STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225661	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Auburn	14 Masonic Circle Auburn, MA 01501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42761 Based on interview, record and policy review, the facility failed to notify the Physician/Non Physician Practitioner (NPP: Nurse Practitioner) of a significant change in physical status for one Resident (#102) out of a total sample of 25 residents, resulting in a lack of medical evaluation of the Resident's status relative to weight loss. Specifically, the facility staff failed to notify Resident #102's NPP of the Resident's severe weight loss (greater than five percent (%) in one month and greater than seven point five % in three months) when: a. Staff identified the Resident had a severe weight loss. b. The NPP requested to be notified if the severe weight loss was verified. Findings include: Review of the facility's policy titled Changes in Resident's Condition or Status, dated 11/26/18 and reviewed 8/9/23, indicated the following: -Facility would notify a resident's primary care provider (PCP: Physician/NPP) of changes in the resident's condition or status. -Notable changes included weight loss in excess of 5% of a resident's body weight. Review of the facility's policy titled Weights and Heights: Weight Monitoring Long-Term Care, revised 8/21/23, indicated the following: - Weight loss in adults can result from various conditions. - A decrease in weight of 5% or more in a month or of more than 10% in six months should be reported to the PCP for further evaluation. Resident #102 was admitted to the facility in October 2021 with diagnoses including: Diverticulitis (small, bulging pouches that can form in the lining of the digestive system and can cause abdominal pain, nausea, and vomiting) and Dysphagia (difficulty swallowing). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #102's active Nutrition Care Plan initiated 5/4/22, indicated: -The Resident was at increased nutrition risk. -The Resident had a history of weight loss. -One of the Resident's goals was to maintain a stable weight. -Facility staff were to report significant weight loss to the Physician. Review of Resident #102's Minimum Data Set (MDS) Assessment, dated 1/31/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of 15 total possible points. -The Resident experienced signs and symptoms of a swallowing disorder. -The Resident did not have weight loss. Review of Resident #102's Plan of Care Note, dated 2/14/24, indicated: -The Resident was nutritionally stable. -Meal intakes ranged from 76%-100%. -The Resident's weight was stable. Review of a Physician's order dated 2/26/24, indicated: Weekly weights due to weight loss. Review of Resident #102's Weight Record indicated the following: -189.9 lbs. on 11/20/23 -189.6 lbs. on 1/26/24 -173.8 lbs. on 2/29/24 (indicating severe weight loss). Review of Resident #102's Weight Change Note, dated 3/5/24, indicated: -The Resident's weight was 173.8 lbs. -The Resident's weight loss was 16 lbs (severe). Further review of the Weight Change Note indicated the Resident's weight was much lower than his/her usual body weight (UBW) and that a re-weigh was requested. Review of Resident #102's Weight Record indicated the Resident was next re-weighed on 3/14/24 and was 173.8 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #102's Weight Change Note, dated 3/15/24, indicated: -The Resident's UBW was upper 180s. -The Resident had no change in appetite. -Another re-weigh was requested. Review of Resident #102's Weight Change Note, dated 3/19/24, indicated: -Another re-weigh was requested for review with the Unit Manager (UM). -The Resident continued with good meal intakes. -The Resident's UBW ranged around 180s with most recent weight of 173.9 lbs. Review of Resident #102's clinical record included no evidence that facility staff notified the Resident's NPP of the Resident's severe weight loss at any time after weekly weights were ordered on 2/26/24. During an interview on 4/9/24 at 3:21 P.M., the Registered Dietician (RD) said she had been monitoring Resident #102 for weight loss since February 2024, when it was identified that the Resident had a potential severe weight loss. The RD said the severe weight loss was first identified on 2/26/24 and that she recommended weekly weight monitoring and requested the Resident be re-weighed to determine whether the severe weight loss was accurate. The RD said an order was obtained for weekly weight monitoring for Resident #102 on 2/26/24, and if the severe weight loss was verified, the NPP was to be notified. The RD said re-weights for Resident #102 were obtained on 3/14/24 and 3/18/24, both of which indicated severe weight loss, but she could not provide any evidence the NPP was notified. The RD further said she was not sure what the Resident's current weight was because the facility staff had not weighed the Resident for three consecutive weeks. Review of Resident #102's Weight Record indicated a weight was obtained on 4/9/24 at 4:08 P.M., following the surveyor's inquiry, and that the Resident weighed 171.8 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/24 at 8:10 A.M., the NPP said facility staff were required to notify her when a resident was identified to have a significant change in weight. The NPP said if a resident's weight changed significantly, facility staff would re-weigh the resident and that once the re-weight was obtained, facility staff were to notify her if the new weight confirmed a significant change in weight. The NPP said when staff notified her of a resident's significant change in weight, she would consult with the Physician and evaluate the resident for any medical concerns that could be related to the significant weight change. The NPP said she ordered weekly weights to be completed for Resident #102 in February 2024 when facility staff identified that the Resident had a potential severe weight loss. The NPP said facility staff communicated they would re-weigh the Resident to determine whether the weight loss was accurate. The NPP also said she requested facility staff to notify her if Resident #102's severe weight loss was identified to be accurate. The NPP said Resident #102 had not been feeling well over the previous two days with stomach upset, so that may have contributed to the Resident's most recent weight change from 173.9 lbs to 171.8 lbs, but this occurred after the Resident's confirmed severe weight loss on 3/14/24. The NPP further said facility staff did not notify her of Resident #102's severe weight loss until 4/9/24, but they should have notified her when the Resident's re-weight was obtained on 3/14/24, when severe weight loss was confirmed, so that a medical evaluation could have been initiated.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on interview and record review, the facility failed to accurately complete, encode and transmit Minimum Data Set (MDS) Assessments as required for three Residents (#101, #164, and #131) out of a total sample of 25 residents. Specifically, the facility failed to: 1. Elecronically transmit a Discharge MDS Assessment for Resident #101, within 14 days of completing the Discharge MDS Assessment. 2. Complete a Death in Facility Tracking Record for Resident #164, when the Resident expired at the facility. 3. Complete a Discharge MDS Assessment for Resident #131, within 14 days of the Resident's discharge from the facility when the Resident's return to the facility was not anticipated. Findings include: 1. Resident #101 was admitted to the facility in [DATE] with a diagnosis of Congestive Heart Failure (CHF - a condition in which the heart does not pump blood the way it should resulting in fluid build-up in the lungs, arms, feet and other organs). Review of Resident #101's MDS Assessment, dated [DATE], indicated the Resident was discharged from the facility on [DATE]. Further review the MDS Assessment indicated that the MDS Discharge Assessment had not been transmitted to the Centers for Medicare and Medicaid Services (CMS) within 14 days of the final completion date as required. 2. Resident #164 was admitted to the facility in [DATE] with a diagnosis of Hypertension (HTN - high blood pressure). Review of Resident #164's medical record, indicated that the Resident expired in the facility on [DATE]. Further review the medical record did not contain any evidence that a Death in Facility Tracking Record had been completed for Resident #164. 3. Resident #131 was admitted to the facility in [DATE] with a diagnosis of Spinal Stenosis (a narrowing of space in the spinal canal). Review of Resident #131's Discharge MDS Assessment, dated [DATE], indicated the Resident was discharged from the facility on [DATE], but the MDS Discharge Assessment was not completed until [DATE] (six days past the completion due date of [DATE]). (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interiew on [DATE] at 2:45 P.M., the MDS Nurse said the facility was required to follow the CMS RAI (Resident Assessment Instrument) instructions for resident MDS data completion and processing. The MDS Nurse said Resident #101 had been discharged from the facility on [DATE] and the MDS was completed on [DATE]. The MDS Nurse then said Resident #101's Discharge MDS Assessment should have been transmitted to the CMS system no later than [DATE], but the Discharge MDS Assessment was never transmitted. The MDS Nurse also said Resident #164 expired in the facility on [DATE] and the facility never completed the required Death in Facility Tracking Record, but a Death in Facility Tracking Record should have been completed for Resident #164 and transmitted to the CMS system within 14 days of the Resident's death. The MDS Nurse further said that Resident #131 had been discharged from the facility on [DATE], so the Discharge MDS Assessment should have been completed by [DATE], but it was not completed until [DATE] (six days past the due date for completion). The MDS Nurse said that timely completion and processing of MDS data was important because it could affect facility data.