STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225221	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champion Rehabilitation and Nursing Center	2 Beaumont Avenue Brockton, MA 02302

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49424 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan for three Residents (#43, #2, and #36), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #43, to develop and implement a care plan for the Resident's smoking needs; 2. For Resident #2, to develop and implement a care plan for epilepsy (seizure disorder); and 3. For Resident #36, to develop and implement a care plan for the Resident's suicidal ideation. Findings include: 1. Review of Resident Smoking Policy and Procedure, dated 2022, indicated but was not limited to the following: -Resident deemed to need assistance to smoke should have the designation noted in the care plan. -The determination of the smoking assessment should be noted in the Resident's care plan. Resident #43 was admitted to the facility in August 2021 with diagnoses which included: hypertension, ambulatory dysfunction, and asthma. Review of the Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #43 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating the Resident was cognitively intact. During an observation with an interview on 08/27/24 at 10:58 A.M., the surveyor observed Resident #43 outside in the designated smoking area with two other residents smoking cigarettes. The Resident said they go out four times a day to smoke and was not sure if his/her care plan indicated any special restrictions or instructions for smoking. During an interview on 8/27/24 at 11:00 A.M., Unit Manager #2 said she was not sure if there were any special instructions for Resident's smoking needs. She said information regarding needs and accommodations would be found in a smoking care plan. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the record indicated there was no smoking care plan developed. Further review revealed a smoking assessment was completed on 4/26/24 which indicated the Resident must be supervised by staff, volunteer or family member at all times when smoking. During an interview on 8/28/24 at 1:31 P.M., the Director of Nursing (DON) said any resident who smokes should have a care plan. She said the care plan links to the Kardex (summary of resident's care and preferences) so Certified Nursing Assistants (CNA) can see the individual information related to the resident's smoking needs. She said the Resident should have a smoking care plan and that it was missed. 48084 2. Resident #2 was admitted to the facility in April 2024 with diagnoses including epilepsy. Review of the MDS assessment, dated 7/31/24, indicated Resident #2 scored 9 out of 15 on the BIMS indicating he/she had moderate cognitive impairment and he/she had epilepsy. Review of the active Physician's Orders indicated the following: -Seizure Activity: monitor for signs and symptoms of seizure activity. Document seizure activity and update Doctor/Nurse Practitioner every shift. (6/19/24) -Gabapentin Oral Capsule 400 milligrams (mg) give one capsule two times daily related to epilepsy. (6/4/24) -Lamictal Oral Tablet 25 mg-give 50 mg by mouth one time a day related to epilepsy. (4/2/24) -Lamictal Oral Tablet 150 mg-give one tablet by mouth one time a day related to epilepsy. (1/29/24) -Levetiracetam (Keppra) Oral Tablet 500 mg-give three tablets by mouth two times a day related to epilepsy. (4/30/24) -Phenobarbital Oral Tablet 32.4 mg-give three tablets two times a day related to epilepsy. (5/5/24) Review of the comprehensive care plan failed to indicate a care plan for epilepsy had been developed. Review of the medical record including physician and nursing progress notes indicated Resident #2 had been transferred to the hospital multiple times for seizure activity and had been having increased frequency of seizure activity. During an interview on 8/29/24 at 1:15 P.M., Nurse #4 said Resident #2 keeps having seizures. We are trying to get an inpatient appointment, but it is taking a long time. She said she was not sure why there was not a care plan developed as there should be one with triggers on it. She said she knows that the door alarm is a trigger and will cause a seizure, so she keeps him/her away from the door and if he/she wants to go outside she knows to take him/her outside first. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/24 at 2:00 P.M., the DON said there should be a care plan with triggers and interventions in place and there was not. She said the MDS Nurse usually does the care plans but this one was missed. 46862 3. Resident #36 was admitted to the facility in June 2024 with diagnoses including dementia with behavioral disturbance, post-traumatic stress disorder (PTSD- occurs in some individuals who have encountered a shocking, scary, or dangerous situation), and personal history of suicidal behavior. Review of the MDS assessment, dated 6/17/24, indicated Resident #36 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of Resident #36's Hospital Discharge Summary indicated Resident #36 reported symptoms for worsening depression and suicidal ideation. Resident #36 expressed he/she had a plan to end his/her life. Further review of Resident #36's medical record failed to indicate facility staff gathered information related to Resident #36's suicidal ideation to develop an individualized person-centered plan of care. During an interview on 8/28/24 at 10:31 A.M., CNA #4 said she took care of Resident #36 regularly. CNA #4 said she was unaware that Resident #36 had been hospitalized for suicidal ideation. During an interview on 8/28/24 at 3:20 P.M., Social Worker (SW) #1 said she was aware that Resident #36 had been discharged following a psychiatric stay. SW #1 said she was unable to review the hospital discharge summary for Resident #36. SW #1 said she should have developed a care plan to monitor for suicidal ideation to keep him/her safe. During an interview on 8/29/24 at 7:45 A.M., Unit Manager (UM) #3 said she was unaware of Resident #36's history of suicidal ideation. UM #3 said she had admitted Resident #36 however, she only writes the medications and reviews them with the physician. UM #3 said she did not have time to read through the whole discharge summary. UM #3 said Resident #36's care plan for suicidal ideation should have been developed and staff taking care of him/her should have been aware. During an interview on 8/29/24 at 11:09 A.M., the DON said Resident #36's care plan should have been developed to include suicidal ideation and staff educated to monitor for signs of worsening depression.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 36542 Based on observations, interviews, and record review, the facility failed to ensure one Resident (#53), out of a total sample of 18 residents, received care and treatment to promote healing of a pressure ulcer. Specifically, the facility failed for Resident #53, to implement treatments as ordered for an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (necrotic (dead) tissue that is green, yellow, tan, or brown and may be moist, loose, or stringy) or eschar (dry, thick, leathery tissue)) on the sacrum (lower spine area). Findings include: Review of the facility's policy titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated as revised in December 2023, indicated the following: -the physician will order pertinent wound treatments including dressings and application of topical agents -the nurses shall describe and document current treatments Resident #53 was admitted to the facility in July 2022 with a diagnosis of dementia and was on hospice services. Review of the care plans indicated Resident #53 had actual skin impairment on the sacrum with interventions to complete the treatments as ordered by the physician. Review of the medical record indicated Resident #53 developed a Deep Tissue Injury (DTI) (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) on the sacrum on 4/9/24. Review of the Wound Evaluation and Management Summary from the wound consultant physician, dated 8/8/24, indicated Resident #53 had a stage 3 (full-thickness loss of skin in which fat is visible in the ulcer and granulation tissue and rolled wound edges are often present) pressure ulcer on the sacrum measuring 3.0 centimeters (cm) in length by 1 cm in width by 0.1 cm