STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215337	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fahrney-Keedy Memorial Home	8507 Mapleville Road Boonsboro, MD 21713

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48470 Based on observations, records review and interviews, it was determined that the facility failed to ensure resident's urine collection bag was kept in a privacy bag to maintain dignity. This was evident for 1 (Resident #11) of 3 residents reviewed for dignity. The findings include: Resident #11 was admitted into the facility in 2024. During the initial tour of the facility on 1/27/25 at 9:59 AM, the resident's urine collection bag was observed by the foot of the bed with no privacy bag. The urine collection bag was visible from the hallway of the unit where the resident resided. The Registered Nurse (RN #2) who was currently assigned to Resident #11, was interviewed on 1/27/25 at 10 AM. During the interview, the concern was discussed that Resident #11's urine collection bag did not have a privacy bag applied and was visible from the unit's hallway. RN #2 came into the resident's room, confirmed the finding and indicated that she would look for a privacy bag. Afterwards, RN #2 stated, I did not find one in the room. A Foley catheter is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons. Another name for a Foley catheter is an indwelling urinary catheter. A review of Resident #11's care plan on 1/29/25 at 8:51 AM, indicated that the resident was readmitted from the hospital with a Foley catheter in place. The interventions for this care plan included: a) Position catheter bag and tubing below the level of the bladder and away from entrance room door. b) foley catheter care shift and prn On 1/29/25 at 3:09 PM, the Director of Nursing (DON) was interviewed. During the interview, the concern was discussed that Resident #11's urine collection bag was observed with no privacy bag applied and was visible from outside the resident's room. The DON acknowledged the concern and stated, We will fix it. The DON reported that all residents with a urine collection bag will be placed in a privacy bag whether it's hung on the side away from the door or not.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48259 Based on medical record review and interviews, it was determined that the facility failed to ensure that allegations of abuse were reported to the State Agency no later than 2 hours after the allegation was made. This was evident for 1 (#406) of 12 residents reviewed for abuse. The findings include: On 1/30/25 at 9:12 AM, a review of a facility-reported incident related to Resident #406 with MD#00203203 showed that the resident reported an allegation of abuse to an evening nursing supervisor, a licensed practical nurse (LPN #14) on the morning of 3/1/24. A record review of the facility's investigation into the abuse allegation later that day showed that the allegation was reported to the Nursing Home Administrator (NHA) on 3/4/24 at 11:15 AM. Further review of the facility's report of the allegation to the state agency revealed that the incident was initially reported to the state agency on 3/4/24 at 11:59 AM. The facility sent the final report on 3/8/25 at 3:14 PM. The review failed to show that the facility immediately forwarded a first report of the allegation of abuse to the state agency but not later than 2 hours after the facility staff became aware of the allegation. In an interview on 1/30/25 at 10:28 AM, the social services director stated that, per his written statement for 3/1/24, Resident #406 had mentioned the allegation of abuse to him on 3/1/24, at which time the facility was already aware of it and had initiated an investigation. In an interview on 1/30/25 at 12:53 PM, the director of nursing confirmed concerns and stated that the facility lacked documentation to prove that Resident #406's allegation of abuse was reported to the state agency office timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48259 Based on record reviews and staff interviews, it was determined that the facility failed to ensure that thorough investigations were completed for allegations of abuse. This was evident for 3 (#59, #406, #47) out of 12 residents reviewed for abuse. The findings include: 1) A review on 1/28/25 at 2:54 PM of a facility-reported incident related to Resident #59 with MD#00201953 was done. The review showed that on 1/27/24 at approximately 8:15 AM, an environmental services aide (staff #17) alleged abuse to the facility's supervisor on behalf of Resident #59. Staff #17 reported that the resident was verbally abused by a licensed practical nurse (LPN #18) on 1/27/24 at approximately 8:15 AM. The continued review revealed that Resident #59 and his/her roommate were interviewed by staff. The review also showed that Resident #59 was assessed from head to toe and a statement by staff. However, the review lacked documentation that other residents who had been taken care of by LPN #18 that shift were assessed or interviewed by the facility. In an interview on 1/29/25 at 10:00 AM, the director of nursing (DON) stated that the facility did not have documentation showing that other residents were assessed or interviewed when the allegation was made for Resident #59. 