STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195323	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Health & Rehab	2575 Airline Drive Bossier City, LA 71111

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on record review and interviews, the facility failed to ensure a resident's advanced directive was honored for 1 (#1) of 5 (#1, #2, #3, #4, and #5) sampled residents. Findings: The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Review of the provider's Cardiopulmonary Resuscitation (CPR) policy (undated) revealed in part: Procedure-Delegate another individual to check the resident's orders and advance directives for CPR or no CPR order. Review of the provider's Advance Directives policy (revised [DATE]) revealed in part: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Definitions-Do Not Resuscitate (DNR) indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation or other life-sustaining treatments or methods are to be used. If the resident has an advance directive: 1. If the resident or the resident's representative has executed one or more advance directives, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The resident's wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings. 8. The nurse supervisor is required to inform emergency medical personnel of a residents advance directive regarding treatment options and provide such personnel with a copy of the advance directive or POLST when transfer from the facility via ambulance or other means is made. Refusing or Requesting Treatment: 1. The resident has the right to refuse medical or surgical treatment, whether or not he or she has an advance directive. a. A resident will not be treated against his or her own wishes. Review of Resident #1's record revealed an admitted [DATE] and diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, congestive heart failure, Atherosclerotic heart disease of a native coronary artery, dependence on supplemental oxygen, presence of a cardiac pacemaker, type 2 diabetes mellitus, acute respiratory failure with hypercapnia (high levels of carbon dioxide in the blood), and nicotine dependence. Review of Resident #1's physician orders revealed an order dated [DATE]- Do NOT Resuscitate (DNR) ordered by S9 MD (Medical Doctor), and an order dated [DATE]-Do NOT Resuscitate ordered by S10 MD. Review of Resident #1's quarterly MDS (Minimum Data Set) assessments with an ARD (Assessment Reference Date) of [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15 indicating she was cognitively intact. Review of Resident #1's comprehensive care plan revealed the resident was care planned as DNR-no life sustaining measures to be provided. Review of Resident #1's DNR DO NOT RESUSCITATE ORDER signed by Resident #1 on [DATE], signed by S9 MD [DATE] revealed in part: On this 10th day of October, I Resident #1 communicated to my physician my willful and voluntary desire that my dying shall not be artificially prolonged. I requested my Physician to order and by signing this document he/she does so order that: IN the event of respiratory or cardiac arrest or other system failure that will result in death, all persons are to forgo resuscitation attempts of any type. It is my intention that this order be honored by my family, physician, and all others involved in my care as the final expression of my legal right to refuse medical interventions. By my signature below, I acknowledge that I understand CPR constitutes as an extraordinary measure and should NOT be done. Review of Resident #1's LaPOST (Louisiana Physician Orders for Scope of Treatment) signed by resident [DATE] and by S9 MD on [DATE] revealed the resident had selected DNR/Do Not Attempt Resuscitation (Allow Natural Death). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's nursing notes revealed a noted dated [DATE] at 1:35 a.m. by S11 LPN (Licensed Practical Nurse): at 1:35 a.m. writer was called to resident room and resident was noted to be in respiratory distress. Breathing treatment was attempted by writer but resident was not responding to it. Oxygen was increased from 2 liters to 4.5 liters per nasal cannula. At 1:40 a.m. 911 was called. Resident was noted to have pulse. At 2:00 a.m. 911 arrived and assessed resident. 911 initiated CPR code status. 