55's room without performing hand hygiene and was noted to have a remote control from R55's television in her hand. She placed the television remote control on the handrail outside R55's room. SRNA 6 was then observed to walk down the hallway to speak with RN1. She then came back to retrieve the remote control and noticed the contact precautions signage on R 55's door. SRNA6, then without performing hand hygiene, took a gown and gloves out of the cart and donned it prior to re-entering R55's room. Review of SRNA 6's personnel file, revealed a document titled, Agency Orientation Guide/Checklist, revealing the SRNA was trained on the topics of infection control and PPE and had signed the document on 05/02/2024. In an interview with SRNA6, on 06/12/2024 at 10:11 AM, she was interviewed related to the signage on R55's. She stated it meant she was to put on a gown and gloves before entering the resident's room. She further stated she should have performed hand hygiene and then donned a gown and gloves before entering R55's room. Further, she stated she should have performed hand hygiene prior to exiting the room and should not have taken the television remote control out of the resident's room as the resident was on contact precautions. In further interview, she stated she had received education related to hand hygiene, isolation precautions, and donning PPE both by her agency and during orientation at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Licensed Practical Nurse (LPN)3/Unit Manager, on 06/13/2024 at 3:41 PM, she stated she asked SRNA6 why she did not perform hand hygiene or don PPE prior to entering R55's room, and she stated it was because she chose not to do so. Further, she stated she sent SRNA6 home and she would not be working at the facility again. She further stated hand hygiene should be performed upon entering and prior to exiting a resident's room; and PPE should be donned prior to staff entering a room where a resident was on contact precautions. 4b. Review of R58's electronic medical record (EMR) Face Sheet revealed the facility readmitted the resident on 05/24/2024 with diagnoses including acute systolic heart failure, dementia, chronic obstructive pulmonary disease (COPD), and benign prostatic hyperplasia (BPH). Review of R58's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 05/06/2024, revealed the facility assessed the resident as having a BIMS' score of 12 out of 15, indicating moderate cognitive impairment. Review of R58's Physician's orders dated 05/24/2024, revealed orders for Enhanced Barrier Precautions (EBP). Review of R58's Comprehensive Care Plan, dated 05/24/2024, revealed the resident required Enhanced Barrier Precautions related to a wound. The goal stated the resident will not experience any adverse outcomes related to Enhanced Barrier Precautions. Interventions included: attempt to maintain environment cleanliness; disinfect high touch surfaces as able; encourage social interactions within the limitation of precautions; enhanced barrier protection; personal protective equipment as needed; and report to physician signs and symptoms of infection as needed. Observation of the Scheduler/Kentucky Medicine Aide (KMA), on 06/10/2024 at 5:33 PM, revealed she failed to don PPE prior to entering R58's room to deliver and set up a meal tray. She also failed to perform hand hygiene prior to exiting R58's room. There was signage posted on the resident's door stating, Enhanced Barrier Precautions, and there was a PPE cart beside the door. Scheduler/KMA then returned to the food cart to remove sugar packets from a communal container and took it to resident room [ROOM NUMBER]. In an interview with the Scheduler/KMA, on 06/10/2024 at 5:42 PM, she stated facility policy was to don gown and gloves prior to entering an Enhanced Barrier Precautions room. Further, she stated staff was to sanitize hands after passing each meal tray. 5a. Observation of the Scheduler/KMA, on 06/12/2024 at 10:21 AM, revealed she was passing out snacks to residents in the 200 hallway and entered R58's room. There was still signage posted on the resident's door stating, Enhanced Barrier Precautions, and there was a PPE cart beside the door. Scheduler/KMA failed to don PPE (gown and gloves) prior to entering the room to set up the resident's cereal. Additionally, she failed to perform hand hygiene prior to exiting the room. After exiting the room, she picked up another snack off the cart and delivered it to room [ROOM NUMBER]. In an interview with Licensed Practical Nurse (LPN)3/Unit Manager, on 06/13/2024 at 3:41 PM, she stated PPE should be donned prior to entering a room where a resident was in Enhanced Barrier Precautions (EBP). Further, PPE should be removed prior to exiting the contact/EBP room and hand hygiene performed. She stated this was her expectation for all her staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON), on 06/14/2024 at 8:47 AM, she stated it was her expectation staff don PPE before entering a resident's room who was in contact precautions. She further stated she expected staff to use hand sanitizer or wash their hands before and after providing care. In an interview with the Administrator, on 06/14/2023 at 9:12 AM, she stated it was her expectation staff don PPE prior to entering a contact precaution room. Further, she stated staff was expected to wash their hands or use hand sanitizer prior to and after resident care. The Administrator stated staff was educated upon hire and periodically when there was