in depth with DTI within the wound bed. The treatment indicated to utilize Alginate Calcium with silver and Mupirocin topical ointment with a superabsorbent gelling fiber with silicone border dressing. Review of the medical record included a recommendation, dated 8/2/24, from hospice for wound care: cleanse with normal saline, pat dry, apply barrier cream to periwound, apply Calcium Alginate to wound bed, cover with non-adhesive foam followed by transparent dressing, three times weekly and as needed for soilage or dislodgement. Review of the Treatment Administration Record (TAR) for August 2024 indicated a new treatment started on 8/9/24: Sacrum- cleanse with normal saline, pat dry, apply barrier cream to periwound, apply Calcium Alginate to wound bed, cover with superabsorbent silicone dressing every evening shift every Monday, Wednesday, Friday for wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 2:00 P.M., the Staff Development Coordinator (SDC) said she had contacted the primary physician with the hospice recommendation to change the treatment, including decreasing the frequency to three times per week and left a message. During an interview on 8/29/24 at 11:00 A.M., the primary physician said he could not recall specifically speaking with staff about changing the treatment on 8/9/24 but he does verify all orders or treatments that are presented. Review of the Wound Evaluation and Management Summary from the wound consultant physician, dated 8/15/24, indicated Resident #53 had an unstable (due to necrosis) pressure ulcer of the lower sacrum measuring 3.5 cm in length by 1.5 cm in width by 0.1 cm in depth with 40% necrotic tissue. The treatment indicated to add Santyl and continue to utilize Alginate Calcium with silver and Mupirocin topical ointment with a superabsorbent gelling fiber with silicone border dressing. Review of the August 2024 TAR indicated the treatment order for changing the dressing three times per week remained in place until Monday 8/19/24 and the last treatment was completed on Friday 8/16/24. The TAR indicated the order was discontinued on 8/19/24 before the treatment was completed. The TAR indicated the treatment recommended on 8/15/24 by the wound consultant physician began on 8/20/24. Review of the TAR indicated no treatment was completed on 8/20/24. The sacrum pressure ulcer dressing was not changed for five days. During an interview on 8/28/24 at 3:33 P.M., the SDC said she had spoken with hospice and the hospice staff did not provide a dressing change for Resident #53 on 8/19/24 or 8/20/24. During an interview on 8/29/24 at 12:46 P.M., the Director of Nurses (DON) said the nursing supervisor, who completed rounds with the wound consultant physician on 8/15/24, had not updated the treatment orders. The DON said she noticed on 8/19/24 that the order was not up to date and initiated the new treatment. She said the treatment order had changed in the electronic medical record prior to the treatment being completed on 8/19/24 and therefore the treatment was missed. The DON said the nurse should have completed the treatment on 8/20/24. During an interview on 8/30/24 at 6:00 P.M., the wound consultant physician said he had not known that on 8/9/24 the wound treatment had changed to be completed three times per week. He said a dressing cannot be left on that long on a necrotic wound. He said the treatment was now twice per day due to the incontinence (including feces) and to keep the dressing and the wound clean. Review of the active Physician's Orders indicated the following: -Sacrum: Cleanse with 1/4 strength Dakins (topical antiseptic used to prevent infections in wounds) pat dry apply Santyl (ointment used for debriding necrotic tissue from the wound) to slough (collection of dead tissue usually yellow or tan in color) and mupricin (sic) (Mupirocin-ointment used to treat skin infections) to remaining areas, then cover with calcium alginate with silver (antimicrobial dressing to prevent infection in wounds). Skin Prep (wipe used to create a barrier between skin and dressing) wound edges and cover with a super absorbent silicone bordered dressing daily and as needed for displacement. (8/23/24) On 8/29/24 at 10:00 A.M., the surveyor observed Nurse #1 perform Resident #35's wound care which included but was not limited to the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 gathered supplies at the doorway to the Resident's room, entered the room, and prepared the worktable with the following supplies: 1/2 strength Dakins solution, 4x4 gauze pads, a super absorbent dressing, calcium alginate, skin prep wipes, and a zip lock bag with two ointments. The nurse failed to obtain the correct Dakins solution, the correct calcium alginate, and the correct ointments. -Dakins 1/4 strength was ordered and 1/2 was placed in the work field. -Calcium Alginate with silver was ordered and calcium alginate was placed in the work field. -Santyl and Mupirocin ointments were ordered, and the zip lock bag placed on the work field contained ointments belonging to another resident. -Nurse #1 and Unit Manager #2 (UM) performed hand hygiene (HH), put on a gown and gloves before turning Resident #53 to provide wound care. -Nurse #1 removed the soiled dressing, removed gloves, and put on clean gloves without performing HH. -Nurse #1 cleansed the wound with the Dakins 1/2 strength solution and 4x4 gauze pads, removed gloves, performed HH, and put on clean gloves. -Nurse #1 opened the zip lock bag, after inspecting the tubes, he realized they did not belong to Resident #53. He then walked to the treatment cart (at the doorway), opened the drawer to get the correct supplies, returned to the work field and placed the ointments on the table. -Nurse #1 failed to change gloves or perform HH after handling the wrong tubes of ointment and touching the treatment cart. -Nurse #1 proceeded to open the tube of Santyl and squeezed the ointment directly from the tube onto to deep open wound, touching the wound bed and covering the entire wound bed (not just the area with slough). -Nurse #1 picked up the Mupirocin ointment and proceeded to squeeze the ointment directly from the tube onto the superficial open areas surrounding the deep wound. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 cut the Calcium Alginate to fit in the wound bed and packed the dressing into the wound bed. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 applied skin prep to the peri wound (skin surrounding the wound). -Nurse #1 removed his gloves, performed HH, and put on new gloves. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 folded a 4x4 piece of gauze, placed it over the calcium alginate, and covered the wound with the super absorbent dressing. -Nurse #1 removed gloves to get a marker from UM #2, put on new gloves without performing HH, proceeded to write the date on the dressing that was on Resident #53's body and then put the incontinent brief back on. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 opened skin prep pads and applied skin prep to Resident #53's bilateral heels. -Nurse #1 removed his gloves and did not perform HH, then proceeded to clean up the supplies on the table. During an interview on 8/29/24 at 10:33 A.M., Nurse #1 said he did not have the correct supplies (he used 1/2 strength Dakins and regular Calcium Alginate) because that was all they had. Additionally, he said the order says for the Santyl to be applied to the slough, but it goes in the entire wound bed and the Mupirocin goes around it on the smaller areas. He said he squeezed the ointment directly from the tubes onto the wound and he should not have. He said sometimes he puts the ointment directly onto the Calcium Alginate but not always and he said the extra 4x4 piece of gauze he put on was not part of the order, but he always puts it there for reinforcement. Nurse #1 said he does not perform HH every time he changes his gloves and usually only does it every 2-3 times he changes them. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurse (DON) and Infection Preventionist/Staff Development (IP/SDC) said HH should be done with every glove change. Additionally, they said the ointments should never be applied directly to the wound for infection control purposes, the ointments should be squeezed to a clean surface and then applied. The DON said the 4x4 is not part of the order and should not have been added to the dressing. Additionally, she said the 1/4 strength Dakins and Calcium Alginate with Silver are in the building and he should have used the correct wound supplies and followed the treatment order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48084 Based on observation, record review, and interview, the facility failed to ensure the environment was free from accident hazards for one Resident (#51), out of a total sample of 18 residents. Specifically, the facility failed to implement interventions on the comprehensive care plan to ensure safety precautions were taken for resident safety related to smoking, and to complete quarterly smoking evaluations. Findings include: Review of the facility's policy titled Resident Smoking Policy and Procedure, dated 2022, indicated but was not limited to the following: -The facility will maintain an environment that remains as free from accidental hazards as possible. The facility will ensure that each resident receives adequate supervision and assistance to prevent accidents. The facility will provide accommodation of individual needs and preferences without endangering the health or safety of any resident in the facility. -Residents deemed to need assistance should have this designation noted in the care plan. RESIDENTS: -Each resident should be individually assessed to determine whether or not he/she can safely smoke without supervision. -Residents are not permitted to have any smoking paraphernalia in their room or on their person. All smoking paraphernalia should be given to the nursing staff for safe keeping. -Residents who have been determined to require supervision must be actively supervised by a staff member while in the designated smoking area. CONTRACT: -Smoking materials are stored at the nurses' station or as per facility policy. -Use ashtrays provided to extinguish cigarettes. -Follow the plan of care established for the use of safety devices. Review of the facility's policy titled Clinical Assessment, dated 3/17/23, indicated but was not limited to the following: -Assessments to be completed on admission, quarterly, and significant change: Smoking - if applicable. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 was admitted to the facility in September 2021 with diagnoses including muscular dystrophy, ambulatory dysfunction, and generalized weakness. Review of the Minimum Data Set (MDS) assessment, dated 8/14/24, indicated Resident #51 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and he/she smoked. Review of the Smoking Evaluations in the medical record indicated evaluations were completed on the following dates: 11/30/21 and 3/27/23. The facility failed to complete quarterly assessments per policy. Review of the most current evaluation, dated 3/27/24, indicated Resident #51 was not able to light a cigarette safely, was not able to utilize an ashtray safely and properly, and was not able to extinguish a cigarette safely. Additionally, he/she must be supervised by staff and must wear a smoking apron. Review of the comprehensive care plan indicated the following: FOCUS: Resident #51 likes to smoke. (Initiated 11/30/21) GOAL: Resident # 51 will remain safe while smoking. INTERVENTIONS: -Resident #51 uses an adaptive ashtray to aid in smoking. (Ashtray that holds the cigarette in the ashtray away from the body, the cigarette is attached to a plastic tube with a mouth adapter that goes into the Resident's mouth to prevent ashes and the cigarette from falling onto lap if unable to hold the cigarette with own hands. (3/3/22) -Ensure Resident is aware of facility smoking policy. (11/30/21) -Smokers Apron. (11/15/22) Review of the active Physician's Orders indicated the following: -Adaptive Equipment: Smokers Apron (1/30/23) The surveyor made the following observations: -8/27/24 at 10:00 A.M., Resident #51 was sitting outside on the smoking patio with a staff member with the smokers apron on. Resident #51 had the cigarette hanging out of his/her mouth with his/her arms at their side under the smokers apron. No adaptive ashtray was in use. -8/28/24 at 1:40 P.M., Resident #51 was sitting in a wheelchair in his/her room with two cigarettes on his/her lap, waiting for staff to come back to take him/her outside. At 1:44 P.M., Certified Nursing Assistant (CNA) #6 arrived to bring Resident #51 to the smoking patio. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/28/24 at 1:48 P.M., Resident #51 was sitting outside on the smoking patio with smokers apron on. Resident #51 had a cigarette hanging out of his/her mouth with his/her arms at their side under the smokers apron. No adaptive ashtray was in use. Nurse #3 was standing inside the building behind the glass doors to supervise smoking. Ashes from the cigarette fell from the cigarette that was hanging from his/her mouth onto the apron then Resident #51 dropped the cigarette onto the apron. The resident sitting next to Resident #51 picked the cigarette up from the apron and disposed of it. The resident then picked up Resident #51's second cigarette from his/her lap and put it in his/her mouth. Nurse #3 then opened the door and entered the patio to light the cigarette for Resident #51. Resident #51 proceeded to smoke the second cigarette with it hanging out of his/her mouth only held in place by his/her lips. Resident #51 was attempting to talk while balancing the cigarette in place. Neither Nurse #3 nor the other nurse that came to the patio looking for a resident to administer medications provided intervention to ensure the cigarette was secure while he/she was smoking. During an interview on 8/29/24 at 1:05 P.M., Resident #51 said they keep their cigarettes in their room because they are afraid someone will steal them. Additionally, he/she said they don't use that stupid tube smoke thing; they like to hang the cigarette from their mouth. He/she said, If I drop it, one of the other residents that sits near me usually pick it up for me. During an interview on 8/29/24 at 1:12 P.M., CNA #6 said Resident #51 keeps his/her cigarettes in the top drawer of the dresser with the lock. She said Resident #51 thinks people will steal them, so we keep them there and put two on his/her lap before he/she goes out to smoke. During an interview on 8/29/24 at 2:00 P.M, the Director of Nurses (DON) said she just found out Resident #51 likes to keep cigarettes in their room which is against policy. The DON said the care plan indicates an adaptive ashtray is in use. However, we tried it a while ago and he/she did not like it, so he/she does not use it. The DON said Resident #51 likes to smoke with the cigarette hanging from their mouth which really is not safe. Additionally, she said Resident #51 used to shake their head to get the ashes to fall off into the taller ashtray outside but having them just fall onto the apron is not safe. (The taller ashtray the DON was referring to was not in reach of Resident #51 during either smoking observation.) The DON said other residents should not be picking up cigarettes to help Resident #51 and he/she needs to be reevaluated. At 3:00 P.M, the DON said although staff can observe smoking from inside for most people, someone should be sitting with Resident #51 (1:1) as he/she cannot safety hold the cigarette or ensure ashes and the cigarette do not fall on him/her. During an interview on 8/29/24 at 2:45 P.M., the Staff Development Coordinator said Resident #51 holds his/her cigarette in their mouth; he/she does not use an adaptive ashtray; he/she usually bends their neck and shakes their head to flick ashes off. She said staff can stand inside to supervise in general but with Resident #51 there should be a staff member sitting next to the Resident (1:1), because he/she cannot hold the cigarette in their mouth or pick it up if it falls. Additionally, she said other residents should not be picking up the cigarette if it falls from someone else's mouth.