2:10 .a.m. 911 left with resident on stretcher to hospital. During an interview on [DATE] at 7:53 a.m. S12 RN (Registered Nurse) reported she was working the early morning hours of [DATE] at around 1:30 a.m. when Resident #1 began having trouble breathing and 911 was called when the resident was not improving after having a breathing treatment and increasing her oxygen. S12 RN reported EMS (Emergency Medical Services) started CPR when they arrived and confirmed she did not tell EMS staff Resident #1 had a DNR order. During a telephone interview on [DATE] at 9:06 a.m. S11 LPN reported she was the nurse assigned to care for Resident #1 on [DATE]. S11 LPN confirmed she called 911 when Resident #1 was in respiratory distress that was not improving with treatment and increased oxygen. S11 LPN confirmed EMS initiated CPR as soon as they got there. S11 LPN further confirmed she did not tell EMS staff the resident had a DNR order. S11 LPN further reported in her haste to get Resident #1 out of the facility to the hospital she did not look at the code status and should have. During the survey, in-service records and monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to surveyors entering the facility: Corrective actions were initiated on [DATE] with a completion date of [DATE] with ongoing monitoring still in place. Corrective actions included policy reviews, staff inservice education which included a review of the facility's CPR/Advance Directives policies, printing the resident's LaPost, Advance Directives, orders, MAR (Medication Administration Record), and face sheet to send with a resident when transported to the hospital, and communicating a resident's code status to EMS staff when 911 was called. The latest inservice was conducted on [DATE]. Corrective actions further included discussions in the daily quality assurance meetings with the interdisciplinary team, ongoing weekly monitoring of code status for all new admissions by S13 Social Worker, and ongoing weekly monitoring of resident records by S14 Medical Records to ensure resident code status was in all of the required areas of the medical record and documents including code status were provided to transport personnel.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on observations, interviews and record reviews the facility failed to develop and implement a comprehensive, resident centered plan of care for 2 (#3, #4) out of 5 (#1, #2. #3, #4, #5) sampled residents. Findings: Resident #3 Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses including but not limited to: Type 2 diabetes mellitus with diabetic chronic kidney disease, morbid obesity, congestive heart failure, generalized edema, dependence on renal dialysis. Review of Resident #3's MDS (Minimum Data Set) assessments dated 03/04/2025 a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating the resident was cognitively intact. An observation on 04/07/2025 at 8:55 a.m. revealed Resident #3 had an indwelling urinary catheter draining cloudy urine and a right chest wall dialysis access site. During an interview on 04/07/2025 at 8:55 a.m. Resident #3 reported he was admitted to the facility with the urinary catheter and with the dialysis access site in his right chest wall. Review of Resident #3's comprehensive care plan failed to reveal any problems, goals, or approaches for the care for the resident's indwelling catheter or right chest wall dialysis site. During an interview on 04/10/2025 at 10:40 a.m. S2 Interim DON (Director of Nursing) confirmed Resident #3's care plan did not include any problems, goals, or approaches for the care of the resident's indwelling catheter or right chest wall dialysis site and it should. Resident #4 Review of Resident #4's medical record revealed an initial admitted [DATE] with the following diagnoses which included but not limited to: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side, acute and chronic respiratory failure, moderate protein-calorie malnutrition and encounter for attention to gastrostomy. Review of Resident #4's MDS revealed no BIMS score due to Resident #4 was rarely/never understood. Further review revealed Resident #4 was marked as having a feeding tube. An observation on 04/10/2025 at 8:05a.m.with S3 LPN (Licensed Practical Nurse)/Treatment Nurse revealed Resident #4 had a PEG (Percutaneous Endoscopic Gastrostomy) tube. Review of resident #4's comprehensive care plan failed to reveal any problems, goals, or approaches for PEG tube care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2025 at 12:37 p.m. S5 MDS Nurse confirmed Resident #4 was not care planned for a PEG tube and should have been.