STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195484	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Nursing Center Hammond	42250 North Oaks Dr Hammond, LA 70403

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on interviews and record review, the facility failed to ensure medications were administered to meet the needs of each resident by failing to ensure orders were entered correctly and administered for 1 (#2) of 5 (#1, #2, #3, #4, and #R1) residents reviewed for rashes. Findings: Review of the facility policy titled, Elements of a Medication Order with a revision date of 11/2017 revealed the following, in part: Medication orders should specify the following: d. Time or frequency of administration PRN (as needed) clearly states the reason/condition for which they are being administered. Review of Resident #2's clinical record revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Pruritus and Disorder of the Skin and Subcutaneous Tissue, Unspecified. Review of Resident #2's Physician Order's revealed the following, in part: 08/01/2024 Mupirocin 2% cream apply to affected area twice daily and as needed. Review of Resident #2's Medication Administration Record (MAR) from 08/01/2024 to 08/07/2024 revealed the following, in part: Mupirocin 2% cream apply to affected area twice daily and as needed. Further review of Resident #2's MAR revealed the record did not have scheduled times for administration and the following doses were administered: 08/01/2024 at 7:09 p.m. - Administered 08/02/2024 at 8:43 p.m. - Administered (continued on next page)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/05/2024 at 8:18 a.m. - Administered 08/05/2024 at 9:18 p.m. - Administered 08/06/2024 at 5:39 p.m. - Administered On 08/09/2024 at 11:41 a.m., an interview was conducted with S16LPN. S16LPN confirmed she worked a double shift on 08/03/2024 and 08/04/2024. S16LPN stated if Resident #2's Mupirocin 2% cream was entered on the MAR as a scheduled medication she would have administered the medication. S16LPN stated if the medication was entered as a PRN medication, the resident would have to request it for it to be administered. S16LPN stated if there was an order for a medication to be administered at a scheduled time and PRN two separate orders would have to be entered in the MAR. S16LPN confirmed if a medication was not signed out on the MAR it was not administered. On 08/09/2024 at 12:44 p.m., an interview was conducted with S15LPN. S15LPN confirmed she entered Resident #2's Mupirocin 2% order. S15LPN confirmed she entered the order as a PRN order to be applied twice daily. S15LPN stated she should have entered the medication order as twice daily and an additional order for as needed. S15LPN confirmed she did not administer Resident #2's morning dose on 08/02/2024. S15LPN further confirmed if the medication was not marked off on the MAR the medication was not administered. On 08/09/2024 at 1:44 p.m., an interview was conducted with S2DON. S2DON reviewed Resident #2's MAR and confirmed Mupirocin 2% order had been entered wrong. S2DON confirmed the order should have been entered a scheduled order and as a PRN order. S2DON confirmed the resident did not get administered scheduled doses of the medication because the order was entered as PRN. S2DON confirmed Resident #2's Mupirocin 2% was not administered as ordered.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39121 46645 Based on interviews and record reviews, the administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of each resident. The administration failed to implement a system to help prevent the development and/or transmission of infections by failing to: 1 Utilize its Infection Control and Prevention Program, follow its policies and procedures to surveil, and isolate known clusters of rashes for 5 of 5 (#1, #2, #3, #4 and #R1) residents reviewed for rashes; and 2 Ensure 4 of 4 (S17CNA, S20LPN, S4HK and S10HK) staff adhered to proper infection control practices when providing care for 1 of 1 (#R2) of residents reviewed for Enhanced Barrier Precautions (EBP). This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 06/10/2024 when Resident #4 presented with generalized itching and a rash. Resident #2 presented with a similar rash on 07/16/2024. Resident #3 presented with a similar rash on 07/24/2024. On 07/26/2024, Residents #1 and #R1 presented with similar rashes. On 07/31/2024, Resident #4 was treated for Scabies. The facility failed to identify Resident's #1, #2, #3, #4, and #R1 similar rashes as a potentially transmittable skin infection and did