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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 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. 48084 Based on record review and interview, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care and management consistent with professional standards for one Resident (#2), out of a total sample of 18 residents. Specifically, the facility failed to ensure the Foley catheter was assessed for removal as soon as possible after returning from the hospital and failed to ensure he/she followed up with Urology as recommended. Findings include: Resident #2 was admitted to the facility in April 2024 with diagnoses including overactive bladder and epilepsy (seizure disorder). Review of the Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #2 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment, had epilepsy, had been hospitalized recently, and had a Foley catheter. Review of the active Physician's Orders indicated but were not limited to the following: -Foley Catheter Care every shift for urinary elimination. (7/25/24) -Foley Catheter 16 French/10 milliliter (16F/10cc) balloon every shift for monitoring. (7/25/24) Review of the Comprehensive Care plan indicated Resident #2 had a Foley catheter for neurogenic bladder (bladder dysfunction caused by the nervous system). Review of the medical record failed to indicate a diagnosis of neurogenic bladder. Further review of the medical record indicated Resident #2 had been hospitalized from 7/19/24 through 7/24/24 for seizures and did not have a Foley catheter prior to this hospitalization . Review of the discharge summary, dated 7/24/24, indicated Resident #2 had acute urinary retention (inability to empty the bladder) resulting in repeated straight catheterizations (small tube inserted to drain urine but not left in place) and urethral trauma, requiring Foley catheter placement. Discharge recommendation included Urology follow up in 3-4 weeks and a voiding trial (attempt to remove Foley to evaluate if able to void without it). Review of the medical record including physician and nursing notes, orders, and treatment sheets failed to indicate a voiding trial had been attempted or discussed. Review of the Physician's progress note, dated 7/26/24, indicated Resident was noted with urinary retention, Foley inserted while inpatient with recommendation to follow up with urology in 3-4 weeks. Review of the Appointment book on the unit failed to indicate a urology appointment had been made. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes indicated the following: -8/22/24, Resident #2 had a seizure, was restless and repeatedly asked staff to check the catheter. The catheter was draining, but not closed all the way, and was leaking into the privacy bag. -8/24/24, Resident #2 pulled the Foley catheter out and was transferred to the hospital at his/her request. -8/25/24, Resident #2 returned from the emergency room with a new catheter in place. -8/27/24, Resident #2 stated the catheter was leaking, the bag had a hole in it and was replaced. -8/28/24, Resident #2 said the room smelled like urine and he/she was not sleeping in there. Resident was out of bed in the wheelchair and at 6:30 A.M., was observed sideways in bed, and stated they were trying to get into bed. Further review of the progress notes failed to indicate staff had reached out to the physician to discuss a voiding trial or to inquire if a Urology follow-up was scheduled. During an interview on 8/28/24 at 9:51 A.M., Nurse #4 said every appointment is logged into the binder and that it is used to book transport as well. She was unsure if he/she had a Urology appointment scheduled. During an interview on 8/29/24 at 1:15 P.M., Nurse #4 said she did not know why the Urology appointment was never made but she was going to call the office. She said she thought the Unit Manager had booked it but there was nothing in the book. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurses (DON) said she was not sure how the appointment was missed but the ball was dropped, and the process needs improvement. The DON said the Foley catheter is new and the appointment should have been made. The DON said we want him/her to have a voiding trial and not have a Foley catheter that is not needed. During an interview on 8/29/24 at 3:11 P.M., Nurse #4 said she called the Urologist's Office and unfortunately Resident #2 had an appointment yesterday and missed it because it was never put into the appointment book and transportation was never booked. She said the next available appointment now is not until October. She said she was going to call the physician to see what he wanted to do about the voiding trial. No additional information was provided to the surveyor prior to exit.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 36542 Based on observations, interviews, record review, and policy review, the facility failed to monitor the nutritional status for one Resident (#18) with an unplanned gradual weight loss, in a total sample of 18 residents. Specifically, the facility failed for Resident #18, to obtain weekly weights as ordered and to monitor the gradual weight loss of 9.68% over six months. Findings include: Review of the facility's Weight Management policy, undated, indicated the healthcare staff will perform the following best practice guidelines to manage risk of significant unplanned weight change: -residents are weighed a minimum of monthly with more frequent weights obtained as ordered or deemed necessary Review of the facility's Clinical Assessment policy, dated 3/17/23, indicated it was the policy of the facility to complete appropriate assessments on residents on admission, quarterly, significant change, annually and at any time an assessment would be indicated. The purpose of the assessments is to get an accurate picture/evaluation of the resident to ensure the development of an appropriate and comprehensive plan of care. Assessments to be completed on admission, quarterly and significant change include Nutritional Assessment. Resident #18 was admitted to the facility in September 2006 with diagnoses of anoxic brain damage, dysphagia (difficulty swallowing), and dementia. Review of the care plans indicated Resident #18 was nutritionally at risk due to diagnoses of anoxic brain damage and dysphagia. The care plan goals indicated the Resident would consume greater than 50 percent (%) of all meals and would maintain a weight of 185 pounds (lbs.) plus or minus 5 lbs., last revised April 2024. Review of the medical record indicated on 2/2/24, Resident #18 weighed 169.4 lbs. and on 8/1/24, the resident weighed 153 lbs., a loss of 9.68%. During an interview on 8/28/24 at 8:20 A.M., Certified Nursing Assistant (CNA) #2 said the intake for Resident #18 can vary, sometimes the Resident was alert, like today and sometimes the Resident was more tired. The CNA said the Resident's ability to self-feed also depended on how alert the Resident was. Review of the most recent Mini Nutritional Assessment, dated 3/25/24, indicated Resident #18 was at risk for malnutrition. Review of the most recent Nutritional Risk Evaluation, dated 3/25/24, indicated Resident #18: -weighed 168 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had a usual body weight of 175 lbs., plus or minus 5 lbs. (10 lbs. less than indicated on the care plan) -received double portions and super cereal (dietary supplement) with breakfast -weight history indicated weight was stable for one month with a loss of 4.5% in six months, insignificant. Review of the progress notes indicated the following: -on 3/1/24, the Nurse Practitioner initiated Mighty Shakes (dietary supplement) twice per day -on 3/12/24, the physician reviewed the Resident's weights and did not feel it was a true weight loss because of good intake of meals. Review of the Physician's Orders indicated an order to obtain weekly weights for Resident #18 was written on 3/5/24. Review of the electronic and paper medical record failed to indicate weights were obtained weekly. Review of the weight record indicated the following weights were obtained for Resident #18: 3/5/24: 168.3 lbs. 4/2/24: 170.0 lbs. 4/9/24: 170.2 lbs. 4/16/24: 169.4 lbs. 4/30/24: 166.6 lbs. 5/14/24: 165.4 lbs. 5/28/24: 162.6 lbs. 6/11/24: 160.0 lbs. 6/18/24: 197.6 lbs. (reweigh requested) 6/25/24: 161.0 lbs. 7/15/24: 156.8 lbs. 8/1/24: 153.0 lbs. 8/6/24: 154.1 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 8:45 A.M., CNA #1 said there was a list of residents who needed to be weighed weekly. She reviewed the list with the surveyor and said Resident #18 was not on the list. Review of the physician's Progress Note, dated 8/20/24, indicated Resident #18 had no signs of weight loss, despite the loss of 14.2 lbs. since the order for weekly weights was written on 3/5/24. Review of all assessments and progress notes on 8/27/24 indicated a Registered Dietitian (RD) had not completed an assessment or written a progress note for Resident #18 since 3/25/24. During an interview on 8/29/24 at 11:05 A.M., the RD said she had been covering the facility since June 2024. She said the facility process was for every resident to be assessed quarterly by an RD and she was unable to locate a quarterly assessment for Resident #18 since March 2024. She said the RD also pulled reports to check that all residents with orders for weekly weights were being weighed weekly. She said she did not know Resident #18 was not being weighed weekly. She said she had become aware of the insidious weight loss (gradual, unintended, progressive weight loss over time) for Resident #18 this week and had planned to see and assess the Resident this week. During an interview on 8/29/24 at 2:16 P.M., the RD said she had met with and assessed Resident #18 and would be adding additional interventions.