2) A review of a facility-reported incident with MD#00203203 on 1/30/25 at 9:12 AM contained an allegation of abuse by Resident #406 involving a staff. Further review of the facility's investigation of the allegation showed that the facility staff assessed Resident #406's skin with no concerns. The review revealed statements from the alleged perpetrator and other staff who had taken care of Resident #406. The review also stated that the alleged perpetrator, an agency nursing staff, had been placed on a Do not return list to the facility. However, the review failed to show that the facility had completed a thorough investigation, including assessment and statements from other residents who had been cared for by the alleged perpetrator. During an interview on 2/3/25 at 11:21 AM, the DON said the facility lacked documentation to prove that other residents were assessed and interviewed when the allegation was made. The DON also added that the facility would include that in their investigations in the future. 51489 3) On 1/31/25 at 10:39 AM a record review of the facility's investigation file regarding facility-reported incident MD00157045 revealed: On 8/8/20 at 4:30 PM, Resident #47 complained to facility Licensed Practical Nurse (LPN) #24 about an alleged incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/20 at 7:35 PM, Registered Nurse (RN) #25 initiated a self-report to nh.selfreport@maryland.gov. The investigation file included several handwritten staff testimonies dated: 8/8/20 at 4 PM, 8/8/20 at 4:58 PM, 8/8/20 at 7:58 PM, 8/9/20 night shift, and 8/10/20 at 10:27 AM all of which did not support the resident's allegation. On 8/10/20, Staff #26, 1st-floor unit manager interviewed Resident #47 and concluded that Resident #47 was confused, making contradictory statements regarding the day the alleged abuse occurred. On 8/11/20 at 11:04 AM Staff #25 submitted a final report not substantiating the incident to nh. selfreport@maryland.gov. On 1/29/25 at 9:50 AM in an interview, the Director of Nursing (DON) acknowledged that an allegation of abuse should be immediately reported to the nurse on duty who then reports to the DON. The nurse who receives the initial allegation should document it in writing then the DON and another nurse interview the resident. The Nursing Home Administrator (NHA) reviews requirements and reports the incident. Facility staff interview other residents in the immediate area. On 1/31/25 at 11:13 AM, in an interview, the DON acknowledged that the investigation involving Resident #47's alleged abuse did not meet facility expectations that include other resident interviews or a resident assessment conducted by a Nurse Practitioner or Physician as part of the investigation.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on interviews and record review, it was determined that the facility failed to notify a resident and/or his/her representative in writing of the facility's bed hold policy upon transfer to an acute care facility. This was evident for one (#39) of 5 Residents reviewed for hospitalization s. The findings include: In an interview on 1/27/25 at 4:17 PM, Resident #39 reported that she was recently hospitalized for an infection. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. A record review on 1/28/25 at 3:29 PM showed that Resident #39 had been residing in the facility since August 2023 and was alert, oriented, and cognitively intact per an MDS assessment dated [DATE]. Further review revealed a nurse's note dated 12/22/24 that indicated that Resident #39 was transferred to the hospital for lethargy, unresponsiveness, and increased tremors. However, the review failed to show that a copy of the facility's bed hold policy was mailed to the Resident's representative. In an interview on 1/29/25 at 2:39 PM, a nursing supervisor (LPN #14) reported that the facility gave the 911 staff a packet that included the facility's bed hold policy upon a resident's transfer to an acute care facility. However, a staff member from the admissions department later called the Resident's representative. During an interview on 1/29/25 at 2:48 PM, the admissions director, staff #19, said the facility's bed hold policy was not addressed with residents who resided in the facility long term but addressed it with residents who lived there for a short-term basis. Staff #19 was questioned about the bed hold policy for Resident #39 when she was transferred to the hospital on 12/22/24. Staff #19 responded that the bed hold policy was not addressed with Resident #39 and/or his/her representative upon transfer to the hospital on 12/22/24. In an interview on 2/3/25 at 12:34 PM, the director of nursing (DON) reported that per the nursing home administrator, he understood the concern of failing to notify the Resident and/or representative in writing of the facility's bed hold policy upon transfer to an acute hospital. The DON also added that the facility would work on fixing the concern going forward.