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 (#4, #5) of 5 (#1, #2, #3, #4, #5) sampled residents with peg tubes (a feeding tube inserted through the abdomen and into the stomach). The facility failed to ensure accurate skin assessments that reflected a peg tube site for Residents #4 and #5. Findings: Review of the facility's Wound Assessment Policy (no revision date) revealed: Weekly skin review should be done on each resident in PCC [Point Click Care (Electronic Health Record)]. Residents with pressure areas will be reassessed and evaluated by the treatment nurse and assisting RN Registered Nurse) in weekly clinical meeting. Resident #4 Review of Resident #4's medical record revealed an initial admitted [DATE] with the following diagnoses which included but not limited to: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side, acute and chronic respiratory failure, moderate protein-calorie malnutrition and encounter for attention to gastrostomy. Review of Resident #4's MDS (Minimum Data Set) revealed no BIMS (Brief Interview of Mental Status) score due to Resident #5 was rarely/never understood. Further review revealed Resident #4 was marked as having a feeding tube. Review of Resident #4's physician orders revealed an order dated 01/27/2025 to clean Resident #4's PEG (Percutaneous Endoscopic Gastrostomy) tube site with wound cleanser, pat dry, and apply dry dressing every day and PRN (as needed) for soilage, every day. Review of Resident #4's 2025 TAR (Treatment Administration Record) revealed: Review of the 2025 TAR revealed: clean peg tube site with wound cleanser, pat dry and apply dry dressing every day and PRN (as needed) for soilage, with a start date of 01/28/2025. Review of Resident #4's Consulate Weekly Skin Integrity Review (skin review assessment) failed to reveal documentation of a peg tube wound on the following dates: 03/03/2025, 03/18/2025, 03/25/2025 and 04/01/2025. Resident #5 Review of Resident #5's medical record revealed an initial admitted [DATE] with the following diagnoses which included but not limited to: Closed fracture of the right femur, congestive heart failure, hemiplegia affecting the right dominant side, cerebral infarction due to thrombosis of left middle cerebral artery, unspecified dementia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's MDS revealed no BIMS score due to Resident #5 was rarely/never understood. Further review revealed Resident #5 was marked as having a feeding tube. Review of Resident #5's physician orders revealed an order dated 02/08/2025 to clean Resident #5's PEG tube site with wound cleanser, pat dry, and apply dry dressing every day and PRN for soilage, every day. Review of Resident #5's 2025 TAR revealed: Review of the 2025 TAR revealed: clean peg tube site with wound cleanser, pat dry and apply dry dressing every day and PRN for soilage, with a start date of 02/09/2025. Review of Resident #5's Consulate Weekly Skin Integrity Review failed to reveal documentation of a peg tube wound on the following dates: 03/07/2025, 03/14/2025, 03/21/2025, 03/28/2025, and 04/03/2025. During an interview on 04/09/2025 at 12:43 p.m. S3 LPN/Treatment Nurse reviewed Resident #4's Consulate Skin Integrity Reviews and acknowledged the assessment did not accurately reflect Resident #4's peg tube on 03/03/2025, 03/18/2025, 03/25/2025 and 04/01/2025 and should have. S3 LPN/Treatment Nurse further reviewed Resident #5's Consulate Skin Integrity Reviews (skin assessment) and acknowledged the assessment did not accurately reflect Resident #5's peg tube on 03/07/2025, 03/14/2025, 03/21/2025, 03/28/2025, and 04/03/2025 and should have. During an interview on 4/9/25 at 3:45 p.m. S3 LPN/Treatment Nurse reported she was just clicking when completing skin assessments in Resident #4 and #5's electronic medical records, and confirmed the skin assessments did not accurately reflect Resident #4 and #5's peg tubes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on interviews, observations, and record reviews, the facility failed to ensure a resident admitted with a urinary catheter received necessary treatment and services, consistent with professional standards to promote healing and prevent infections for 1 (#3) of 5 (#1, #2, #3, #4, and #5) sampled residents. Findings: Review of the provider's