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 45435 Based on observation, interview, and record review, the facility failed to provide treatment, services and care that met professional standards of quality for one Resident (#18) out of a total sample of 25 residents. Specifically, the facility staff failed to provide the correct topical wound medication as ordered by the Physician resulting in removal and re-application of the dressing causing additional discomfort to the Resident. Findings include: Review of the facility policy titled Treatment of Wounds, dated 3/31/23 indicated the following: -Policy: It is the intent of this center that a resident having a wound receives necessary medical treatment to prevent infection, deterioration, or development of wounds in keeping with the resident's medical condition. -Procedure: This facility will utilize the Lippincott procedures: Traumatic wound care: abrasion, lacerations, and puncture wounds. Review of the Lippincott Manual of Nursing Procedures -9th Edition (2023), Traumatic Wound Management indicated the following: -Apply antibacterial ointment, if prescribed, following safe medication administration practices to help prevent infection. Resident #18 was admitted to the facility in April 2023 with diagnoses including peripheral vascular disease (PVD-a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and non-pressure chronic ulcer of the skin. Review of the Minimum Data Set (MDS) Assessment, dated 1/31/24, indicated Resident #18: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14 out of 15 points. -had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of the damage within the ulcer cannot be confirmed because the wound bed is obscured by dead tissue) that was present on admission. Review of the Wound Consultant's note, dated 3/11/24, indicated that the Resident had a wound on his/her left heel and a wound on his/her left dorsal foot (the upper surface of the foot) and was ordered to have daily dressing changes. Review of the Physician orders dated April 2023, indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left foot: *cleanse with normal saline (a mixture of salt and water often used to cleanse wounds), pat dry. *Apply Silver Sulfadiazine (an antibiotic cream used to prevent and treat infection) to top of left foot. *Cover with ABD pad (a bulky pad used where high absorbency is needed to manage heavy draining wounds) and wrap with KLING wrap (rolled gauze). *Secure with tape. Every day shift for wound care. -Left heel: *clean with normal saline and thoroughly dry. *Apply nickel thick amount of Santyl (an ointment that is used to remove dead tissue from chronic skin ulcers) with damp to dry 4 x 4 CDD (4-inch by 4-inch gauze dressing). *wrap with KERLIX fluff (rolled gauze) and paper tape. Every day shift. During a dressing change observation on 4/8/24 at 2:25 P.M., the surveyor observed the following: -Nurse #1 cut the gauze wrap off the Resident's left foot then reached a small gauze pad covering the left foot dorsal wound. -Nurse #1 soaked off the gauze on the left dorsal foot with normal saline. The surveyor observed that the wound measured approximately 0.5 centimeters (cm) in diameter, the wound bed was beefy red with white fibrous material and very tender to touch. -Nurse #1 cleansed and dried the wound, then proceeded to apply Santyl to a cotton swab and placed the Santyl in the wound bed. -Nurse #1 then applied Silver Sulfadiazine cream to a cotton swab and placed the Sulfadiazine cream on top of the Santyl, then applied an ABD pad to the top of the foot. -Nurse #1 then proceeded to the left heel wound where she cleansed and dried the wound. The surveyor observed the wound to measure approximately 0.5 cm in diameter, the wound bed contained dry yellow material, and appeared non-tender to touch. -Nurse #1 applied Santyl to a cotton swab and placed the Santyl in the heel wound bed, then applied Silver Sulfadiazine cream to a cotton swab and placed the Silver Sulfadiazine cream on top of the Santyl. -Nurse #1 then applied an ABD pad to the bottom of the foot and wrapped the foot, including both wound dressings, in gauze wrap. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/24 at 4:08 P.M., Nurse #1 said that she put Santyl and Silver Sulfadiazine on both wounds. The surveyor and Nurse #1 reviewed the Physician's orders and Nurse #1 said that she did the wound treatment incorrectly and that she would notify the Unit Manager (UM) of the mistake. During an interview on 4/8/24 at 4:31 P.M., the UM said Nurse #1 should have put Silver Sulfadiazine cream on the wound on the top of the left foot, and Santyl on the wound on the Resident's left heel. During an interview on 4/9/24 at 1:30 P.M., Physician #1 said he had been made aware of the wound care errors and said that utilizing both Santyl and Silver Sulfadiazine on the same wound is counterproductive to healing. Physician #1 said that he had recommended cleansing the area with normal saline and applying the treatment as ordered, Silver Sulfadiazine to top of left foot wound and Santyl to the left heel wound. Please refer to F697

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46138 Based on observation, interview, record and policy review, the facility failed to provide care consistent with professional standards to prevent and treat a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) and prevent further skin and pressure injury for one Resident (#85), out of a total sample of 25 residents. Specifically, the facility staff failed to: -Assess the fit and use of an orthopedic surgical shoe (type of shoes that provides support and stability for the foot after an injury or surgery) for Resident #85 who had a high risk of developing pressure ulcers due to a history of Diabetes (condition that result in too much sugar [glucose] in the blood). -Provide skin care and treatments timely for ulcers on the right plantar foot, back of right ankle and right heel, resulting from the use of an orthopedic surgical shoe. Findings include: Review of the facility policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management, reviewed March 2023, indicated the following: - A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and - A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. -Skin observations also occur throughout points of care provided by Certified Nursing Assistance (CNA) during activity of daily living (ADL) care (bathing, dressing, incontinent care, etc.) Any changes or open areas are reported to the Nurse. -Nurse will complete further inspection/assessment and provide treatment if needed. -When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. -Successful pressure injury treatment involves relieving pressure, restoring circulation, promoting adequate nutrition and, if possible, resolving or managing related disorders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #85 was admitted to the facility in March 2024, with diagnoses including Diabetes with Neuropathy (condition that results in too much sugar in the blood resulting in high blood glucose[sugar] with nerve damage) and Peripheral Vascular Disease (PVD - circulatory disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #85: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 14 out of a total 15. -Had range of motion impairments affecting one side upper extremity. -Was dependent on staff for putting on and taking off footwear. -Required assistance from staff with upper and lower dressing, rolling side to side, lying to sitting and with transfers. -Was at risk for pressure ulcers -Had no pressure ulcers/injuries -Had two venous and arterial ulcers (no location identified). Review of the April 2024 Physician's orders, included the following: -Diabetic foot care, initiated 3/8/24 -Monitor heels every shift, initiated 3/7/24 -Bilateral heels: Apply skin prep, initiated 3/7/24 Review of the Norton Plus Pressure Ulcer Scale (used to determine whether a patient is at high risk of pressure ulcer development) dated 3/29/24, indicated a total score of 11 indicating moderate risk (high risk - score of 10 and below, moderate risk - score of 11-15) for skin breakdown. Review of the Weekly Wound assessment dated [DATE], indicated Resident #85 had the following: -Pink heels (the Weekly Wound Assessment did not specify one or both heels). Review of the Physical Therapy Treatment encounter dated 3/22/24, indicated Resident #85: -Had an x-ray taken of the right foot due to a loud crack experienced when ambulating to the bathroom [in the Resident's room in the facility]. -The x-ray report was negative, but the Resident is experiencing significant pain with putting pressure on the right foot. -Physician Assistant (PA) requested a right soft cushion orthopedic surgical shoe. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Physical Therapy (PT) Treatment encounter dated 3/25/24, indicated Resident #85: -Was unable to initiate steps due to pain in right lower extremity. -Was wearing the right cast shoe (a soft cushion surgical shoe that provides support and stability for the foot after an injury or surgery). -Received pain medication prior to the therapy session. Review of the Physical Therapy Treatment encounter dated 3/28/24, indicated Resident #85: -continues to report pain in the right heel with weight bearing. -declined all additional standing and therapy activities. -An Orthopedic appointment was scheduled for 4/4/24 due to right heel pain. Review of the Physical Therapy Treatment encounter dated 3/29/24, indicated Resident #85: -had pain in the right heel with weight bearing. -declined gait training and standing activities. Review of the Physical Therapy Treatment encounter dated 4/2/24, indicated Resident #85: -had pain in right heel/ankle with weight bearing. -had pain medication prior to the PT session. Review of the Resident's Orthopedic Consultation dated 4/4/24, indicated the following: -Fracture of the Right Calcaneus with Achilles Tendon Disruption (an injury that is usually painful and likely to affect the ability to walk). -Skin Care for ulcers right plantar, right heel and back of right ankle. -Keep NWB (non weight bearing- for a certain period of time following injury or surgery you are not allowed to put any weight through the operated or injured limb to allow it to heal as much as possible). -Monitor skin back of [right] ankle. Review of the Physician's Progress Note, 4/5/24 indicated Resident #85: -Was seen by the Physician's Assistant (PA) on 3/22/24, for complaints of acute left [error] ankle pain when walking back from the bathroom. -Had an x-ray of right ankle 3/21/24 that showed no acute fracture. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Was seen by the PA on 3/26/24, for complaints of right heel pain, not able to bear weight without significant pain, is wearing a post-operative [soft cushion surgical]shoe on the [right foot] for support. -Was seen by the PA on 4/2/24, and continued with right heel pain, relieved with Tramadol (pain medication). -Orthopedic appointment scheduled 4/4/24. Review of the Nursing Progress Note dated 4/9/24, indicated Resident #85: -had a Deep Tissue Injury (DTI-purple or maroon localized area of discolored intact skin or fluid filled blister due to damage of underlying soft tissue from pressure) to the back of right heel, origin believed to be from back of the ortho (orthopedic) shoe. Further Review of the medical record indicated that Resident #85 was provided the surgical shoe (also referred to as post-op shoe/orthopedic shoe) on 3/22/24 and continued wearing it on the right foot until after the orthopedic appointment on 4/4/24. Review of the Physician's orders dated 4/10/24 (6 days after the ulcers were identified by the Orthopedic Physician), indicated the following: -Monitor DTI to right heel, initiated 4/10/24 -Maintain NWB to RLE (right lower extremity), initiated 4/9/24 -Monitor CSM (circulatory, motor, sensory- a physical exam of a resident whenever there is a high index of suspicion that there may be circulatory or neurological impairment to a limb) to right lower extremity (RLE), initiated 4/9/24 -Pain Assessment/Interventions prior to PRN (as needed) pain medication administration: Location of pain: ankle med interventions prior to administering pain medication, initiated 4/10/24 -Skin prep to bilateral heels and moisturize legs and feet two times a day, initiated 4/10/24 -Offload (minimizing or removing weight placed on the foot to help prevent and heal ulcers) pressure at all times, initiated 4/10/24 -Right plantar foot care, assess daily, clean foot with soap and water, pat dry, apply betadine to the small round Diabetic Ulcer on the mid-foot and cover with a padded dressing. -For Diabetic foot care assessments, initiated 4/10/24 Review of the current Diabetes Care Plan, initiated 3/7/24, indicated Resident #85 will have no complications related to Diabetes through the next review date. Review of the care plan, Unstageable DTI pressure ulcer right heel or potential for pressure ulcer development related to immobility, initiated 4/4/24, indicated Resident #85 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Auburn	14 Masonic Circle Auburn, MA 01501

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Pressure ulcer will show signs of healing and remain free from infection by/through next review date. -Administer treatments as ordered. -Assess wound healing. -Educate the resident/family/caregivers as to causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. -Follow facility policies/protocol for the prevention/treatment of skin breakdown. Review of the Weekly Wound assessment dated [DATE], indicated Resident #85 had the following: -Right heel DTI pressure wound-unstageable acquired in facility 1.3 centimeters (cm) length by (x) 0.3 cm width x 0 cm depth. During an interview on 4/9/24 at 12:32 P.M., the Director of Nurses (DON) said that Resident #85 had an Orthopedic appointment on 4/4/24 with recommendations for the fracture of the Right Calcaneus with Achilles Tendon Disruption and the ulcers located on the right foot and heel areas. The DON further said the Resident had been ordered an orthopedic surgical shoe for comfort prior to the Orthopedic appointment. During an interview on 4/10/24 at 9:11 A.M., Nurse #3 and Physician Assistant (PA) #2 reviewed the medical record and Nurse #3 said Resident #85 had a new DTI to the right heel due to the orthopedic surgical shoe. Nurse #3 said the DTI was identified on 4/4/24 during the Orthopedic appointment but Nurse #3 only evaluated Resident #85 on 4/9/24 during the facility's weekly skin rounds. Nurse #3 said the last skin evaluation for Resident #85 was completed on 4/3/24 and not again until 4/9/24. PA #2 said she ordered the orthopedic surgical shoe for Resident #85 for comfort after the x-rays to the right heel on 3/22/24 were negative. Nurse #3 reviewed the Orthopedic consult from 4/4/24 and said when the Orthopedic Physician identified ulcers on the right plantar surface, right heel and back of right ankle, there was no evidence that any Physician orders for treatments were put into place and Resident #85 continued to wear the orthopedic surgical shoe. Nurse #3 said when a resident returns from a consultation the recommendations should be given to the medical provider and therapy department. Nurse #3 further said that based on the Orthopedic consultation, the Director of Nurses (DON) should have been notified and a skin assessment should have been completed immediately by the nursing staff to identify the areas of skin breakdown. Nurse #3 said Resident #85's skin was not assessed after the Orthopedic consult on 4/4/24 until weekly skin rounds on 4/9/24. During a follow-up interview on 4/10/24 at 9:26 A.M., PA #2 said she was notified of the Fracture of the Right Calcaneus on 4/4/24 and Resident #85 was still using the orthopedic surgical shoe that was provided on 3/22/24 in the facility, to keep the right foot off of the ground. PA #2 further said that she never saw any ulcers on Resident #85's feet and that she relies on the facility staff to assess those areas. PA #2 said she was not aware of any current skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/10/24 9:35 A.M., Resident #85 said he/she had pain in his/her right foot yesterday, and there is an ulcer. Resident #85 further said that he/she wears the orthopedic surgical shoe all of the time. During a follow-up interview 4/10/24 at 10:45 A.M., PA #2 said she saw Resident #85 on 3/22/24 after the first set of x-rays and there were no ulcers or open areas to the right foot and an orthopedic surgical shoe was given to the Resident at that time. PA #2 reviewed the medical record and found no evidence of an order for the orthopedic surgical shoe or instructions for care of the orthopedic surgical shoe. PA #2 said that facility staff should have done an assessment to make sure that the shoe was not too tight and that the Resident should only have the orthopedic shoe on when out of bed. PA #2 said because the Resident is Diabetic and at risk for skin breakdown, the facility staff should be doing foot care daily. PA #2 reviewed the Orthopedic consult dated 4/4/24 and said that her initials are on the consult and when she initialed the recommendation, the facility staff should enter the orders into the medical record and obtain follow-up. PA #2 said that she did not inspect Resident #85 right foot between 4/4/24 and 4/8/24. PA #2 further said that Resident #85 did not have proper treatment in place to treat the ulcerations to his/her right foot. During an interview and observation on 4/10/24 at 12:35 P.M., Resident #85 said that staff had not been removing the orthopedic surgical shoe at night and that he/she remained in the shoe throughout the night. Resident #85 said he/she had pain because of the ulcer. The surveyor, PA #2, and Nurse #3 viewed Resident #85's right foot ulcerations. During an interview on 4/10/24 at 12:59 P.M., PA #2 said the skin breakdown on the plantar surface of the right foot was the beginning of a diabetic ulcer. PA #2 further said that there is a DTI on the right heel and that orders would be put in place to treat the areas.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42761 Based on observation, interview, and record review, the facility failed to provide services and to assist with obtaining a specialist consultation for one Resident (#102), out of a total sample of 25 residents. Specifically, the facility staff failed to provide assistance for Resident #102, who had an indwelling urinary catheter (flexible tube inserted into the bladder to drain urine), to obtain a consultation with a Urologist (Physician who specializes in treatment of the urinary tract) when: a. The Resident developed a Ventral Erosion (complication of an indwelling urinary catheter that can result in a partial or full thickness wound and can increase one's risk for urinary tract infection [UTI]) of his/her [genitalia]. b. The Resident's Physician ordered facility staff to obtain a consultation appointment with a Urologist for Resident #102. Findings include: Resident #102 was admitted to the facility in October 2021 with diagnoses including: Neuromuscular Dysfunction (lack of muscle control) of the Bladder and Retention of Urine (when the bladder does not completely empty upon urinating). Review of Resident #102's Health Status Note, dated 2/2/24 and written by Nurse #3, indicated: -The Resident had a new order to obtain a urine sample for urinalysis (UA: urine specimen test used to detect a UTI) culture and sensitivity (C&S: set of tests performed on a clinical specimen, where isolation of bacteria is followed by antibiotic susceptibility testing) due to increased sediment (crystals, bacteria, or blood) in the Resident's Foley (also known as a urinary catheter) catheter urine. -The Resident should also be seen by Urology re: Ventral Erosion of [genitalia]. Review of a Physician's order, dated 2/2/24 with no stop date, indicated: -Patient should see Urology re: Ventral Erosion of [genitalia]. On 4/7/24 at 8:57 A.M., the surveyor observed a catheter tube exiting Resident #102's pant leg. The surveyor further observed the catheter tube led to a urine collection bag that was secured under the Resident's chair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 12:19 P.M., the surveyor observed Resident #102 sitting up in bed. The Resident's lower body was covered with bed linens and the surveyor observed a catheter tube draining clear light yellow urine into a urine collection bag that was secured to the frame of the Resident's bed. During an interview at the time, Resident #102 said he/she had a urinary catheter and that he/she sometimes experienced an aching pain in his/her [genitalia], but had no pain at that moment. Resident #102 also said he/she did not think he/she had seen a specialist for the urinary catheter, and then said he/she probably should. Review of Resident #102's clinical record indicated no evidence the Resident had been seen by a Urologist at anytime since the Physician's order on 2/2/24, for the Resident to be seen by Urology. Review of the Primrose Unit's 2024 Appointment Book indicated no evidence Resident #102 had a Urology appointment scheduled anytime between 2/2/24 and 12/31/24. During an interview on 4/9/24 at 4:00 P.M., Medical Record Staff #1 said one of her job duties was to schedule appointments for residents to be seen by specialists. Medical records Staff #1said she did not recall being asked to schedule an appointment with a Urologist for Resident #102 anytime since February 2024, but that she would look into whether the appointment should have been scheduled and get