STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on observation, interviews, and record review, the facility failed to ensure a resident received services in the facility with reasonable accommodation of needs for 1 (#3) of 3 (#1, #2 and #3) sampled residents. The facility failed to ensure Resident #3's request to get out of bed was honored in a timely fashion. Findings: Review of Resident #3's Clinical Record revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Cerebral Infarction and Primary Disorders of Muscles. Review of Resident #3's Admission MDS with an Assessment Reference Date of 06/12/2024 revealed the resident had a BIMS score of 15, which indicated intact cognition. Further review revealed Resident #3 was dependent on transfers. Review of Resident #3's current Care Plan revealed the following, in part: Problem: ADLs: Requires assistance with ADL's related to Impaired Mobility Interventions: Transfers: Requires a mechanical lift On 07/17/2024 at 9:36 a.m., an interview was conducted with Resident #3. Resident #3 was lying in her bed. Resident #3 stated around 6:20 a.m. she told S18CNA she wanted to get out of bed. Resident #3 stated S18CNA told her she would get her up after breakfast. On 07/17/2024 at 9:43 a.m., an interview was conducted with S18CNA. S18CNA confirmed Resident #3 asked to get out of bed around 6:00 a.m. S18CNA stated Resident #3 required two person assist with transfers. She confirmed she had not transferred Resident #2 as requested. On 07/17/2024 at 9:45 a.m., an observation was made of S18CNA entering the resident's room with another CNA to transfer Resident #3 out of bed. On 07/17/2024 at 10:50 a.m., an interview was conducted with S2ADON. S2ADON was notified of the aforementioned findings. S2ADON confirmed a resident requesting to get out of bed at approximately 6:20 a. m. and not getting up until after 9:45 a.m. was unacceptable. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/2024 at 3:37 p.m., an interview was conducted with S1DON. S1DON confirmed a resident should be transferred out of bed upon request. S1DON was made aware of the aforementioned findings. S1DON confirmed Resident #3 should have been transferred out of bed sooner and the amount of time it took to get her out of bed was unacceptable.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on observations, interviews, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good hygiene for 1 (#3) of 3 (#1, #2, and #3) sampled residents reviewed for ADLs. The facility failed to ensure Resident #3 received incontinence care timely. Findings: Review of the undated facility policy titled, Incontinence Programs revealed the following, in part: (3) Check and Change Staff Involvement: Monitor for incontinent episodes and provide incontinence care Suggested Interventions: 1. Provide Incontinence care on a predetermined schedule and as needed. Review of Resident #3's Clinical Record revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Cerebral Infarction and Primary Disorders of Muscles. Review of Resident #3's Admission MDS with an Assessment Reference Date of 06/12/2024 revealed the resident had a BIMS score of 15, which indicated intact cognition. Further review revealed Resident #3 was dependent for toileting hygiene and was substantial/maximum assistance with rolling left and right in the bed. Review of Resident #3's current Care Plan revealed the following, in part: ADLs: Requires assistance for toileting On 07/15/2024 at 8:31 a.m., an interview was conducted with Resident #3. Resident #3 stated she was aggravated because her gown and the pillow on her left side were wet. Resident #3 stated the last time she was changed was at 5:00 a.m. On 07/15/2024 at 8:54 a.m., an observation was made of S17LPN performing incontinent care for Resident #3. S17LPN touched Resident #3's under pad and confirmed it was wet with urine. S17LPN confirmed Resident #3's brief was really damp. On 07/15/2024 at 9:20 a.m., an observation was made of CNAs preparing to transfer Resident #3. S19CNA touched the pillow on Resident #3's left side and confirmed it was wet with urine. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 8:38 a.m., an interview was conducted with Resident #3. Resident #3 stated the last time her brief was changed was at 1:30 a.m. Resident #3 stated she has been wet since 6:00 a.m. and no one had come to change her. On 07/16/2024 at 8:55 a.m., an interview was conducted with S18CNA. S18CNA confirmed she came on her shift a little after 6:00 a.m. S18CNA confirmed she had not changed Resident #3's brief. S18CNA stated residents should be changed every two hours. S18CNA confirmed Resident #3's brief was not changed within two hours. On 07/17/2024 at 10:50 a.m., an interview was conducted with S2ADON. S2ADON was made aware of the aforementioned observations of Resident #3. S2ADON confirmed residents should have incontinence checks performed every 2 hours and changed as needed. On 07/18/2024 at 3:37 p.m., an interview was conducted with S1DON. S1DON was made aware of the aforementioned observations of Resident #3. S1DON stated incontinence checks should be conducted every 2 hours and incontinence care provided as needed.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39121 Based on observations, interviews, and record review the facility failed to provide the necessary treatment and services, consistent with professional standards, to promote healing and prevent the development of new pressure ulcers by failing to ensure a resident's heels were floated as ordered for 1(#2) of 3 (#2, #R1 and #R4) residents reviewed for facility acquired pressure ulcers. This deficient practice resulted in an actual harm for Resident #2, a paraplegic with no sensation to the lower extremities, on 07/16/2024 at 8:58 a.m. when the resident was observed lying in bed with his feet resting directly on the foot board and heels not floated off the surface of the mattress. Further observations were made at 10:39 a.m., 11:51 a.m., and 1:00 p.m. when S6TN confirmed there were new areas of discoloration on both the resident's right and left heel. On 07/17/2023 at 7:25 a.m., Resident #2 was assessed by S7NP and was found to have a Deep Tissue Injury (DTI) to the left heel measuring 3.5 cm x 6.0 cm x 0 cm. Findings: Review of the undated facility policy titled Skin Program, Pressure Ulcers and Other Wounds revealed the following, in part: Risk Assessment and Routine Care for All Residents 1. All residents will be assessed for risk of impaired skin integrity at admission 3. Risk factors identified will be evaluated for possible reduction or elimination and preventative interventions implemented accordingly. Review of Resident #2's Clinical Record revealed the resident was admitted to the facility on [DATE]. Further review revealed Resident #2 had diagnoses which included Unspecified Injury at Unspecified Level of Thoracic Spinal Cord and Osteomyelitis of Vertebra Cervicothoracic Region. Review of Resident #2's Admission MDS with an ARD of 06/19/2024 revealed a BIMS of 15 which indicated intact cognition. Further review revealed Resident #2 was dependent on rolling left and right and was assessed by the facility as being at risk for developing pressure ulcers. Review of Resident #2's Braden Scale Risk Assessment - For Predicting Pressure Sore Risk dated 06/13/2024 revealed the following, in part: Sensory Perception - Slightly Limited Mobility - Very Limited Braden Risk Total Score - 16 Braden Risk Level - The resident is at risk for the development of pressure ulcers (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's Current Physician's Orders revealed an order dated 07/08/2024 to float heels while in bed. Review of Resident #2's current Care Plan revealed the following, in part: Problem: At risk for skin impairment 06/19/2024 Moisture Associated Skin Damage Interventions: Float Heels Review of Resident #2's Physical Therapy Evaluation and Plan of Treatment dated 06/13/2024 revealed the following, in part: Current Referral - .patient underwent T3-T6 decompressive laminectomy with posterior fusion and washout . post operatively was found to have complete T4 sensory and motor level paralysis. Sensation / Sensory Processing - Impaired (loss of sensory T4 distally) Sharp / Dull = Impaired Touch / Pressure = Impaired Review of Resident #2's Nurse's Notes revealed the following, in part: 07/11/2024 at 7:10 p.m., Skin assessment complete. No new skin issues noted. On 07/16/2024 at 8:58 a.m., an observation