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 46862 Based on record review and interviews, the facility failed to ensure three Residents (#36, #51, and #89), out of a total sample of 18 residents, received culturally competent, trauma-informed care in accordance with professional standards of practice. Specifically, the facility failed to assess and identify triggers of trauma to prevent potential re-traumatization. Findings include: Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma. SAMHSA-HRSA Center for Integrated Health Solutions. Substance Abuse and Mental Health Services Administration, 11/30/2016. Review of the facility's policy titled Trauma Informed Care and Culturally Competent Care, dated revised 8/2022, indicated but was not limited to: -Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events -Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers -Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments -Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate -Identify and decrease exposure to triggers that may re-traumatize the resident -Ensure that residents have a sense of psychological, social, cultural, moral and physical safety 1. Resident #36 was admitted to the facility in June 2024 with diagnoses including dementia with behavioral disturbance, post-traumatic stress disorder (PTSD- occurs in some individuals who have encountered a shocking, scary, or dangerous situation), and personal history of suicidal behavior. Review of the Minimum Data Set (MDS) assessment, dated 6/17/24, indicated Resident #36 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the Resident's Level I Preadmission Screenings and Resident Reviews (PASRR) completed on 7/12/24 indicated PTSD as a current diagnosis. Review of the Discharge Summary from Resident #36's hospitalization indicated the Resident reported symptoms of PTSD which included: nightmares, flashbacks, difficulty sleeping, and changes in mood. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #36's medical record failed to indicate a trauma informed care assessment had been conducted since admission. Further review of Resident #36's medical record failed to indicate facility staff gathered information related to Resident #36's PTSD to develop an individualized person-centered plan of care that identified potential triggers of trauma and prevented re-traumatization. During an interview on 8/28/24 at 10:31 A.M., Certified Nursing Assistant (CNA) #4 said she took care of Resident #36 regularly. CNA #4 said she was unaware of any trauma indicators or triggers for this Resident and did not know about his/her trauma history. During an interview on 8/28/24 at 3:20 P.M., Social Worker (SW) #1 said she did not realize Resident #36 had a diagnosis of PTSD. SW #1 said she should have completed a trauma assessment. During an interview on 8/29/24 at 7:45 A.M., Unit Manager #3 said she was unaware of Resident #36's trauma history and could not identify triggers or interventions to prevent potential re-traumatization. During an interview on 8/29/24 at 11:09 A.M., the Director of Nurses (DON) said the Social Worker should complete an assessment to identify a history of trauma upon admission for all residents. The DON said Resident #36's trauma assessment was not done. 48084 2. Resident #51 was admitted to the facility in September 2021 with diagnoses including muscular dystrophy, depression, and anxiety. Review of the MDS assessment, dated 8/14/24, indicated Resident #51 scored 15 out of 15 on the BIMS indicating he/she was cognitively intact and had a diagnosis of PTSD. Review of the medical record indicated the diagnosis of PTSD was a new diagnosis added to the profile on 8/5/24. During an interview on 8/27/24 at 9:00 A.M., Resident #51 reported to the surveyor that he/she had experienced a traumatic event in July 2024. Review of the nursing progress notes indicated that in July 2024 Resident #51 was transferred to the hospital and was admitted for further care. Resident #51 returned to the facility in August 2024. Review of the medical record, including hospital paperwork and discharge summary, indicated Resident #51 was admitted with a chief complaint of Abuse/Trauma. He/she was medically/psychologically cleared in agreement to return to the facility as long as issues were addressed. He/she returned to the facility for continued medical management in August 2024. Review of the nursing note, dated 8/6/24, indicated Resident #51 was seen by psychiatric services on 8/5/24 and a new diagnosis of PTSD was to be added to the resident record. Doctor aware and diagnosis added with a start date of 8/5/24. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan indicated a care plan had been developed on 8/7/24 for PTSD, however the care plan failed to indicate resident specific triggers that may cause re-traumatization of the Resident. Review of the Psychiatric Evaluation and Consultation progress notes indicated he/she was seen on 8/5/24 for monthly follow up after returning from the hospital and no medication changes were made. Further review indicated he/she was seen again on 8/12/24 due to persistent breakthrough anxiety and a recommendation for an as needed antianxiety medication was made. Review of the Trauma Questionnaire, dated 8/2/24, indicated the facility failed to complete the questionnaire. The assessment was opened in the electronic medical record and was blank; none of the questions were answered. During an interview on 8/28/24 at 12:21 P.M., Social Worker #1 said the Trauma Questionnaire should have been completed and it was not. During an interview on 8/29/24 at 1:15 P.M., Nurse #4 said she did not know who did the Trauma Questionnaire or who put the specific triggers onto the care plan. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurses (DON) said the Trauma Questionnaire should have been completed when he/she returned from the hospital and the new diagnosis was added. She said she opened the questionnaire so the Social Worker would complete it and it was not done. Additionally, the DON said his/her care plan is generic and should have resident-specific interventions and triggers to avoid on it and it does not. She said the questionnaire, had it been completed, would have provided staff with more information to add to the care plan to guide staff to provide resident centered care related to the new diagnosis of PTSD and the events surrounding the new diagnosis. 49424 3. Resident #89 admitted to the facility in July 2004 with diagnoses including suicidal ideation and major depressive disorder. Review of the MDS assessment, dated 7/19/24, indicated the Resident scored 12 out of 15 on the BIMS assessment indicating a moderate cognitive impairment. Review of the Resident's documentation from the hospital indicated the Resident had a past medical history of trauma. Review of the Resident's care plan failed to include any history of trauma, triggers, or interventions to eliminate or mitigate triggers that may cause re-traumatization of the Resident. Review of hospital discharge documents in Resident #89's chart indicated that he/she had endured a history of sexual and physical abuse and had nightmares and flashbacks associated with these and described sometimes waking up screaming from these memories. Review of the Resident's Level II PASRR completed on 7/10/24 indicated PTSD as a current diagnosis. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/24 at 11:33 A.M., Resident #89 said the facility staff never asked him/her any questions about their trauma history. The Resident said he/she would have told them if they asked as there are specific things he/she can identify that bother him/her. For example, he/she said they had increased anxiety when he/she was in the hospital and there was a man disrobing in the hallway. Review of the Behavioral Health Services evaluation, completed on 8/27/24, indicated the Resident had been in a serious accident, witnessed an extremely frightening situation, and had been in a situation that was extremely frightening. Review of the medical record failed to indicate that the facility staff had assessed the Resident for trauma or implemented a care plan related to his/her diagnosis of PTSD. During an interview on 8/28/24 at 12:21 P.M., the Social Worker said she cannot remember if Resident #89 was assessed for trauma, as she cannot find any supporting information to indicate it was completed. She said if a resident has a diagnosis or trauma history she should go back and obtain additional information and develop a care plan. She said there is no additional information in the Resident's medical record indicating he/she was asked about his/her trauma and triggers and she must have missed the information in the Resident's PASARR and the psychiatric hospital discharge summary.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48084 Based on record review and staff interviews, the facility failed to ensure for one Resident (#42), out of a total sample of 18 residents, that the Resident's drug regimen was free from unnecessary drugs. Specifically, the facility failed to ensure Azithromycin (antibiotic) was not administered without an adequate indication for use for an excessive duration of time (one year). Findings include: Resident #42 was admitted to the facility in December 2022 with diagnoses which included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and pneumonia. Review of the Minimum Data Set (MDS) assessment, dated 6/26/24, indicated Resident #42 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS), was cognitively intact, and was taking an antibiotic. Review of the medical record indicated Resident #42 had been admitted to the hospital in August 2023. Review of the hospital Discharge Summary, dated 8/8/23, indicated the Resident was discharged back to the facility on a 5-day course of antibiotics for pneumonia. The Discharge Summary failed to indicate the need or recommendation for long-term prophylactic treatment with antibiotics. Review of the Medication Administration Record (MAR) for August 2023 indicated he/she completed the 5-day course of antibiotics as recommended in the discharge orders. Review of the primary care physician (PCP) progress note, dated 8/22/23, indicated Resident #42 was being seen for follow up from pneumonia, had no shortness of breath or overnight issues. Additionally, his/her lungs were clear and oxygen saturation levels were over 90% and to continue current management. Review of the respiratory progress note, dated 8/22/23, indicated Resident #42 was seen by the respiratory therapist and pulmonary doctor, and indicated that the pulmonary doctor recommended Azithromycin and Prednisone (steroid) taper. Review of the nursing progress note, dated 8/22/23, indicated new orders per pulmonologist: Prednisone Taper 40-10 milligram (mg) (two days each dose) and Azithromycin 250 mg three times a week. MD in agreement. Review of the active Physician's Orders indicated but were not limited to the following: -Azithromycin Oral tablet 250 mg give one tablet by mouth one time a day every Monday, Wednesday, Friday related to COPD. (8/23/23) Review of the comprehensive care plan failed to indicate a care plan had been developed for the prophylactic use of antibiotics with an indication for use or for the diagnosis of COPD. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records (paper and electronic) failed to indicate a progress note from the pulmonologist indicating his evaluation, recommendation for prophylactic antibiotic, and the indication for use. Review of the medical records (paper and electronic) failed to indicate the primary care physician had evaluated the need for prophylactic antibiotics and the indication for use. During an interview on 8/29/24 at 1:19 P.M., Nurse #4 said she thinks the recommendation came from respiratory therapist and/or pulmonologist. Nurse #4 was unable to provide the surveyor with any documentation regarding the indication for prophylactic antibiotic use. Additionally, Nurse #4 said she did not know why he/she has been on the antibiotic for a year now. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurses (DON) said she was unable to find any documentation in the medical record except the one respiratory note, dated 8/22/23, indicating the recommendation came from the pulmonologist. She said he usually would write notes in the chart and was not sure why there was not a note in the paper or electronic medical record. The DON said she placed a call to the respiratory therapist to try and contact the pulmonologist. She said the pulmonologist no longer comes to the facility, however the respiratory therapist was still in contact with him, so she reached out to see if there was a progress note that was not uploaded. She said there should be a note from the Pulmonologist and the PCP in the medical record regarding the indication for use and there is not. The facility failed to provide any additional documentation regarding the prophylactic antibiotic use by the conclusion of the survey.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 49424 Based on observations, interviews, and record review, the facility failed to ensure the physician ordered therapeutic diet was followed for one Resident (#29), in a total sample of 18 residents. Findings include: Resident #29 was admitted to the facility in July 2015 with diagnoses which included: dysphagia oropharyngeal phase (an impairment in the ability to swallow), pneumonitis due to inhalation of other solids and liquids, gastrostomy status (presence of a feeding tube), and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side. Review of Resident #29's Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the staff assessed the Resident to be severely cognitively impaired. Review of the Physician's Orders for Resident #29 indicated the following: regular diet, puree texture, thin consistency. Review of the care plan for Resident #51 indicated the following: Focus: Resident #29 has an ADL self-care performance deficit. Goal: Resident #29 will maintain current level of function through the review date, revised on 3/26/24. Intervention: Resident requires tube feedings for nutrition, pureed diet for pleasure foods and requires continual supervision by staff. He/she may require physical assistance to eat by mouth. Review of the Nurse Practitioner's note, dated 8/1/24, indicated Resident #29 was to continue the current diet and monitor for signs of aspiration. Further review indicated that the Resident has been tolerating the pureed diet with thin liquids. Review of the Speech and Language Pathologist's (SLP) discharge summary, dated 4/6/23, indicated Resident #29 was to continue to require a pureed diet for safe swallowing; he/she continued to present with difficulty managing non-pureed solids at discharge. On 8/28/24 at 10:35 A.M., the surveyor observed Resident #29 in bed, awake, with a box of crackers on the bedside table and an opened sleeve of crackers in the bed. The Resident's privacy curtain was pulled past the Resident's end of bed. The surveyor observed the Resident with crackers in his/her mouth and he/she was actively chewing. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 10:41 A.M., Unit Manager #2 said she doesn't know where the information would be kept if the Resident could have crackers on their diet. She said she was aware that the Resident had them. She said that a staff member would have had to hand the crackers to the Resident and open them as he/she wasn't able to do that without assistance. Unit Manager #2 said the staff keeps an eye on the Resident by checking on him/her and walking by the room. Unit Manager #2 said Resident #29 is on a therapeutic diet and isn't aware of any exceptions to the puree diet order. During an interview on 8/28/24 at 3:17 P.M., the Director of Nursing (DON) said the Rehab Director could not find any documentation indicating the Resident could eat the crackers safely and unsupervised. During an interview on 8/29/24 at 8:15 A.M., the Rehabilitation Director said the Resident was last treated by SLP in 2023. She said not adhering to the therapeutic diet puts the Resident at risk for choking and aspiration. She said the Resident should be supervised and if there were exceptions for the Resident to eat foods outside of the therapeutic diet there would be a physician's order. During an interview on 8/29/24 at 1:24 P.M., Rehab Staff #1 said that a screen was placed for the Resident to be evaluated by SLP. He said that after the evaluation, he had concerns for aspiration due to the Resident's positioning, lack of dentition, and he recommended that the puree diet be adhered to for safety with no exceptions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41106 Based on observations, interview, and policy review, the facility failed to store, prepare, and serve food in accordance with professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to perform hand hygiene during meal service on two of three units observed. Findings include: Review of the facility's policy titled hand washing/hand hygiene, revised August 2019, indicated but was not limited to the following: -The facility considers hand hygiene the primary means to prevent the spread of infections. -All personnel shall follow the hand washing/hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Use an alcohol-based rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after direct contact with residents; b. Contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and, c. Before and after assisting a resident with meals. On 8/28/24 at 11:55 A.M., the surveyor observed a meal pass on the [NAME] Unit and observed the Nurses and Certified Nursing Assistants (CNA) serve food trays from the meal truck and deliver them to resident rooms. In delivering the trays, they moved overbed tables, assisted residents in positioning, and set up the meal on the overbed table. This process was repeated until the meal truck was empty. The surveyor observed the nurses and the CNAs to occasionally perform hand hygiene when exiting the residents' room prior to retrieving and delivering another tray to a different resident. On 8/29/24 at 7:58 A.M., the surveyor observed breakfast service on the [NAME] Unit and observed the CNAs remove food trays from the meal truck and deliver them to resident rooms. In delivering the trays, they moved overbed tables, assisted residents in positioning, and set up the meal on the overbed table. This process was repeated until the meal truck was empty. The surveyor did not observe any of the CNAs perform hand hygiene after exiting the residents' room and prior to retrieving and delivering another tray to a different resident. During an interview on 8/29/24 at 8:25 A.M., the Food Service Manager (FSM) said he noticed the CNAs were not performing hand hygiene during the meal service. The surveyor reviewed the observations of meal service on 8/28/24 in which the CNAs and the nurses did not consistently perform hand hygiene during meal pass. He said they should be performing hand hygiene every time they leave the residents' room.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 48084 Based on record review and interview, the facility failed to ensure for one Resident (#2), out of a total sample of 18 residents, recommended specialist appointments were scheduled. Specifically, the facility failed to ensure Inpatient Epilepsy (seizure disorder)and Neurology appointments were scheduled. Findings include: Review of the facility's policy titled Consultation Follow (sic), dated 2/2/24, indicated the facility will schedule the appointment and arrange transportation. Resident #2 was admitted to the facility in April 2024 with diagnoses including epilepsy. Review of the Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident #2 scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment, he/she had epilepsy, and had been hospitalized recently. Review of the medical record indicated Resident #2 was having frequent seizures. Review of the Appointment Communication Form, dated 5/28/24, indicated Electro-encephalogram (EEG) (test to measure electrical activity in the brain) was completed and to follow up on 6/26/24. Review of the Appointment Communication Form, dated 6/26/24, indicated to consider inpatient evaluation at Epilepsy Center- patient refuses. Follow up as needed. Review of the nursing progress note, dated 7/1/24 (late entry), indicated 6/26/24 clinic recommendations-continue current medications-could consider inpatient evaluation at Epilepsy Center-patient refuses. Review of the nursing and physician progress notes failed to indicate facility staff had a discussion with the Resident regarding the inpatient Epilepsy Center upon return from the appointment (6/26/24 through 7/12/24). Review of the Physician progress note, dated 7/12/24, indicated patient seen for neurology follow up 6/26/24 to discuss EEG results, recommendations for additional follow up- nursing staff to schedule. Review of the Appointment book failed to indicate an appointment at the Epilepsy Center had been made or was in progress. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated a fax transmittal cover sheet, dated 7/15/24, was in the paper chart. The cover sheet indicated it was sent to the Neurology Office and indicated Resident #2 was seen on 6/26/24 and there was a recommendation to consider inpatient evaluation at Epilepsy Center but he/she had refused. He/she has been having more frequent seizures and is now in agreement. Please let us know what steps are needed to get him/her admitted . No confirmation page was attached. No additional documentation was attached. Review of the nursing progress note, dated 7/15/24, indicated a call was placed and a message left with the Neurology office to schedule an appointment at the Epilepsy Center. Further review of the nursing notes indicated Resident #2 continued having more frequent seizures. The notes failed to indicate staff had reached out to schedule an Epilepsy Center inpatient appointment. Resident #2 was hospitalized in July 2024 due to increased seizures and the physician wanted a full neuro evaluation. Review of the Hospital Discharge Summary, dated 7/24/24, indicated the following: -Continuing prior Neuro meds. Recommend Neurology follow up in 4 weeks and outpatient referral for Epilepsy Monitoring Unit (EMU-specialized unit that monitors brain activity to evaluate, diagnose, and treat seizures) Admission. If having recurrent seizure type episode at the skilled nursing facility, recommend these be recorded for outpatient Neurology. Review of the comprehensive care plans failed to indicate an Epilepsy care plan had been developed. Review of the nursing and physician's progress notes and physician's orders failed to indicate the recommendation to record seizure activity had been addressed. Review of the Appointment book failed to indicate the appointments had been made. Review of the nursing progress notes indicated Resident #2 had seizures on 7/28/24, 7/30/24, and 8/1/24. Further review of the progress note, dated 8/1/24, indicated a call was placed to the Neurology Office to inquire about the Epilepsy Center Appointment process. The note indicated the Neurology Office said the process had been started, a return call was pending, and a direct number for the Epilepsy Center was provided to the nurse. Further review of the nursing progress notes failed to indicate a call was placed to the Epilepsy Center regarding the appointment process/status. Further review of the Appointment Binder on the unit failed to indicate Resident #2 had any appointments for Neurology or the Epilepsy Center scheduled or pending return calls. Review of the nursing progress notes indicated Resident #2 had seizures on 8/18/24, 8/22/24 times 2, and 8/27/24. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the nursing progress notes failed to indicate a call was placed to the Epilepsy Center regarding the appointment process or to the Neurology Office to schedule a follow up appointment. During an interview on 8/28/24 at 9:51 A.M., Nurse #4 said every appointment is logged into the Appointment binder and that is used to book transport as well. She was unsure if he/she had a Neurology or an appointment at the Epilepsy Center booked. During an interview on 8/29/24 at 1:15 P.M., Nurse #4 said she did not know why neither of the appointments were ever made. She said the Epilepsy Center sent a fax on 7/15/24 but they haven't called back. Nurse #4 said Resident #2 keeps having seizures and she did not know what the plan was. Nurse #4 reviewed the Discharge Summary with the surveyor and said she did not know anything about a Neurology follow up or recording the seizure activity and was not sure of the status of the other appointment. She said it should not take this long to make appointments and we should have followed up. Nurse #4 called the Neurology Office, with the surveyor present, and the office confirmed a Neurology Appointment was never made. Additionally, she said the Epilepsy Center will not take Resident #2's insurance, but we (facility) did not know that because we never spoke to the office. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurses (DON) said she was not sure how the appointments were missed but the ball was dropped, and the process needs improvement. She said she did not know anything about the recommendation to record the seizure activity but would have to look into that as they would need a secured device. The DON said Resident #2 has had more frequent seizures (a few times a week now) and it is to the point that the Physician doesn't know what to do with him/her. She said we need to get those appointments made and if the Epilepsy Center won't take his/her insurance we will have to call the Physician and come up with a new plan. Additionally, she said the Neurology Appointment was booked today (after surveyor inquiry), but it should have been done when he/she came back from the hospital a month ago. She said making follow up appointments should not take this long. No additional information was provided to the surveyor prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48084 Based on observation, record review, and interviews, the facility failed to ensure for one Resident (#53), out of a total sample of 18 residents, infection prevention and control measures were implemented to prevent the potential transmission of infections. Specifically, the facility failed to ensure staff followed basic infection control practices, including hand hygiene, resulting in potential cross contamination (transfer of pathogens from one surface to another). Findings include: Review of the facility's policy titled Handwashing/Hand Hygiene, dated as last revised August 2019, indicated but was not limited to the following: -This facility considers hand hygiene the primary means to prevent the spread of infections. -Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: a. Before and after direct contact with a resident. b. Before performing any non-surgical invasive procedures. c. Before handling clean or soiled dressings, gauze pads, etc. d. Before moving from a contaminated body site to a clean body site during resident care. e. After handling used dressings, contaminated equipment, etc. f. After contact with objects in the immediate vicinity of the resident. g. After removing gloves. -Applying and Removing Gloves: Perform hand hygiene before applying non-sterile gloves and after removing gloves. Review of Centers for Disease Control and Prevention (CDC) guidance titled Infection Control in Healthcare: An Overview, dated 2/7/24, indicated but not limited to the following: Common reservoirs in and on the human body: Skin -Many germs live and grow on healthy skin and normally do not cause harm. -Your skin interacts with the environment daily, especially when you touch things with your hands. -Pathways for germs to spread from skin include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Touch, especially with your hands. Review of Centers for Disease Control and Prevention titled Infection Control Basics, dated 4/3/24, indicated but not limited to the following: Transmission can happen through activities such as: -Physical contact, like when a healthcare provider touches medical equipment that has germs on it and then touches a patient before cleaning their hands. Resident #53 was admitted to the facility in July 2022 with diagnoses including dementia, scoliosis, and protein calorie malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 6/4/24, indicated Resident #53 was rarely/never understood, had severe cognitive impairment, and had an unhealed pressure ulcer. Review of the Wound Evaluation and Management Summary, dated 8/22/24, indicated but was not limited to the following: -Focused Exam (Site 2): Unstageable (due to necrosis) (full thickness tissue loss that is covered by a layer of dead tissue, or eschar, that prevents the physician from seeing the wound bed to determine the stage) of the lower sacrum (area located at the base of the lumbar vertebrae connected the pelvis) -Wound Size: 4.5 centimeters (cm) x 3.5 cm x 0.2 cm Review of the active Physician's Orders indicated the following: -Sacrum: Cleanse with 1/4 strength Dakins (topical antiseptic used to prevent infections in wounds) pat dry apply Santyl (ointment used for debriding necrotic tissue from the wound) to slough (collection of dead tissue usually yellow or tan in color) and mupricin (sic) (Mupirocin-ointment used to treat skin infections) to remaining areas, then cover with calcium alginate with silver (antimicrobial dressing to prevent infection in wounds). Skin Prep (wipe used to create a barrier between skin and dressing) wound edges and cover with a super absorbent silicone bordered dressing daily and as needed for displacement. (8/23/24) On 8/29/24 at 10:00 A.M., the surveyor, with Unit Manager #2 present, observed Nurse #1 perform wound care on Resident #53 which included but was not limited the following: -Nurse #1 removed the soiled dressing, removed gloves, and put on clean gloves without performing HH. -Nurse #1 opened a zip lock bag, after inspecting the tubes, he realized they did not belong to Resident #53. He then walked to the treatment cart (at the doorway), opened the drawer to get the correct supplies, returned to the work field and placed the ointments on the table. -Nurse #1 failed to change gloves or perform HH after handling the wrong tubes of ointment and touching the treatment cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 proceeded to open the tube of Santyl and squeezed the ointment directly from the tube onto the deep open wound, touching the wound bed. -Nurse #1 picked up the Mupirocin ointment and proceeded to squeeze the ointment directly from the tube onto the superficial open areas surrounding the deep wound. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 cut the Calcium Alginate to fit in the wound bed and packed the dressing into the wound bed. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 applied skin prep to the periwound (skin surrounding the wound). -Nurse #1 removed his gloves, performed HH, and put on new gloves. -Nurse #1 folded a 4x4 piece of gauze, placed it over the calcium alginate, and covered the wound with the super absorbent dressing. -Nurse #1 removed gloves to get a marker from UM #2, put on new gloves without performing HH, proceeded to write the date on the dressing that was on Resident #53's body and then put the incontinent brief back on. -Nurse #1 removed his gloves and put on new gloves without performing HH. -Nurse #1 opened skin prep pads and applied skin prep to Resident #53's bilateral heels. -Nurse #1 removed his gloves and did not perform HH, then proceeded to clean up the supplies on the table. During an interview on 8/29/24 at 10:33 A.M., Nurse #1 said he did squeeze the ointment directly from the tubes onto the wound and he should not have. He said sometimes he puts the ointment directly onto the Calcium Alginate but not always. Nurse #1 said he does not perform HH every time he changes his gloves and usually only does it every 2-3 times he changes them. During an interview on 8/29/24 at 2:00 P.M., the Director of Nurse (DON) and Infection Preventionist/Staff Development (IP/SDC) said HH should be done with every glove change. Additionally, they said the ointments should never be applied directly to the wound for infection control purposes, the ointments should be squeezed to a clean surface and then applied.