STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225543	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Wilbraham	2399 Boston Road Wilbraham, MA 01095

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview, and record review, the facility failed to ensure two Residents (#1 and #75), out of a total sample of 22 residents, were able to exercise their right to make decisions regarding their medical care when their Health Care Proxy (HCP: a document that gives someone the power to make healthcare decisions for a person who was unable to) was not invoked, and the facility had the HCP's sign advanced directives forms and consent forms. Specifically: 1. For Resident #1, the facility failed to ensure a Medical Order for Life-Sustaining Treatment (MOLST: a medical form that outlines the wishes of a person with a usually serious, progressive health condition regarding life-sustaining measures and end-of-life care (such as life support, palliative care, or Cardiopulmonary Resuscitation [CPR]), and that must be signed by an authorized health care professional (Physician, Nurse Practitioner, or Physician Assistant) form was not signed by the HCP, when the HCP was not invoked for the Resident. 2. For Resident #75, the facility failed to ensure that a MOLST form, consent for psychotropic medications and vaccination for the Respiratory Syncytial Virus (RSV: respiratory virus that infects the nose, throat, and lungs), was not signed by the HCP, when the Resident's HCP was not yet invoked. Findings include: 1. Resident #1 was admitted to the facility in February 2025 with diagnoses including Cerebrovascular accident (stroke) with aphasia (conditions that cause problems with communication) and Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated [DATE], indicated Resident #1: -preferred language was English and Resident did not need interpreter services -was able to understand and understood others -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 Review of the Resident's clinical record indicated the following: (continued on next page)

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	-Nurse's Note, dated [DATE]: Resident's HCP will be in on [DATE] to sign paperwork as the Resident was Russian/Ukrainian speaking deeming it difficult to communicate. -Nurse's Notes, dated [DATE]: Resident was able to communicate his/her needs/wants, did understand and speak some English. -MOLST form, signed by the Resident's HCP on [DATE] -Social Service Note, dated [DATE]: the Resident was his/her own decision maker. Further review of the clinical record failed to indicate that Resident #1's HCP was invoked by the Physician. On [DATE] at 11:37 A.M., the surveyor observed Resident #1 dressed and seated in a wheelchair. During an interview at the time, the Resident said his/her primary language was Russian, but he/she was able to communicate in English and had no difficulty communicating with facility staff. During a follow-up interview on [DATE] at 1:31 P.M., Resident #1 said his/her HCP visited him/her and theResident was not sure if the HCP signed paperwork on his/her behalf. The Resident further said that he/she could not recall filling out paperwork about his/her wishes for life-sustaining treatment. During an interview on [DATE] at 11:40 A.M., the Assistant Director of Nurses (ADON) said nursing reviews the MOLST forms with residents. The surveyor reviewed Resident #1's MOLST form which was signed by the HCP on [DATE], and the ADON said if the Resident deferred to a HCP to sign the MOLST form, there should be a note in the chart to indicate this. During a follow-up interview on [DATE] at 3:23 P.M., the ADON said the HCP signed the Resident's MOLST form due to a language barrier as indicated in the Nursing Note dated [DATE]. The surveyor and the ADON reviewed the Resident's clinical record which indicated the Resident's HCP was not invoked and the Resident was able to make his/her own decisions. When the surveyor asked if information was provided to the Resident in his/her primary language if communication was determined to be difficult, the ADON said good point. 2. Resident #75 was admitted to the facility in February 2025 with diagnoses including Cognitive Communication Deficit and Dementia. Review of the MDS Assessment, dated [DATE] indicated Resident #75: -preferred language was English and he/she did not need interpreter services -was rarely understood or understands -was severely cognitively impaired as evidenced by a BIMS score of 0 out of 15 Review of the Resident's clinical record indicated the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing Admission Note, dated [DATE]: Resident was alert but did not speak English, Portuguese speaking only -MOLST form, signed by the Resident's HCP on [DATE] -Vaccination consent for RSV, signed by the HCP on [DATE] -Psychotropic medication consent for Zyprexa (antipsychotic medication) signed by the HCP on [DATE], and another on [DATE] -Psychotropic medication consent for Trazodone (antidepressant medication), signed by the HCP on [DATE] -Psychotropic medication consent for Cymbalta (antidepressant medication), signed by the HCP on [DATE] -HCP invocation form, signed by the Provider on [DATE] -Physician's order to invoke Resident #75's HCP on [DATE] Review of the Resident's Communication Care Plan, initiated on [DATE], indicated Resident #75 had a communication problem related to severe cognitive impairment due to Dementia and Cognitive Communication Deficit. Further review of the Communication Care Plan interventions failed to indicate documented evidence that the HCP was invoked due to language barriers and difficulty communicating with the Resident. On [DATE] at 11:26 A.M., the surveyor observed the following: -Certified Nurses Aide (CNA) #3 was assisting Resident #75, who was seated in a wheelchair, into another room across the hallway where he/she was previously located. Resident #75 was heard continuously state No .No . when the CNA attempted to have him/her enter the room. -CNA #3 was observed to communicate with Resident #75 in English and then CNA #3 said out loud I don't understand you . On [DATE] at 9:56 A.M., the surveyor and Nurse #2 reviewed Resident #75's clinical record. Nurse #2 said the Nurses on the floor obtain the consents for the psychotropic medications and also review the MOLST form. Nurse #2 said Resident #75 was Portuguese speaking and had cognition issues. Nurse #2 said there should be a Physician's order to invoke a Resident's HCP if this was indicated and that the Resident's HCP was invoked on [DATE]. The surveyor and Nurse #2 reviewed the Resident's paperwork including the MOLST form and consents for vaccines and psychotropic medications which were signed prior to the HCP invocation, and Nurse #2 said the Nurses would notify the Provider about invoking the HCP. Nurse #2 further said sometimes Residents defer to their family to sign paperwork, and if this was the case, there should be a documentation indicating this. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:49 A.M., the ADON said she would look into why the Resident's paperwork was signed by the HCP prior to invocation and said sometimes a Resident may defer to their HCP for signing paperwork, but if this was the case, there should be notation in the clinical record. During a follow-up interview on [DATE] at 3:23 P.M., the ADON said she reviewed Resident #75's clinical record and there was notation in a Nurse's Admission Note that the staff deferred to the Resident's HCP due to a language barrier. The ADON said she was not sure if the clinical information relative to completing the MOLST form or consent forms were provided to the Resident in his/her native language prior to the HCP being invoked on [DATE]. During an interview on [DATE] at 11:50 A.M., the Director of Nursing (DON) said he was made aware of the concerns relative to Resident #1 and Resident #75's paperwork which were signed by their HCP prior to or without HCP invocation.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to ensure reasonable accommodations of resident's needs and preference were provided for five Residents (#98, #75, #101, #169 and #72) out of a total sample of 22 residents and on one Unit ([NAME] Terrace Unit) of three units observed. Specifically, the facility failed to: 1. answer call lights timely for Resident #98 and Resident #75 during the early morning times during shift change. 2. respond to resident call lights timely: a. on the [NAME] Terrace Unit. b. for Resident #101, resulting in the Resident being incontinent due to long wait times. 3. answer the Resident's call light timely for Resident #169, when he/she required staff assistance with mobility/transfers. 4. have staff respond timely to the call light for Resident #72, who required assistance to the bathroom and return to further assist the Resident after bathroom use as indicated. Findings include: Review of the facility policy titled Resident Call System, revised 9/12/22, indicated the nurses' station in the facility will be equipped to receive resident calls with a communication system through audible or visual signals from resident rooms, toilets, and bathing facilities. The policy also included the following: -Facility associates should always be aware of the call lights -Associates should answer call lights whether they are assigned to provide care to that resident Review of the Resident Council Meeting Meetings, dated 1/30/25, indicated the following: -Nursing: ----Old Minutes: Call bells are not being answered in a timely manner. ----New Business: Residents were reminded that the call bells are to be answered within five minutes. Staff reminded that any staff member can answer a call bell. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a Resident Council meeting held on 3/6/25 from 11:00 A.M. to 11:30 A.M., the following was said relative to call bell wait times: -Resident #98 said that he/she has had to wait 15 to 30 minutes for someone to answer his/her call light. Resident #98 said he/she had to wait so long that he/she had an accident before he/she was able to get to the bathroom. Resident #98 said that long wait times occur most often on the early morning shift. Resident #98 further said his/her anxiety increased when he/she had to wait so long to use the bathroom. -Resident #75 said he/she recently had to wait 30 minutes to go to the bathroom. Resident #75 said this happened most often during the early morning, often when the staff changed shifts from the overnight shift (11:00 P.M. to 7:00 A.M.) to the daytime shift (7:00 A.M. to 3:00 P.M.). 2a. On 3/11/25 from 8:13 A.M. until 8:21 A.M., the surveyor observed the following on the [NAME] Terrace Unit: -8:13 A.M.: room [ROOM NUMBER] call light was turned on. -Certified Nurses Aide (CNA) #2 was passing breakfast trays -Nurse #2 was passing medications -CNA #2 and Nurse #2 remained in the hallway for the duration of this observation, walking by room [ROOM NUMBER] multiple times without responding to the lit-up call bell light. -8:21 A.M. (eight minutes later), Nurse #2 the entered room [ROOM NUMBER] and the call bell was turned off. 37400 2b. During the initial pool process on the [NAME] Terrace Unit on 3/5/25 and 3/6/25, the following concerns were expressed by residents: -One Resident, who requested to remain anonymous, said he/she was not given timely care or response to needs when he/she had them, that he/she did not ring the call light often, but did utilize it recently and it took an hour for a facility staff person to respond when he/she had to use the bathroom. The Resident said he/she also rang the call light for his/her roommate on the 3:00 P.M. to 11:00 P.M. shift on 3/4/25, and it took a staff person an hour and half to respond. -Resident #101 said he/she had episodes of incontinence which were new since admission to the facility because he/she had to wait for staff to assist him/her with toileting. Resident #101 said he/she had never been incontinent at home, and that it sometimes took a while for his/her call light to be answered. Resident #101 said that he/she had been given an incontinence brief, and that facility staff said if he/she needed to go an incontinence brief was in place, but the Resident said he/she prided him/herself on never being incontinent at home. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #72 said he/she had to wait 30 minutes to an hour for assistance from staff on the 7:00 A.M. to 3:00 P.M. shift. The Resident said the staff are wonderful but that he/she needed assistance from staff when using the bathroom and because he/she had to wait, it has affected his/her ability to remain continent. 3. Resident #169 was admitted to the facility in March 2025 with diagnoses including history of falls, pubic fracture (one of the two bones forming the pelvis), muscle weakness and difficulty ambulating. Review of Resident 169's active Care Plans included the following: -Risk for falls, initiated 3/4/25 and included the following intervention (also initiated 3/4/25): assist with activities of daily living (ADLs) as needed -ADL assistance and Therapy Services were needed to maintain or attain the highest level of function ., initiated 3/4/25 and included the following interventions (also initiated 3/4/25 and revised 3/7/25): Assist of two staff with mobility/transfers with rolling walker and ADLs/toileting assist of two staff. On 3/6/25 at 2:13 P.M., the surveyor observed the following: -Resident #169's call light was lit and audible from the nursing station -Two Nurses were observed seated at the nursing station -2:20 P.M., Resident #169's call light remained lit. The surveyor observed Resident #169 in his/her room seated in a wheelchair positioned next to the bed. During an interview at the time, Resident #169 said he/she rang the call light to ask for assistance from staff to go back to bed. -2:27 P.M., the Resident's call light remained lit and was audible from the nursing station. During an interview at this time, Resident #169 said no staff had checked in with him/her yet since he/she originally initiated the call light. -2:30 P.M., the Resident's call light remained on, and staff were observed in the hallway. -2:32 P.M. (19 minutes later), a nurse was observed entering the Resident's room. 4. Resident #72 was admitted to the facility in December 2024 with diagnoses including muscle weakness and need for assistance with personal care. Review of the Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident #72: -had clear speech, was understood and understands others -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 -had bilateral range of motion impairments (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's active Care Plans, included the following: -Risk for falls related to history of falls, muscle weakness, impaired balance ., initiated 12/15/24, included the following intervention: assist with ADLs as needed, (also initiated 12/15/24) -ADL Assistance and Therapy Services needed to maintain or attain the highest level of function, initiated on 12/15/24, included the following interventions: assist with mobility and ADLs as needed (initiated 12/15/24), ambulate to/from bathroom with four wheeled walker and one assist during the day shift and assist with wheelchair and one assist for toileting during the night shift (initiated 3/6/25) On 3/7/25 at 9:31 A.M., the surveyor observed the following: -Resident #72's call light was lit and was audible at the nursing station -One facility staff member and two Certified Nurse Aides (CNAs), including CNA #1, were observed at the nursing station conversing and and a Nurse was observed at a medication cart at the end of the hallway where the Resident's room was located. -9:33 A.M., a staff person was observed walking down the hallway and stopped at the Resident's room. Resident #72 told the staff person that he/she needed staff immediately because he/she needed to use the bathroom. The staff person was observed to inform CNA #1 who was standing near the nursing station that Resident #72 needed assistance. CNA #1 was observed to remain standing near the nursing station with the second CNA after this interaction. -9:35 A.M., the Administrator was observed to walk down the hallway and stopped at Resident #72's room and entered. -9:36 A.M., the Administrator approached CNA #1 (who remained standing with the other CNA near the nursing station), and CNA #1 said I know, they told me . and then went to Resident #72's room. CNA #1 was observed to assist Resident #72 to the bathroom, went to the Resident's closet, retrieved a pair of dark colored pants and returned to the bathroom. CNA #1 said to Resident #72 to ring when he/she was done and exited the room. -9:47 A.M., Resident #72's call light was lit, blinking red and was audible from the nursing station. A Nurse was observed at the medication cart in the hallway and other facility staff including Housekeeping and Rehabilitation staff were observed walking up/down hallway. -9:49 A.M. both call lights (white and red blinking) were observed on in Resident #72's room. -9:50 A.M. facility staff were observed seated at the nursing station where the call light was audible. -From 9:52 A.M. to 9:56 A.M., Resident #72 was heard yelling out for help numerous times, stating he/she was in the bathroom and needed help. The Resident's roommate (who had also engaged the call light) was heard telling him/her Nobody is coming . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9:56 A.M., (nine minutes after being assisted to the bathroom), Resident #72 continued to yell he/she needed help, and a CNA was observed to enter the room at this time stating she was coming. During an interview on 3/12/25 at 10:32 A.M., the Infection Preventionist (IP), who was assisting with staffing on the [NAME] Terrace Unit, said every staff person should be responding to resident call lights, including CNAs, Nursing, and Therapy. The IP said the resident call bells should be answered within four minutes, and that even if the staff who respond to the call light cannot assist, they were expected to answer the call light, speak with the resident and alert the staff who could assist with the resident's needs. The IP further said the resident call lights were audible at the nursing station, and that all staff who hear/see the call lights should respond.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50563 Based on interview, and record review, the facility failed to ensure one Resident (#62) of four applicable residents reviewed, out of a total sample of 22 residents, had the opportunity to formulate advanced directives and/or ensure that their wishes relative to advances directives were implemented. Specifically, for Resident #62, the facility failed to ensure that the Nurse Practitioner (NP) signed all required areas of the Medical Order for Life Sustaining Treatment (MOLST) form. Findings include: Review of the facility policy titled Advanced Directives and Advance Care Planning, reviewed 9/26/24, indicated the following: -Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advanced directive. Resident #62 was admitted to the facility in February 2025 with diagnoses including Acute Respiratory Failure with Hypoxia and Chronic Obstructive Pulmonary Disorder (COPD). Review of Resident #62's Documentation of Resident Incapacity Pursuant to Massachusetts Health Care Proxy Act Form indicated the Resident's Health Care Proxy was invoked on 2/19/25. Review of Resident #62's MOLST form indicated the following: -The front page of the form was signed and completed by the Resident's Health Care Proxy and Nurse Practitioner (NP). -The back page of the form was completed, indicating no artificial nutrition and signed by the Resident's Health Care Proxy on 2/23/25. -The Nurse Practitioner (NP) failed to sign the back side of the MOLST form. During an interview on 3/12/25 at 8:10 A.M., the surveyor and the Assistant Director of Nursing (ADON) reviewed the current MOLST form. The ADON said the back side of the form was invalid because it was not signed by the Provider (Nurse Practitioner).