was made of Resident #2 lying in bed with his feet resting directly on the foot board. Resident #2's heels were not floated off the mattress. On 07/16/2024 at 10:39 a.m., an observation was made of Resident #2 lying in bed with his feet resting directly on the foot board. Resident #2's heels were not floated off the mattress. On 07/16/2024 at 11:51 p.m., an observation was made of Resident #2 with S8CNA. Resident #2 was lying in bed with his feet resting directly on the foot board. Resident #2's heels were not floated off the mattress. S8CNA removed Resident #2's sock and his right heel was observed to have a large round discolored area. On 07/16/2024 at 1:00 p.m., an observation was made of Resident #2 with S6TN. Resident #2 was lying in bed with his feet resting directly on the footboard. Resident #2's heels were not floated off the mattress and he was not wearing heel boots. S6TN confirmed Resident #2's feet were resting directly on the foot board. Resident #2's heel boots were observed in his wheelchair. S6TN removed Resident #2's socks to find a large circular discolored area to Resident #2's right heel and a linear appearing discoloration to Resident #2's left heel. S6TN stated the last time she performed wound care for Resident #2 was on 07/12/2024 and the areas of discoloration were not present on the heels. S6TN confirmed no one reported the discolored areas to Resident #2's heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 07/17/2024 at 7:25 a.m., an observation was made of Resident #2 with S6TN and S7NP. Resident #2's feet were observed to be directly on the foot board. Resident #2's heels were not floated off the mattress and he was not wearing heel boots. S6TN confirmed Resident #2's feet were resting directly on the foot board. S6TN instructed Resident #2 to pull himself up in bed. Resident #2 attempted to pull himself up in bed with a trapeze bar and the sides of the mattress, but was unable to independently pull himself up to get his feet off the footboard. S7NP assessed both the left and right heel. She stated the right heel had a blister on it and the left heel had a DTI. S7NP measured the left foot heel discoloration. S7NP stated the left heel discoloration was a DTI which was caused by pressure. S7NP stated the DTI could have been caused by Resident #2's feet touching the bed and not wearing the heel protectors. On 07/17/2024 at 10:50 a.m., an interview was conducted with S2ADON. S2ADON stated Resident #2 cannot move his lower body at all. S2ADON stated Resident #2 would require someone to pull him over. On 07/17/2024 at 2:03 p.m., an interview was conducted with S16LPN. S16LPN stated Resident #2 required significant assistance with repositioning. S16LPN stated Resident #2 could pull himself a little to the side but needed his leg moved to turn to his side. S16LPN stated Resident #2 gets help turning to his side he can do the rest. S16LPN confirmed she cared for the resident on 07/14/2024 and stated she did not notice discoloration to his heels. On 07/17/2024 at 4:07 p.m., an interview was conducted with Resident #2. Resident #2 confirmed he could not feel his feet and did not know when they were resting directly on the footboard. Resident #2 confirmed he never refused his heel boots or requested them to be removed. Resident #2 stated does not know if the heel boots are on or not due to his lack of sensation. On 07/18/2024 at 9:07 a.m., an interview was conducted with S6TN. S6TN stated due to Resident #2's immobility of his lower body he would be at risk for pressure ulcers. S6TN stated she does not know if Resident #2 can feel his feet. S6TN stated Resident #2 can use the trapeze to pull himself up and confirmed the resident could not pull himself up enough to get his feet off of the footboard. S6TN confirmed Resident #2 required assistance with repositioning. S6TN stated if the CNAs had placed the heel protectors on Resident #2's feet the left heel DTI could have been prevented. On 07/18/2024 at 2:58 p.m., an interview was conducted with S4LPN. S4LPN confirmed she cared for Resident #2 on 07/16/2024. S4LPN stated CNAs were responsible for placing heel boots and floating heels. S4LPN stated if a resident had heel boots provided, the heel boots would be used to