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48470 Based on records review, observations and interviews, it was determined that the facility failed to ensure that the resident's care plan was reviewed and revised to meet the resident's needs. This was evident for 1 (Resident #62) of 1 resident reviewed for tube feeding. The findings include: Tube feeding is a therapy where a feeding tube supplies nutrients to people who cannot get enough nutrition through eating. A flexible tube is inserted through the nose or belly area to provide nutrients by delivering liquid nutrition directly into the stomach or small intestine. Resident #62 was admitted to the facility in early 2024. A quick look into the resident's medical record indicated that s/he received tube feedings. On 1/28/25 at 10:39 AM, the resident reported that s/he received nutrients by tube feedings and by mouth. On 1/29/25 at 9:49 AM, Resident #62's care plan related to nutrition was reviewed. The review revealed interventions that indicated the resident feeds him/herself and was independent after setup. However, other interventions indicated that s/he needed supervision for all intakes. On 1/29/25 at 1:40 PM, a Geriatric Nursing Assistant (GNA #12) was interviewed about Resident #62. GNA #12 reported that she usually worked on the floor where the resident resided and was familiar with Resident #62. GNA #12 reported about the resident's usual dietary intake. She indicated that the resident was a tube feeder but also received a meal tray each time and was on a clear liquid diet. GNA #12 reported and confirmed that staff does not provide assistance with feeding other than setting up the meal tray and adjusting the bed. On 1/29/25 at 1:59 PM, a review of staff documentation on how the resident eats and drinks revealed majority of the staff had documented that the resident was independent. Shortly after at 2:PM, the Director of Nursing (DON) was interviewed and asked about how the GNA's knew the resident's level of assistance needed for different tasks or activities of daily living. The DON reported that the GNA's would look in the Kardex and indicated that she would print a copy of Resident #62's Kardex On 1/29/25 at 3 PM, a printed copy of Resident #62's Kardex was provided and reviewed. The review revealed that the Kardex had the residents' information with instructions specific to the resident's different care areas. Special Instructions on the front page, printed in bold letters, indicated 1 to 1 Supervision with any intake by mouth, Meds via Gastric tube, clear liquid diet. Do not leave tube feeding, tube feeding syringes or cups in room. On 1/30/25 at 12:14 PM, Resident #62 was observed sitting in the common area with other residents. Resident #62 had a cup of water on the table in front of him/her. No staff was observed supervising the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 1/30/25 at 12:56 PM. During the interview, the concern was discussed that Resident #62's care plan had conflicting interventions regarding the level of assistance needed for eating. The DON reported that the resident was able to tolerate liquids and stated, we should change the instructions in his/her Kardex and care plan. She also reported that she would consult with the speech therapist to confirm that the resident was safe to have liquids on his/her own. The DON acknowledged the concern.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observations, medical record review, and interviews, it was determined that the facility failed to ensure that a resident who could not carry out activities of daily living (ADL). This was evident for one Resident (#82) who was reviewed for activities of daily living (ADL) during the survey. The findings include: In an observation on 1/27/25 at 10:26 AM, Resident #82 was noted sitting in a wheelchair in his/her room and had long toenails on bilateral feet. The Resident's representative was present at the bedside and reported he had made staff aware of Resident #82's long toenails three weeks ago. A record review on 1/28/25 at 2:53 PM showed that Resident #82 had been living in the facility since August 2024 with diagnoses including Alzheimer's Dementia (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks). Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. The continued review contained an MDS assessment dated [DATE] that recorded that Resident #82 required substantial/maximal to complete dependence on staff for his/her self-care needs. Further review of Resident #82's plan of care for self-care included an intervention initiated on 8/14/2024 that said, Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #82's shower days were on Tuesdays and Fridays on the day shift. In an interview on 1/30/25 at 9:53 AM, a licensed practical nurse (LPN#23) said that the geriatric nurse aides (GNAs) were to trim the toenails of residents who were not diagnosed with diabetes on their shower days. However, earlier observation on Resident #82's shower day failed to show that his/her toenails were trimmed even though s/he was not diagnosed with diabetes. On 1/30/25 at 10:09 AM, LPN #23 observed Resident #82's toenails with the surveyor. The observation showed that the Resident's long toenails remained. LPN #23 stated that the GNAs should have trimmed the Resident's toenails. On 1/30/25 at 10:16 AM, LPN #23 reported to the surveyor that she trimmed Resident #82's toenails after the surveyor's intervention. During an interview with the director of nursing (DON) on 1/30/25 at 12:58 PM, she stated that the GNAs should have clipped Resident #82's toenails. The DON also reported that the facility would have a process to correct the concern going forward.