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 42741 Based on interview, and record review, the facility failed to provide a Notice of Bed-Hold Policy and Return in writing to the Resident and/or the Resident's Representative upon transfer to the hospital for two Residents (#64 and #61), out of a sample of 22 residents, and for one Resident (#17) out of three closed records reviewed. Findings include: Review of the facility policy titled Massachusetts Bed-Hold Notification, dated 3/22/23, indicated the following: -The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours) .The facility will provide written information to the resident or resident representative regarding the nursing facility policy on bed-hold periods and the residents return to the facility to ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital . 1. Resident #64 was admitted to the facility in October 2024 with diagnoses including Dementia without behavioral disturbance. Review of the Nurse's Note, dated 10/4/24, indicated Resident #64 was transferred to the hospital. Further review of the Resident's medical record failed to indicate documentation that a written Bed-Hold Notice was provided to the Resident's Representative. During an interview on 3/5/25 at 2:51 P.M., Resident #64's Resident Representative said he/she never received any paperwork relative to a Bed-Hold Notice when Resident #64 was hospitalized in October 2024. During an interview on 3/10/25 at 4:08 P.M., the Admissions Assistant said the Admissions Department did not provide Bed-Hold Notices to the Resident Representatives when a long-term care resident was transferred from the facility, and Resident #64 was a long- term care Resident. The Admissions Assistant said she thought the Social Services Department was in charge of sending Bed-Hold Notices to Resident Representatives for the long- term care residents. During an interview on 3/10/25 at 4:09 P.M., Social Worker (SW) #2 said the Social Services Department did not send out Bed-Hold Notices to the Resident Representatives when a resident was transferred from the facility. SW #2 said she thought it was the Business Office's job to send the notices out. During an interview on 3/10/25 at 4:10 P.M., the Business Office Manager said she did not provide Bed-Hold Notices to Resident's Representatives when they were transferred from the facility and thought the Admission Department sent the notices. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 3/10/25 at 4:21 P.M., SW #1 said at this time no one at the facility was responsible for sending out Bed-Hold Notices to Resident Representatives when a resident was transferred to the hospital and no Bed-Hold Notice had been sent to Resident #64's Resident Representative when he/she was transferred to the hospital in October 2024. 50563 2. Resident #61 was admitted to the facility in December 2023 with diagnoses including Chronic Obstructive Pulmonary Disorder (COPD) and Influenza. Review of Resident #61's Nurse Practitioner (NP) Progress Note dated 2/26/25, indicated the Resident was assessed and sent to the hospital on 2/26/25 for an acute change in medical status. Review of Resident #61's medical record failed to indicate evidence that a Bed-Hold Notification had been completed and provided to the Resident and/or his/her Representative. 42690 4. Resident #17 was admitted to the facility in April 2021. Review of the daily census dated 2/26/25, indicated Resident #17's status was out of the facility on a hospital paid leave. During an interview on 3/10/25 at 11:38 A.M., Unit Manager (UM) #1 said when a Resident is sent out to the hospital, the Bed-Hold Notice was one of the items included in the paperwork that was sent with the Resident. Review of Resident #17's medical record failed to indicate documented evidence that the Bed-Hold Notice had been provided to the Resident or Resident's Representative when the Resident was transferred to the hospital on 2/26/25. During an interview on 3/10/25 at 4:38 P.M., the Admissions Assistant said that she reviewed the medical records for Resident's #61 and #17. The Admissions Assistant said that she did not find evidence that a Bed-Hold Notice had been provided to the Resident or their Representative(s) as required when the Residents were transferred out to the hospital.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37400 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice relative to a Peripherally Inserted Central Catheter (PICC: central venous access catheter inserted through a vein and can provide intravenous [IV] access for the administration of medications, parenteral nutrition or other solutions) for one Resident (#110), of one applicable resident who was receiving IV antibiotics, out of a total sample of 22 residents. Specifically, for Resident #110, the facility failed to ensure: -accurate measurement and documentation of the external catheter length (measured from the catheter exit site to the 0 mark or, if no 0 mark is present, to the suture flange. Each line is measured as 1 centimeter/cm) and arm circumference. -identify a change in the external catheter length placing the Resident at risk for potential catheter related complications. Findings include: Review of the facility policy/procedure titled PICC Dressing Change, revised 8/19/24, indicated the following: -A transparent semipermeable dressing over a PICC requires changing at least every seven [7] days . -PICC line dressing changes require sterile technique to reduce the risk of vascular catheter-associated infection . -Use a sterile disposable tape measure or the incremental markings on the catheter to measure the external length of the catheter from the hub (end of the catheter tubing) to skin entry. -Compare the measurement to the external length documented at the time of PICC insertion to make sure the catheter hasn't migrated (moved out of place) . -Measure upper-arm circumference when clinically indicated to assess the presence of edema and deep vein thrombosis. Take the measurement ten [10] cm above the antecubital fossa (inner elbow) and compare the measurement to the baseline -If you withdraw the catheter a significant amount inadvertently during a dressing change, measure the catheter from the exit site to the hub and reapply a sterile dressing. Never advance the catheter back inside the insertion site because the contact with the skin may introduce microorganisms to the catheter. Notify the practitioner, and prepare for a chest X-ray or other diagnostic test to determine the position of the PICC tip (inside the body) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #110 was admitted to the facility in February 2025 with diagnoses including Metabolic Enchalopathy, Sepsis, Methicillin Susceptible Staphylococcus Aureus (MSSA) infection and Aspiration Pneumonia. Review of the Hospital Vascular Access Insertion Procedure Note, dated 2/13/25, indicated the following: -PICC line was placed into the Resident's upper right extremity for medication that required vascular access -the total catheter length was 41 cm -the tip location of the PICC line was placed in the superior vena cava -the external catheter length was two [2] cm out. -the arm circumference was 36 cm Review of the Hospital Discharge Summary, dated 2/25/25, indicated the following relative to Resident #110: -admitted to the hospital for severe acidosis (high levels of acid in the blood) and Diabetic Ketoacidosis (DKA: serious and can be life-threatening, develops when the body does not produce enough insulin), complicated by respiratory failure, Influenza Type A, Respiratory Syncytial Virus (RSV), severe sepsis, and MSSA secondary to aspiration pneumonia. -Discharge medications included: Cefazolin (antibiotic) two [2] gram (gm) IV push every eight [8] hours. Review of the IV Infusion Note, dated 2/25/25, indicated: -IV Infusion Provider was contacted by the facility due to the staff being unable to flush the Resident's PICC line. -The needle-less catheter was exchanged -the PICC was able to be flushed -the PICC was secured at the 2 cm (external catheter length) mark and was ready for use. Review of the February 2025 and March 2025 Physician's orders included the following: -Cefazolin Sodium Solution Reconstituted 1 gm, use 1 gram intravenously every 8 hours for infection, bacteremia, initiated 2/25/25 and discontinued 2/26/25 -Cefazolin Sodium Injection Solution Reconstituted 2 gm, use 2 grams intravenously every 8 hours for infection, bacteremia, initiated 2/26/25 and discontinued on 3/10/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change PICC line transparent dressing, as needed for concern of line movement or infection. -Measure upper arm circumference (10 cm above antecubital. -Measure external catheter length. If length has changed since last measurement; if concern of line movement, infection, hold antibiotic and notify Medical Doctor (MD), initiated 2/25/25 -PICC Gauge: 4 French (Fr: unit of measure): Total Length: 41 cm # Lumens 1 Type of infusion: intermittent, for Bacteremia, initiated 2/25/25 -Observe PICC line insertion site, every shift for s/s (signs/symptoms) of infection. Notify MD, accordingly, initiated 2/2/25 -Change PICC line dressing on admission one time only for one day. Measure upper arm circumference (10 cm above antecubital). Measure external catheter length, initiated 2/25/25 Review of the Infection Care Plan, initiated 2/25/25, indicated the Resident was on IV antibiotics via PICC line in his/her right upper arm for MSSA Bacteremia. The care plan included the following interventions: -Medications as ordered, initiated 2/25/25 -Care of PICC line as ordered. Report any abnormalities to Nurse Practitioner (NP)/MD (initiated 3/7/25) Review of the February 2025 and March 2025 Medication Administration Records (MARs) indicated Resident #110 received the IV antibiotic medication as ordered by the Physician. Review of the Minimum Data Set (MDS) Assessment, dated 3/1/25, indicated Resident #110: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 of 15 -received antibiotics during the reference period. Review of the February 2025 Treatment Administration Record (TAR) indicated the following was documented on 2/25/25 for Resident #110: -arm circumference was measured at 36 cm -external catheter length was measured at 41 cm Review