back to the surveyor. During an interview on 4/9/24 at 5:00 P.M., the Director of Nurses (DON) responding to the inquiry made to Medical Record Staff #1, said appointments for residents to see specialists should be made when orders for appointments are obtained. The DON said an appointment for Resident #102 to be seen by a Urologist had not been scheduled until 4/9/24, after the surveyor's inquiry, and that the Resident would not be seen until August 2024. The DON further said that the Urology appointment should have been scheduled for Resident #102 when the order was obtained on 2/2/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 42761 Based on observation, interview, record and policy review, the facility failed to provide nutrition care and services for one Resident (#102) out of a total sample of 25 residents, with a history of weight loss. Specifically, facility staff failed to do the following when Resident #102 experienced severe weight loss (greater than: five percent[%] in one month, 7.5% in three months, and 10% in six months): a. Obtain weekly weights as ordered by the Physician. b. Monitor weights weekly as recommended by the Registered Dietician (RD). c. Coordinate care among the facility's interdisciplinary team (IDT), to include Resident #102's Physician/Non Physician Practitioner (NPP). d. Evaluate for causative factors relative to Resident #102's severe weight loss to determine if the Resident's weight loss was avoidable. Findings include: Review of the facility's policy titled Weights and Heights: Weight Monitoring, Long-Term Care, dated 8/21/23, indicated: -Residents were weighed as ordered by their Physician. -Weighing a resident in a Long-Term Care facility was an important part of assessing a resident's health. -Following a routine weighing schedule helps detect weight changes. -Some residents require frequent weight assessments. -Weight loss in older adults can result from various conditions. -Unplanned weight loss in residents is associated with increased mortality. -A decrease in five percent (%) or more in a month or 10% in six months should be reported to the Practitioner (Physician/NPP) for further evaluation. Review of the facility's policy titled Physician Orders, dated 2/26/24, indicated: -A Physician or NPP must provide orders for the resident's immediate care and ongoing care of the resident. -The facility is obligated to follow and carry out the orders of the prescriber (Physician/NPP) . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #102 was admitted to the facility in October 2021 with diagnoses including: Diverticulitis (small, bulging pouches that can form in the lining of ones digestive system and cause abdominal pain, nausea, and vomiting) and Dysphagia (difficulty swallowing). Review of Resident #102's active Nutrition Care Plan, initiated 5/4/22, indicated: -The Resident was at increased nutrition risk. -The Resident had a history of weight loss. -The Resident's goals included maintaining a stable weight. -Facility staff were to monitor and record weights as ordered. -Facility staff were to report significant weight loss to the Physician. Review of Resident #102's Weight Record indicated the following weights: -191 pounds (lbs) on 8/15/23 -189.9 lbs on 11/20/23 -189.6 lbs on 1/26/24 -173.8 lbs (indicating severe weight loss had occurred) per Weight Record dated 2/29/24 Review of Resident #102's Minimum Data Set (MDS) Assessment, dated 1/31/24, indicated: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of seven out of 15 total possible points. -The Resident experienced signs and symptoms of a swallowing disorder. -The Resident did not have weight loss. Review of Resident #102's Plan of Care Note, dated 2/14/24, indicated: -The Resident was nutritionally stable. -Meal intakes ranged from 76%-100%. -The Resident's weight was stable. Review of a Health Status Note, dated 2/22/24, indicated Resident #102 was experiencing difficulty swallowing and the Resident's diet texture was changed to a puree (soft, pudding consistency) diet. Review of a Physician's order, dated 2/26/24 with no stop date, indicated: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weekly weights due to weight loss. Review of a Physician's Encounter Note, dated 2/27/24 indicated the following: -The Resident had been treated for a urinary tract infection (UTI) in February 2024. -The Physician evaluated the Resident on 2/27/24 for a rash, per Nursing request, and treatment was initiated. Further review of the Physician's Encounter Note indicated no evidence that the Resident was seen relative to weight loss. Review of Resident #102's Weight Change Note, written by the RD and dated 3/5/24, indicated: -The Resident's weight was 173.8 lbs as of 2/29/24. -The Resident's weight loss was 16 lbs (severe). Further review of the Weight Change Note indicated the Resident's weight was much lower than his/her usual body weight (UBW) and that a re-weight was requested. Review of Resident #102's clinical record indicated: -The Resident was not re-weighed until 3/14/24. -The Resident's weight on 3/14/24 was 173.8 lbs. (indicating severe weight loss). Review of Resident #102's Weight Change Note, dated 3/15/24, indicated: -The Resident's UBW was upper 180s. -The Resident had no change in appetite. -Another re-weigh was requested. Review of Resident #102's Weight Change Note, written by the RD and dated 3/19/24, indicated: -Another re-weigh was requested for review with Unit Manager (UM) #2. -The Resident continued with good meal intakes. -The Resident's UBW ranged around 180s with most recent weight on 3/18/24 of 173.9 lbs. Review of Resident #102's clinical record indicated the following: -No evidence that facility staff alerted the Resident's Physician/NPP of the Resident's severe weight loss or requested the Physician/NPP to evaluate the Resident for severe weight loss any time after the Resident was re-weighed on 3/14/24 and severe weight loss was documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No evidence any weights had been obtained and monitored after 3/18/24. On 4/7/24 at 8:59 A.M., the surveyor observed Resident #102 sitting in the dining room, eating breakfast. The surveyor observed pureed food items that covered the entire surface of the Resident's plate. The surveyor observed Resident #102 feed him/her self all of the food. When the Resident was done eating, he/she said I'm still hungry. At the time, the surveyor observed a facility staff member make a phone call and request more food for Resident #102. Review of an NPP Encounter Note, dated 4/8/24, indicated the NPP saw the Resident for nausea, loose stools, and vomiting two times that morning, which was reported by Nursing staff. Further review of the NPP Encounter Note indicated no evidence the Resident was evaluated for severe weight loss. On 4/9/24 at 7:47 A.M., the surveyor observed Resident #102 sitting upright in bed. During an interview at the time, Resident #102 said he/she had not been feeling well the previous day (4/8/24) and had experienced nausea and loose stools. Resident #102 said he/she did not think he/she ate any solid food the previous day, but drank a lot of fluids. Resident #102 also said he/she was hungry and wanted to eat breakfast. Resident #102 further said his/her food was made to be soft, and when asked whether the Resident liked the soft food, the Resident said, I'm all for it. Bring it on. On 4/9/24, between 9:09 A.M. and 9:29 A.M., the surveyor observed the following: -Resident #102 was sitting upright in bed. -Certified Nurse Aide (CNA) #2 delivered and set up Resident #102's meal tray on the Resident's rolling table which was positioned in front of the Resident. -The Resident's breakfast tray contained double portions of pureed toast and eggs, one bowl of hot cereal, one cup of coffee, and one small cup of cranberry juice. -CNA #2 sat at Resident #102's bedside while the Resident ate breakfast. -CNA #2 removed Resident #102's breakfast tray at 9:29 A.M. -The surveyor observed that Resident #102 had eaten the double portions of pureed toast and eggs, and drank all of the coffee and cranberry juice. -The surveyor observed that Resident #102 did not eat the bowl of hot cereal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/24 at 9:31 A.M., CNA #2 said Resident #102 always received double portions and always ate very well. CNA #2 also said that Resident #102 would ask for additional food at times, and staff would provide it for him/her. When the surveyor asked how the facility monitored residents' weights, CNA #2 said that CNAs were to weigh residents on the residents' shower days and then enter the weights into the computer. CNA #2 said when CNAs entered the weights into the computer, the entry would automatically carry over to the residents' electronic administration records for the Nurses to review. CNA #2 further said when CNAs weighed residents, they did not need to tell the Nurses what the weights were because the weights were already in the computer for the Nurses to review. CNA #2 said CNAs also recorded resident weights in the Weight Book on the unit for the Dietitian to review. The surveyor observed the unit's Weight Book which included a list of residents who required weekly weights for the current week. Resident #102 was indicated on the current list. No other weeks' lists were stored in the Weight Book. When the surveyor asked about the previous weeks weights, CNA #2 said she was not sure whether anyone kept the previous weeks' lists of resident weights, but that Unit Manager (UM) #2 may have known where the lists were kept. During an interview on 4/9/24 at 9:35 A.M., UM #2 said the weight lists in the Unit's Weight Book were used by the RD. UM #2 said the RD may have had the previous weeks' weights for residents in the Dietary Office. UM #2 also said she would have to review Resident #102's clinical record to identify the Resident's current weight. /18/24. UM #2 further said she knew the Resident refused care at times, so there was a potential the Resident refused to be weighed. Review of Resident #102's Weight Change Note, written by the RD and dated 3/19/24, indicated: -Another re-weigh was requested for review with Unit Manager (UM) #2. -The Resident continued with good meal intakes. -The Resident's UBW ranged around 180s with most recent weight on 3/18/24 of 173.9 lbs. Review of Resident #102's clinical record indicated the following: -No evidence that facility staff alerted the Resident's Physician/NPP of the Resident's severe weight loss or requested the Physician/NPP to evaluate the Resident for severe weight loss any time after the Resident was re-weighed on 3/14/24 and severe weight loss was documented. -No evidence any weights had been obtained and monitored after 3/18/24. On 4/7/24 at 8:59 A.M., the surveyor observed Resident #102 sitting in the dining room, eating breakfast. The surveyor observed pureed food items that covered the entire surface of the Resident's plate. The surveyor observed Resident #102 feed him/her self all of the food. When the Resident was done eating, he/she said I'm still hungry. At the time, the surveyor observed a facility staff member make a phone call and request more food for Resident #102. Review of an NPP Encounter Note, dated 4/8/24, indicated the NPP saw the Resident for nausea, loose stools, and vomiting two times that morning, which was reported by Nursing staff. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the NPP Encounter Note indicated no evidence the Resident was evaluated for severe weight loss. On 4/9/24 at 7:47 A.M., the surveyor observed Resident #102 sitting upright in bed. During an interview at the time, Resident #102 said he/she had not been feeling well the previous day (4/8/24) and had experienced nausea and loose stools. Resident #102 said he/she did not think he/she ate any solid food the previous day, but drank a lot of fluids. Resident #102 also said he/she was hungry and wanted to eat breakfast. Resident #102 further said his/her food was made to be soft, and when asked whether the Resident liked the soft food, the Resident said, I'm all for it. Bring it on. On 4/9/24, between 9:09 A.M. and 9:29 A.M., the surveyor observed the following: -Resident #102 was sitting upright in bed. -Certified Nurse Aide (CNA) #2 delivered and set up Resident #102's meal tray on the Resident's rolling table which was positioned in front of the Resident. -The Resident's breakfast tray contained double portions of pureed toast and eggs, one bowl of hot cereal, one cup of coffee, and one small cup of cranberry juice. -CNA #2 sat at Resident #102's bedside while the Resident ate breakfast. -CNA #2 removed Resident #102's breakfast tray at 9:29 A.M. -The surveyor observed that Resident #102 had eaten the double portions of pureed toast and eggs, and drank all of the coffee and cranberry juice. -The surveyor observed that Resident #102 did not eat the bowl of hot cereal. During an interview on 4/9/24 at 9:31 A.M., CNA #2 said Resident #102 always received double portions and always ate very well. CNA #2 also said that Resident #102 would ask for additional food at times, and staff would provide it for him/her. When the surveyor asked how the facility monitored residents' weights, CNA #2 said that CNAs were to weigh residents on the residents' shower days and then enter the weights into the computer. CNA #2 said when CNAs entered the weights into the computer, the entry would automatically carry over to the residents' electronic administration records for the Nurses to review. CNA #2 further said when CNAs weighed residents, they did not need to tell the Nurses what the weights were because the weights were already in the computer for the Nurses to review. CNA #2 said CNAs also recorded resident weights in the Weight Book on the unit for the Dietitian to review. The surveyor observed the unit's Weight Book which included a list of residents who required weekly weights for the current week. Resident #102 was indicated on the current list. No other weeks' lists were stored in the Weight Book. When the surveyor asked about the previous weeks weights, CNA #2 said she was not sure whether anyone kept the previous weeks' lists of resident weights, but that Unit Manager (UM) #2 may have known where the lists were kept. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/9/24 at 9:35 A.M., UM #2 said the weight lists in the Unit's Weight Book were used by the RD. UM #2 said the RD may have had the previous weeks' weights for residents in the Dietary Office. UM #2 also said she would have to review Resident #102's clinical record to identify the Resident's current weight. UM #2 reviewed Resident #102's clinical record and said no weights had been entered into the record since 3/18/24. UM #2 further said she knew the Resident refused care at times, so there was a potential the Resident refused to be weighed. Review of Resident #102's CNA Behavior Monitoring Report indicated no evidence that the Resident refused care provided by CNAs between 2/26/24 and 4/9/24. Review of Resident #102's clinical record indicated no evidence the Resident refused to be weighed between 2/26/24 and 4/9/24. During an interview on 4/9/24 at 3:21 P.M., the Registered Dietician (RD) said she had been monitoring Resident #102 for weight loss since February 2024, when the Resident was identified to have had a potential weight loss. The RD said the weight loss was first suspected on 2/26/24 and she recommended weekly weight monitoring and requested the Resident be re-weighed at that time to determine whether the severe weight loss was accurate. The RD said an order was obtained for weekly monitoring of Resident #102's weights on 2/26/24, and if the severe weight loss was verified, the NPP was to be notified that Resident #102 had severe weight loss. The RD said Resident #102 was weighed on 2/29/24, which was 173.8 lbs (down from 189.9 lbs on 11/20/23 and 189.6 on 1/26/24, indicating severe weight loss). The RD then said she requested another re-weight which was not obtained for Resident #102 until 3/14/24, and again on 3/18/24, which indicated severe weight loss had occurred over the last three months. The RD said she was not sure what the Resident's current weight was because facility staff had not weighed the Resident for three consecutive weeks. The RD further said there was no evidence the NPP had been alerted to Resident #102's severe weight loss so that the Resident could be evaluated for causative factors for weight loss and new interventions implemented. Review of Resident #102's Weight Record indicated the Resident's weight was obtained on 4/9/24 at 4:08 P. M., following the surveyor's inquiry, and that the Resident weighed 171.8 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/24 at 8:10 A.M., the NPP said facility staff were required to alert her when a resident was identified to have a severe change in weight. The NPP said if a resident's weight changed significantly, facility staff would re-weigh the resident and that once the re-weight was obtained, facility staff were to alert her if the re-weight confirmed the significant weight change. The NPP said when staff notified her of a resident's significant change in weight, she would confer with Nursing staff, the Speech Therapist if there had been a change in diet texture, consult with the Physician, and evaluate the resident for any medical concerns that could be related to the significant weight change. The NPP said she was aware Resident #102 had experienced difficulty swallowing and that the Resident's diet texture had been changed to pureed texture, but that the Resident continued to have a good appetite and eat well when the diet texture was changed. The NPP said she ordered weekly weights to be completed for Resident #102 in February 2024 when facility staff identified the Resident had a potential severe weight loss and that facility staff communicated they would re-weigh the Resident to determine whether the weight loss was accurate. The NPP also said she requested facility staff to alert her if Resident #102's weight loss was identified to be accurate. The NPP further said facility staff did not alert her that Resident #102's re-weight confirmed severe weight loss until 4/9/24, following the surveyor's inquiry, but the staff should have alerted her on 3/14/24 when the Resident's re-weight confirmed severe weight loss. The NPP said since the Resident had been receiving double portions at meals and eating well, alerting her to the severe weight loss would have prompted a medical evaluation of the Resident's condition. The NPP also said she was aware Resident #102 had not been feeling well over the previous two days with stomach upset, so that may have contributed to the Resident's most recent weight change from 173.9 lbs to 171.8 lbs, but this occurred after facility staff re-weighed the Resident on 3/14/24 and severe weight loss was indicated. The NPP said since facility staff did not alert her to Resident #102's severe weight loss, no medical evaluation had been initiated to determine causative factors, or to initiate interventions to treat the Resident's weight loss.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45435 Based on observation, interview and record review, the facility failed to provide pain management that was consistent with professional standards of practice for one Resident (#18) out of a total sample of 25 residents. Specifically, the facility staff failed to offer Resident #18 prescribed pain medication prior to an identified painful dressing change procedure. Findings include: Review of the facility policy titled, Pain Assessment and Management dated 9/12/23, indicated the following: -The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. -Based on the assessment, the facility, in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or his/her representative, develops, implements, monitors, and revises as necessary interventions to prevent or manage each individual resident's pain, beginning at admission. These interventions may be integrated into components of the comprehensive care plan, addressing conditions or situations that may be associated with pain, or may be included as a specific pain management need or goal. Review of the facility policy titled Treatment of Wounds dated 3/31/23, indicated the following: -Policy: It is the intent of this center that a resident having a wound receives necessary medical treatment to prevent infection, deterioration or development of wounds in keeping with the resident's medical condition. -Procedure: This facility will utilize the Lippincott procedures: Traumatic wound care: abrasion, lacerations, and puncture wounds. Review of the Lippincott Manual of Nursing Procedures-9th edition (2023), Traumatic Wound Management indicated the following: -Treat the patient's pain, as needed and ordered, using nonpharmacologic or pharmacologic approaches, or a combination. -Base the treatment plan on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals. -Give the patient prescribed medication before painful dressing changes. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #18 was admitted to the facility in April 2023 with diagnoses including peripheral vascular disease (PVD-a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and non-pressure chronic ulcer of the skin. Review of the Minimum Data Set (MDS) Assessment, dated 1/31/24, indicated Resident #18: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14 out of 15 points. -had almost constant, severe pain, that affected sleep and day-to-day activities. -received scheduled pain medication. -did not receive PRN (as needed) pain medication. -did not receive non-medication interventions for pain. Review of the At Risk for Pain care plan, revised 11/14/22, indicated the following intervention: -Anticipate the Resident's need for pain relief and respond immediately to any complaint of pain. Review of the Physician's Progress Note, dated 3/26/24, indicated the following: -Left foot dorsal ulcer: small, about 0.5 centimeters (cm), fibrinous debris (inflammatory fluid that forms at the site of tissue injury). -Continue Oxycodone PRN (as needed) for pain management AND Oxycontin 10 milligrams (mg) daily BID (twice a day). Review of the April 2024 Physician's orders indicated the following: -Left foot (dressing change, ordered to be done daily): *cleanse with normal saline (a mixture of salt and water often used to cleanse wounds), pat dry. *Apply silver sulfadiazine (an antibiotic cream used to prevent and treat infection) to top of left foot. *Cover with ABD pad (a bulky pad used where high absorbency is needed to manage heavy draining wounds) and wrap with KLING wrap (rolled gauze). *Secure with tape. -Oxycodone HCL ER 12-hour 10 mg (an extended-release opioid pain reliever, also known as Oxycontin)-give one tablet by mouth every 12 hours for moderate to severe pain. -Oxycodone HCL oral capsule 5 mg (an opioid pain reliever used to treat moderate to severe pain) - give 5 mg by mouth every six hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Acetaminophen oral tablet 325 mg - give three tablets by mouth every eight hours as needed for pain. Review of the Medication Administration Record (MAR), dated 4/8/24, indicated the Resident was administered the following medications: -Oxycodone HCL ER 12-hour 10 mg, one tablet at 8 A.M. -Acetaminophen oral tablet 325 mg, three tablets at 12:30 A.M. On 4/8/24 at 2:25 P.M., during a dressing change observation, the surveyor observed Nurse #1 began to cut the gauze wrap off the Resident's left foot when the Resident winced and told the Nurse to be careful. While Nurse #1 was removing the outer dressing, the Resident yelled STOP and began to cry. After Nurse #1 removed the outer dressing, she reached a small gauze pad covering the wound and the Resident said, it hurts so much and asked the Nurse to pour water, or whatever is in the bottle on it first. Nurse #1 then proceeded to soak a gauze pad with saline solution and placed it over the wound. The Resident screamed and said, it is like a knife being twisted! After the Resident screamed out in pain, the surveyor intervened and asked Nurse #1 to pause the dressing change and assess the Resident. Nurse #1 stopped and asked the Resident if he/she would like to take pain medication. The Resident responded by saying it won't work, it takes 45 minutes for it to work, you should have given me a pain pill before you started. Nurse #1 then proceeded to remove the gauze, cleanse, and re-dress the wound while the Resident was wincing and crying. When the dressing change procedure was completed, the Resident rated his/her pain level as nine out of ten and said he/she was going to be in pain all night. During an interview on 4/8/24 at 3:10 P.M., Nurse #1 said that she should have informed the Resident as to when she was going to do the dressing change and should have offered him/her pain medication prior to starting the dressing change procedure. Nurse #1 said she had asked the Resident if he/she wanted a pain pill during the dressing change, but the Resident said it would take too long to work and Nurse #1 determined it would only take five minutes to finish the dressing and that the Resident wanted the dressing change to be finished. Review of the April 2024 MAR indicated the following: -Gabapentin 100 mg - give 1 capsule by mouth every 8 hours: 6:00 A.M., 2:00 P.M. and 10:00 P.M. -Oxycodone HCL ER 12-hour 10 mg - give one tablet by mouth every 12 hours: at 8:00 A.M. and 8 P.M. Further review of the April 2024 MAR indicated that Oxycodone 5 mg PRN every 6 hours was administered as follows: -4/1/24 at 12:14 A.M. and 2:41 P.M. (administered after a dressing change completed at 1:45 P.M., pain level documented as 9 out of 10) -4/2/24 at 12:30 A.M. and 4:00 P.M.(administered after a dressing change at 3:20 P.M, pain level documented as 7 out of 10) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-4/4/24 at 12:24 A.M. and 1:35 P.M. (prior to dressing change at approximately 3:00 P.M, pain level documented as 7 out of 10) -4/5/24 at 2:00 P.M.(prior to the dressing change at approximately 3:00 P.M., pain level documented as 8 out of 10) and 9:53 P.M. -4/7/24 at 10:01 P.M. -4/8/24 at 3:45 P.M. (after the dressing change observed by the surveyor) During an interview on 4/8/24 at 3:15 P.M., the Director of Nurses (DON) said the Resident should have been assessed and medicated if needed for pain prior to the dressing change. During an observation and interview on 4/8/24 at 4:00 P.M., approximately one hour after the dressing change procedure, the surveyor observed the Resident lying in bed. Resident #18 said he/she had received a pain pill after the dressing change and rated his/her pain level as 4 or 5 out of 10 at the current time. During an observation on 4/9/24 at 12:17 P.M., the surveyor observed the Resident lying in bed. The Resident said that his/her foot had hurt all night but not as bad as when the dressing was being changed. During an interview on 4/10/24 at 9:45 A.M., Nurse Practitioner (NP) #1 said the Resident is very sensitive to any touch of his/her foot. NP #1 said that at one point the Resident had been hospitalized and his/her narcotics had been discontinued but the NP has gradually been adding them back while the Resident is deciding if he/she is going to have surgery. NP #1 said that she would expect that the Resident with a known sensitivity would have been pre-medicated for pain prior to a dressing change. Please refer to F726

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45435 Based on observation, interview, and record reviewed the facility failed to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one Resident (#18) out of a total sample of 25 residents. Specifically, the facility failed to: -ensure that Nurse #1 had the specific competencies and skills necessary to provide appropriate pain management prior to administering dressing change procedure resulting in poor pain control for Resident #18. -ensure that Nurse #1 had the specific competencies and skills necessary to perform wound care during a dressing change resulting in the Physician orders not being followed for the wound treatment procedure and potential compromise of healing for the Resident. Findings include: According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Review of the Facility Assessment, dated 5/20/23, indicated the following services and care offered based on Residents' needs: -Pain management- assessment for pain, pharmacological and nonpharmacological pain management. -Skin integrity-pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). Resident #18 was admitted to the facility in April 2023 with diagnoses including peripheral vascular disease (PVD -a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and non-pressure chronic ulcer of the skin. Review of the Minimum Data Set (MDS) Assessment, dated 1/31/24, indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) Assessment score of 14 out of a possible 15 points. -The Resident had almost constant, severe pain, that affected sleep and day to day activities. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-received scheduled pain medication. -did not receive PRN (as needed) pain medication. -and did not receive non-medication interventions for pain. -The Resident had an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of the damage within the ulcer cannot be confirmed because the wound bed is obscured by dead tissue) that was present on admission. Review of the At Risk for Pain Care Plan, revised 11/14/22, indicated the following: -Anticipate the Resident's need for pain relief and respond immediately to any complaint of pain. Review of the Skin Integrity Care Plan, revised 2/29/24, indicated the following: -wound treatment as ordered. Review of the Physician's orders dated April 2024, indicated the following: -Oxycodone HCL ER 12-hour 10 milligram (mg) (an extended-release opioid pain reliever)- give one tablet by mouth every 12 hours for moderate to severe pain. -Oxycodone HCL oral capsule 5 mg (an opioid pain reliever used to treat moderate to severe pain) - give 5 mg by mouth every six hours as needed for pain. -Acetaminophen oral tablet 325 mg - give three tablets by mouth every eight hours as needed for pain. -Left foot: *cleanse with normal saline (a mixture of salt and water often used to cleanse wounds), pat dry. *Apply silver sulfadiazine (an antibiotic cream used to prevent and treat infection) to the top of the left foot. *Cover with ABD pad (a bulky pad used where high absorbency is needed to manage heavy draining wounds) and wrap with KLING wrap (rolled gauze). *Secure with tape. Every day shift (7:00 A.M. to 3:00 P.M.) for wound care. -Left heel: *clean with normal saline and thoroughly dry. *Apply nickel thick amount of Santyl (an ointment that is used to remove dead tissue from chronic skin ulcers) with damp to dry 4 x 4 CDD (4-inch by 4-inch gauze clean dry dressing), (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*wrap with KERLIX fluff (rolled gauze) and paper tape. Every day shift. On 4/8/24 at 2:25 P.M., during a dressing change observation, the surveyor observed Nurse #1 began to cut the gauze wrap off the Resident's left dorsal foot (area of foot facing upwards when standing) when the Resident winced and told the Nurse to be careful. The Nurse proceeded to remove the outer dressing, causing the Resident to yell STOP and began to cry. Resident #18 said that it hurts so much, when Nurse #1 proceeded with removing the outer dressing, and reached for the gauze pad covering the wound. The Resident and asked Nurse #1 to pour water, or whatever is in the bottle on the dressing first. Nurse #1 then proceeded to a soak a gauze pad with saline solution