STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225475	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor Nursing Home	85 North Washington Street North Attleboro, MA 02760

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 42742 Based on observation and interview, the facility failed to ensure one Resident (#13), out of a total sample of 18 residents, was treated with respect and dignity. Specifically, the facility failed to ensure staff provided a privacy cover for Resident #13's Foley catheter (tube inserted into the bladder to drain urine) drainage bag when the bag was exposed, containing urine, and visible for others to see. Findings include: Resident #13 was admitted to the facility in May 2023 and had diagnoses including urinary tract infection. Review of the Minimum Data Set (MDS) assessment, dated 7/18/24, indicated Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15, had an indwelling Foley catheter, and was dependent on staff for personal hygiene and showering/bathing. Review of current Physician's Orders indicated the following: -Foley catheter care: Provide Foley catheter hygiene every shift. Add to POC instructions: Click on select POC charting category and pick miscellaneous tasks from the list every shift; 7:00 A.M. - 3:00 P.M., 3:00 P. M. - 11:00 P.M., 11:00 P.M. - 7:00 A.M., 7/10/24 -Foley to collection device at all times, ensure leg bag or overnight bag is connected and containing output every shift, 7:00 A.M. - 3:00 P.M., 3:00 P.M. - 11:00 P.M., 11:00 P.M. - 7:00 A.M., 7/10/24 On 8/20/24 at 10:17 A.M. and 11:28 A.M., the surveyor observed Resident #13 sitting in a recliner chair in his/her room. A Foley catheter was observed hanging from the side of the chair draining yellow urine into a urinary drainage bag. The Foley catheter was not stored in a privacy bag and was fully visible to the surveyor from the doorway and to anyone passing by. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 8/20/24 at 3:23 P.M., the surveyor and Certified Nursing Assistant (CNA) #1 observed Resident #13 lying in bed. A Foley catheter was observed hanging from the right side of the Resident's bed, closest to the doorway, draining yellow urine into a urinary drainage bag. The Foley catheter was not stored in a privacy bag and was fully visible to anyone entering the room. CNA #1 said it was the first thing she saw when she entered the room as it was resting on the floor but did not place the drainage bag into a privacy bag after placing a protective barrier underneath it. On 8/21/24 at 1:52 P.M., 2:32 P.M., and 4:41 P.M., the surveyor observed Resident #13 lying in bed. A Foley catheter was observed hanging from the right side of the bed draining yellow urine into a urinary drainage bag. The drainage bag was not stored in a privacy bag and was fully visible to the surveyor from the doorway and to anyone passing by. During an interview on 8/21/24 at 4:41 P.M., CNA #5 said no one should be able to visualize the urine in the bag. During an interview on 8/21/24 at 4:45 P.M., Nurse #5 said catheter bags should be covered so the urine cannot be visualized. During an interview on 8/21/24 at 4:50 P.M., the Infection Preventionist said to maintain dignity, urine should be covered and not visualized while in the bag.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43935 Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure concerns from the Resident Council were documented to ensure they were acted upon timely and included the facility response. Findings include: Review of the facility's policy titled Resident Council, dated as reviewed 9/2023, indicated but was not limited to the following: - the home will listen to and follow up on residents' complaints and grievances through Resident Council meetings and individual resident requests - distribute minutes of the last meeting to the administrator and resident council president - notify department heads of complaints when presented - schedule department head to answer complaints of residents at the next council meeting or immediately, if required - each facility shall have a resident council consisting of representatives elected by facility residents elected annually Review of the Resident Council Meeting Minutes from February 2024 through July 2024 indicated the residents in attendance at those meetings had no concerns for any department for the entire six months reviewed. On 8/16/24 at 11:00 A.M., the surveyor held a Resident group meeting with 13 residents in attendance, including the Resident Council President and [NAME] President. The following concerns were discussed: - 9 of the 13 residents said they were told not to discuss what happened in Resident council with anyone not in the council meeting but the facility's Activity Director (AD) - 9 of 13 residents said that concerns voiced are only responded to if the AD feels the concern rises to the level of requiring a response and not all their concerns are followed up on - 7 of 13 residents said the Resident council meeting is supposed to be for them but is run by the AD who takes the minutes and directs them in what is to be discussed - the President and [NAME] President said they have never seen the meeting minutes, been offered to review the minutes, or offered a copy of the minutes and they felt that would be helpful in knowing what issues were addressed and documented as being brought up as a concern (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5 of 13 residents said missing clothing has been discussed at the resident council meeting in the last two months - 3 of 13 residents said concerns of housekeeping not filling the bathrooms with paper goods has been brought up in the last one to three months - all of the residents in attendance agreed the food service director (FSD) had been present in the last few meetings to discuss food questions and concerns that had been brought up over the last few months The last six months of meeting minutes were shared with the Resident Council and failed to include any of the concerns the residents discussed in this meeting, 6 of the 13 residents said the Resident Council meeting minutes were inaccurate and did not include information they have brought forward in the last few months that they expected to be documented and followed up on. During an interview on 8/16/24 at 11:58 A.M., the AD said she runs the Resident Council meeting, organizes inviting all the residents and inviting any department heads she thinks the residents would like to see for a check-in even when there are no concerns or issues for that department head. She said she also writes the minutes of the meeting and keeps attendance records. She said if a concern is brought forward it is written on a separate piece of paper for Resident Council response and provided to the department head that would be responsible for addressing the concern. She said the department head is then required to respond with a plan within about 48 hours and the Resident Council is made aware of the response and the department head would usually attend the next meeting. She said there have been no concerns or issues brought forth by the Resident Council in the last six months or so but wanted to verify that in her records and offered to supply the survey team with any response forms she may have. During a follow up interview on 8/16/24 at 12:15 P.M., the AD provided the surveyor with two Resident Council response forms dated in December 2022. She said there had been no voiced concerns for the Resident Council since that time and she did not have any more recent response forms. She said she documents any information or concerns brought forward in Resident Council on the meeting minutes. She said she doesn't recall any of the residents discussing issues with missing clothing, housekeeping not filling paper products in the bathrooms sufficiently, or any food concerns. She said she invited the FSD to the council meeting in the last few months to discuss changes to the menus and adding additional cookouts to the activity schedule. She reviewed the Resident Council meeting notes and said although the dietary section indicated no concerns because there were no issues and she didn't feel the information needed to be in the meeting minutes and said she feels the meeting minutes reflect all discussions in the Resident Council meetings. She said the majority of the Resident Council meetings are discussing activity programs and any activities they would like to see or events they would like planned. She said she can see how the residents may feel that the meeting isn't centered around them based on this and her need to refocus them on things that need to be discussed. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/16/24 at 1:16 P.M., the FSD said she attended the last three or four Resident Council meetings after being invited by the AD. She said they did not discuss menu changes but she was asked to assist with holding a cookout. She said when she attended not many issues were brought up at the meetings, and what was, she considered to be minor and she addressed them. This last month, there were no concerns at all communicated. She said she did not keep any notes or minutes on what concerns the residents voiced and cannot specifically remember what the issues were. She said she believed the process was that the AD would put the concerns and resolution information in the Resident Council meeting notes and she was not required to maintain separate records. She said she was surprised the information was not in the Resident Council meeting minutes and did not know why it would not be documented in there. During an interview on 8/16/24 at 1:19 P.M., the Administrator said the expectation is that the Resident Council meeting minutes reflect all discussions the residents have in the meeting both good and bad to ensure any concerns are followed up on. He said he was not aware of any recent concerns the Resident Council had and the meeting minutes should have reflected them and did not. He said he was not aware the Resident Council President or [NAME] President were not reviewing the meeting minutes for accuracy and the process would need to be looked at.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43935 Based on interview and document review, the facility failed to notify the physician of an ongoing and significant weight loss for one Resident (#26), out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Weight Loss Policy, dated as reviewed 2/2024, indicated but was not limited to the following: - all confirmed weight loss of 5 pounds (lbs.) or more within one month is reported to the dietician, the weight information is recorded in the chart - staff must also report any continuing trends of monthly weight loss, even if it is below 5 lbs. - the dietician is responsible for determining if weight loss is significant, unplanned (weight loss greater than (>) 5% in one month, 10% in 6 months) - the physician is to be notified by nursing staff of any significant weight loss Resident #26 was admitted to the facility in December 2023 and has diagnoses including: Hypothyroidism and dysphagia (difficulty swallowing). The Brief Interview for Mental Status (BIMS), dated 6/14/24, indicated the Resident was cognitively intact with a score of 15 out of 15. Review of the current Physician's Orders, dated 8/21/24, indicated but were not limited to the following: - Weekly weight to be obtained: notify MD/NP of any significant weight loss/gains over past week and any trends, once a day on Thursdays (12/14/23) During an interview on 8/15/24 at 8:09 A.M., Resident #26 said he/she had lost at least 20 pounds since being admitted to the facility. During an interview on 8/15/24 at 4:13 P.M., Nurse #2 said Resident #26 has had a weight loss but has recently started to gain a little back. She said she does not know the exact amount of weight loss. Review of Resident #26's weight monitoring report from 12/2023 to 8/15/24 indicated but was not limited to the following: 2/29/24- 119.0 lbs. 3/28/24- 112.8 lbs. (significant weight loss in one month (2/29/24) of 5.21%) 4/04/24- 113.9 lbs. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	4/25/24- 110.8 lbs. 5/02/24- 106.8 lbs. (significant weight loss in one month (4/4/24) of 6.23%) 5/09/24- 104.6 lbs. Review of the Minimum Data Set (MDS) assessment for Resident #26 indicated the following weights were used on the following MDSs: - 12/14/23 - MDS recorded a weight of 125 lbs. - 03/07/24 - MDS recorded a weight of 115 lbs. - 06/14/24 - MDS recorded a weight of 104 lbs. In the three months from the December 2023 MDS to the March 2024 MDS the Resident had a significant loss of 8.12%. In addition, in the three months between the March 2024 MDS and the June 2024 MDS, the Resident had another significant weight loss of 9.88% (significant weight loss is = > 7.5% in 3 months). Review of the MDS assessment, dated 6/14/24, indicated, but was not limited to the following: SECTION K (Swallowing/Nutritional Status): K0200: Height = 66 inches Weight = 104 lbs. (most recent and measured in the last 30 days) K0300: Weight loss: Loss of 5% or more in the last month or 10% or more in the last 6 months: YES, not on a physician prescribed weight loss regimen The MDS indicated that from the 12/14/23 MDS recorded weight of 125 lbs. to the 6/14/24 MDS recorded weight of 104 lbs. Resident #26 experienced a significant weight loss of 16.8% over 6 months. Review of the progress notes for Resident #26 from 1/2024 to 8/21/24 failed to indicate the physician was made aware of the significant and ongoing weight loss. During an interview on 8/21/24 at 12:57 P.M., Nurse #3 said the Resident had been losing weight and has only started gaining weight in the last few weeks. She said the Resident was admitted at 125.6 lbs. and was currently 111 lbs. She reviewed the progress notes for the Resident from admission to 8/21/24 and said she could not find any evidence that the physician was made aware of the weight loss that had occurred. Review of the Registered Dietitian's (RD) documentation for Resident #26 from 12/2023 to 8/21/24 indicated but was not limited to the following: - 12/21/24: Comprehensive dietary assessment and note: weight = 125.6 lbs.; BMI = 20.1; stable when compared to hospital weights; reported a poor to fair appetite; goal to maximize intake to maintain current weights and heal skin integrity (related to recent surgery) (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	- 3/14/24: Quarterly assessment and note: weight = 115.4 lbs., ideal body weight is 125 - 132 lbs.; intake fair to good; previous goals achieved; weight decline of 3% in 30 days and 8% since December 2023. Add: 240 milliliters (ml) fortified apple juice supplement to all meals to promote weight maintenance - 4/11/24: Note: discontinue fortified juice at breakfast, lunch and dinner due to resident not drinking; continue to monitor weights - 6/6/24: Quarterly assessment and note: weight 104 lbs., this is a weight loss; intake mostly variable; stable weights in 30 days with a significant loss since admission Further review of the RD's documentation failed to indicate that the RD notified the physician of the significant weight loss. During an interview on 8/21/24 at 1:28 P.M., the RD said Resident #26 has an ideal body weight of 125 - 132 lbs. and currently weighs 111 lbs. She said she does not typically notify the physicians of weight loss or significant weight loss and she believes that is done by nursing. She said, on review of the nursing progress notes for Resident #26, she could not find any evidence that the physician was made aware of the significant weight loss for the Resident. During an interview on 8/21/24 at 2:08 P.M., Physician #1 said he did not recall being made aware of Resident #26's progressive and significant weight loss and therefore no further evaluation of the situation had been completed at this time. He said he is unaware of any medical reason for Resident #26 to have an ongoing or significant weight loss and the loss was unplanned. During an interview on 8/21/24 at 2:22 P.M., the Director of Nurses reviewed the medical record of Resident #26 and said she could not find any evidence that the physician was aware of the ongoing and significant weight loss for Resident #26. She said the process is for the physician to be notified of changes to a resident's condition and there is no evidence that had occurred. See F692