of the March 2025 TAR indicated the following documented on 3/4/25 for Resident #110: -arm circumference was measured at 12 -external catheter length was measured at 4 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 7:31 A.M., the surveyor observed Resident #110 lying upright in bed and dressed in a hospital gown. An IV pole was observed on the side of the Resident's bed and had an empty bag labeled Cefazolin 2 gm per 100 milliliters (ml) dated 3/6/25 at 6:00 A.M., and was being infused. During an interview at the time, the Resident said he/she was septic, recently had the flu and pneumonia, and had a PICC placed. The Resident showed the surveyor his/her upper inner elbow where a transparent dressing was observed dated 3/4/25. On 3/7/25 at 9:24 A.M., the surveyor observed Resident #110 awake and lying upright in bed. An IV pole was observed on the side of the bed, and an empty bag labeled Cefazolin 2 gm per 100 milliliters (ml) dated 3/7/25 at 6:00 A.M. was hung on the IV pole and was not infusing. During an interview at the time, the Resident said he/she received the IV antibiotic that morning and had no issues or side effects from the infusion. The surveyor observed the Resident's transparent dressing on his/her right upper inner arm was dated 3/4/25. On 3/7/25 at 3:51 P.M., the surveyor observed Resident #110 dressed and ambulating with Rehabilitation Staff in the hallway heading towards his/her room. The Resident was dressed in a short-sleeved shirt, and the PICC tubing was observed hanging from his/her right arm. During an interview on 3/7/25 at 4:21 P.M., Nurse #1, who had cared for Resident #110, said the arm circumference and external catheter length were measured weekly during the Resident's scheduled dressing change. Nurse #1 said the staff would measure 10 cm from the antecubital site (inner elbow) in order to obtain a measurement for the Resident's arm circumference. Nurse #1 further said that the external catheter would be measured from the insertion site to the end of the exposed tubing. Nurse #1 said it was important to obtain accurate measurements to ensure the PICC had not migrated because it would be a major issue since it should be positioned in the superior vena cava. Nurse #1 said the measurements obtained should be compared to what the measurements were when the PICC was initially placed to ensure the PICC was in the correct location. On 3/7/25 at 4:32 P.M., the surveyor and the Assistant Director of Nurses (ADON), who was overseeing the Unit reviewed the documented measurements for the Resident's arm circumference and external catheter length obtained on 2/25/25 and on 3/4/25. The ADON said there was a discrepancy with the measurements and that she would have to re-measure the Resident's arm circumference and external catheter length immediately. The surveyor accompanied the ADON into Resident #110's room and the ADON obtained the following measurements with the surveyor present: -arm circumference: 35.5 cm -external catheter length: 12 cm (difference of 10 cm since insertion) During an interview following the observation, the ADON said she could not speak to the measurements that were obtained on 2/25/25 and 3/4/25 and documented in the Resident's record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 4:48 P.M., the surveyor and the Infection Preventionist (IP) reviewed the Resident's hospital paperwork and IV Infusion paperwork, both dated 2/25/25. The IP said the Resident's PICC total catheter length was 41 cm, the external catheter length was 2 cm, and the arm circumference was 36 cm prior to admission. The IP said she also went to observe Resident #110's PICC after the ADON and the surveyor, did not obtain measurements, but said the external catheter length was definitely not 2 cm. The IP said if the external catheter length changed by 1 cm, the Nurse should not have used the PICC and should have contacted the Provider for additional orders on how to proceed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42741 Based on observation, interview, and record review the facility failed to provide treatment and care in accordance with professional standards of practice related to skin care for two Residents (#22 and #62), out of a total sample of 22 residents. Specifically, the facility failed to ensure: -a new skin alteration was identified by facility staff and an investigation completed to determine the cause of the skin alteration for one Resident (#22). -weekly skin checks were completed for one Resident (#62) as indicated per their comprehensive care plan. Findings include: Review of the facility policy titled Area of Focus: Basic Skin Management, revised 11/21/24, indicated the following: -All residents have a head-to-toe skin inspection upon admission/readmission, then completed weekly, and as needed by nursing . -It is the responsibility of the Certified Nurses Aides (CNAs) and therapy department to notify nursing if a change of the resident's skin is identified . -If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document an assessment/observation, obtain treatment orders, and notify medical doctor (MD) and responsible party. {sic} 1. Resident #22 was admitted to the facility in February 2022 with diagnoses including Vascular Dementia with behavioral disturbance. Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/25/24 indicated Resident #22 had a Brief Interview of Mental Status (BIMS)) score of seven out of 15 indicating he/she was severely cognitively impaired. On 3/5/25 at 11:05 A.M., the surveyor observed Resident #22 seated in his/her room in his/her wheelchair. Resident #22 was observed to have bilateral scabbed areas on either side of his/her philtrum (middle space underneath the nose on the upper lip. When the surveyor asked about the scabbed areas on his/her upper lip the Resident said he/she was unsure where they came from. Review of Resident #22's Weekly Skin Assessments from 1/4/25 through 3/6/25 failed to indicate documentation pertaining to how Resident #22 acquired the injuries on his/her bilateral upper lip or when the injuries occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 8:29 A.M., the surveyor observed Resident #22 seated in the hallway in his/her wheelchair. The Resident was observed to still have the bilateral scabbed areas on the upper lip. During an interview on 3/10/25 at 9:26 A.M., Certified Nurses Aide (CNA) #5 said she regularly took care of Resident #22. CNA #5 said she was unsure what the bilateral scabbed areas on Resident #22's upper lip was from or when they first appeared. During a follow-up interview on 3/10/25 at 9:32 A.M., CNA #5 said she spoke with Resident #22 and Resident #22 told her he/she thought the scabbed areas were from being shaved. During an interview on 3/10/25 at 12:55 P.M., Nurse #5 said she thought the bilateral scabbed areas on Resident #22's upper lip were from being shaved. Nurse #5 said there should be documentation in the Resident's medical record indicating what the scabs were from, how the injuries occurred, and when the injuries occurred. Nurse #5 further said this information should be documented on the weekly skin report until the areas were resolved. Review of the Nursing Progress Notes from 1/30/25 through 3/11/25 failed to indicate documentation as to how Resident #22 acquired the injuries on his/her bilateral upper lip or when the injuries occurred. During an interview on 3/11/25 at 10:05 A.M., Unit Manager (UM) #1 said she was unaware of the bilateral scabbed areas on Resident #22's upper lip until it was brought to the Nurse's attention by the surveyor on 3/10/25. UM #1 said she had reviewed the Resident's medical record and could find no documentation to indicate how the injuries occurred or when the injuries occurred to the Resident's bilateral upper lip. UM #1 further said as soon as any staff members had noticed the injuries it should have been reported immediately so staff could check the Resident's skin for additional injuries and to investigate how the injuries occurred, and this was never done. UM #1 said Resident #22 was not usually one of the Resident's who had his/her face shaved so she would need to look further into the situation to see if she could figure out how the injuries occurred as there was no documentation to support how or when the incident occurred. UM #1 said skin injuries for Resident #22 were especially a concern because he/she was on an anticoagulant (medication that thins the blood) and having injuries to his/her skin put the Resident at risk for increased bleeding. 37400 2. Resident #62 was admitted to the facility in February 2025 with diagnoses including Congestive Heart Failure (CHF), cellulitis and open wound of left lower leg, muscle weakness, and protein-calorie malnutrition. Review of the MDS Assessment, dated 2/17/25, indicated Resident #62: -had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15 -was at risk for pressure ulcers, and had no pressure ulcers at the time of admission -had two or more venous or arterial ulcers (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Potential/Actual Impairment to Skin Integrity Care Plan, initiated 2/12/25, indicated the Resident had impaired strength/range of motion, impaired functional mobility, impaired balance, fragile skin, cellulitis, edema, and vascular wound on his/her left lower extremity and included the following intervention: -weekly skin checks, initiated 2/12/25 Review of the Resident's clinical record included a Weekly Skin Assessment completed on 3/10/25. Further review of the clinical record failed to indicate documented evidence that the Weekly Skin Assessments were completed as required during the weeks of 2/16/25 and 2/23/25. On 3/12/25 at 10:30 A.M., the surveyor requested evidence of the Resident's weekly skin assessment since admission from the Assistant Director of Nurses (ADON), who was overseeing the Unit. During an interview on 3/12/25 at 11:30 A.M., the Director of Nursing (DON) said there were no weekly skin assessments completed as scheduled on 2/18/25 and 2/25/25 for Resident #62. The DON said the weekly skin assessments should have been completed, they were scheduled in the electronic medical record to be completed weekly. The DON further said the facility utilized a paper tool in addition to ensure the completion of weekly skin assessments.