not take precautions to prevent the spread of the rash from resident to resident S1ADM was notified of the Immediate Jeopardy situation on 08/07/2024 at 6:00 p.m. The Immediate Jeopardy situation was removed on 08/09/2024 at 1:32 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at more than minimal harm for the remaining 137 residents residing in the facility. Findings: Cross Reference F-880 1 Observations were made of Resident's #1, #2, #3, #4 and #R1 rashes on 08/06/2024 and 08/07/2024. The rashes had similar characteristics and remained unresolved on 08/07/2024. The rashes were sporadic to diffuse, red with papules, pustules, and crusted areas which were located on their torsos, arms and legs. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 3:27 p.m., an interview was conducted with S11WCN. S11WCN confirmed the rashes for Resident's #2, #3, #4 and R1 appeared similar. On 08/06/2024 at 1:35 p.m., an interview was conducted with S7IPN. S7IPN confirmed she was the infection preventionist nurse for the facility and was responsible for surveillance of possible infections within the facility. S7IPN confirmed she was aware Resident #4 started receiving treatment for Scabies on 07/31/2024 as ordered by a local Dermatologist. S7IPN confirmed she was aware Residents #1, #2, #3, #4 and #R1 had similar and persistent rashes. S7IPN confirmed Residents #2, #3, #4 and #R1 resided on Hall b and Resident #1 resided on Hall a, but received care from the same Hospice Nurse as Resident #3. S7IPN confirmed she did not implement surveillance and tracking for the similar skin rashes and should have. S7IPN stated she had not identified the rashes of these residents' rashes as having a potential for spreading or being a possible transmittable disease or infection and should have. S7IPN confirmed the failure to surveil and track these rashes resulted in a failure to recognize the clustering and increasing rate. S7IPN confirmed the aforementioned residents were not placed on Contact Isolation Precautions but should have been due to their rashes presenting and persisting with similarities within a short timeframe and within a close proximity. On 08/06/2024 at 10:16 a.m., an interview was conducted with S2DON. S2DON confirmed she was aware of Residents #1, #2, #3, #4 and #R1 had similar rashes and Residents #2, #3, #4 and #R1 resided on Hall b and Resident #1 resided on Hall a, but received care from the same Hospice Nurse as Resident #3. S2DON confirmed these residents' rashes should have been surveilled and tracked by S7IPN for the possibility of transmittable conditions. S2DON confirmed the aforementioned residents were not placed on contact isolation precautions. S2DON confirmed she was aware Resident #4 was receiving treatment for Scabies. After reviewing the facility's policy and procedure on Isolation Precautions, S2DON confirmed Resident #4 should have been placed on Contact Isolation Precautions after receiving new orders from the dermatologist to treat for Scabies on 07/31/2024. On 08/07/2024 at 11:50 a.m., an interview was conducted with S8NP after he assessed Residents #1, #2, #3, #4 and #R1's skin rashes. S8NP stated Resident #4's rash was consistent with Scabies and should continue treatment for Scabies as well as being put on Contact Isolation Precautions. He confirmed he could not rule out a transmittable condition for the aforementioned rashes. S8NP confirmed Resident #2, #3, #4 and #R1 should have been and should now be placed on Contact Isolation Precautions due to their rashes being similar in nature and located on Hall b. On 08/07/2024 at 7:22 p.m., S1ADM confirmed Resident's #1, #2, #3, #4, and #R1 should have been placed on Contact Isolation Precautions when each presented with similar rashes. On 08/08/2024 at 9:08 a.m., an interview was conducted with S5MD. S5MD confirmed Residents #1, #2, #3, #4 and #R1 should have been placed on Contact Isolation Precautions after each rash was identified with similarities and given the close proximity of the resident's rooms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/08/2024 at 9:08 a.m., an interview was conducted with S5MD. S5MD confirmed Residents #1, #2, #3, #4 and #R1 should have been placed on Contact Isolation Precautions following the identification of similarities in the rashes and with the close proximity of the resident's rooms. S5MD confirmed any resident with suspected or known scabies must be placed on contact isolation precautions. S5MD stated scabies is most commonly diagnosed by visual assessment and signs and symptoms. S5MD confirmed it was hard to get a definitive diagnosis/confirmation of the presence of scabies by skin scraping or biopsy because they are not seen with the naked eye and a mite would have to present in the exact location of the tested area, which is very small. 