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43935 Based on interviews, document review, and observations, the facility failed to have information on how to file a grievance in resident care and public areas and have forms accessible, so residents and/or visitors were able to anonymously notify the facility of their concerns. Findings include: Review of the facility's policy titled Resident/Staff/Family Member Grievances, dated as reviewed 4/2023, indicated but was not limited to the following: - any resident/staff/family member or designated representative who has a complaint or suggestion, shall report to the charge nurse or social worker on the unit involved, or complete a grievance form - the nurse or social worker will respond appropriately, after assessing the nature of the complaint and will complete the grievance form if one has not already been completed - the grievance report itself will be submitted to the Administrator/Department head as soon as possible - grievances, actions taken and results are to be documented on the grievance report and kept on file in the Administrator's office Review of the facility Grievance Book for 2024 indicated four grievances were completed throughout the year. Of the four completed grievances on file, three were reported by families using e-mail and all four forms were completed by facility staff for tracking purposes. During a Resident Group Meeting on 8/16/24 at 11:00 A.M., 11 of the 13 residents in attendance said they were unaware of how to file a grievance. During a tour on 8/16/24 at 11:41 A.M., of the first floor including the main lobby, community rooms and first floor nursing unit there was no evidence observed of the procedure for a family or resident to file a grievance or the availability of grievance forms for a grievance to be completed anonymously. During an interview on 8/16/24 at 11:42 A.M., Nurse #2 said grievance forms are not available for residents or families to complete on their own and if she was made aware of a grievance or concern, she would direct the person to the Administrator or nursing supervisor. She said there are grievance forms available in the filing cabinet behind the nurses' station if neither of those people were available. During a tour on 8/16/24 at 11:51 A.M., of the second floor nursing unit there was no evidence observed of the procedure for a family or resident to file a grievance or the availability of grievance forms for a grievance to be completed anonymously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/16/24 at 11:52 A.M., Nurse #4 said she was not aware and has never seen any grievance forms or information posted for residents or families. She said if a resident or family voiced a concern to her that she couldn't fix immediately she would direct them to the nursing supervisor, Administrator or Director of Nurses (DON). She checked the filing cabinet and form storage areas behind the nurses' station and said she could not locate a grievance form to supply the family or resident with and would have to direct them to someone else for assistance. During a tour on 8/16/24 at 11:54 A.M., of the third floor there was no evidence observed of the procedure for a family or resident to file a grievance or the availability of grievance forms for a grievance to be completed anonymously. During an interview on 8/16/24 at 11:55 A.M., Certified Nurse Aide (CNA) #1 said if a resident or family informed her they had a concern or grievance they wanted to report, she would direct them to the posted information for the Ombudsman office. She said if they wanted it to be dealt with in the facility, she would alert a Nurse or Nursing supervisor to try and assist them. She said she was not aware that there were any grievance forms they could provide or what the grievance process entailed. During an interview on 8/16/24 at 12:15 P.M., the Activity Director said she was not aware of where any grievance forms may be available for residents or families to complete without notifying the staff of a concern. She said the process for filing a grievance if one is voiced is to obtain a form from the Administrator and to assist a resident or family with completing one. During an interview on 8/16/24 at 12:42 P.M., the Social Worker said the Administrator is the grievance official for the facility but they have open communication if any concerns are brought forward. She said if a grievance should occur the staff will direct the resident or family member to the Administrator or DON if they are available and in the facility at the time and if not a nursing supervisor so the resident or family member can be assisted in completing a grievance form. She said the facility does not keep grievance forms available in public areas. She said grievance forms are stored in the management offices and behind the nurses' stations in filing cabinets. She said if a family or resident wanted to place a grievance anonymously within the facility, they would not have the capability of doing so because the forms are not available to them without speaking with a staff member and the facility does not have a process for that to occur at this time. She said residents and families have the right to make grievances anonymously and not having a process in place for them to do that does not meet the regulatory requirements for grievances. During an interview on 8/16/24 at 1:19 P.M., the Administrator said he was not aware that residents and families had the right to formulate grievances anonymously and that the facility should have a mechanism in place for them to do so. He said grievance forms are not available in any public area that would make it possible for a family member or resident to formulate a grievance without notifying a staff member and the process would need to be looked at for improvement to meet the regulatory guideline.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43935 Based on record review, interview, and document review, the facility failed to evaluate the use of a one-piece jumpsuit as a restraint for one Resident (#67), to ensure it was the least restricted device and necessary, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Physical Restraint Policy, dated as reviewed 4/2024, indicated but was not limited to the following: - restraints will only be used in circumstances in which the resident has medical symptoms that warrant the use of the restraint - the need for restraint use if assessed by the interdisciplinary team as needed, quarterly and with any significant changes for residents with restraints - the facility follows a systematic process of evaluation and care planning prior to using restraints Resident #67 was admitted to the facility in February 2023 and had diagnoses including: dementia without behavioral disturbance and late onset Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment for Resident #67, dated 7/17/24, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicating he/she was not cognitively intact. The MDS also indicated the Resident used a restraint daily, exhibited no behaviors in the look back period and had no mood disturbance based on their PHQ-9 score in the look back period. Review of the current Physician's Orders, as of 8/20/24, indicated but were not limited to the following: - one piece clothing jumpsuit to be worn at all times except personal hygiene - remove jumpsuit for hygiene only (3/25/24) - behaviors: monitor