Catheter Care, Indwelling Catheter policy (undated) revealed in part: Purpose-to prevent urinary tract infection, reduce urethral irritation. -Assessment guidelines may include, but are not limited to: color, consistency, amount of urine -Documentation Guidelines-Documentation includes: date, time, procedure, condition of the perineum and catheter insertion site, any unusual condition or change in condition, color, amount, consistency and odor of urine, notification of the physician of any condition change, intake and output and evaluation of intake and output, signature and title. -Care Plan Documentation Guidelines-record the catheter care as an approach under the appropriate underlying problem on the resident's care plan. Review of Resident #3's record revealed an admitted [DATE] and diagnoses including but not limited to: morbid obesity, type 2 diabetes mellitus with chronic kidney disease, diabetic foot ulcers, congestive heart failure, generalized edema, dependence on renal dialysis, and malignant neoplasm of hepatic flexure. Review of Resident #3's MDS (Minimum Data Set) assessments dated 03/04/2025 a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating the resident was cognitively intact. Further review revealed Section H Bowel and Bladder-Indwelling Catheter was marked No. An observation on 04/07/2025 at 8:55 a.m. revealed Resident #3 had an indwelling urinary catheter draining cloudy urine. During an interview on 04/07/2025 at 8:55 a.m. Resident #3 reported he was admitted to the facility with the urinary catheter. Review of Resident #3's physician Active Orders as of 04/09/2025 failed to reveal an order for an indwelling urinary catheter. Further review revealed an order dated 03/26/2025 for Doxycycline Hyclate (an antibiotic) 100mg (milligrams) by mouth every morning and at bed time for infection for 10 days (completed 04/04/2025). Review of Resident #3's March 2025 and April 2025 MAR (Medication Administration Record) failed to reveal any catheter care or monitoring of the color, character, or amount of Resident #3's urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's comprehensive care plan revealed he was care planned for a UTI (urinary tract infection) with interventions including monitoring for and reporting any signs and symptoms of a UTI. Further review revealed no interventions related to the presence of an indwelling urinary catheter. Observation on 04/08/2025 at 7:45 a.m. revealed Resident #3 lying in bed with his eyes closed, urinary catheter draining cloudy yellow urine. During an interview on 04/10/2025 S6 LPN (Licensed Practical Nurse) reviewed Resident #3's active physician orders and confirmed there was not an order for the resident's indwelling urinary catheter and there should be. S6 LPN further confirmed there was no documentation of monitoring of the Resident #3's urine for color, character, and amount and there should be. S6 LPN further reported Resident #3 completed a round of antibiotics on 04/04/2025 for an infection but did not know if it was for a skin infection or a UTI. S6 LPN further confirmed the resident's care plan did not include any problems, goals, or approaches for his indwelling urinary catheter and it should. During an interview on 04/10/2025 at 8:07 a.m. S15 CNA (Certified Nursing Assistant) reported Resident #3 had a urinary catheter that she emptied at the end of her shift or before him going to dialysis, but there was nowhere for her to document how much urine she emptied from his catheter or what it looked and smelled like. S15 CNA further reported she did catheter care every day, but there was nowhere for her to document it. During an interview on 04/10/2025 at 10:40 a.m. S2 Interim DON (Director of Nursing) confirmed there was no physician order for Resident #3's indwelling urinary catheter, no monitoring of the color, character, or amount of his urine, and no documentation of catheter care and there should be.