2 On 08/06/2024 at 1:35 p.m., and interview was conducted with S7IPN. S7IPN confirmed she was the infection preventionist nurse for the facility and trained the staff on infection control practices. S7IPN confirmed Resident #R2 was on EBP. S7IPN confirmed that the gowns used at the facility for EBP were one time use, then laundered and reused. S7IPN confirmed the gowns should never be used more than once without laundering. S7IPN confirmed the gowns should be removed prior to exiting the room and placed in a yellow barrel which should be inside the resident's room. S7IPN confirmed the yellow barrels at the nurses' station were used for housing residents' laundry if they were not on any precautions. On 08/06/2024 at 10:16 a.m., an interview was conducted with S2DON. S2DON stated the gowns used for EBP should not to be used more than once before being laundered. S2DON stated gowns should not be removed after exiting a resident's room. S2DON confirmed gowns should be removed within the resident's room prior to exiting and placed in the proper receptacle in the Resident's room. S2DON confirmed the laundry receptacles located at the nurses' station were for housing dirty laundry of residents that were not on any precautions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 46645 Based on observations, interviews and record review, the facility failed to help prevent the development and/or transmission of infections by failing to: 1 Implement a system for controlling and preventing the spread of transmittable infections for 5 of 5 (#1, #2, #3, #4, and #R1) residents reviewed for rashes; and 2 Ensure 4 of 4 (S17CNA, S20LPN, S4HK and S10HK) staff adhered to proper infection control practices when providing care for 1 of 1 (#R2) of residents reviewed for Enhanced Barrier Precautions(EBP). This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 06/10/2024 when Resident #4 presented with generalized itching and a rash. Resident #2 presented with a similar rash on 07/16/2024. Resident #3 presented with a similar rash on 07/24/2024. On 07/26/2024, Residents #1 and #R1 presented with similar rashes. On 07/31/2024, Resident #4 was treated for Scabies. The facility failed to identify Resident's #1, #2, #3, #4, and #R1 similar rashes as a potentially transmittable skin infection and did not take precautions to prevent the spread of the rash from resident to resident S1ADM was notified of the Immediate Jeopardy situation on 08/07/2024 at 6:00 p.m. The Immediate Jeopardy situation was removed on 08/09/2024 at 1:32 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The deficient practice continued at more than minimal harm for the remaining 137 residents residing in the facility. Findings: 1 Review of the facility's policy titled Infection Prevention and Control Program with a revision date of 08/21 (no year listed) revealed the following, in part: The facility has developed and maintains an infection prevention and control program that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection. This program will: Develop prevention, surveillance, and control measures to protect residents and personnel from healthcare-associated infections. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Perform surveillance activities to monitor and investigate causes of infection and manner of spread in order to prevent infections in the facility. Analyze, in a timely manner, clusters or trends of infection, changes in prevalent organisms, and any increase in the rate of infection. Develop procedures to be applied in certain individual residents, such as isolation. Develop specific policies and procedures governing such activities as aseptic technique, outbreak investigation, wound care . Review of the facility's policy titled Procedure for Isolation: Isolation Precautions with a revision date of 08/21 (no year listed) revealed the following, in part: 3. Contact Precautions: use for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact. This includes other transmissible conditions such as scabies and conditions such as rash of unknown origin. Review of the Center for Disease Control's (CDC) webpage article titled Scabies and Public Health Strategies for Scabies Outbreaks in Institutional Settings at www.cdc.gov revealed the following, in part: Overview: Early detection, treatment, and implementation of appropriate isolation and infection control practices are essential in preventing scabies outbreaks, especially when providing hands-on care to patients/residents who might have scabies. Establish surveillance. Have an active program for early detection of infested patients/residents and staff. Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; evaluate and confirm suspected cases by obtaining skin scrapings. Signs and Symptoms: The most common symptoms of scabies are intense itching, especially at night, and a pimple-like skin rash. Crusted scabies?: Crusted scabies is a severe form of scabies that is very contagious. It spreads quickly and easily, even from limited direct contact or from contaminated bedding, clothing, or furniture. Delayed diagnosis and treatment of crusted scabies can often cause outbreaks. Risk Factors: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Places where scabies outbreaks more commonly occur include Nursing homes. How it spreads: Direct, extended, skin-to-skin contact with a person who has scabies or Less commonly, sharing clothing, towels, or bedding used by an infected person. You may need retreatment if itching is present more than 2 to 4 weeks after treatment, new burrows appear, or new pimple-like rashes appear. Resident #4 Review of Resident #4's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #4's Nurses Notes dated 06/10/2024 through 08/06/2024 revealed a rash was identified on 06/10/2024 and had not resolved. Review of Resident #4's local Dermatologist's Physician Consultation Report dated 07/31/2024 revealed findings of erythematous heme crusted papules scattered especially to truck but extending down all extremities with significant scaling to hands and interweb spaces. To cover for Scabies if not done in past 4 weeks: Ivermectin 15mg X 1, then repeat in 1 week. Permethrin 5 % cream apply to entire body, leave on overnight and wash off in the morning; repeat in 1 week. Review of Resident #4's physician's orders revealed the following: 07/31/2024 Permethrin 5% cream; apply to the entire body and leave on overnight Stop date: 08/07/2024. 07/31/2024 Ivermectine 3mg tablet; give 5 tablets by mouth (15mg) total X 1 dose. Stop date: 08/07/2024 08/06/2024 Allegra 180mg tablet; one tablet by mouth every morning 08/08/2024 Ivermectin 3 milligram tablet; give 5 tablets oral (15mg total dose) at night every Thursday for 2 doses. Stop date: 08/22/2024 08/08/2024 Permethrin 5% topical cream; topical at night every Thursday for 2 doses. Apply to the entire body below the neck, leave on overnight and wash off in the AM X 2. Stop date: 08/22/2024. On 08/06/2024 at 1:05 p.m., an interview was conducted with S15LPN. S15LPN confirmed Resident #4 resided on Hall b and had a rash for over a month. S15LPN stated Resident #4 was always itching and was being treated for Scabies. She stated Resident #4 had not been placed on Contact Isolation Precautions. S15LPN confirmed Resident #4's rash looked similar to Resident #3 and #2's rashes. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 3:10 p.m., an observation was made of S11WCN assessing Resident #4's rash, assisted by S12CNA. Resident #4's rash was diffuse to the back and sporadic to the backs of the legs abdomen and both arms. The rash was red with pustules and papules; some were crusted and more linear in nature. Resident #4 verbalized the rash caused itching and the rash/itching had been ongoing for more than a month. An observation was made of Resident #4 actively scratching her right arm. Resident #4 was not placed on Contact Isolation Precautions. On 08/07/2024 at 10:31 a.m., an interview was conducted with S6NP. S6NP confirmed she was aware Resident #4 had a persistent rash and itching for months. S6NP stated she was aware Resident #4 was being treated for Scabies. S6NP confirmed Resident #4 should have been put on Contact Isolation Precautions for the duration of the treatment for Scabies. On 08/07/2024 at 11:45 a.m., an observation was made of S8NP assessing Resident #4's skin rash. S8NP stated Resident #4's skin rash was consistent with Scabies. He stated Resident #4 should have been placed on Contact Isolation Precautions. Resident #2 Review of Resident #2's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #2's Nurses Notes dated 07/16/2024 through 08/01/2024 revealed a rash was identified on 07/16/2024 and had not resolved. On 08/06/2024 at 12:05 p.m., an observation and interview was conducted with Resident #2. Resident #2 stated there were bugs which climbed on him at night, and he had bites all on his chest. Resident #2 stated the rash was all