float the resident's heels. S4LPN stated she did not notice if Resident #2's heels were floated or in heel boots on 07/16/2024. On 07/18/2024 at 3:10 p.m., an interview was conducted with S8CNA. S8CNA confirmed she worked with Resident #2 on 07/16/2024. S8CNA stated Resident #2's feet should have been floated and confirmed the resident's heel boots were not on his feet on 07/16/2024. S8CNA stated CNAs and nurses assigned to the resident were responsible for floating the heels and putting the heel boots on. S8CNA confirmed Resident #2 was not wearing his heel boots when she arrived for her shift at 6:00 a.m. On 07/18/2024 at 3:37 p.m., an interview was conducted with S1DON. S1DON was made aware of the aforementioned findings. S1DON confirmed Resident #2's feet should not have been on the footboard of the bed. S1DON stated she expected for a resident who was ordered to have heels floated to have the heels floated at all times while in bed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46975 Based on interviews and record review, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (#R3) of 3 (#3, #R2, and #R3) residents reviewed for diabetes. Findings: Review of Resident #R3's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Diabetes. Review of Resident #R3's Yearly Minimum Data Set with an Assessment Reference Date of 07/01/2024 revealed he had a BIMS of 10, which indicated he was moderately cognitively impaired. Review of Resident #R3's current Physician Orders revealed the following, in part: Humalog 100 Unit/Ml Kwikpen Blood Glucose AC and HS If FSBS 0-199=0Units, 200-250=2Units SQ, 251-300= 4Units SQ, 301-350= 6Units SQ, 351-400= 8Units SQ, greater than 400, administer 12 units and notify MD. Start date 05/04/2024. Review of Resident #R3's July 2024 Medication Administration Record (MAR) revealed the following, in part: July 5th-7:00 a.m.-BG 150, box checked that insulin was administered by S4LPN. July 5th-5:00 p.m.-BG 184, box checked that insulin was administered by S4LPN. July 7th-7:00 a.m.-BG 100, box checked that insulin was administered by S5LPN. July 7th-5:00 p.m.-BG 146, box checked that insulin was administered by S5LPN. July 8th-12:00 p.m.-BG 177, box checked that insulin was administered by S5LPN. July 8th-5:00 p.m.-BG 76, box checked that insulin was administered by S4LPN. July 9th-7:00 a.m.-BG 186, box checked that insulin was administered by S4LPN. July 9th-12:00 p.m.-BG 115, box checked that insulin was administered by S4LPN. July 9th-5:00 p.m.-BG 122, box checked that insulin was administered by S4LPN. July 10th-5:00 p.m.-BG 171, box checked that insulin was administered by S3LPN. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	July 11th-12:00 p.m.-BG 129, box checked that insulin was administered by S3LPN. July 12th-7:00 a.m.-BG 161, box checked that insulin was administered by S3LPN. July 12th-12:00 p.m.-BG 145, box checked that insulin was administered by S3LPN. July 13th-12:00 p.m.-BG 97, box checked that insulin was administered by S5LPN. On 07/17/2024 at 12:50 p.m., an interview was conducted with Resident #R3. He verified he was a diabetic. He stated the nurses checked his blood glucose levels before meals and at night. He stated they told him what his blood glucose results were and did not administer insulin unless his blood glucose was 200 or higher. On 07/17/2024 at 12:30 p.m., an interview was conducted with S3LPN. She reviewed Resident #R3's July 2024 MAR. She confirmed Resident #R3's MAR indicated she gave insulin to Resident #R3 when his blood glucose levels were below 200. She confirmed this was a documentation error and she had not administered insulin to Resident #R3 for blood glucose results lower than 200. She confirmed medications should not be documented as given if they were not administered. On 07/17/2024 at 3:00 p.m., an interview was conducted with S4LPN. She reviewed Resident #R3's July 2024 MAR. She confirmed Resident #R3's MAR indicated she gave insulin to Resident #R3 when his blood glucose levels were below 200. She confirmed this was a documentation error and she had not administered insulin to Resident #R3 for blood glucose results lower than 200. She confirmed medications should not be documented as given if they were not administered. On 07/17/2024 at 3:54 p.m., an interview was conducted with S1DON. She reviewed Resident #R3's July 2024 MAR and the findings mentioned above. She verified per Resident #R3's sliding scale, he should not receive insulin unless his blood glucose was 200 or above. She confirmed insulin should not be documented as given if it was not administered.