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on observations, interviews and record review, the facility failed to ensure appropriate care and services had been provided for 1 (#3) of 1 (#3) residents reviewed for Dialysis out of a total of 5 sampled residents. The facility failed to ensure Resident #3 was accurately assessed and monitored for the care of his dialysis access site. Findings: Review of Resident #3's record revealed an admitted [DATE] and diagnoses including but not limited to: type 2 diabetes mellitus with chronic kidney disease, and dependence on renal dialysis. An observation on 04/07/2025 at 8:55 a.m. revealed Resident #3 had a dressing in place to his right chest wall. During an interview on 04/07/2025 at 8:55 a.m. Resident #3 reported his dialysis access site was in his right chest wall where the dressing was. Review of Resident #3's MDS (Minimum Data Set) assessments dated 03/04/2025 a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating the resident was cognitively intact. Further review of section O-Special Treatments, Procedures, and Programs revealed the resident was not coded for receiving hemodialysis. Review of Resident #3's physician Active Orders as of 04/09/2025 revealed orders including: -02/17/2025-Hemodialysis every Monday, Wednesday, and Friday; -02/14/2025-Hemodialysis- Assess site (right arm) for bruising/bleeding/symptoms of infection; and -02/14/2025-Check AV (arteriovenous) shunt each shift-assess for bruit (an audible swishing sound) and thrill (a palpable vibration) every shift for monitoring Review of Resident #3's March 2025 and April 2025 MAR (Medication Administration Record) revealed: -monitoring of AV shunt for bruit and thrill -no monitoring of any kind for Resident #3's right chest wall hemodialysis access site Review of Resident #3's comprehensive care plan failed to reveal any interventions related to his dialysis access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2025, S6 LPN (Licensed Practical Nurse) reported Resident #3's dialysis access site was in in right chest wall and did not have a thrill or bruit like a graft in the arm would. S6 LPN reported Resident #3 did not have a right arm dialysis access site. S6 LPN reviewed Resident #3's active physician orders and confirmed his order was for monitoring of a right arm dialysis access graft. S6 LPN confirmed she had been documenting monitoring of a right arm graft having a thrill and bruit and should not have. S6 LPN further confirmed there was no documented monitoring of any kind of Resident #3's right chest wall dialysis access and there should be. S6 LPN further confirmed the resident's care plan did not include monitoring of his right chest wall dialysis access site and should. During an interview on 04/10/2025 at 10:08 a.m. Resident #3 reported he used to have a right arm graft but it was removed about 3 months ago. During an interview on 04/10/2025 at 10:40 a.m. S2 Interim DON (Director of Nursing) confirmed there was no monitoring of Resident #3's right chest wall dialysis access site and there should be.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37867 Based on record reviews and interviews the facility failed to ensure there was a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs. The facility failed to: 1. provide the minimum required staffing hours for 20 of 37 days reviewed and 2. ensure a licensed nurse was designated as a charge nurse for each shift. Findings: Review of the facility completed Nursing Personnel Staffing Pattern Reporting Forms for 03/01/25 to 04/06/2025 revealed insufficient staff below the required minimum hours for the following dates: 03/08/2025: negative 14.93 hours 03/09/2025: negative 23.28 hours 03/11/2025: negative 1.07 hours 03/16/2025: negative 17 hours 03/18/2025: negative 0.29 hours 03/23/2025: negative 16.15 hours 03/24/2025: negative 14.56 hours 03/25/2025: negative 23.05 hours 03/26/2025: negative 7.52 hours 03/27/2025: negative 3.71 hours 03/28/2025: negative 1.83 hours 03/29/2025: negative 6.45 hours 03/30/2025: negative 4.67 hours 03/31/2025: negative 15.74 hours 04/01/2025: negative 12:81 hours (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Health & Rehab	2575 Airline Drive Bossier City, LA 71111