over his shoulders and on his right leg. Resident #2 stated the facility ordered him medications, which helped with the itching but it did not help with the bugs crawling on him. Resident #2 stated the itching was off and on for the last 6 weeks. Observations of Resident #2 revealed a splotchy, raised red rash to his right and left hand, and a discolored raised patch to his right posterior thigh. Resident #2 was not on Contact Isolation Precautions. On 08/06/2024 at 1:05 p.m., an interview was conducted with S15LPN. S15LPN confirmed Resident #2 resided on Hall b. S15LPN confirmed Resident #2 had a rash and was being treated with a cream. S15LPN stated the rash started on Resident #2's right side and treated with a Clotrimazole-Betamethasone cream, but it did not help. S15LPN stated Resident #2 was currently taking Bactrim and Mupirocin cream, but they were not effective. S15LPN stated Resident #2 had complaints of the rash itching and reported it feels like something was biting him. S15LPN stated Resident #2's rash was red raised bumps on the right side of his torso, right thigh, and the back of the right thigh. Resident #3 Review of Resident #3's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #3's MDS with an ARD of 06/17/2024 revealed a blank BIMS score, which indicated the interview could not be completed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's Nurses Notes dated 07/24/2024 through 08/02/2024 revealed a rash was identified on 07/24/2024 and had not resolved. Review of Resident #3's visit note report from Hospice visits dated 07/18/2024 through 08/06/2024 revealed a rash was identified on 07/28/2024 and had not resolved. On 08/06/2024 at 1:05 p.m., an interview was conducted with S15LPN. S15LPN confirmed Resident #3 resided on Hall b. S15LPN stated Resident #3 had red raised bumps all over. S15LPN stated the rash started as a few little red pustules/raised areas on the on the resident's right side. S15LPN stated it was reported to the Hospice Nurse and she was instructed to monitor the rash. S15LPN stated the rash had gotten worse and Hospice ordered a Triamcinolone cream. S15LPN stated Resident #3 had a rash of raised bumps on her entire back, her shoulders, around her ankles, arm pit to the breast. S15LPN stated Resident #3 was started on Triamcinolone cream on 07/25/2024 and was now on a Medrol Dose pack, Doxycycline, and Benadryl PRN. S15LPN stated Resident #3's rash was not resolving and had spread all over her back and shoulders. On 08/06/2024 at 3:00 p.m., an observation was made of Resident #3 with S11WCN. Resident #3 was noted to have a raised red rash on her bilateral arms, upper thighs, right and left torso, the left shoulder, and the right neck. S11WCN described the red raised bumps as pustules. Resident #3's back was observed to be covered in a diffuse bright red rash with some raised areas and some areas of opened skin. Resident #3 was not on Contact Isolation Precautions. On 08/06/2024 at 2:36 p.m., an interview was conducted with Resident #3's Hospice Nurse. She stated Resident #3's rash started about 2 weeks ago and originally looked like 5-6 small ant bites. She stated Resident #3's rash had spread and worsened as of today. On 08/07/2024 at 9:33 a.m., an interview was conducted with Resident #3's Responsible Party. He stated Resident #3 had the rash for a few weeks. He stated the rash initially looked like few insect bites on her back and had got progressively worse. Resident #1 Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #1's quarterly MDS with an ARD of 06/25/2024 revealed Resident #1 had a BIMS of 9, which indicated she was moderately cognitively impaired. Review of Resident #1's Nurses Notes dated 07/01/2024 through 08/06/2024 revealed a rash was identified on 07/26/2024 and had not resolved. On 08/06/2024 at 12:48 p.m., a telephone interview was conducted with Resident #1's Hospice nurse. She confirmed she was the Hospice nurse for Residents #1 and #3 She stated on 07/26/2024 she identified Resident #1 had a rash of unknown origin similar to Resident #3's rash. She stated the rash on Resident #1 was sporadic over the torso, arms and thighs with some pustules and patches or plaques and had not improved as of today. (continued on next page)