an issue related to infection control. She stated house staff and agency staff both received the same training. During interview with the Infection Preventionist (IP), on 06/12/2024 at 2:37 PM, she stated the facility followed CDC guidelines related to infection control, personal protective equipment (PPE), hand hygiene, and contact precautions. Per interview, staff was to perform hand hygiene before donning and after doffing (removing) PPE including gloves. Further, staff was to perform hand hygiene upon entering a resident's room, prior to and after completing a procedure, and prior to exiting a resident room. 5b. Observation on 06/10/2024, starting at 5:10 PM, revealed the Business Office Manager was not performing hand hygiene between passing dinner trays on the 200 hallway for resident rooms 211, 212, 213, 214, 215, and 216. In an interview with the Business Office Manager (BOM), on 06/10/2024 at 5:51 PM, she stated when passing meal trays, staff was to sanitize hands after each tray and wash their hands after every third tray. She further stated she should have been performing hand hygiene in between passing each supper tray. 6. Review of R58's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 5/24/2024 with diagnoses including acute systolic heart failure, dementia, chronic obstructive pulmonary disease (COPD), and benign prostatic hyperplasia (BPH). Review of R58's Admission Minimum Data Set (MDS) with an ARD date of 05/13/2024, revealed the facility assessed the resident as having a BIMS' score of 12 out of 15, indicating moderate cognitive impairment. Further review revealed the resident had an indwelling urinary catheter. Review of R58's Physician's Orders, dated 05/24/2024, revealed orders for a Foley catheter (brand name of indwelling catheter) related to benign prostatic hyperplasia with lower urinary tract symptoms. Review of R58's Comprehensive Care Plan, dated 06/11/2024, revealed a focus of indwelling catheter. The goal stated the resident will remain free from complications related to use of indwelling urinary catheter. Interventions included: observe for abdominal pain, urinary retention, and changes in urine characteristics; and catheter care as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/12/2024 at 11:42 AM, revealed SRNA5 removed a urinal with no identification from the shared bathroom and emptied R58's urine form the urinary catheter drainage bag into the unlabeled urinal. SRNA5 touched the top and inside of the urinal with the tip of the urinary catheter drainage bag spigot. After the urinary catheter drainage bag was emptied, SRNA5 stated the urinal needed to be labeled with R58's name, but she did not have a sharpie marker. SRNA5 then rinsed the urinal and stored it back on the handrail in the bathroom, but did not label or bag the urinal. In an interview with SRNA5, on 06/12/2024 at 11:50 AM, she stated urinals were changed out when soiled and should be dated, and labeled with the resident's name. Further, she stated urinals should be stored in a bag after use. In continued interview, she stated the spigot of the urinary drainage bag should not come in contact with the urinal due to possibility of cross contamination. In an interview with RN1, on 06/12/2024 at 2:22 PM, she stated it was common practice for staff to empty catheters into urinals. She stated urinals were to be labeled with the resident's name and date, and then rinsed after use, and placed in a plastic bag. Further, she stated it was important to not contaminate the urinary drainage bag when emptying it into the urinal. In an interview with the DON, on 06/14/2023 at 8:51 AM, she stated urinals should be emptied and rinsed out after each use and then stored in a bag. Further, she stated urinals should be labeled with the resident's name. Additionally, she stated urinary drainage bags were to be emptied into urinals with care taken to not contaminate the urinary drainage bag. In an interview with the Administrator, on 06/14/2024 at 9:10 AM, she stated urinals should be labeled with the resident's name and stored in a bag in the resident's bedside table or in the bathroom. She stated urinals were to be changed when they became soiled or had an odor. In an interview with the IP, on 06/12/2024 at 2:37 PM, she stated nursing leadership audited staff on their daily rounds and mentored staff as well as observed competencies related to infection control while the staff was working on the floor. The IP stated the staffing agencies trained all agency nurses and the facility was responsible for checking the education of agency staff before they worked the floor. The IP stated if an agency staff was new, a seasoned staff member would work with the staff for five (5) shifts or until their competencies were validated. In an interview with the DON, on 06/14/2023 at 8:51 AM, she stated agency and in-house staff received the same training before starting work. Furthermore, she stated she along with the Managers and the IP, provided training on contact precautions, hand hygiene, and the correct use of personal protective equipment (PPE). Following the training, nursing leadership assessed staff through a return demonstration and a post-test, requiring a score of 100%. She stated while the outside agency educated its staff related to infection control, the facility ensured compliance. She stated nurse leadership made daily rounds and did spot audits to ensure compliance with infection control; however, she stated daily rounds were not documented. 50442