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/02/2025: negative 6.12 hours 04/03/2025: negative 37.1 hours 04/04/2025: negative 6.63 hours 04/05/2025: negative 15.48 hours 04/06/2025: negative 22.53 hours During an interview on 04/07/2025 at 7:35 a.m. S6 LPN (Licensed Practical Nurse), S7 LPN, and S8 LPN were all at the nursing station and reported the administrator was not in facility. S6 LPN, S7 LPN, and S8 LPN were further asked who was in charge for the shift, and they replied they did not have a charge nurse. During an interview on 04/07/2025 at 8:15 a.m. S1 Administrator was asked who the charge nurse was on duty, and she was unable to answer the question. During an interview on 04/07/25 at 12:20 p.m. S4 HR (Human Resources) confirmed the facility had insufficient staffing levels for the above dates that did not meet the required minimum staffing hours. During an interview on 04/07/2025 at 3:28 p.m. S1 Administrator confirmed the facility had insufficient staffing levels for the above dates that did not meet the required staffing hours, and said they were due to a lack of CNAs (Certified Nursing Assistants). S1 administrator confirmed there was no charge nurse assigned for each shift. S1 Administrator further reported the average daily census was 60-62 residents and the facility had no staffing waivers.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37867 Based on record review and interviews, the provider failed to ensure the facility had 8 consecutive hours per day of Registered Nurse (RN) coverage for 2 of 37 days reviewed for RN hours, and failed to have a DON (Director of Nursing) for 33 consecutive days. This deficient practice had the potential to affect any of the 59 Residents residing in the facility according to the facility's detailed census report. Findings: Review of the facility completed Nursing Personnel Staffing Pattern Reporting Forms for 03/01/2025 to 04/06/2025 revealed no RN coverage 04/02/2025 and 04/03/2025. During an interview on 04/07/2025 at 7:35 a.m. S6 LPN (Licensed Practical Nurse), S7 LPN, and S8 LPN were all at the nursing station and reported the administrator was not in facility and they did not currently have a DON. During an interview on 04/07/2025 at 8:15 a.m. S1 Administrator reported they did not currently have a director of nursing. During an interview on 04/07/25 at 12:20 p.m. S4 HR (Human Resources) confirmed the facility did not have an RN on duty 8 consecutive hours for every day during the time frame of 03/01/2025 to 04/06/2025. During an interview on 04/07/2025 at 3:28 p.m. S1 Administrator confirmed there was no RN on duty for 04/02/2025 and 04/03/2025 and there should have been. S1 Administrator further reported the facility did not have a DON from 03/06/2025 to 04/07/2025 and should have. S1 Administrator further reported the average daily census was 60-62 residents and the facility had no staffing waivers.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on interviews and record review, the facility failed to ensure medical records were accurately documented for 2 (#3, #5) of 5 (#1, #2, #3, #4, #5) sampled residents. The facility failed to ensure accurate documentation of weekly skin assessments for Resident #3 and #5, and accurate documentation of dressing changes for Resident #5. Findings: Review of the facility's Wound Assessment Policy (no revision date) revealed: Weekly skin review should be done on each resident in PCC [Point Click Care (Electronic Health Record)]. Residents with pressure areas will be reassessed and evaluated by the treatment nurse and assisting RN (Registered Nurse) in weekly clinical meeting. Resident #3 Review of Resident #3's medical record revealed an admitted [DATE] and diagnoses including but not limited to: Type 2 Diabetes Mellitus with diabetic chronic kidney disease, type 2 diabetes mellitus with foot ulcers, Fournier gangrene, generalized edema, complete traumatic amputation of right foot. Review of Resident #3's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating Resident #3 was cognitively intact. Review of Resident #3's physician orders revealed an order dated 02/17/2025-weekly skin sweeps. Review of Resident #5's Consulate Weekly Skin Integrity Reviews revealed weekly skin assessments including assessments dated 02/21/2025, 02/24/2025, and 02/28/2025. Review of Resident #3's progress notes revealed the resident was in the hospital from 02/20/2025 to 03/03/2025. During an interview on 04/09/2025 at 3:43 p.m. S3 LPN (Licensed Practical Nurse)/Treatment Nurse reviewed Resident #3's Consulate Weekly Skin Integrity Reviews for 02/21/2025, 02/24/2025, and 02/28/2025 and confirmed she had completed them for a time period the resident was out of the facility in the hospital and should not have. S3 LPN/Treatment Nurse further reported that was me just clicking and she shouldn't have done that. Resident #5 Review of Resident #5's medical record revealed an initial admitted [DATE]. Review of Resident #5's medical record revealed the following diagnoses which included