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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. 42741 Based on observation, interview, and record review, the facility failed to ensure that necessary respiratory care and services in accordance with professional standards of practice were in place for one Resident (#4) out of a total sample of 22 residents. Specifically, for Resident #4, the facility failed to ensure Physician's orders were in place for the daily use of Continuous Positive Airway Pressure (CPAP) machine and oxygen therapy. Findings include: Review of the facility policy titled BiPAP/CPAP Administration Policy, revised 9/3/24, indicated the following: -When CPAP or BiPAP is ordered, the following must be included in the written order: a. Mode (i.e. CPAP, BiPAP, CPAP Auto set etc.). b. Pressure setting c. Size and type of mask (i.e. small, nasal, or full-face mask.) d. Liters of Oxygen (if ordered.) e. Frequency of use (example-at night when sleeping and with naps as tolerated.) Resident #4 was admitted to the facility in October 2020 with diagnoses including Complex Sleep Apnea. Review of the most recent comprehensive Minimum Data Set (MDS) Assessment, dated 8/21/24, indicated Resident #4 scored a 15 out of 15 on the Brief Interview of Mental Status (BIMS) indicating that he/she was cognitively intact. On 3/5/25 at 10:23 A.M., the surveyor observed Resident #4 sitting in his/her room. The surveyor also observed a CPAP machine and oxygen concentrator in the Resident's room. During an interview at the time, Resident #4 said he/she utilized the CPAP every night with oxygen added to the machine. Resident #4 said the nursing staff at the facility set the CPAP up for him/her and he/she was unsure of the exact settings that were being used. Review of Resident #4's March 2025 Physician's orders failed to indicate orders for the required CPAP pressure settings and the oxygen flow rate (LPM-liters per minute) to be added when the CPAP machine was in use. Further review of March 2025 Physician's orders indicated: -CPAP .on while sleeping/napping and off while awake, start date 4/26/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2025 Treatment Administration Record (TAR) indicated the Resident utilized his/her CPAP daily from 3/1/25 through 3/9/25. Review of Resident #4's Altered Respiratory Status Care Plan dated 10/27/20, indicated the following: -Oxygen with CPAP .Pressure setting 4/0 with 1.5% humidity, Medium size with nasal pillows, liter of oxygen 2 lp/m .{sic} During an interview on 3/11/25 at 6:55 A.M., Nurse #3 said Resident #4 utilized his/her CPAP with oxygen every night. Nurse #3 said when a Resident has CPAP with oxygen there should be Physician's orders in place that included the settings for the CPAP and the oxygen liter flow rate. Nurse #3 reviewed Resident #4's Physician's orders and said Resident #4 had no orders in place for the use of the CPAP machine with oxygen. During an interview on 3/11/25 at 7:39 A.M., Unit Manager (UM) #1 said Resident #4 had no orders in place for CPAP settings or an oxygen flow rate. UM #1 said there was documentation in the care plan that included the correct CPAP setting and oxygen flow rate but there also needed to be a Physician's order in place for the administration of any treatment such as CPAP and oxygen use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 42741 Based on record review, and interview, the facility failed to ensure that professional standards of care and treatment for hemodialysis (treatment that cleans the blood by removing waste and excess fluids when a person's kidneys no longer functioned properly) were implemented for one Resident (#15), of one applicable resident, out of a total sample of 22 residents. Specifically, for Resident #15, the facility failed to ensure a Physician's order was in place for fluid restriction and documentation was maintained for the amount of fluid intake the Resident consumed during a 24-hour period when the Resident was receiving hemodialysis services. Findings include: Review of the facility policy titled Hemodialysis Offsite Policy, reviewed 9/6/24, indicated the following: -The facility and dialysis facility dieticians should coordinate the nutritional care including monitoring, documenting and deciding how and when to address weight changes in nutrition issues. a. This included identifying weight fluctuations due to fluid depletion between dialysis sessions, possible fluid volume deletion in the immediate post-dialysis period or associated with anorexia which may be due to renal failure. b. Observe fluid restriction as ordered by the physician. Review of the facility policy Monitoring Intake and Output, reviewed 9/10/24, indicated the following: -The facility will ensure the nursing staff monitors and documents intake and output consistent with Practitioner orders and professional standards. Resident #15 was admitted to the facility in May 2020 with diagnoses including End Stage Renal Disease (ESRD) and received dialysis services three days weekly. Review of Resident #15's March 2025 Physician's orders failed to indicate documentation that the resident was on fluid restriction. Review of Resident #15's Alteration in Nutrition and Hydration due to ESRD on Hemodialysis Care Plan, revised 6/2/21, indicated the following: -Encourage good fluid intake up to 1200 cubic centimeter (cc- unit of measure) per day. Further review of the Resident's medical record failed to indicate evidence that the nursing staff maintained documentation of how much fluid intake Resident #15 had daily. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/10/25 at 1:47 P.M., Nurse #6 said when a resident is on a fluid restriction there should be a Physician's order in place for the amount of fluid the resident is not to exceed each day. Nurse #6 said documentation is done in the intake and output (I&O) book. The surveyor and Nurse #6 reviewed the I&O book and failed to find documentation to show Resident #15's fluid intake was being monitored and recorded daily. Nurse #6 said she could not be sure exactly how much fluid intake Resident #15 was getting each day as there was no documentation. During an interview on 3/10/25 at 2:12 P.M., Unit Manager (UM) #1 said Resident #15 should have had a Physician's order in place for his/her fluid restriction and nursing staff should be documenting daily, exactly how much fluid intake Resident #15 was getting, and this was not being done. UM #1 said she could not be sure exactly how much fluid Resident #15 took in each day as there was no documentation. During an interview post survey on 3/17/25 at 9:26 A.M., the Dialysis UM, from the dialysis facility that provided treatment to Resident #15 said the nursing facility should be able to provide the Dialysis Dietician or Dialysis Nursing Staff information regarding daily fluid intake if it was requested. The Dialysis UM said fluid intake information could be utilized if the Resident was experiencing unexpected changes in his/her weight that needed to be addressed.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 42741 Based on interview, and record review, the facility failed to implement recommendations made by the Behavioral Health Care Team for one Resident (#51), out of a total sample of 22 residents. Specifically, for Resident #51, the facility failed to ensure a recommended lipid panel (blood test that measures the levels of various fats in the blood stream) and Hemoglobin A1C (HbgA1c-test used to identify Diabetes [disease that affects how the body uses blood sugar]) labs were drawn as recommended by the Behavioral Health Physician Assistant (PA) for monitoring after the Resident was started on antipsychotic medication. Findings include: Review of the National Alliance on Mental Illness (NAMI) website article (https://www.nami.org/general/why-screening-for-diabetes-is-important-especially-if-you-take-psychiatric-medications/), titled Why Screening for Diabetes is Important (Especially if You Take Psychiatric Medications), dated 3/25/14, indicated: -the American Diabetes Association suggests screening regularly for Diabetes for those who use medications to treat mental health conditions as medications used to treat mental health conditions pose an additional risk for the increase in Diabetes. Resident #51 was admitted to the facility in December 2023 with diagnoses including generalized anxiety disorder, psychotic disorder, Depression, adjustment disorder with depressed mood, Major Depressive Disorder recurrent severe with psychotic symptoms, and Dementia with psychosis. Review of the Physician Assistant's Behavioral Health Group Note, dated 6/25/24, indicated that Resident #51 was started on an antipsychotic medication due to psychosis, and a lipid panel and HbgA1c lab work should be drawn after three months of antipsychotic medication use. Review of the June 2024 Physician's orders indicated the following orders: -Zyprexa (antipsychotic medication) 2.5 milligrams (mg) .one time a day, start date 6/19/24 and end date 6/24/24. -Risperidone (antipsychotic medication) 0.5 mg .at bedtime, start date 6/26/24 and end date 7/3/24. Review of the July 2024 Physician's orders indicated the following orders: -Risperidone 0.25 mg .in the morning, start date 7/3/24 and end date 7/8/24. -Risperidone 0.5 mg .in the afternoon, start date 7/3/24 and end date 7/8/24. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Risperdal (Brand name for Risperidone) 0.5 mg .two times a day, start date 7/8/24 and end date 7/10/24. -Risperdal 0.5 mg .in the morning, start date 7/10/24 and end date 9/2/24. -Risperdal 1 mg .at bedtime, start date 7/10/24 and end date 9/2/24. Review of the September 2024 Physician's orders indicated the following orders: -Risperdal 0.5 mg .in the morning, start date 9/3/24 and end date 3/4/25. Review of Resident #51's June 2024, July 2024, August 2024, and September 2024, Medication Administration Records (MARs) indicated the Resident was administered antipsychotic medications as ordered. Review of Resident #51's medical record failed to indicate any evidence that the recommended lipid panel or HbgA1c lab had been drawn since the Behavioral Health PA's recommendation was made on 6/25/24. During an interview on 3/11/25 at 2:15 P.M., Nurse #7 said the Behavioral Health Team notes and recommendations were faxed directly to the Resident's Primary Care Provider (PCP). Nurse #7 said the PCP reads the recommendations and then returns a copy of the notes to the facility that is signed, showing that it has been reviewed. During an interview on 3/11/25 at 2:38 P.M., Unit Manager (UM) #2 said the Behavioral Health Team notes and recommendations were faxed directly to the Resident's Primary Care Provider (PCP). UM #2 said the PCP reads the recommendations and then returns a copy of the notes to the facility that is signed, showing it was reviewed and if the PCP want any recommendations implemented, the PCP would write a telephone order or verbally tell the nursing staff at the facility. UM #2 said she was unable to find any documentation that orders were put into place for the Behavioral Health Teams' recommendation for a lipid panel and a HbgA1c test. UM #2 said she was unsure why it was not ordered by the PCP after reviewing the Behavioral Health Teams' notes. UM #2 further said no one at the facility typically reads the Behavioral Health Teams' notes to ensure that recommendations were not missed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42741 Based on interview, and record review, the facility failed to limit the timeframe for a PRN (as needed) psychotropic medication to 14 days for one Resident (#40), out of a total sample of 22 total residents. Specifically, for Resident #40, the facility failed to ensure the PRN use of Trazodone (antidepressant medication) was limited to 14 days. Findings include: Review of the facility policy titled Psychotropic drug use, long term care {sic}, reviewed 5/20/24, indicated the following: -As-needed orders for psychotropic drugs should be limited to 14 days, at which time the prescribing practitioner should then review the order . Resident #40 was admitted to the facility in February 2025 with diagnoses including Depression and Adjustment Disorder with Anxiety. Review of Resident #40's March 2025 Physician's orders indicated the following order: -Trazodone .Give 25 milligrams (mg) every 24 hours as needed .start date 2/23/25 and no end date. Review of Resident #40's March 2025 Medication Administration Record (MAR) indicated that the Resident was administered the PRN Trazodone on 3/2/25 and 3/10/25. During an interview on 3/11/25 at 9:02 A.M., Nurse #9 said PRN psychotropic medications need to be reviewed and a new order put into place by the Physician after 14 days of use. Nurse #9 said PRN psychotropic medications should have a stop day of Day 14, it would fall off the orders and could not be given after Day 14 without Physician review. During an interview on 3/11/25 at 9:50 A.M., Unit Manager (UM) #1 said Resident #40's PRN order for Trazodone exceeded the 14-day limit, should have had a stop date of 3/9/25, and been reviewed by the Physician at that time for continued use and it was not.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50563 Based on observation, and interview, the facility failed to ensure that medications were stored in a secure manner for one medication cart (Hampden Garden Long Hall Cart) out of three medication carts observed, out of a total of six medication carts. Specifically, the facility failed to ensure that an injectible Insulin Lispro Pen was securely stored when the medication cart was left unattended in the hallway, and accessible to Unit residents. Findings include: Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, revised 8/1/24, indicated the following: -Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. On 3/7/25 at 4:00 P.M., the surveyor observed the Hampden Garden Long Hall Cart was unattended with an Insulin Lispro Pen on top of the medication cart. The surveyor observed a resident wheeling past the cart with the unattended medication and into his/her room. The surveyor observed that the medication cart with the Insulin Lispro Pen remained unattended until 4:19 P.M., when Nurse # 4 returned to the medication cart. During an interview on 3/7/25 at 4:19 P.M., Nurse #4 said the Nurse who was assigned to the Hampden Garden Long Hall medication cart, where the Insulin Lispro Pen remained on top of the cart had left the floor and was on a on break. Nurse #4 further said that the Insulin Lispro Pen should not be left unattended due to the risk that a resident could take it. Nurse #4 removed the pen to store in her medication cart until the assigned Nurse returned to the Unit. During an interview on 3/12/25 at 9:35 A.M., the surveyor reviewed the observations of the unattended Insulin Lispro Pen on top of the medication cart with the Assistant Director of Nursing (ADON). The ADON said that no medications should be left on top of the medication cart unsupervised.

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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** 42741 Based on observation and interview, the facility failed to ensure three Unit ([NAME] Terrace, Hampshire Woods, and Hampden Gardens) kitchenettes were maintained in a safe and sanitary condition, out of three unit kitchenettes observed. Findings include: Review of the facility's policy titled Cleaning Schedule, reviewed 4/30/24, indicated the following: -Equipment and Utensil Cleaning and Sanitization- A potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of equipment and protecting equipment from contamination via splash, dust, grease, etc. -The Director of Food and Nutrition Services develops a cleaning schedule to include all equipment and areas to be cleaned. Review of the facility's Stocking List for Unit's Nourishment Room, updated 9/6/24, indicated the following: -Make sure to clean fridge, microwave, cupboards, and counters. On 3/5/25 at 5:02 P.M., the surveyor observed the following in the Hampden Garden Unit kitchenette: -Toaster was laden with crumbs -Inside the cabinet that stored snacks had dried dark brown splatter noted on the shelves and door. On 3/5/25 at 5:06 P.M., the surveyor observed the following in the [NAME] Terrace Unit kitchenette: -Toaster was laden with crumbs, and dried pieces of bread were stuck in the toaster; crumbs were black in color. During an interview on 3/5/25 at 5:13 P.M., the Food Service Director (FSD) said the [NAME] Terrace Unit toaster was laden with crumbs and this could pose a fire risk due to the large amount of crumbs left in the toaster. The FSD said he was unsure who was responsible for cleaning the toasters on a regular basis. On 3/6/25 at 7:35 A.M., the surveyor observed the following in the Hampden Garden Unit kitchenette: -Bottom of the refrigerator had a large dried brown spot and multiple dried dirty paper towels under the lower refrigerator drawer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Inside the cabinet that stored snacks there was dried, dark brown splatter noted on the shelves and door. On 3/6/25 at 7:38 A.M., the surveyor observed the following in the [NAME] Terrace Unit kitchenette: -Refrigerator had dried yellow material on the floor. During observations of the Unit Kitchenettes on 3/11/25 from 10:23 A.M. to 10:32 A.M., with Dietary Aide #1, the surveyor observed the following: Hampshire Woods Unit kitchenette: -Thick dried brown material on the refrigerator floor. Hampden Garden Unit kitchenette: -Large dried brown spot and dirty paper towels remained on the bottom of the unit refrigerator. -Dried brown splatter was still noted inside the snack cabinets on the shelving and door. [NAME] Terrace Unit kitchenette: -Refrigerator had dried yellow material on the floor. Following the observations Dietary Aide #1 said the kitchenettes should be cleaned daily and it was the job of the afternoon dietary aides who stocked the snacks to make sure the kitchenettes were cleaned. Dietary Aide #1 said the refrigerators on all the units should have been wiped clean and the cabinets on the Hampden Gardens Unit should have been wiped down. During observations of the Unit Kitchenettes on 3/11/25 at 10:47 A.M., with the FSD, the surveyor observed the following: Hampshire Woods Unit kitchenette: -Thick dried brown material on the refrigerator floor. Hampden Garden Unit kitchenette: -Large dried brown spot and dirty paper towels remained on the bottom of the unit refrigerator. -Dried brown splatter was still noted inside the snack cabinets on the shelving and door. [NAME] Terrace Unit kitchenette: -Refrigerator had dried yellow material on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Following the observation the FSD said all the Unit refrigerators should be cleaned daily by staff and this did not appear to have been happening on a daily basis. The FSD said all dried food or liquid materials should have been cleaned out of the refrigerator on all the Units and the cabinets on the Hampden Garden Unit as this could lead to foodborne illness concerns.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42741 Based on interview, and record review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at one out of four quarterly meetings reviewed. Specifically, the facility failed to ensure the Director of Nursing (DON) and Infection Preventionist (IP) or a person designated to represent them were in attendance at the June 2024 quarterly QAPI meeting. Findings include: Review of the facility policy titled Quality Assessment and Assurance Committee, revised 8/30/22 indicated the following: >The QAA Committee must be composed of, at a minimum: -The Director of Nursing (DON) -The Medical Director or his/her designee -The Infection Preventionist (IP), and -At least three other staff members, one of whom must be the facility's Administrator . Review of the Meeting Attendance Sign-in Sheet for the QAPI Meeting held on 6/17/24 failed to indicate evidence that the DON or the IP were in attendance at the meeting. During an interview on 3/12/25 at 10:48 A.M., with the Administrator and the DON, the Administrator said he had no documented evidence that the DON or the IP was at the June 2024 QAPI Meeting. The Administrator further said it was required to have the DON or IP present at QAPI meetings or a Representative who would provide an updated report for the DON or IP to the QAPI committee. The Administrator said he did not have documented evidence the DON or the IP were in attendance or that their reports were presented at the QAPI meeting by a designee as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the transmission of communicable diseases and infections on one unit ([NAME] Terrace), out of a total of three units, affecting eight Residents (#167, #99, #75, #95, #62, #72 #170, and #50), out of a total sample of 22 residents. Specifically, 1. for Resident #167, the facility failed to ensure Personal Protective Equipment (PPE: items such as gowns, gloves, etc. to prevent the spread of infection from one person to another) was donned correctly, the surface used to set up treatment supplies was cleaned and disinfected before use, and that the scissors used to cut of an old dressing were cleaned and disinfected before using them to cut new dressing materials, placing the Resident at increased risk of contamination and infection. 