every shift for depression - document behaviors in resident progress notes (2/6/23) Review of the assessments for Resident #67 in the medical record as of 3/15/24 failed to indicate a restraint assessment had been completed to determine if the one-piece jumpsuit was a restraint and the least restrictive device for the management of the Resident's behaviors. Review of the Certified Nurse Aide (CNA) Care plan card on 8/16/24 for Resident #67 indicated but was not limited to the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Behavior/Cognitive Section: Target behaviors: wandering and smearing feces; Interventions: redirect and offer snack - Restraint section: Blank - Special care/needs: 3/25/24 one piece clothing - Resident information: maintain adequate bowel movements, toilet for good fecal evacuation, prompt care related to smearing feces, one piece clothing added secondary to this behavior Review of the CNA Behavior analysis report for Resident #67 from 3/1/24 through 8/20/24 indicated but was not limited to the following: - Behavior of throwing/smearing bodily waste not at others: occurred 6 times out of 173 opportunities, and four times prior to the order for the one-piece jumpsuit on 3/25/24 Review of the nursing and social service progress notes from 3/1/24 through 8/20/24 indicated but were not limited to the following behaviors: - 3/1/24 at 9:20 P.M., routinely defecates and smears feces, toileted every two hours, can be resistive to care - 3/5/24 at 2:30 P.M., smearing feces times 3 [sic] - 3/8/24 at 10:44 P.M., in the last seven days the resident has had behaviors of smearing feces, redirected with some effect - 3/25/24 at 10:31 A.M., Resident is to wear a one-piece jumpsuit at all times except for hygiene, the plan was initiated due to smearing of feces to maintain resident dignity, healthcare proxy (HCP) in agreement and purchased outfits - 3/29/24 at 7:59 P.M., tolerating jumpsuit well, have been a few instances when the Resident got into his/her brief but all was contained in the jumpsuit - 5/3/24 at 9:49 A.M., since the introduction of the jumpsuit bodily waste is better contained, dignity and hygiene have been improved - 7/26/24 at 10:58 A.M., in the last seven days the resident has had behaviors of smearing, one piece set of clothes effective - 8/1/24 at 5:25 P.M., wearing a jumpsuit continues to assist in managing bodily waste The surveyor made the following observations of Resident #67: - 8/15/24 at 7:58 A.M., the Resident was sitting in a rocking recliner, appeared calm and easily engaged in conversation with the surveyor, pleasantly confused, well-groomed and dressed in a one piece outfit which zipped up the back and appeared to be two separate clothing pieces (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madonna Manor Nursing Home	85 North Washington Street North Attleboro, MA 02760

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 8/16/24 at 7:40 A.M., Resident was smiling and easily engaged with surveyor, well-groomed and dressed in one piece clothing with zipper on the back - 8/20/24 at 10:40 A.M., Resident well-groomed and dressed in one piece clothing, appeared comfortable Review of the current care plans for Resident #67 indicated but were not limited to the following: PROBLEM: ADLs functional: I have a diagnosis of Alzheimer's with subsequent cognitive loss. I am unable to initiate and sequence tasks to completion and require assist with most efforts. APPROACH: One piece jumpsuit to be worn at all times except for hygiene, HCP aware and in agreement with plan to prevent smearing of feces and maintain dignity for Resident, toileting schedule for bowel movements failed to correct this and it was becoming an infection control issue (3/25/24), no agitation or anxiety related to jumpsuit use (5/15/24) During an interview on 8/16/24 at 7:48 A.M., Nurse #2 said the Resident wore a one-piece jumpsuit, which is a restraint for him/her since they cannot remove it independently and it is in place to prevent them from smearing feces. She said the outfits started about five or six months ago and she can't be sure of the exact date. She said there is a doctor's order for the outfits but as far as other interventions that may have been attempted and the care plan or any assessments that would need to be completed, she would not be aware of those and that type of paperwork was completed at a management level. During an interview on 8/20/24 at 10:42 A.M., the Director of Nurses (DON) said the Resident wore a one-piece jumpsuit, which was a restraint. She said on review of the record she could not locate any evidence that prior devices or interventions were attempted to ensure the jumpsuit restraint was the least restrictive device and there was no restraint assessment completed at the time the restraint was initiated or for a re-evaluation of the device in July. She said she was aware that the guidelines were not followed and the process needed to be looked at.

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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. 42742 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for the care of an indwelling catheter (tube inserted into the bladder to drain urine into a collection bag outside the body) for one Resident (#13), out of total sample of 18 residents. Specifically, the facility failed to ensure the Resident's indwelling Foley catheter device was maintained in a sanitary manner. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Summary of Recommendations, Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated March 2024, indicated but was not limited to the following: -Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Resident #13 was admitted to the facility in May 2023 and had diagnoses including urinary tract infection, bacteremia, difficulty in walking, and muscle weakness. Review of the Minimum Data Set (MDS) assessment, dated 7/18/24, indicated Resident #13 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15, had an indwelling Foley catheter (tube inserted into the bladder to drain urine), and was dependent on staff for personal hygiene and showering/bathing. Review of current Physician's Orders indicated the following: -Foley catheter care: Provide Foley catheter hygiene every shift. Add to POC instructions: Click on select POC charting category and pick miscellaneous tasks from the list every shift; 7:00 A.M. - 3:00 P.M., 3:00 P. M. - 11:00 P.M., 11:00 P.M. - 7:00 A.M., 7/10/24 -Foley to collection device at all times, ensure leg bag or overnight bag is connected and containing output every shift, 7:00 A.M. - 3:00 P.M., 3:00 P.M. - 11:00 P.M., 11:00 P.M. - 7:00 A.M., 7/10/24 Review of the Indwelling Catheter care plan, initiated 7/21/24, indicated the goal was to not contaminate or be contaminated. During an observation with interview on 8/20/24 at 3:23 P.M., the surveyor and Certified Nursing Assistant (CNA) #1 observed Resident #13 lying in bed. A Foley catheter was observed hanging from the side of the bed draining yellow urine into a urinary drainage bag. The bag was fully resting on the floor without a protective barrier underneath and was potentially exposed to environmental contaminants. CNA #1 said it was the first thing she saw upon entering the room then placed a protective barrier underneath. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 1:52 P.M., the surveyor observed Resident #13 lying in bed. A Foley catheter was observed hanging from the side of the bed draining yellow urine into a urinary drainage bag. The bag was partially touching the floor without a protective barrier underneath potentially exposing it to environmental contaminants. During an interview on 8/21/24 at 4:41 P.M., CNA #5 said the catheter bag shouldn't ever be on the floor because of germs. During an interview on 8/21/24 at 4:45 P.M., Nurse #5 said catheter bags should never be on the floor. During an interview on 8/21/24 at 4:50 P.M., the Infection Preventionist said the catheter bag should not be on the ground as it increases the risk of contamination.