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48470 Based on observations, records review and interviews, it was determined that the facility failed to provide appropriate treatment and services for care of a resident with an indwelling catheter. This was evident for 1 (Resident #11) of 1 resident reviewed for urinary catheters. The findings include: Resident #11 was admitted into the facility in 2024. During the initial tour of the facility on 1/27/25 at 9:59 AM, the resident was observed in bed with the urine collection bag placed directly on the floor. The Registered Nurse (RN #2) who was currently assigned to Resident #11, was interviewed on 1/27/25 at 10 AM. During the interview, the concern was discussed that Resident #11's urine collection bag was laying directly on the floor. RN #2 came into the resident's room, confirmed the finding and hung the urine collection bag on the resident's bedframe. A Foley catheter is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons. Another name for a Foley catheter is an indwelling urinary catheter. A review of Resident #11's care plan on 1/29/25 at 8:51 AM, indicated that the resident was readmitted from the hospital with a Foley catheter in place. The interventions for this care plan included: a) Position catheter bag and tubing below the level of the bladder and away from entrance room door. b) foley catheter care shift and prn On 1/29/25 at 3:09 PM, the Director of Nursing (DON) was interviewed. During the interview, the concern was discussed that Resident #11's urine collection bag was observed laying directly on the floor. The DON verbalized understanding and acknowledged the concern.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48259 Based on observation and interviews, it was determined that the facility failed to ensure that a resident was served a meal according to a predetermined menu that incorporated the resident's preferences. This was evident from one observation made during the survey. The findings include: On 1/30/25 at 12:30 PM, the surveyor requested a test tray while observing the lunch tray line. The observation showed a meal ticket on the tray for Resident #51 that listed smothered pork chop for entree, 1/2 cup mashed potatoes for starch, 1/2 cup seasoned zucchini for vegetable, 1 white dinner roll, 1pkg [package] pepper and 1 butter for condiment, 1/2 cup cinnamon applesauce, 4oz iced tea for beverage and 4fl.oz water. However, further observation showed that the tray contained an apple pie, pork chop, mashed potatoes, seasoned zucchini, white dinner roll, pkg pepper, and one butter. The Food service manager was present and was made aware that Resident #51's meal ticket listed 1/2 cup of cinnamon applesauce as dessert; however, the observation found apple pie on the tray. And he said, the dietary staff should have put apple sauce on the tray and not apple pie as Resident #51's food texture was mechanical soft and not regular. The nursing home administrator was notified of the above concerns on 2/3/25 at approximately 3:00 PM, and he stated that he was already made aware of the concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observations and interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards. This deficient practice has the potential to affect all residents. The findings include: 1) An initial tour of the facility's kitchen was conducted on 1/27/25 at 8:40 AM with staff #4, food services manager. An observation of the kitchen's walk-in refrigerator revealed the following: -opened Greek yogurt, Pineapple juice, chicken base seasoning, Hungarian paprika seasoning, Dijon mustard sauce, Worcestershire sauce, and an opened lemon juice and cooking wine halfway used. The observation failed to show the items' open and use-by dates. Staff #4 said they should have been labeled with these dates. After the surveyor's intervention, staff #4 removed the items from the refrigerator to dispose of them. A continued observation of the refrigerator noted the following: -an opened [NAME] Italian dressing with a label that stated, prep date 12/27/24 and use by 1/25/25. - chopped garlic labeled prep date 12/27/24 and use by 12/29/24. -chicken broth with a label that stated, prep date 1/24/25 and use by 1/26/25. -cooked ground beef labeled with a prep date of 1/22/25 and use by 1/24/25. -cooked pasta labeled prep date 1/21/25 and use by 1/23/25. -cooked pork loin labeled prep date 12/24/24 and use by 1/26/25. -coleslaw labeled use by 1/22/25. -sliced fresh tomatoes labeled prep date 1/23/25 and use by 1/25/25. -leftover cabbage and carrots labeled prep date 1/23/25 and use by 1/25/25. Leftover cream of wheat labeled prep date 1/22/25 and use by 1/24/25. Staff stated that we usually don't keep leftover cream of wheat; it should have been disposed of. -leftover cooked turkey labeled prep date 1/23/25 and use by 1/25/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two containers of diced cantaloupes labeled use by 1/18/25. -fresh diced parsley labeled prep date 1/16/25 and use by 1/18/25. Staff #4 said he would dispose of them immediately and added that they usually don't keep leftovers from some foods like cream of wheat but could not explain why they were still in the refrigerator. In an interview later that day, staff #4 indicated that the facility was changing its food labeling system to fix its food labeling challenges. 