but not limited to: Closed fracture of the right femur, congestive heart failure, hemiplegia affecting the right dominant side, cerebral infarction due to thrombosis of left middle cerebral artery, unspecified dementia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's MDS revealed no BIMS score due to Resident #5 was rarely/never understood. Review of Resident #5's physician orders revealed an order dated 02/08/2025 to clean Resident #5's Peg Tube (Percutaneous Endoscopic Gastrostomy) site with wound cleanser, pat dry, and apply dry dressing every day and PRN (as needed) for soilage, every day. Review of Resident #5's Consulate Weekly Skin Integrity Review dated 04/04/2025 revealed Resident #5's current skin condition was marked yes for skin intact. Review of Resident #5's April 2025 TAR (Treatment Administration Record) revealed Resident #5's Peg Tube site dressing was changed on 04/05/2025 and 04/06/2025 by S3 LPN/Wound Care Nurse. Review of Resident #5's progress notes dated 04/03/2025 at 11:14 p.m. revealed Resident #5's right hip x-ray report came in, indicating that resident has a displaced acute appearing fracture noted of the femoral neck. Resident #5 was sent out to the emergency room via ambulance. A phone order was received to send Resident #5 out to the emergency room . Review of Resident #5's progress notes revealed Resident #5 was in the hospital on 04/03/2025, 04/04/2025, 04/05/2025, 04/06,2025 and returned from the hospital to the facility on [DATE]. During an interview on 04/09/2025 at 12:43 p.m. S3 LPN/Treatement Nurse reviewed Resident #5's Consulate Skin Integrity Reviews (skin assessment) and confirmed she could not have done a skin assessment of Resident #5 on 04/04/2025 due to the resident being hospitalized from 04/03/2025 to 04/07/2025. S3 LPN/Wound Care Nurse further acknowledged the documentation on 04/04/2025 was not accurate. During an interview on 04/09/2025 at 4:20 p.m. S3 LPN Treatment Nurse reviewed Resident #5's April 2025 TAR and acknowledged Resident #5's Peg tube site dressing changes on 04/05/2025 and 04/06/2025 were not accurate. S3 LPN/Treatment Nurse further confirmed Resident #5 was in the hospital on those dates.

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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** 37867 Based on record review, observations, and interviews, the facility failed to maintain an effective infection prevention and control program help prevent the development and transmission of communicable diseases and infections for 2 (#3 and #4) of 5 (#1, #2, #3, #4, and #5) sampled residents as evidenced by failing to ensure: 1. Staff wore appropriate PPE (Personal Protective Equipment) when providing high contact patient care for Resident #3, and #4 who were had Enhanced Barrier Precautions (EBP) in place; 2. Followed appropriate hand hygiene during wound care and incontinence care for Resident #3; and 3. Followed accepted infection control principals during wound care and incontinence care for Resident #3. Findings: Resident #4 Review of Resident #4's medical record revealed an initial admitted [DATE] with diagnoses including but not limited to: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side, acute and chronic respiratory failure, moderate protein-calorie malnutrition and encounter for attention to gastrostomy. Review of Resident #4's physician orders revealed and order dated 01/27/2025 for EBP utilized when performing high-contact resident care activities related to PEG (percutaneous endoscopic gastrostomy) tube every shift. An observation on 04/09/2025 at 2:31 p.m. revealed S3 LPN (Licensed Practical Nurse)/Treatment Nurse changed the PEG tube dressing of Resident #4. S3 LPN/Treatment Nurse failed to wear a protective gown while changing the PEG Tube dressing of Resident #4. Resident #3 Review of Resident #3's medical record revealed an admitted [DATE] and diagnoses including but not limited to: Type 2 Diabetes Mellitus with diabetic chronic kidney disease, type 2 diabetes mellitus with foot ulcers, Fournier gangrene, generalized edema, complete traumatic amputation of right foot. Review of Resident #3's MDS (Minimum Data Set) assessments dated 03/04/2025 a BIMS (Brief Interview of Mental Status) score of 15 out of 15 indicating the resident was cognitively intact. Review of Resident #3's active physician orders revealed orders including: -04/08/2025-Sacrum: cleanse with wound cleanser. Pat dry. Apply skin prep to perineal area. Apply hydrocolloid dressing to open area every 3 days and as needed until resolved. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-03/23/2025-left heel diabetic foot ulcer: cleanse with wound cleanser. Pat dry. Apply skin prep to perineal area. Apply betadine to escar and calcium alginate to granular tissue, then cover with ABD (abdominal dressing) pad, then wrap with kerlix every other day until resolved and as needed. -03/23/2025-right foot diabetic foot ulcer: cleanse with wound cleanser. Pat dry. Apply skin prep to perineal area. Apply betadine to escar and calcium alginate to granular tissue, then cover with ABD (abdominal dressing) pad, then wrap with kerlix every other day until resolved and as needed. -02/17/2025-EBP every shift related to dialysis port/wounds/foley catheter Observation on 04/10/2025 at 9:45 a.m. revealed S3 LPN/Treatment Nurse perform wound care to Resident #3's bilateral diabetic foot ulcers and his sacral moisture associated wound assisted by S15 CNA (Certified Nursing Assistant) and observed by S2 Interim DON (Director of Nursing). S3 LPN/Treatment Nurse and S15 CNA failed to don a protective gown prior to providing this high contact resident care. S3 LPN/Treatment Nurse was observed performing care to Resident #3's left leg diabetic foot ulcer removing the soiled dressing while leaning her upper body against the bed and soiled bed linens. S3 LPN/Treatment Nurse removed her gloves and donned a clean pair of gloves without sanitizing her hands and began cleaning areas of the foot moving from one area to another with the same section of the gauze. There was bloody drainage from the foot. S3 LPN/Treatment Nurse changed gloves again without sanitizing her hands, and began applying betadine with a swab moving from one area of the foot to another area with the same swab. S3 LPN/Treatment Nurse repeated the process on the right foot again without sanitizing her hands between glove changes and moving from one area of the right foot to another with the same section of the gauze and with the same betadine swab. S3 LPN/Treatment Nurse's upper body and clothing was touching Resident #3's bed linens which were soiled with drainage from the wounds as well as touching the soiled dressings. S3 LPN/Treatment Nurse was further observed to be wearing a bracelet with dangling charms which was outside of her gloves and was repeatedly touching the soiled linens. Resident #3 was then rolled to his left side toward S15 CNA to perform care to his sacral moisture associated wound. S15 CNA was observed to use her upper body against the Resident #3's body to assist in positioning. Resident #3 had had a bowel movement (BM), so S3 LPN/Treatment Nurse cleaned the BM before performing the sacral wound care. S3 LPN/Treatment Nurse's bracelet with dangling charms repeatedly came into contact with the inside of Resident #3's soiled incontinence brief throughout the incontinence care. S3 LPN/Treatment Nurse then proceeded to remove her soiled gloves, don a clean pair of gloves, and initiate wound care to Resident #3's sacrum without sanitizing her hands. S3 LPN/Treatment Nurse further proceeded to apply wound cleanser from the edges of the wound to the center and pat back and forth across the wound/red macerated areas. S3 LPN/Treatment Nurse and S15 CNA then proceeded to change the resident's soiled linens with both their unprotected upper bodies touching the soiled linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/10/2025 at 10:37 a.m. S3 LPN/Treatment Nurse confirmed she did not don a protective gown prior to performing wound care on Resident #3 involving contact with soiled linens and dressings and should have. S3 LPN/Treatment Nurse further confirmed she did not sanitize her hands between glove changes when moving from dirty to clean tasks and should have. S3 LPN/Treatment Nurse confirmed she should have used a clean section of gauze for each area cleansed and should have used a separate betadine swab for each area of the feet and did not. S3 LPN/Treatment Nurse reported she thought her bracelet with dangling charms had been inside her gloves, and she should have taken it off before providing high contact care to Resident #3. S3 LPN/Treatment Nurse further confirmed she did not don a protective gown when performing PEG tube care to Resident #4 on 04/09/2025 and should have.