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43935 Based on record review, interviews, and documentation review, the facility failed to ensure acceptable parameters of nutritional status were maintained for one Resident (#26), out of 18 sampled residents. Specifically, the facility failed to ensure ideal or usual body weight was maintained and interventions implemented and re-evaluated to prevent significant and ongoing weight loss for the Resident which was unplanned and undesired. Findings include: Review of the facility's policy titled Weight Loss Policy, dated as reviewed 2/2024, indicated but was not limited to the following: - all confirmed weight loss of 5 pounds (lbs.) or more within one month is reported to the dietician, the weight information is recorded in the chart - staff must also report any continuing trends of monthly weight loss, even if it is below 5 lbs. - the dietician is responsible for determining if weight loss is significant, unplanned (weight loss greater than (>) 5% in one month, 10% in 6 months) - if the dietician determines weight loss is significant, an interim note is written documenting the weight loss and including suggested approaches for prevention of further loss - the dietician is responsible to ensure the interdisciplinary care plan is updated for weight loss prevention as warranted Review of the facility's policy titled Meal Replacement, dated as reviewed 10/2023, indicated but was not limited to the following: - every possible effort will be made to maintain meal satisfaction and intake by residents - as soon as nursing or dietary staff discover the resident has consumed less than 50% of a meal, they will offer additional forms of nourishment - nursing and dietary staff should encourage residents to accept the alternate to the prepared meal - if the resident refuses the alternate selection to the menu, he/she should be offered food items on the additional readily available food list - if a resident refuses all alternate foods available a commercial supplement may be offered and is a last resort of meal replacement Review of the facility's policy titled Selective Menu Policy, dated as reviewed 10/2023, indicated but was not limited to the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- every possible effort will be made to maintain meal satisfaction and intake by residents - menus are posted on floors for reference - a representative from dietary meets with all new residents within 24 hours for an initial interview to discuss food preferences, likes and dislikes in accordance with the resident's diet restrictions - cycle menus will be individually reviewed with the resident until they are completed - main dining room is open for all meals, menus are posted, residents in the main dining room make their choices Resident #26 was admitted to the facility in December 2023 with diagnoses which included hypothyroidism and dysphagia (difficulty swallowing). Review of the Brief Interview for Mental Status (BIMS), dated 6/14/24, indicated Resident #26 was cognitively intact with a score of 15 out of 15. During an interview on 8/15/24 at 8:09 A.M., Resident #26 said he/she had lost at least 20 pounds since being admitted to the facility. The Resident was observed to have breakfast of scrambled eggs and toast in front of them and consumed about 25% at that time. He/She said the coffee is like an oil slick. He/She said people have talked to him/her about the food and weight loss and he/she thinks the food is overall not bad but prefers other things brought in by their family. The Resident said he/she has always been a picky eater. During an interview on 8/15/24 at 4:13 P.M., Nurse #2 said Resident #26 was not a good eater and will decline meals at times, adding that the Resident's family will bring in food and snacks because the Resident is a picky eater. She said she knows the Resident has had a weight loss but has recently started to gain a little back. She said she does not know the exact amount of weight loss or if there are any interventions in place to prevent the weight loss, but she offers the Resident ice cream in the afternoons and it is usually accepted. She said the Resident doesn't get any type of supplements and is not offered any other meals if he/she doesn't eat well unless they request something else. She said the Resident needs lots of encouragement to eat. She said the Resident will usually accept foods brought in by the family. Review of the current Physician's Orders, dated 8/21/24, indicated but were not limited to the following: - DIET: NAS (No added salt diet) (1/23/24 and 4/12/24) - May omit diet restrictions on special occasions (12/14/23) - Snack offered at bedtime (12/14/23) - Speech therapy evaluation and treatment as indicated (1/9/24) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- Weekly weight to be obtained: notify MD/NP of any significant weight loss/gains over past week and any trends, once a day on Thursdays (12/14/23) - Aspiration precautions: Resident is an aspiration risk monitor for signs and symptoms (s/s) such as: cough, congestion, fever, runny nose, etc., monitor lung sounds, oxygen saturation, and temperature every shift (1/8/24) Review of the Certified Nurse Assistant (CNA) care plan Kardex currently in use by the facility indicated but was not limited to the following: NUTRITION: Diet/Texture: Regular; Ability to eat: Independent During an interview on 8/21/24 at 8:17 A.M., CNA #3 said Resident #26 eats independently after meal set up. She said the Resident's intake fluctuates and sometimes the Resident eats well and sometimes not so good. She said the Resident is weighed weekly and she knows the Resident has a history of weight loss but had a gain this past week and is up to 111 pounds (lbs.). She said she is not aware of any interventions for the staff to provide to help the Resident not lose any more weight, but the Resident has told her he/she prefers sandwiches with tomatoes for lunch and pancakes for breakfast. During an interview on 8/21/24 at 8:31 A.M., the surveyor observed Resident #26 eating breakfast consisting of scrambled eggs and toast with jelly. The meal ticket on the tray indicated the Resident was supposed to have a hard-boiled egg. The Resident said the breakfast was fine but they wished it was pancakes or waffles; they are sick of eggs everyday. The Resident said he/she gained weight this past week because he/she can't resist the treats and ice cream in the afternoons. The Resident said there are foods that they like but the facility has not offered them to him/her and he/she likes to have options with his/her meals and may change his/her mind on the meal daily depending on what might be available. The Resident said he/she was offered milkshakes and juice drinks to purposely get fat but the use of those are against his/her beliefs. Resident #26 said he/she enjoys sandwiches but only gets them when his/her family brings them in because the facility sends him/her whatever they want for meals and he/she doesn't have any options. During an interview on 8/21/24 at 9:22 A.M., the Food Service Director (FSD) said the process for selective menus and meal preferences for the unit Resident #26 resides on is for staff to call for a meal replacement if necessary. She said she learns different resident preferences as time goes on and the nursing staff, residents, and dietitian will also communicate items of preference to her so she can update the meal tray tickets. She said residents should get what their tickets say are their preferences with each meal because the kitchen staff will automatically follow the ticket and make the substitution and she does not keep any other system to track preferences. She said she would provide the surveyor with a copy of Resident #26's meal tickets for the day which would reflect the daily preferences. Review of the 