2) An observation of the kitchen staff preparing food and the residents' lunch food trays on 1/30/25 at 11:45 AM revealed the following concerns: a) Staff #5, a dietary aide, was observed picking up a tray with multiple plates containing food from the kitchen to the dining room. She served them to residents in the dining room, then picked up meal tickets from various tables. Staff #5 returned to the kitchen, put on gloves, and then picked up the phone in the kitchen. Staff #5 did not remove gloves or wash her hands and returned to pick up food from the tray line. Staff #4, the food services manager, was present and was immediately made aware. Staff #4 called out staff #5 to wash their hands before touching any food. Staff #4 then told the surveyor that he understood the concern about hand hygiene and would ensure hand sanitizers were available in the dining room for hand hygiene between servings. b) On 1/30/25 at 11:50 AM, staff #7, a dietary aide, was observed picking up the residents' food from the tray line to the meal carts. The observation failed to show that Resident #7 had a hair restraint (covering for the hair to prevent hair from contacting food). Staff #4 was immediately made aware. After the surveyor's intervention, staff #7 was noted with a hair net. c) An observation was made on 1/30/25 at 11:55 AM of staff #6 wearing gloves and dishing food at the tray line. Staff #6 stepped away from the tray line, touched a food warmer with the gloves, and opened it. He then returned to the tray line and touched bread with the same gloves. After the surveyor's intervention, staff #6 removed his gloves, washed his hands, and changed his gloves. Staff #4 said he did afternoon hurdles with the dietary staff and would go over hand hygiene in those sessions. He also added that his staff received hand hygiene training upon hire and yearly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215337	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fahrney-Keedy Memorial Home	8507 Mapleville Road Boonsboro, MD 21713

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 51712 Based on observations, record reviews, and staff interviews, it was determined that the facility failed: to comply with isolation protocols, to have a prevention plan for Legionella, and staff failed to use appropriate personal protective equipment (PPE). This was evident for 3 (Resident #71, #85, #39) of 6 residents reviewed for infection control; and 1 of 1 plan reviewed for water management which has the potential to affect all residents. The findings include: 1) Resident #71 was diagnosis with pneumonia on 1/22/25 after chest x-ray confirmed it. On 1/27/25 at 9:11 AM the Assistant Director of Nursing (Staff #1) reported that Resident #71 is on droplet precautions, and will require gowning to enter the room. At 9:20 AM, in front of Resident #71's room, surveyor observed droplet precaution sign posted on outside of the room, the supplies were located on the door, and the door was open. Resident #71 was observed in a recliner chair in the room. Record review confirmed that Resident #71 was placed on Droplet precautions on 1/23/25 for 11 days by the Nurse Practitioner. According to the Centers for Disease Control and Prevention (CDC), health care personnel caring for residents on Droplet Precautions must wear a fit tested N-95 mask, a gown, and gloves for close patient contact, which is considered to be within six feet or less or in the room of the residents. Use Droplet Precautions for patients known or suspected to be infected with germs transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. On 1/28/25 at 9:08 AM Surveyor observed a Geriatric Nursing Assistant (GNA) #8 sitting in a chair in resident #71's room. GNA #8 was wearing a surgical mask but no other Personal Protective Equipment (PPE); no gown or N95. At 9:10 AM, an interview with the Director of Nursing (DON), confirmed Resident #71 was still on droplet precautions. Surveyor reviewed the concern with the DON about observed staff person in the room only wearing mask, and no gown. The DON indicated she would address the issue. On 1/29/25 at 11:51 AM, the surveyor interviewed GNA #8 who acknowledged that she went into Resident #71's room the day before and did not put on the appropriate Personal Protective Equipment (PPE). 2) According to the CDC, Legionella is a type of bacteria that causes Legionnaires' disease and Pontiac fever. Legionella grows best in large, complex water systems that are not adequately maintained. The bacteria can become a health concern when they grow and spread in human-made building water systems like: showerheads and sink faucets, hot tubs, decorative fountains and water features such as hot water tanks and heaters, large, complex plumbing systems, and cooling towers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/29/25, the facility provide a copy of their Legionella Water Management Program policy, which was last revised in September 2022. Review of this policy revealed that the water management program would include a detailed description and diagram of the water system in the facility, and would identify areas in the water system that could encourage the growth and spread of Legionella and other waterborne bacteria. The program would be able to identify any situations that could lead to Legionella growth and specific measure to be used to control the introduction and/or spread of Legionella; the control limits or parameters that are acceptable and that are monitored. There would be a diagram of where control measures are applied; and a system to