and placed it over the Resident's wound, which caused the Resident to scream and say, the pain felt like a knife being twisted. The surveyor intervened and asked Nurse #1 to pause the dressing change and assess the Resident after the Resident screamed out in pain. Nurse #1 stopped and asked the Resident if he/she would like to take pain medication. The Resident responded that the pain medication would not work as it takes 45 minutes for it to work, and the Nurse should have given the pain pill before starting the dressing change. The surveyor further observed Nurse #1 proceed with the dressing change procedure as follows: >Left dorsal foot: -to soak off the gauze, cleanse the wound with normal saline and dried the wound. -apply Santyl to a cotton swab and placed the Santyl in the wound bed. -apply Silver Sulfadiazine cream to a cotton swab and placed the Sulfadiazine cream on top of the Santyl, -then applied an ABD pad to the top of the foot. >Left heel wound: -Nurse #1 cleansed and dried the wound. -applied Santyl to a cotton swab and placed the Santyl in the heel wound bed. -then applied Silver Sulfadiazine cream to a cotton swab and placed the Silver Sulfadiazine cream on top of the Santyl. -then applied an ABD pad to the bottom of the foot and wrapped the foot, including both dressings, in gauze wrap. When the dressing was completed by Nuse #1, the Resident rated his/her pain level as nine out of ten and said he/she was going to be in pain all night. During an interview on 4/8/24 at 3:10 P.M., Nurse #1 said that she should have informed the Resident when she was planning to do the dressing change and should have offered him/her pain medication prior to starting the dressing change procedure. Nurse #1 said she had asked the Resident if he/she wanted a pain pill during the dressing change, but the Resident said the pain pill would take too long to work and the Resident wanted the dressing change to be finished. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/24 at 3:15 P.M., the Director of Nurses (DON) said the Resident should have been assessed and medicated if needed for pain prior to the dressing change. During an interview on 4/8/24 at 4:08 P.M., Nurse #1 said that she put Santyl and Silver Sulfadiazine on both wounds. The surveyor and Nurse #1 reviewed the Physician's orders and Nurse #1 said that she did the treatment incorrectly and that she would notify the Unit Manager (UM) of the mistake. Review of Nurse #1's Education File indicated the following: -Facility Associate Orientation Checklist dated 4/26/23, indicated no evidence of training or competency in pain management or wound care. -Facility on-line training certificates dated April 2023, indicated no documented evidence of training or competency in pain management or wound care. -In-service education attendance, dated 6/5/23 and 3/8/24, indicated no documented evidence of trainng or competency in pain management or wound care. During an interview on 4/10/24 at 8:10 A.M., the surveyor and the Staff Development Coordinator (SDC) reviewed Nurse #1's Education File. The SDC said Nurse #1 had been hired in April 2023 and had completed general orientation, facility on-line computer trainings, and had attended two in-services since she was hired. The SDC said she was not sure of the content of the facility on-line training courses and did not know if the online trainings included pain management or wound care. The SDC further said that the in-service training provided on 6/5/23 and 3/8/24 did not include training on pain management or wound care. The SDC said that after general orientation new Nurses are assigned a preceptor and that pain management and wound care training may have been done by the preceptor. The SDC indicated that a skill check sheet would have been completed, but she could not provide the skills check sheet when the surveyor requested it. The SDC said she was not sure who decided when a Nurse had completed training and was ready to work independently. The SDC said that she was not aware of any education or training offered to Nurse #1 related to pain management or wound care and that she did not have any evidence of competency in those areas. During an interview on 4/10/24 at 10:41 A.M., the SDC said she checked with the Scheduler and determined that the facility had not yet implemented the skills check list for newly hired Nurses. During an interview on 4/10/24 at 12:21 P.M., the Administrator said the SDC had been hired three or four months ago. The Administrator said that she was not sure who decides when a Nurse is ready to come out of training and work independently and said that she would check with the DON because she wanted to connect the dots. The facility failed to provide any evidence to the surveyor of training or competency in pain management or wound care for Nurse #1 by the end of survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42761 Based on observation, interview, and policy review, the facility failed to adhere to professional standards of practice for food service safety in the facilty's main kitchen, and for one Resident (#86) out of a total sample of 25 residents. Specifically, the facility staff failed to: 1. Ensure that three Dietary Staff (#3, #4, and #2) wore hair restraints while they worked in the food preparation and food service areas of the facility's main kitchen, increasing the risk for contamination of food and the spread of foodborne illness. 2. Re-heat Resident #86's meal in a safe and appropriate manner to prevent accidental burns and kill microorganisms that may cause foodborne illness. Findings include: 1a. Review of the facility policy titled, Associate Conduct and Dress Code dated December 2022, indicated: -Dietary staff must wear hair restraints; hair net, hat and/or beard restraint, to prevent hair from contacting food. 1. On 4/7/24 at 7:20 A.M., the surveyor observed the following in the main kitchen during the initial kitchen visit: -Dietary Staff #3 was covering small bowls of chocolate mousse with plastic wrap. -Dietary Staff #4 walked through the food service and food preparation areas while food was being prepared for the residents' breakfast meals. -Neither Dietary Staff #3 or Dietary Staff #4 wore hair restraints during the surveyor's observation. During an interview on 4/7/24 at 7:36 A.M., Dietary Staff #4 said all staff who worked with food in the kitchen were required to wear restraints. Dietary Staff #4 then said he was covering bowls of chocolate mousse in preparation for the residents' lunch meals that day and that he was not wearing a hair restraint, but he should have been. During an interview on 4/7/24 at 7:38 A.M., Dietary Staff #3 said he sometimes wore a hair restraint when he worked in the kitchen, but that he usually did not, and that he was not wearing a hair restraint when the surveyor observed him in the food preparation area. The surveyor observed Dietary Staff #3 walk from the food preparation area into the dry food storage area and back into the food preparation area. Dietary Staff #3 did not don (put on) a hair restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/24 at 7:40 A.M., the Food Service Director (FSD) said all staff working in the kitchen were required to wear hair restraints. The FSD further said that both Dietary Staff #3 and Dietary Staff #4 should have been wearing hair restraints while they worked in the food preparation and food service areas of the kitchen, as required by the facility's policy. 50138 1b. On 4/8/24 at 7:50 A.M., the surveyor observed the following during the follow-up visit to the main kitchen: -Dietary Staff #2 prepared food items on the service line with an improperly placed hair restraint on top of her head. -Large amounts of hair from the front, back and sides of Dietary Staff #2's head were hanging outside of the hair restraint. During an interview at the time, the FSD said Dietary Staff #2's hair restraint was not placed properly and should have been placed to cover all of Dietary Staff #2's hair. During interview on 4/9/24 at 3:14 P.M., the Assistant FSD said she was aware that dietary staff did not wear hair restraints while they worked in the kitchen on 4/7/24 and 4/8/24. The Assistant FSD said hair restraints were important for food safety and to prevent hair from falling into the residents' food. The Assistant FSD further said that it was the facility's expectation that hair restraints would be worn in the kitchen by all dietary staff. 45435 2. Review of the facility policy titled Food Temperature Control, dated 3/5/2024 indicated the following: -Food temperatures are maintained during mealtimes to ensure residents receive safe food served at acceptable temperatures. -Food reheated in the microwave is heated so that all parts of the food reach 165 degrees Fahrenheit (F) and food is rotated, stirred, covered and allowed to stand covered for two minutes after reheating. Resident #86 was admitted to the facility in March 2024 with a diagnosis of Alzheimer's disease (a progressive disease that affects memory, thinking and behavior). On 4/8/24 at 8:43 A.M., during an observation on the Gardenia unit, the surveyor observed Resident #86's breakfast tray being removed from the Resident's room and delivered to the unit dining room where the Resident was sitting. The surveyor observed CNA #1 remove the plate containing scrambled eggs and toast, and bring it into the unit kitchenette to re-heat. The surveyor observed CNA #1 returning the breakfast plate to the Resident without checking the temperature of the re-heated food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/24 at 8:50 A.M., CNA #1 said the Resident's breakfast meal was cold because it had been delivered to his/her room instead of the dining room. CNA #1 said that she had re-heated the Resident's plate in the microwave oven for one and a half minutes. CNA #1 said that she did not know how long she was supposed to heat up the food, and that there was no thermometer to check the temperature of the reheated food. CNA #1 said that after she takes the food out of the microwave, she holds her hand over the top of the food to see if it is warm. During an interview on 4/8/24 at 10:33 A.M., the Food Service Director (FSD) said nursing staff typically call the main kitchen for a new tray if food needs to be re-heated. The FSD said that Resident's families are allowed to use the microwave to reheat food and that she was unaware that staff were using the microwave to reheat resident meals. The FSD said that she placed thermometers and the policy for reheating resident food in the kitchenettes today.