8/21/24 meal tickets for Resident #26 indicated but were not limited to the following: BREAKFAST: Hard-boiled egg, cereal, toast, juice, coffee, milk, jelly, sugar LUNCH: Meatloaf, brown gravy, broccoli, mashed potatoes, bread, peach cobbler, milk, coffee, sugar, tomato slices (Serve sliced tomatoes when ordering a sandwich) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	DINNER: Glazed ham, mixed vegetables, sweet potato, fruit cocktail, milk, coffee, sugar, tomato slices (Serve sliced tomatoes when ordering a sandwich) During an interview on 8/21/24 at 10:02 A.M., the FSD said Resident #26 only gets tomatoes if he/she orders a sandwich, but he/she gets a hard-boiled egg each morning. When she was informed the Resident had scrambled eggs this A.M., she said scrambled eggs were available this morning but the Resident should have gotten a hard-boiled egg and she does not know how that error occurred. She said the process is for the Resident to get their preferred foods according to their meal tickets. Review of Resident #26's weight monitoring report from 12/2023 to 8/15/24 indicated but was not limited to the following: 2/29/24- 119.0 lbs. 3/28/24- 112.8 lbs. (significant weight loss in one month (2/29/24) of 5.21%) 4/04/24- 113.9 lbs. 4/25/24- 110.8 lbs. 5/02/24- 106.8 lbs. (significant weight loss in one month (4/4/24) of 6.23%) 5/09/24- 104.6 lbs. Review of the Minimum Data Set (MDS) assessments for Resident #26 indicated the following weights were used: - 12/14/23 - MDS recorded weight of 125 lbs. - 3/7/24 - MDS recorded weight of 115 lbs. - 6/14/24 - MDS recorded weight of 104 lbs. In the three months from the December 2023 to the March 2024 MDS assessments the Resident experienced a significant loss of 8.12%. In addition, in the three months between the March 2024 MDS and the June 2024 MDS the Resident had another significant weight loss of 9.88% (significant weight loss is = > 7.5% in 3 months). Review of the MDS assessment, dated 6/14/24, indicated but was not limited to the following: SECTION K (Swallowing/Nutritional Status): K0100: Signs and symptoms of swallowing disorders: None K0200: Height = 66 inches Weight = 104 lbs. (most recent and measured in the last 30 days) K0300: Weight loss: Loss of 5% or more in the last month or 10% or more in the last 6 months: YES, not on a physician prescribed weight loss regimen (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	K0520: Nutritional approaches: Therapeutic diet while a resident The MDS indicated that from the 12/14/23 MDS recorded weight of 125 lbs. to the 6/14/24 MDS recorded weight of 104 lbs. Resident #26 experienced a significant weight loss of 16.8% over 6 months. Review of the Speech Language Pathology (SLP) evaluation and treatment notes for Resident #26 in May 2024 indicated but were not limited to the following: - 5/16/24 Evaluation: Reason for referral: This patient was noted to have a significant weight loss as follows: 4/4/24 - 113.9 lbs., 4/25/24 - 110.8 lbs., 5/2/24 - 106.8 lbs., 5/9/24 - 104.6 lbs. [sic] Patient goals: He/She would like to get foods he/she likes so they'd have an appetite to eat them Clinical bedside assessment: Regular solids with mild clinical s/s of dysphagia characterized by poor attention to task Recommendations: distant supervision for intake - 5/16/24 Treatment note: has particular interest in eating certain foods and aversion to others; realizes he/she is losing weight and would like to improve intake if they get the foods they like - 5/24/24 Treatment note: no complaints of dysphagia; patient stated: I ate all that I wanted, don't make me eat anything else - 5/28/24 Treatment note: patient states he/she eats the food they like and denies any difficulties with trouble chewing or swallowing - 5/28/24 Discharge Summary: Previous goal met (5/16/24): patient appetite was sufficient to maintain his/her weight and remain stable but currently has a significant weight loss; current goal met: patient demonstrated safe intake of regular solids and thin liquids consuming at least 50-75% per meal over three consecutive meals without dysphagia. Review of the Meal and Snack intake report for Resident #26 from 3/1/24 through 8/20/24 indicated but was not limited to the following: MARCH 2024: Out of 93 meal opportunities: 20 meals were not documented and out of 31 bedtime snack opportunities 9 snacks were undocumented Of the meals received, the Resident consumed an average of 26-50% of breakfast; 26-50% of lunch; 51-75% of dinner and 51-75 % of bedtime snacks. APRIL: 2024 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Out of 90 meal opportunities: 14 meals were not documented with 2 additional meals refused; and 9 out of 30 bedtime snack opportunities undocumented with an additional 10 refused Of the meals received, the Resident consumed an average of 51-75% of breakfast; 26-50% of lunch; 25-50% of dinner and 25-50% of bedtime snacks. MAY 2024: Out of 93 meal opportunities: 22 meals were not documented with 4 additional meals refused; and 14 and out of 31 bedtime snack opportunities were undocumented with an additional 12 snacks refused Of the meals received, the Resident consumed an average of 26-50% of breakfast; 26-50% of lunch; 1-25% of dinner and 1-25% of bedtime snacks. JUNE 2024: Out of 90 meal opportunities: 21 meals were not documented with an additional 2 meals refused; and 6 out of 30 bedtime snack opportunities were undocumented with an additional 9 snacks refused Of the meals received, the Resident consumed an average of 26-50% of breakfast; 26-50% of lunch; 26-50% of dinner and 1-25% of bedtime snacks. JULY 2024: Out of 93 meal opportunities: 13 meals were not documented with an additional 2 meals refused; and 7 out of 31 bedtime snack opportunities were undocumented with an additional 11 snacks refused Of the meals received, the Resident consumed an average of 26-50% of breakfast; 26-50% of lunch; 26-50% of dinner and 26-50% of bedtime snacks. AUGUST 2024: Out of 60 meal opportunities: 4 meals were not documented with an additional one meal refused; and 1 out of 20 bedtime snack opportunities were undocumented Of the meals received, the Resident consumed an average of 26-50% of breakfast; 26-50% of lunch; 26-50% of dinner and 1-25% of bedtime snacks. Review of the Registered Dietitian's (RD) documentation for Resident #26 from December 2023 to 8/21/24 indicated but was not limited to the following: - 12/21/23: Comprehensive dietary assessment and note: House diet with HS (hour of sleep) snacks; weight = 125.6 lbs.; BMI = 20.1; stable when compared to hospital weights; reported a poor to fair appetite; goal to maximize intake to maintain current weights and heal skin integrity (related to recent surgery) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- 3/14/24: Quarterly assessment and note: NAS diet with HS snacks; weight = 115.4 lbs., ideal body weight is 125 - 132 lbs.; intake fair to good; previous goals achieved; weight decline of 3% in 30 days and 8% since December 2023. Add: 240 milliliters (ml) fortified apple juice supplement to all meals to promote weight maintenance - 4/11/24: Note: discontinue fortified juice at breakfast, lunch and dinner due to Resident not drinking; continue to monitor weights - 5/23/24: Note: please add a plate of sliced tomatoes to lunch and dinner meals per resident preference; resident states he/she will eat any sandwich with tomato on it; likes hard boiled (HB) eggs only - no other kind of eggs; notice provided to kitchen - 6/6/24: Quarterly assessment and note: NAS diet with HS snacks and aspiration precautions; weight 104 lbs., this is a weight loss; intake mostly variable; stable weights in 30 days with a significant loss since admission, self-reported picky eater; Resident declines supplements and will accept sandwiches with tomato slice, provide encouragement at meals During an interview with observation on 8/21/24 at 12:12 P.M., the surveyor observed Resident #26 having lunch in his/her