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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** 39121 Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of infection 2 (#2 and #R1) of 5 (#1, #2, #3, #R1, and #R4) residents reviewed for repositioning. The facility failed to ensure: 1. Staff wore proper Personal Protective Equipment while providing care to Resident #2 and #R1, residents on Enhanced Barrier Precautions; 2. Staff did not hang a urinary drainage bag above the level of Resident #2's bladder during a transfer; and 3. Staff performed proper hand hygiene during the care of Resident #R1. Findings: Review of the facility policy titled Enhanced Barrier Precautions with no date, revealed the following, in part: Enhanced barrier precautions refer to the use of gowns and gloves for use during high contact resident care activities for residents known to be colonized and infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). 3. Implementation of Enhanced Barrier Precautions a. Gowns and gloves will be available outside of the resident's room 4. High-contact resident care activities include: f. Changing briefs or assisting in with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy tubes h. Wound care: any skin opening requiring a dressing Review of the Enhanced Barrier Precautions sign posted on resident doors revealed the following, in part: Doctors and Staff Must: Wear gloves and a gown for the following High-Contact Resident Care Activities: Changing briefs Device care or use: central line, urinary catheter, feeding tube, tracheostomy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound Care: any skin opening requiring a dressing Review of the facility policy titled Hand Hygiene with no date, revealed the following, in part: Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy Explanation and Compliance Guidelines: 2. Additional Considerations: a. The use of gloves does not replace hand washing. Wash hands before donning and removing gloves. Resident #2 Review of Resident #2's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #2's Physician's Orders revealed the following, in part: 06/26/2024 Enhanced Barrier Precautions R/T Wounds / Foley Catheter On 07/15/2024 at 1:54 p.m., an observation was made of Resident #2. A sign for Enhanced Barrier Precautions was posted on Resident #2's door. S14CNA and S13CNA were observed preparing to lift Resident #2 from the wheelchair to the bed without wearing gowns. S14CNA placed Resident #2's urinary drainage bag above the bladder near the resident's right shoulder on the spreader bar of the mechanical lift. Resident #2 was lifted from the wheelchair and placed into the bed. S14CNA removed the urinary drainage bag from the spreader bar of the mechanical lift and hung it on the side of the bed. On 07/15/2024 at 2:01 p.m., an interview was conducted with S13CNA. S13CNA confirmed Resident #2 was on Enhanced Barrier Precautions. S13CNA confirmed a gown was not worn during the transfer. S13CNA confirmed she should have worn a gown. On 07/15/2024 at 2:03 p.m., an interview was conducted with S14CNA. S14CNA observed the Enhanced Barrier Precautions sign on Resident #2's door and confirmed the resident was on Enhanced Barrier Precautions. S14CNA stated if a resident is on Enhanced Barrier Precautions a gown should be worn. S14CNA confirmed a gown was not worn during the transfer of Resident #2 and confirmed she should have. S14CNA confirmed she placed Resident #2's urinary drainage bag on the spreader bar of the mechanical lift and it was over the level of the bladder. On 07/17/2024 at 7:50 a.m., an observation was made of S6TN and S15CNA performing wound care on Resident #2. S6TN performed wound care to Resident #2's sacrum while S15CNA was supporting the resident on the right side. Neither S6TN nor S15CNA were wearing a gown. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Post Acute Care	2828 Westfork Baton Rouge, LA 70816