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Landmark Nursing Center Hammond	42250 North Oaks Dr Hammond, LA 70403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 12:36 p.m., an interview was conducted with S9LPN. S9LPN stated she was the nurse for Resident #1. S9LPN confirmed Resident #1 was nonverbal and resided on Hall a. S9LPN confirmed Resident #1 had a rash to her left upper outer arm and left upper thigh. S9LPN stated she received a new order from Resident #1's Hospice Nurse to restart the Triamcinolone cream due to an unresolved rash. S9LPN confirmed Resident #1 was not placed on Contact Isolation Precautions. On 08/06/2024 at 3:27 p.m., an observation was made of S11WCN assessing Resident #1's rash, assisted by S21CNA. An observation was made of Resident #1's rash on her left elbow, left shoulder, legs, back of knees, face and left abdomen. The rash was sporadic, red, contained papules, pustules, nodules and some crusted dark brown areas. Resident #1 was not on Contact Isolations Precautions. Resident #R1 Review of Resident #R1's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #R1's MDS with an ARD of 05/17/2024 revealed a BIMS score of 11, which indicated moderately impaired cognition. Review of Resident #R1's Nurses Notes dated 07/26/2024 through 08/07/2024 revealed a rash was identified on 07/26/2024 and had not resolved. On 08/06/2024 at 1:05 p.m., an interview was conducted with S15LPN. S15LPN stated confirmed Resident #R1 resided on Hall b. S15LPN stated Resident #R1 had a red rash on him that started the first of August and he was receiving Hydrocortisone cream twice a day. S15LPN reported the rash was not improving. S15LPN stated his rash was a red circle area like a little mosquito bite. S15LPN stated Resident #4's rash looked similar to Resident #3 and Resident #2's rashes. On 08/06/2024 at 3:10 p.m., an observation was made of Resident #R1 with S11WCN. Resident #R1 stated the rash itched more at night when he was in bed. Resident #R1 stated he was treated with a medication cream and Benadryl, but it does not help. Resident #R1's rash was red and raised to his right torso, small of his back, and his left abdomen. Resident #1 was not on Contact Isolation Precautions. On 08/06/2024 at 3:27 p.m., an interview was conducted with S11WCN. S11WCN confirmed the rashes for Resident's #2, #3, #4 and R1 appeared similar. On 08/06/2024 at 1:35 p.m., an interview was conducted with S7IPN. S7IPN confirmed she was the infection preventionist nurse for the facility and was responsible for monitoring for possible infections within the facility. S7IPN confirmed she was aware Residents #1, #2, #3, #4 and #R1 had similar rashes and Residents #2, #3, #4 and #R1 resided on Hall b. S7IPN confirmed Resident #1 resided on Hall a, but received care from the same Hospice Nurse as Resident #3. S7IPN confirmed the aforementioned residents were not placed on Contact Isolation Precautions but should have been. S7IPN stated she had not identified the rashes of these residents as having a potential for spreading or a possible transmittable disease or infection and should have. S7IPN confirmed Resident #4 started receiving treatment for Scabies on 07/31/2024 as ordered by a local Dermatologist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195484	A. Building B. Wing	08/09/2024

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/06/2024 at 10:16 a.m., an interview was conducted with S2DON. S2DON confirmed she was aware of Residents #1, #2, #3, #4 and #R1 had similar rashes. S2DON confirmed these residents were not placed on Contact Isolation Precautions. S2DON confirmed these residents' rashes should have been tracked by S7IPN for the possibility of transmittable conditions. S2DON confirmed she was aware Resident #4 was receiving treatment for Scabies. After reviewing the facility's policy and procedure on Isolation Precautions, S2DON confirmed Resident #4 should have been placed on Contact Isolation Precautions after receiving new orders from the dermatologist to treat for Scabies on 07/31/2024. On 08/07/2024 at 11:50 a.m., an interview was conducted with S8NP after he assessed Residents #1, #2, #3, #4 and #R1's skin rashes. He confirmed he could not rule out a transmittable condition for the aforementioned rashes. S8NP confirmed Resident #2, #3, #4 and #R1 should have been placed on Contact Isolation Precautions due to their rashes being similar in nature and located on the same hall (Hall b). On 08/07/2024 at 7:22 p.m., S1ADM confirmed Resident's #1, #2, #3, #4 and #R1 should have been placed on Contact Isolation Precautions when each presented with similar rashes. On 08/08/2024 at 9:08 a.m., an interview was conducted with S5MD. S5MD confirmed Residents #1, #2, #3, #4 and #R1 should have been placed on Contact Isolation Precautions following the identification of similarities in the rashes with the close proximity of the resident's rooms. S5MD confirmed any resident with suspected or known scabies must be placed on contact isolation precautions. S5MD stated scabies is most commonly diagnosed by visual assessment and signs and symptoms. S5MD confirmed it was hard to get a definitive diagnosis/confirmation of the presence of scabies by skin scraping or biopsy because they are not seen with the naked eye and a mite would have to present in the exact location of the tested area, which is very small. 