room. The meal on the plate consisted of meatloaf with gravy, broccoli, a piece of bread, and a scoop of mashed potatoes. No sandwich or tomato were observed on the tray or in the Resident's room. He/She was not eating the meatloaf but was consuming the bread and mashed potatoes. The Resident said he/she did not like the meatloaf and would love to get sandwiches at lunchtime with tomato but has not gotten them in a few weeks. Resident #26 said he/she does not have the capability of picking their meals and has not been given a large selective menu to complete in ages. The Resident said he/she would not call and bother the nursing staff for a replacement meal since no one cares enough to provide him/her with a menu. Resident #26 said he/she would complete a weekly menu if that was still an option but it was not. The Resident said if the meal was something he/she liked, he/she would eat it. He/She said the facility did try to give him/her supplement drinks a few months ago but he/she would not drink them; he/she preferred real food. During an interview on 8/21/24 at 12:31 P.M., the FSD said Resident #26 doesn't do a selective menu and gets whatever the kitchen has as the meal for the day and can have someone call down if he/she wants something different. She said she could not recall the last time the Resident had completed a selective menu, but said they follow the meal ticket for preferences. (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 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/21/24 at 12:57 P.M., Nurse #3 said she was unsure if Resident #26 had a significant weight loss or any weight loss and would need to review the record. She said the Resident had been losing weight and has only started gaining weight in the last few weeks. She said the Resident was admitted at 125.6 lbs. and currently weighed 111 lbs. She reviewed the assessments, progress notes, orders and care plans for the Resident and said she does not see any interventions currently in place to reflect what the staff should be doing to prevent further weight loss for the Resident. She said she did see that the Resident had attempted to take supplements for a short time in March but did not like them. She said, There are so many types of real foods we could use, I don't know why that's not an option shown in here. She said the facility had the ability to attempt fortified foods and even additional snacks like ice cream in the afternoon to help with weight loss prevention but she did not see any documentation in the record that these things were attempted and said the care plan does not reflect any interventions at all except for providing the Resident with a meal. She said as far as the Resident preferences she noticed the Resident had scrambled eggs this morning and was surprised since the ticket said hard-boiled egg, but the Resident told her, They just send what they want anyway and declined a replacement meal or food item. She said they would only offer any resident a supplement or replacement meal if they ate less than 50% if they had orders to do so, and this Resident did not. She said if the Resident requested an alternate meal the staff would accommodate that, but that had not happened at either meal today. She said she could not find anything on the care plan that would indicate the Resident had weight loss or required any interventions to prevent weight loss so she wasn't aware the concern existed until it was brought to her attention by the surveyor. Review of the care plan currently in place for Resident #26 indicated the following: PROBLEM: Nutritional status, Nutritionally related medical diagnoses: hypertension (HTN), hypothyroidism, hyperlipidemia, and Vitamin D deficiency; requires a therapeutic diet at this time related to HTN. Supplementation in place and accepted by Resident to promote weight maintenance. (6/25/24) GOAL: Maintain current status; prevent exacerbation of medical diagnosis (6/25/24) APPROACHES: House diet (6/25/24) The care plan failed to indicate the Resident experienced any weight loss or provided any interventions to prevent further weight loss for the Resident. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/21/24 at 1:28 P.M., the RD said Resident #26 is a self-admitted picky eater and resistant to any creamy supplements so she recommended the juice supplement, but the Resident did not consume it and it was discontinued. She said she did send a preference update to the kitchen in May alerting them to the Resident's preference to eat sandwiches with sliced tomato. She said once the information is sent to the kitchen they place it on the tray ticket. She said this Resident has an ideal body weight of 125 - 132 lbs. and is currently 111 lbs., but that is an increase from previous and at one point the Resident got as low as 103 lbs. so she is happy with the weight coming back up. She said the Resident remains below ideal body weight at this time because they are very particular about what they will eat. She said the FSD is the person that would provide a selective menu to residents, but only to those who are willing to complete them and want to select their own foods and she doesn't know if the Resident does those menus but thinks it would likely benefit Resident #26 to have this option so they can receive foods they are more interested in. She said she was aware of the significant weight loss for the Resident but when reviewing the care plan said she realizes the care plan is not specific to the Resident losing weight, and does not have any interventions on it that may help prevent further weight loss and only indicates a current diet order for the Resident. She said the Resident has had a continual weight loss since admission until just recently and she would need to reevaluate the Resident and the documentation since it appears to be lacking. During an interview on 8/21/24 at 2:08 P.M., Physician #1 said he is not aware of any medical reason for Resident #26 to have an ongoing or significant weight loss and it was unplanned. He said he doesn't recall being made aware of the situation and therefore no further evaluation of the situation had been completed and the issue has not been documented by him in the medical record. During an interview on 8/21/24 at 2:22 P.M., the Director of Nurses reviewed the medical record of Resident #26 and said there were no interventions she could find documented anywhere, except for the juice supplement in March that was discontinued, to prevent further weight loss for the Resident. She said it did not appear by viewing the current and history of the nutritional care plan that any interventions were ever attempted to prevent weight loss and the care plan does not indicate the Resident had experienced any weight loss and inaccurately reflected the Resident's use and acceptance of supplements. She said she could not find any documentation that a medical work up had occurred in an attempt to rule out any cause of the progressive weight loss, nor could she find any evidence the physician was aware of the situation. She said the expectation is that the Resident be evaluated and provided with interventions in an attempt to prevent undesirable ongoing weight loss, especially when a significant weight loss occurs, but also prior to reaching that level. She said the Resident should have been receiving his/her preferences at mealtimes and receiving alternate meals as needed. She said it appears the process for managing weight loss and providing interventions to prevent further weight loss were not followed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43935 Based on observation and interview, the facility failed to maintain sanitary conditions of continuous positive airway pressure (CPAP- respiratory machine used to assist in keeping airways open to ease breathing while sleeping) respiratory tubing and equipment for one Resident (#3), out of a total sample of 18 residents. Findings include: Review of the