monitor control limits and effectiveness of control measures. The water management program was to be reviewed at least once a year or sooner if any of the following occur: the control limits are consistently not met; there a major maintenance of water service change; there are any disease cases associated with the water system; or there are changes in laws, regulations, standards or guidelines. Further record review revealed that there were no text or flow diagrams of the buildings water system, or any information that was stated in the policy. On 1/30/25 at 12:12 PM the surveyor interviewed Staff #9 from maintenance, to discuss the Legionella water management program. Surveyor reviewed with Staff #9 the information that was provided to the survey team, what the policy stated and how none of the information was provide in a written form. Surveyor asked Staff #9 to explain what the plan was for prevention of Legionella and other waterborne pathogens. Staff #9 admitted that he did not have a plan in place but understood what was needed to be completed. 51786 2) Enhanced Barrier Precautions (EBP) refers to a healthcare practice where staff are required to wear gowns and gloves during high-contact resident care activities for certain individuals. On 1/27/25 at 11:37 AM an interview and observation were conducted with Resident #85. The resident stated he/she had a wound on the right shoulder and the right hip. He/She said the right hip wound was healed but the right shoulder wound required a dressing change daily. Wound care supplies were observed on top of the bedside drawer. On 1/31/25 at 11:00 AM, an observation was made of Resident #85's right shoulder wound dressing change by a Licensed Practical Nurse (LPN #3). The LPN donned clean gloves and removed the resident's dirty dressing. After she removed the dirty dressing, LPN #3 removed her dirty gloves and put on clean gloves, cleansed the wound and applied a clean dressing to the resident's right shoulder wound. On 1/31/25 at 11:13 AM, immediately after the dressing change, an interview with LPN #3 was conducted outside the resident's room. On the resident's door, there was an EBP sign that indicated the provider should wear a gown and gloves when wound care was provided. When asked about the EBP sign and what to wear before a dressing change, LPN #3 confirmed that she did not wear a gown that was required as part of EBP measures. The dressing change steps were also reviewed with LPN #3 and she confirmed that she did not clean her hands after she removed her dirty gloves and before she put on clean gloves. She also confirmed that she was aware that this was a deficient practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/31/25 at 4:00 PM The Director of Nursing (DON) was asked to provide the wound care and dressing change policies. On 2/03/25 at 08:00 AM The wound care and dressing change policies were received. A review of these policies revealed that the LPN should wash and dry hands thoroughly after the removal of dirty gloves and before she donned clean gloves. On 2/03/25 at 11:00 AM The DON was asked to provide the facility's EBP policy. On 2/03/25 at 11:20 AM The EBP policy was received and a review revealed that gloves and gowns should be worn for high-contact resident care activities such as dressing change procedures. On 2/03/25 at 11:28 AM an interview with the DON was conducted to review that LPN #3 failed to perform hand hygiene and wear a gown when she changed Resident #85's wound dressing. The DON confirmed this was a deficient practice. 48259 3) An observation on 1/27/25 at 3:52 PM noted a signage on Resident #39's door that indicated the resident was on EBP, which required wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions are infection control interventions designed to reduce transmission of infection in nursing homes. It involves gown and glove use during high-contact Resident care activities like dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with infection or colonization of MDRO (multi-drug-resistant organisms), central line, urinary catheter, feeding tube, tracheostomy, or any skin opening requiring dressing. A subsequent observation on 1/27/25 at 3:55 PM showed that certified nursing assistants (CNAs #10 and #11) were providing incontinent care to Resident #39. Both CNAs had put on gloves, but the observation failed to show that they wore gowns. A record review later that day noted that Resident #39 had been treated for an MDRO urinary tract infection in December 2024. In an interview on 1/27/25 at 4:14 PM, CNAs #10 and #11 were asked what the EBP signage on Resident #39's door meant. Both staff stated it meant to wear gloves and a mask when providing direct care to Resident #39. Both staff continued to say that they used to wear gowns and gloves whenever they had direct contact with the resident. However, they did not see why to continue wearing gowns anymore. In an interview on 1/29/25 at 8:38 AM, RN #1, assistant director of nursing (ADON), stated that after the resident had been treated for active MDRO in December 2024, s/he was placed on EBP for the rest of her/his stay in the facility. The ADON continued to say that before staff had direct contact with the resident, they were to wear gowns and gloves. ADON also added that she was made aware of the surveyor's concerns and had provided education to GNAs #10 and #11.