2 A review of the facility's policy titled Enhanced Barrier Precautions, dated 03/24 (no year) revealed the following, in part: Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care activities. Changing linen is considered a high contact resident care activity; facilities should remember to have an appropriate disposal container available in the resident's room to allow for removal of Personal protective equipment (PPE) inside the room. A review of the facility's procedure titled Removing PPE, dated 08/21 (no year) revealed the following, in part: Remove PPE at doorway before leaving patient room Gown Unfasten neck, then waist ties Remove gown using a peeling motion, pull gown from each shoulder toward the same hand (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Gown will turn inside out Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle On 08/06/2024 at 9:35 a.m., an interview was conducted with S17CNA. S17CNA stated she had just completed incontinence care for Resident #R2. S17CNA stated she did not wear a gown while performing incontinence care on Resident #R2 whom was on EBP. S17CNA stated the gowns used for EBP were reusable and the used gowns were placed in a yellow barrel down the hall near the nurse's station for laundering. S17CNA confirmed Resident #R2's room did not have a yellow barrel in it. On 08/06/2024 at 9:42 a.m., an observation was made of S4HK prior to entering Resident #R2's room. S4HK confirmed Resident #R2 was on EBP. S4HK reached into the metal box on the door and pulled out a gown that was already tied at the neck. S4HK stated this was her gown which she reuses. S4HK confirmed she had previously worn this gown to enter Resident #R2's room. S4HK stated she had placed the used gown it back into the metal box for later use. She stated I save my gowns. An observation was made of S4HK slipping the previously tied gown over her head. S4HK stated she was unaware the gowns could not be used more than once prior to laundering. On 08/06/2024 at 9:46 a.m., an observation was made of Resident #R2's room. The room did not contain a yellow barrel to house used gowns. On 08/06/2024 at 9:48 a.m., an interview was conducted with S20LPN. S20LPN stated she was the nurse for Resident #R2. S20LPN confirmed Resident #R2 was on EBP. S20LPN stated for Enhanced Barrier Precautions, used gowns were to be discarded into a yellow barrel for laundering. S20LPN stated a yellow barrel should be located right outside the resident's room. She stated the gown was to be removed prior to exiting the resident's room. On 08/06/2024 at 9:58 a.m., an interview was conducted with S10HK. S10HK stated after exiting a resident's room, whom was on EBP, the gown was removed in the hallway and placed in a yellow bucket by the nursing station. S10HK confirmed she was unaware the gown should be removed in the resident's room and placed in a receptacle in the resident's room. On 08/06/2024 at 1:35 p.m., and interview was conducted with S7IPN. S7IPN confirmed she was the infection preventionist nurse for the facility and trained the staff on infection control practices. S7IPN confirmed Resident #R2 was on EBP. S7IPN confirmed that the gowns used at the facility for EBP were one time use, then laundered and reused. S7IPN confirmed the gowns should never be used more than once without laundering. S7IPN confirmed the gowns should be removed prior to exiting the room and placed in a yellow barrel which should be inside the resident's room. S7IPN confirmed the yellow barrels at the nurses' station were used for housing residents' laundry if they were not on any precautions. On 08/06/2024 at 10:16 a.m., an interview was conducted with S2DON. S2DON stated the gowns used for EBP should not to be used more than once before being laundered. S2DON stated gowns should not be removed after exiting a resident's room. S2DON confirmed gowns should be removed within the resident's room prior to exiting and placed in the proper receptacle in the Resident's room. S2DON confirmed the laundry receptacles located at the nurses' station were for housing dirty laundry of residents that were not on any precautions.