2. for Resident #99, the facility failed to ensure that dressing materials brought into the Resident's room were not returned to the treatment cart for storage placing the [NAME] Terrace unit at risk for cross contamination. 3. For Resident #75, the facility failed to implement Contact Precautions when the Resident had a suspected infection, and results were pending for Clostridium Difficile (C.Diff: multi-drug resistant organism [MDRO] that is infectious and causes diarrhea and colitis [inflammation of the colon]). 4. For Residents #62 and #95, the facility failed to implement Special Contact/Droplet Precautions for both Residents who were diagnosed with Influenza. 5. For Residents #72 and #170, the facility failed to implement Enhanced Barrier Precautions (EBP) as indicated for both Residents who were at high risk for contracting infections. 6. For Resident #50, the facility failed to implement Contact Plus Precautions for a Resident diagnosed with C-Diff. Findings include: Enhanced Barrier Precautions (EBP) - refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities. 1. Resident #167 was admitted to the facility in February of 2025 with diagnoses including Arthritis due to other bacteria of the left wrist and Heart Failure. On 3/7/25 at 11:28 A.M., the surveyor observed the following during wound care to Resident #167 provided by Nurse #1: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #1 performed hand hygiene at the Resident's room door and began to don a gown. While donning the gown Nurse #1 bent forward causing the lower half of the gown to touch the floor. -Nurse #1 finished donning the gown and prepared to enter the room when the surveyor intervened and made her aware of the observed gown touching the floor. -Nurse #1 removed the gown, performed hand hygiene, donned a new gown and gathered supplies to enter the Resident's room. -Nurse #1 dropped the bleach wipe on the floor and stated she would not be able to wipe the over-bed table to clean and disinfect the table. Nurse #1 then draped the table with a towel without cleaning or disinfecting the table and set up treatment supplies on the towel. -Nurse #1 used new scissors from a suture removal kit to remove the old dressing from the Resident, disposed of the old dressing and set the scissors on the draped table without cleaning or disinfecting the scissors. -Nurse #1 doffed gloves, performed hand hygiene, and donned new gloves. -Nurse #1 cleansed the wound with wound cleanser and gauze and patted the area dry. -Nurse #1 doffed the soiled gloves, performed hand hygiene, and donned new gloves. -Nurse #1 cut a piece of plain packing strip with the previously used scissors that were not cleaned or disinfected and applied the packing strip to the wound. -Nurse #1 covered the wound with gauze, wrapped it with gauze wrap, and secured it with tape. -Nurse #1 disposed of trash, doffed PPE, and performed hand hygiene before exiting the room. During an interview on 3/7/25 at 12:20 P.M., the surveyor reviewed the wound care observations with Nurse #1. Nurse #1 said she should have cleaned and disinfected the scissors between using them to cut off the old dressing and to cut the new dressing supplies because the old dressing was considered dirty, but she did not. Nurse #1 declined to answer any further questions from the surveyor. During an interview on 3/11/25 at 3:42 P.M., the surveyor reviewed the wound care observations with the Infection Preventionist (IP). The IP said there was concern with Nurse #1 entering room to perform wound care with a gown that had touched the floor as the floor was dirty and this could cause contamination of the wound. The IP further said the table and scissors should have been cleaned and disinfected as the table and the old dressing were considered contaminated, and this could contaminate the new dressing and/or wound. 2. Resident #99 was admitted to the facility in September 2024 with diagnoses including Malignant Neoplasm of the Glottis, Gastrostomy Status and Extended-Spectrum Beta Lactamase (ESBL). On 3/12/25 at 9:18 A.M., the surveyor observed the following during a Gastrostomy Tube (G-tube) site care for Resident #99 provided by Nurse #8: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurse #8 performed hand hygiene, donned a gown and gloves. -Nurse #8 gathered supplies off the treatment cart and entered the Resident's room. -Nurse #8 placed supplies on the counter in room, cleaned and disinfected the over-bed table and draped it with a disposable pad. -Nurse #8 gathered the supplies from the counter and set them up on the draped table. -Nurse #8 removed old dressing from G-tube site, disposed of it, doffed gloves, performed hand hygiene and donned new gloves. -Nurse #8 cleansed the G-tube site area with normal saline soaked gauze and patted the area dry. -Nurse #8 doffed gloves, performed hand hygiene and donned new gloves. -Nurse #8 applied a clean drain sponge gauze to the site, and secured it with tape. -Nurse #8 disposed of the used supplies, cleaned and disinfected the table, doffed gown and gloves, performed hand hygiene and exited the room with the opened package of gauze. -Nurse #8 brought the package of opened gauze to the treatment cart and placed it in a drawer. During an interview on 3/12/25 at 9:30 A.M., Nurse #8 said she should not have placed the opened gauze package that was used in Resident #99's room back into the treatment cart. During an interview on 3/12/25 at 9:40 A.M., the IP said that because the gauze had been set on a surface in Resident #99's room and then brought out and placed into the treatment cart, there was a risk for cross-contamination. 37400 3. Review of the facility policy titled Transmission-Based Precautions (TBP) and Isolation Procedure, revised 9/24/24, indicated the facility will implement and utilize TBP to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. The policy also included the following: -TBP must be used when a resident develops signs and symptoms of a transmissible infection . -The facility should refer to CDC- Appendix A to determine the type and duration of precautions recommended for select infections and conditions, unless the facility has been provided more stringent guidance from local and state health authorities. -The facility should also initiate TBP for a constellation of new symptoms consistent with a communicable disease. Empirically initiated TBP may be adjusted or discontinued when additional clinical information becomes available (e.g. confirmatory laboratory testing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Contact Precautions are intended to prevent transmission of pathogens that are spread by direct (e.g. person to person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves before entering or upon entering (i.e. before making contact with the resident or the resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed, and hand hygiene is performed. Review of the Centers for Disease Control and Prevention (CDC) document titled About C. Diff, dated 12/18/24, indicated the following: -C.Diff is a germ that causes diarrhea and colitis and can be life-threatening. -C.Diff can affect anyone. -Most cases of C.Diff infection occur when you've been taking antibiotics or not long after you've finished the antibiotic course. -Symptoms of C.Diff include diarrhea, fever, stomach tenderness or pain, loss of appetite, and nausea. -People are up to 10 times more likely to get C.Diff infection while taking an antibiotic or during the three months after, with longer courses potentially doubling their risk. -Other risk factors include recent stay at a hospital or nursing home and previous infection with C.Diff . -C.Diff germs spread from person to person in poop [sic], but the bacteria are often found in the environment. -When C.Diff germs are outside the body, they become spores. These spores are an inactive form of the germ and have a protective coating allowing them to live for months or years on surfaces . Review of the CDC document titled Appendix A: -Type and Duration of Precautions Recommended for Selected Infections and Conditions, dated 2/7/25, indicated: >Contact Precautions and handwashing with soap and water are recommended for individuals with C.Diff. Resident #75 was admitted to the facility in February 2025 with diagnoses including Dementia and Aspiration Pneumonia. Review of the Minimum Data Set (MDS) Assessment, dated 2/12/25, indicated Resident #75: -was rarely or never understood/understands -had severe cognitive impairment as evidenced by a BIMS score of 0 out of 15 (continued on next page)

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	225543	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Wilbraham	2399 Boston Road Wilbraham, MA 01095

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-was dependent on staff with toileting -required assistance of staff with dressing and personal hygiene On 3/7/25 at 7:58 A.M., the surveyor observed Resident #75 calling out loudly from his/her room. Thesurveyor observed Resident #75 was dressed, seated in a wheelchair, and was shifting back and forth while seated saying, I can't wait please . The Resident was observed to pull at the top back of his/her pants while continuing to call out. The surveyor relayed the observation to Nurse #1 who said she would follow-up with the Resident and also let the Certified Nurses Aide (CNA) know. Review of the Provider Note, dated 3/10/25, indicated Resident #75 was examined and the following was noted: -elevated white blood cell (WBC: could indicate inflammation or symptom of infection) and abdominal pain over past two days -the Resident's abdomen had tenderness -increased restlessness and indication of abdominal pain -Start Augmentin (antibiotic) 500/125 twice daily for three days, for possibility of intra-abdominal infection Review of the March 2025 Physician's orders indicated: -Stool for C.Diff, ordered 3/10/25 at 2:30 P.M., and discontinued 3/11/25 On 3/11/25 at 8:59 A.M., the surveyor observed Resident #75 awake and lying in bed. The surveyor did not observe any signage outside of the Resident's room indicating TBP were in place. The surveyor observed an Activities Assistant going from resident room to resident room and passing water pitchers at this time. Review of Resident #75's laboratory test results, dated 3/11/25 at 10:18 A.M., indicated: -C. Diff positive, critical result -critical results were acknowledged by Nurse #2 During an interview on 3/11/25 at 10:55 A.M., CNA #2 said she was just notified that the Resident was positive for C.Diff infection, and they were in the process of moving the Resident to another room. The surveyor observed the Resident's room had no signage indicating TBP for Resident #75 was in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/25 at 10:56 A.M., Nurse #2 said she entered the Physician's order to test Resident #75 for C.Diff the previous day (3/10/25). Nurse #2 said they were able to obtain a stool specimen on 3/10/25. Nurse #2 said they would typically put a resident on TBP if they were symptomatic or if they had a laboratory culture pending. Nurse #2 said when the Physician's order was obtained, it was change of shift, and she reported to the 3:00 P.M. to 11:00 P.M. shift the Resident's current status. Nurse #2 said she alerted the nursing staff that the Resident was positive for C.Diff, and they were currently in the process of moving the Resident to another room. When the surveyor asked Nurse #2 how staff knew what PPE was required when providing care for the Resident, Nurse #2 said she told the nursing staff. During an interview on 3/11/25 at 11:20 A.M., the Infection Preventionist (IP) said she was unaware that Resident #75 had a C.Diff specimen ordered on 3/10/25. The IP said when the Physician gave an order to obtain a C.Diff specimen, Resident #75 should have been placed on Contact Precautions. 