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/2024 at 7:55 a.m., an interview was conducted with S6TN. S6TN observed the Enhance Barrier Precaution sign on Resident #2's door. S6TN confirmed the resident was on Enhanced Barrier Precautions. S6TN confirmed she and S15CNA were not wearing gowns during Resident #2's wound care. S6TN confirmed she should have worn a gown. Resident #R1 Review of Resident #R1's Clinical Record revealed the resident was admitted to the facility on [DATE]. Review of Resident #R1's current Physician's Orders revealed the following, in part: 06/06/2024 Enhanced Barrier Precautions R/T: Foley Catheter and Wound On 07/14/2024 at 3:29 p.m., an observation was made of Resident #R1. A sign for Enhanced Barrier Precautions was posted on Resident #R1's door. S11CNA entered the room, applied gloves, and pulled the resident's sheet down and gown up. Bowel movement was noted to have leaked from Resident #R1's ostomy appliance. S11CNA proceeded to wipe the bowel movement from Resident R1's abdomen. S12CNA entered the room, applied gloves, and began assisting S11CNA with the brief change. S11CNA placed the wipes in the brief, discarded the brief, removed and discarded her gloves in the trash can. S11CNA applied new gloves without performing hand hygiene. S11CNA proceeded to perform peri-care on Resident #R1. S11CNA and S12CNA applied a clean brief to Resident #R1. S10LPN entered the room, applied gloves, removed Resident #R1's ostomy appliance, discarded it into the trash can, removed her gloves and discarded them in the trash. S10LPN applied new gloves and did not perform hand hygiene. S10LPN applied a new ostomy appliance to Resident #R1's stoma. Neither S10LPN, S11CNA, nor S12CNA wore a gown during the care of Resident #R1. On 07/14/2024 at 3:45 p.m., an interview was conducted with S10LPN. S10LPN confirmed she did not perform hand hygiene when she removed her soiled gloves and before applying clean gloves. S10LPN confirmed Resident #R1 was on Enhanced Barrier Precautions. S10LPN confirmed gowns should be worn for residents on Enhanced Barrier Precautions during any bedside care. S10LPN confirmed she and none of the staff in the room wore a gown during the care of Resident #R1. On 07/14/2024 at 3:51 p.m., an interview was conducted with S11CNA. S11CNA confirmed the sign on Resident #R1's door indicated the resident was on Enhanced Barrier Precautions and a gown should be worn during care. S11CNA confirmed she did not wear a gown during the care of the resident. S11CNA confirmed she did not perform hand hygiene when she removed her soiled gloves and before applying clean gloves. On 07/14/2024 at 3:52 p.m., an interview was conducted with S12CNA. S12CNA confirmed the sign on Resident #R1's door indicated the resident was on Enhanced Barrier Precautions and a gown should have been worn during bedside care. S12CNAconfirmed she was not wearing a gown during the care of Resident #R1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195488	A. Building B. Wing	07/18/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/2024 at 10:50 a.m., an interview was conducted with S2ADON. S2ADON confirmed residents on Enhanced Barrier Precautions required staff to wear gowns when providing high contact resident care such as incontinent care, wound care, or transfers. S2ADON confirmed Residents #2 and #R1 were on Enhanced Barrier Precautions. S2ADON confirmed hand hygiene should be performed after staff remove soiled gloves and before donning clean gloves S2ADON confirmed a urinary drainage bag should never be above the resident's bladder. S2ADON stated if a urinary drainage bag goes above the bladder, urine can go back into the bladder and cause infection. On 07/18/2024 at 3:37 p.m., an interview was conducted with S1DON. S1DON stated residents with wounds, catheters, or infections are placed on Enhanced Barrier Precautions. S1DON stated gowns should be worn during the care of residents on Enhanced Barrier Precautions. S1DON confirmed the urinary drainage bag should never go above the level of the bladder. S1DON stated if the drainage bag goes above the bladder, urine can backflow into the bladder and cause a urinary tract infection.