Lippincott Nursing Procedure, eighth edition, indicated but was not limited to the following in regard to the use and storage of CPAP tubing: - When the CPAP therapy has been completed, follow these steps: remove the headgear and appliance from the patient; clean and disinfect the equipment using a facility-approved disinfectant according to the manufacturer's instructions, and store it properly. Resident #3 was admitted to the facility in June 2011 with a diagnosis of respiratory failure with hypercapnia (abnormally high levels of carbon dioxide in the blood). Review of the most recent Brief Interview for Mental Status (BIMS), dated 7/1/24, indicated the Resident was cognitively intact with a score of 14 out of 15. During an observation with interview on 8/15/24 at 1:12 P.M., Resident #3 said he/she uses a CPAP machine. The surveyor observed the machine and associated tubing and mask at the bedside, unlabeled and undated. The machine was laden with dust and the tubing and mask were lying on top of a plastic bag beside the air conditioner open to air and potential contamination by germs and environmental debris. The Resident said that since they are totally blind they cannot see where the staff puts the mask and tubing once it is removed, but hears them throw it, he/she said the machine and tubing are supposed to be wiped down every day and the mask is supposed to be changed weekly but they do not know if that happens since they cannot see. The surveyor observed the following: - 8/16/24 at 7:54 A.M., CPAP mask and tubing lying on the windowsill, appeared dry and was not stored in a plastic bag, open to potential contamination by germs and environmental debris; the machine was on the bedside table laden with dust. - 8/19/24 at 8:57 A.M., CPAP machine was laden with dust, and the mask and tubing were no longer connected. - 8/20/24 at 12:18 P.M., CPAP machine appeared dirty and a fingerprint could be made in the dust and dirt on the machine, there was tubing and a mask in a storage bag labeled 8/18/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/24 at 12:59 P.M., Nurse #1 said the process for caring for CPAP equipment is to store the mask and tubing in a plastic respiratory equipment bag when not in use to protect it from dirt and germs. She said she would think the machine was wiped down on Thursdays or weekly by the respiratory therapist, but she couldn't be sure. She viewed the photographs the surveyor took of the CPAP mask and tubing and dirty machine and said the machine was dusty and dirty and the mask and tubing should have been stored in the respiratory bag and not left out in the open touching other items in the environment because it was unsanitary. During an interview on 8/20/24 at 2:13 P.M., the Director of Nurses said the expectation is that respiratory equipment be kept clean and free of environmental debris and when any tubing is not in use it is to be stored in a respiratory storage bag to protect it from potential germs. She said the machines should be wiped down and kept clean routinely. She viewed the photographs of Resident #3's CPAP mask, tubing and machine and said the mask and tubing were not stored appropriately and the machine should have been cleaned and the expectation for maintaining this Resident's respiratory equipment was not met.

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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. 49425 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases. Specifically, the facility failed: 1. For Resident #51, to ensure staff wore PPE as required for Isolation/Droplet Precautions (infection control precautions used for residents who are infected with certain infectious agents including COVID-19 for which additional precautions are needed to prevent infection transmission) while entering the room to provide care; and 2. For Resident #13, to ensure staff wore the appropriate personal protective equipment (PPE) while providing high contact care to the Resident who was on enhanced barrier precautions (EBP - infection control intervention that involves wearing gowns and gloves during high contact care to reduce the spread of multi-drug resistant organisms) related to chronic wounds and a Foley catheter device. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions, dated 3/2024, indicated but was not limited to the following: -Purpose: to prevent the spread of multi-drug resistant organisms (MDROs) (germs that are resistant to many antibiotics) -Residents with wounds or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO -Wounds include chronic wounds such as pressure ulcers and diabetic foot ulcers -Indwelling medical device examples include urinary catheters -The use of gown and gloves for high-contact care activities is indicated with EBP -High contact care includes dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting and device care -EBP are intended to be in place for the duration of a resident's stay in the facility or resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk Review of the facility's policy titled Caring for long term residents during the COVID-19 outbreak, dated 4/2024, indicated but was not limited to the following: -Diocesan Health Facilities follow the guidelines that the Department of Public Health (DPH) and Center for Disease Control (CDC) regarding COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Centers for Disease Control (CDC) guidance titled: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated: March 18, 2024, indicated but was not limited to the following: Personal Protective Equipment: Healthcare providers who enter the room of a patient with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to Standard Precautions and use an approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). 1. Resident #51 was admitted to the facility in October 2021. Review of the medical record including progress notes, physician orders, and care plan indicated but were not limited to the following: -He/she tested positive for COVID-19 on 8/6/24 -Isolation Precautions for COVID-19 every shift. On 8/15/24 at 8:40 A.M., the surveyor observed the following: -A RED sign posted outside of Resident #51's doorway that indicated but was not limited to the following: -Isolation Precautions STOP: ISOLATION In addition to Standard Precautions Staff and Providers MUST: -Clean Hands when entering and exiting -Gown: Change between each Resident -N95 Respirator (respiratory protective device designed to achieve a very close facial fit to filtrate airborne particles; the edges form a seal around the nose and mouth) -Eye Protection (goggles or face shield) -Gloves: Change between each Resident - A 3-drawer plastic bin outside of the Resident's door containing PPE -Two Certified Nursing Assistants (CNA) #2 and #6 approaching the 3-drawer plastic bin outside of Resident #51's room, both wearing surgical masks for source control -CNA #2 opened the drawer and removed a protective gown and gloves. She donned (put on) the gown and gloves, leaving her surgical mask in place (not an N95 respirator) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 2:30 P.M, CNA #7 said if a resident has a sign outside of their door that says Enhanced Barrier Precautions, she would wear a gown and gloves for any hands on care. She said if a resident has a sign that says Isolation Precautions, she would put on an N95, gown, gloves and goggles anytime she had to enter the room. During an interview on 8/21/24 at 4:14 P.M., the Infection Preventionist said her expectation is for all staff to follow the PPE guidelines posted on the signage outside of the resident's doors. She said when a resident is on EBP precautions, staff must use a gown and gloves for all high contact care, to reduce the risk of transmission of MDROs. She said when a resident is on Isolation/droplet precautions for COVID-19 everyone needs full PPE to enter the room including eye protection and an N95 respirator.