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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. 45435 Based on observation, interview, record and policy review, the facility failed to ensure that staff adhered to infection control standards for four residents (#18, #95, #58, and #44) out of a total sample of 25 residents, on two out of three Units observed (Primrose and Magnolia). Specifically, the facility staff failed to: 1. Wear appropriate Personal Protective Equipment (PPE) while performing nephrostomy care (nephrostomy-an artificial opening between the kidney and the skin which allows for the drainage of urine) and wound care for Resident #18, who was on Enhanced Barrier Precautions (EBP-an infection control intervention used to reduce transmission of multidrug-reisitant organisms [MDRO-an umbrella term for bacteria and other microorganisms that are resistant to antibiotics and other drugs designed to kill them] that employs targeted gown and glove use during high contact resident care activities), on the Primrose Unit. 2. Wear appropriate PPE while performing wound care for Resident on #95, who was on EBP, on the Magnolia Unit. 3. Perform appropriate hand hygiene for two Residents (#58 and #44) when the Residents were housed in the same room, and Resident #58 was on Contact Precautions (an infection control intervention used to prevent the transmission of infectious agents which are spread by direct or indirect contact) on the Primrose Unit. Findings Include: Review of the facility policy titled Enhanced Barrier Precautions, dated 3/21/24 indicated: -The facility should use EBP as an additional MDRO mitigation strategy for residents that meet the following criteria during high-contact resident care activities. EBP are indicated for residents with any of the following: -Wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. -Wounds generally include chronic wounds .Examples of chronic wounds include .pressure ulcers (Injury to the skin and underlying tissue resulting from prolonged pressure on the skin), diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers (a wound on the leg or ankle caused by abnormal or damaged veins). -Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheotomies (surgical construction of an opening in the windpipe for the insertion of a catheter or tube to facilitate breathing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-High Contact Care Activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, medical device care or use, and wound care. -The facility should develop a process to communicate in which residents require the use of EBP for all high contact resident care activities. The facility may choose to post signage on the door or wall outside of the resident room indicating the resident is on Enhanced Barrier Precautions. -Examples of high contact resident care activities requiring a gown and glove use include . device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. -Enhanced Barrier Precautions should not be used for residents who are infected or colonized with an MDRO in the presence of one of the following situations .: -All residents who have another infection (e.g. C-difficile, Norovirus, scabies) or condition for which Contact Precautions is recommended . in CDC Guideline for Isolation Precautions. 1. Resident #18 was admitted to the facility in April 2023 with diagnoses including peripheral vascular disease (PVD-a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), non-pressure chronic ulcer of the skin and renal ureter calculus (kidney stone in a ureter) and nephrostomy. On 4/8/24 at 2:10 P.M, the surveyor observed the following posted on a sign outside of Resident #18's door: STOP-ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST: -Clean their hands, before entering and when leaving room. PROVIDERS AND STAFF MUST ALSO: -Wear gloves and a gown for the following High-Contact Resident Care Activities. >Dressing Bathing/Showering >Transferring >Changing Linens >Providing Hygiene >Changing briefs or assisting with toileting >Device care or use: central line, urinary catheter, feeding tube, tracheostomy >Wound Care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/24 from 2:10 P.M. through 2:35 P.M., the surveyor observed Nurse #1 put on gloves and proceed to remove and re-apply a dressing to Resident #18's nephrostomy tube site. Nurse #1 did not wear a gown. After hand sanitizing and changing her gloves, Nurse #1 proceeded to remove and re-apply a dressing to the Resident's left foot. Nurse #1 did not wear a gown. During an interview on 4/8/24 at 3:10 P.M., Nurse #1 said that she should have worn a gown while doing the dressing changes to reduce the risk of infection. 48206 2. Resident #95 was admitted to the facility in August 2023 with diagnoses including Pressure Ulcer of Left Heel, Pressure Ulcer of Right Heel, Pressure Ulcer of Unspecified Part of Back, and Pressure Ulcer of Sacral Region (buttocks). During an observation and interview on 4/10/24 at 7:51 A.M, the surveyor observed signage outside of Resident #95's room, which indicated Enhanced Barrier Precautions. The EBP sign indicated that staff were to wear gloves and a gown when providing care. The surveyor entered Resident #95's room and observed the Resident's bed was elevated with his/her left foot exposed and uncovered and Nurse #2 was measuring the Resident's wounds on the left foot. The surveyor observed Nurse #2 wearing gloves, but she was not wearing a gown as indicated by the EBP sign outside of the room. During an interview on 4/10/24 at 8:06 A.M., Nurse #2 said that she should have worn a gown in addition to gloves before she measured Resident #95's foot wounds, but she did not. 42761 3. Review of the facility's policy titled Transmission-Based Precautions (TBP: actions implemented in order to prevent or control infections) and Isolation Procedures, dated 9/15/23, indicated: -The facility would implement and utilize TBPs to ensure the mitigation of infection spread to ensure standards of infection prevention and control are followed. -Contact Precautions (type of TBP) were intended to prevent transmission of pathogens that are spread by direct (person to person) or indirect contact with the resident or environment. -The use of soap and water is more effective at removing spores than the use of alcohol-based hand rubs (ABHRs). -Alcohol does not kill spores of Clostridioides difficile (C. diff: contagious germ [bacterium] that causes diarrhea and colitis [an inflammation of the colon]). Resident #58 was admitted to the facility in November 2014 with a diagnosis of Escherichia (E.) Coli (bacteria found in the environment, foods, and intestines of people and animals). Resident #44 was admitted to the facility in September 2023 with a diagnosis of C. difficile. Review of Resident #44's April 2024 Physician's orders indicated: (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 every shift due to C. difficile. -The Physician order was initiated on 3/27/24 and had no end date. On 4/9/24 at 10:00 A.M., the surveyor observed the following sign posted outside Resident #58's and Resident #44's shared room: -Staff were required to adhere to Contact Precautions when entering the Residents' room. -Staff were required to perform hand hygiene before entering and when leaving the room. -The picture image next to the instructions for hand hygiene indicated ABHR. On 4/9/24, from 10:00 A.M. through 10:29 A.M., the surveyor observed the following from the hallway outside of Resident #58's and Resident #44's shared room: -Housekeeper #1 performed hand hygiene using the ABHR immediately outside of the Residents' door and put on a pair of gloves and a disposable gown. -Housekeeper #1 walked to Resident #44's side of the room and removed the Resident #44's breakfast tray from the Resident's bedside table. -Housekeeper #1 then passed the breakfast tray to a staff member in the hallway. -Housekeeper #1 removed her gloves and gown, then performed hand hygiene using the ABHR. -Housekeeper #1 reached into the bin of clean Personal Protective Equipment (PPE: equipment one wears to protect themself from germs), removed a disposable gown and put it on, then put on a new pair of gloves. -Housekeeper #1 walked to Resident #58's side of the room, removed a small trash bag that was secured to Resident #58's rolling bedside table, then replaced the small trash bag with a new trash bag. -Housekeeper #1 then emptied the small trash can next to Resident #44's bed by removing the bag, then walked back to Resident #44's side of the room and emptied the small trash can located by Resident #44's bed. -Housekeeper #1 then took both trash bags from the small trash cans and placed them into the large trash bin that was positioned immediately inside the room's doorway. -The surveyor observed that the large trash bin contained disposable gowns and gloves. -Housekeeper #1 removed the trash bag containing disposable gowns and gloves from the large trash bin inside the room's doorway, then removed her gown and gloves and performed hand hygiene using ABHR. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Housekeeper #1 then exited Resident #58's and #44's shared room with the large bag of trash and with bare hands, proceeded to the Utility Room, used the door handle to open the door of the Utility Room, and discarded the trash. -Housekeeper #1 then walked back to Resident #58's and Resident #44's shared room, performed hand hygiene using ABHR, reached into the clean PPE bin, and retrieved and put on a new disposable gown. -Housekeeper #1 then retrieved a new pair of gloves from the top of the Housekeeping cart and put them on. -Housekeeper #1 then used a cleaning rag to wipe down Resident #58's pillows, mattress, and bed's footboard. -Housekeeper #1 did not wash her hands with soap and water at any time during the surveyor's observation. During an interview on 4/9/24 at 10:29 A.M., Housekeeper #1 said staff were required to adhere to instructions posted on the signs outside of residents' rooms if any TBPs were required. Housekeeper #1 also said she always performed hand hygiene before entering and upon exiting a resident's room, as well as in between glove changes and that she used the ABHR provided by the facility. Housekeeper #1 said she knew that Contact Precautions were required to enter Resident #58's and Resident #44's shared room because Resident #44 had an infection. Housekeeper #1 then said hand hygiene was required in between cleaning each Resident's environment in the room. Housekeeper #1 further said she did not know whether soap and water was required for hand hygiene when coming into contact and cleaning Resident #44's environment, but that she would find out. During a follow-up interview on 4/9/24 at 10:35., Housekeeper #1 said she spoke with Unit Manager (UM) #2 regarding hand hygiene requirements when working in Resident #44's room. Housekeeper #1 said she should have used soap and water for hand hygiene instead of ABHR because ABHR would not kill the germs from Resident #44's infection. Housekeeper #1 said performing hand hygiene with soap and water was important to keep the infection from spreading to Resident #58, and also to other residents and staff. The surveyor and Housekeeper #1 observed the Contact Precaution sign posted outside of Resident #44's and 58's shared room which indicated a picture of ABHR next to the instructions for hand hygiene and Housekeeper #1 said she was following the sign. During an interview on 4/9/24 at 10:50 A.M., UM #2 said Resident #44 was actively being treated, and was symptomatic for C. difficile. UM #2 also said Resident #58 did not have C. difficile. UM #2 said she thought staff had been educated to use soap and water for hand hygiene after handling items in Resident #44's environment. The surveyor and UM #2 discussed the sign posted outside of Resident #44's and Resident #58's shared room relative to the sign indicating use of ABHR for hand hygiene, and UM #2 said she thought staff were educated to use soap and water. During an interview on 4/9/24 at 11:04 A.M., the Director of Nurses (DON) said Resident #44 had C. difficile and that all staff were required to perform hand hygiene using soap and water anytime they came in contact with Resident #44 and the Resident's environment. The DON also said she did not realize the sign indicated use of ABHR for hand hygiene and that the sign needed to be fixed so staff knew to use soap and water instead of ABHR.