4. Review of the facility policy titled Transmission-based Precautions and Isolation Procedures, revised 9/24/24, included the following: -the use of Droplet Precautions applies when respiratory droplets contain pathogens which may spread to another susceptible individual. Respiratory pathogens can enter the body via the nasal mucosa, conjunctivae and less frequently the mouth. -examples of droplet-borne organisms that may cause infections include but are not limited to influenza . Review of the facility matrix, provided to the survey team shortly after entrance on 3/5/25, indicated Resident #95 and Resident #62 were on TBP, and resided in the same room. a. Resident #95 was admitted to the facility in February 2025. Review of a Nurse's Note dated 2/28/25, indicated the Resident was complaining of slight cough and not feeling well. Resident #95 was swabbed for Influenza (Flu) and was positive. Review of a Provider Note, dated 3/8/25, indicated the following: -Resident #95 was positive for flu, changed to full-strength Tamiflu (anti-viral medication) 75 milligrams (mg), twice daily for 5 days through 3/11/25 - Resident has a productive cough and fatigue, receiving updraft [sic] treatments. Review of the March 2025 Physician's orders indicated Isolation: -Contact and Droplet Precautions for Flu, every shift, initiated on 2/28/25 and discontinued on 3/10/25. b. Resident #62 was admitted to the facility in February 2025. Review of a Nurse's Note, dated 2/28/25, indicated the Resident called an ambulance at approximately 1:00 A.M. due to complaints of not being able to breathe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident #62's clinical record indicated: -he/she was readmitted to the facility on [DATE] -Provider note, dated 3/4/25: positive for Influenza upon re-admission from the hospital -Nursing Note, dated 3/4/25: remains on precautions and Tamiflu for Influenza . On 3/5/25 at 10:56 A.M., the surveyor observed Resident #95 and Resident #62 lying in their individual beds in the same room. Two signs were posted outside of the room which indicated the following: -Stop. Enhanced Barrier Precautions (and indicated for B on a round sticker) >everyone must: cleanse their hands before entering and leaving the room >staff and providers must also: wear gloves and a gown for high-contact resident care activities. -Stop. Special Droplet/Contact Precautions (did not indicate a letter on a round sticker) >Only essential personnel should enter this room. >everyone must: cleanse hands when entering and leaving the room >wear a mask >wear eye protection (face shield or goggles) >gown and glove at the door On 3/7/25 at 8:29 A.M. through 8:39 A.M., the surveyor observed the following: -Two signs indicating Enhanced Barrier Precautions and Special Droplet/Contact Precautions were observed outside of the room entrance. -A bin containing PPE including gowns, eye protection and masks. Gloves were observed upon entry into the Residents' room. -Activity Assistant (AA) #1 entered Resident #95 and Resident 62's room with a surgical mask and gown on. AA #1 did not have eye protection or gloves on. AA #1 was observed to remove her gown and exited the room shortly after. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-an alcohol-based hand rub is appropriate for decontaminating the hands: >before direct patient contact, putting on gloves . >after removing gloves >after contact with a patient or with bodily fluids, excretions, mucous membranes, non-intact skin, or wound dressings (if hands are not visibly soiled) >after contact with inanimate objects in the patient's environment a. Resident #72 was admitted to the facility in December 2024 with diagnoses including neuromuscular dysfunction of the bladder and Extended Spectrum Beta Lactamase (ESBL). Review of the CDC document, dated 4/11/2024, indicated the following: -Enterobacterales are a group of bacteria that cause infections in healthcare settings and communities. -Some species are also a normal part of the human gut. -Some Enterobacterales produce enzymes called extended-spectrum beta-lactamases (ESBLs). -Extended-spectrum beta-lactamases (ESBLs) break down certain antibiotics, making some infections caused by ESBL-producing Enterobacterales difficult to treat. -ESBL-producing Enterobacterales can spread from person to person through dirty hands and surfaces. Review of Resident #72's March 2025 Physician's orders indicated the following: -Enhanced Barrier Precautions (EBP) every shift related to history of ESBL in urine, initiated 3/5/25 b. Resident #170 was admitted to the facility in February 2025 with diagnoses including left hip fracture and need for assistance with personal care. On 3/7/25 from 9:31 A.M. through 9:45 A.M., the surveyor observed the following: -EBP signage was posted outside of the Resident's room, and a PPE bin containing gowns outside of the door entry -9:31 A.M., Resident #72 initiated the call light -9:36 A.M., CNA #1 entered the Resident's room with a surgical mask and gloves in place, but did not don a gown. -CNA #1 assisted Resident #72 to the bathroom located inside of the room, then went to the Resident's closet, retrieved some pants, returned to the bathroom and then instructed the Resident to ring when he/she was done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA #1 exited Resident #72's room with a glove on her left hand (did not remove the glove or conduct hand hygiene after exiting the room) and entered Resident #170's room with the same gloved hand. -CNA #1 exited Resident #170's room shortly after with the gloved left hand (did not remove the glove nor perform hand hygiene) and entered the clean linen room. -CNA #1 exited the clean linen room shortly after holding a towel in the gloved left hand and re-entered Resident #170's room. -CNA #1 exited Resident #170's room a second time with the gloved left hand (did not remove the glove nor perform hand hygiene), re-entered the clean linen room and exited short after holding a hospital gown and a brief in the left gloved hand and returned to Resident #170's room. -9:45 A.M., CNA #1 drew the privacy curtain around Resident #170 and at this time, the surveyor intervened prior to care being provided to Resident #170 as CNA #1 continued to have the gloved left hand that was contaminated. During an interview at the time, CNA #1 said she had a bad habit of forgetting to remove her gloves. CNA #1 said she should have removed gloves and performed hand hygiene after caring for Resident #72, but she did not. CNA #1 said there would be a risk for cross contamination by not removing her glove and performing hand hygiene. On 3/7/25 at 10:25 A.M., the surveyor and CNA #1 reviewed the EBP signage outside of Resident #72's room. CNA #1 said the EBP signage indicated the precautions were for Resident #72, but she was not sure why. During an interview on 3/11/25 at 11:20 A.M., the surveyor relayed observations of the precaution signage and infection control concerns relative to Resident's #95, #62, #72 and #170 with the IP. The IP said Resident's #95 and #62 had Influenza, and the expectation was for all staff to defer to the Special Droplet/Contact sign which indicated to put on a gown, gloves, mask and eye protection prior to entering the room. The IP said she understood that there may be confusion from staff on what to do when multiple signs were posted outside of the Residents' room. Relative to the observation with CNA #1, the IP said the facility would need to do more education on the precaution signage and infection control practices. 42690 5. Resident #50 was admitted to the facility in February 2025. Review of Resident #50's March 2025 Order Summary Report indicated the following: -Vancomycin HCl (antibiotic). Give 125 milligrams (mg) by mouth four times a day for C-DIFF until 3/17/25, beginning on 3/8/25. On 3/11/25 at 8:48 A.M., the surveyor observed the following: -CNA #2 entered Resident #50's room, carrying a breakfast tray and wore a surgical mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A Contact Plus sign was located on the outside of the door and indicated that staff and providers must: ---Clean hands before entering the resident's room ---Wear gown and gloves, change between residents ---Wash hands with soap and water before exiting. ---Hand sanitizer alone is not sufficient when exiting a resident's room. -CNA #2 performed hand hygiene using the hand sanitizer located on the wall, prior to exiting the Resident's room. -CNA #2 exited the Resident's room and immediately entered the next room over, which had an EBP sign located on the outside of the door. During an interview immediately following the observations, CNA #2 said she entered Resident #50's room to bring in a breakfast tray and did not have any contact with the Resident in the room therefore did not need to wear all the PPE indicated on the sign posted at the door. CNA #2 said that when she exited the room, she used the hand sanitizer, and did not wash her hands with soap and water before leaving Resident #50's room or before entering the room next door, which had EBP's in place. CNA #2 said that per the sign she should have washed her hands with soap and water before exiting Resident #50's room. During an interview on 3/11/25 at 9:04 A.M., the IP said it was her expectation that when a Contact Plus sign was located outside of a resident's room, that staff were donning all the required PPE noted on the sign prior to entering the room, doffing the PPE and washing their hands with soap and water before exiting the room. The IP said the Contact Plus sign indicated someone in the room was on precautions due to either C.Diff, a gastrointestinal (GI) symptoms or norovirus.