STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235378	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthaven Care Center	280 W 40th St Holland, MI 49423

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interview and record review the facility failed to provide a written notice of transfer for 1 of 2 residents (Resident #98) reviewed for hospitalization , resulting in the potential of residents and/or resident representatives being uninformed of the reason for transfer and their rights, and failed to provide timely notification to a representative of the Office of the State Long-Term Care Ombudsman for emergency transfer of residents being discharged , residents left without an advocate to inform them of their rights, and for the Office of the State Long-T erm Care Ombudsman to be unaware of the facilities practices related to transfers and discharges. | Findings include: Resident #98: Review of an Admission Record revealed Resident #98 was a male with pertinent diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms (BPH has frequent urination, weak stream, leaking or dribbling of urine), obstructive and reflux uropathy (urine flow is blocked causing urine to back up into the kidneys) and bladder neck obstruction, and cystostomy status (suprapubic catheter). Review of current Care Plan for Resident #98, revised on 10/25/22, revealed the focus, .The resident has a suprapubic catheter: due to BPH, urinary retention related to CVA (stroke), and obstructive and reflux uropathy. He has a history of urinary tract infections .Suprapubic was placed on 1/13/22. New surgical placement on 6/28/22 . with the intervention .Enhanced barrier precautions .Monitor for s/sx of discomfort on urination and frequency .Monitor/document for pain/discomfort due to catheter . Review of Secure Conversations dated 2/9/2024 at 7:06 PM, revealed, .(Licensed Practical Nurse (LPN) OO: Resident sent out to (Local Hospital) for an eval via AMR for severe distention of abdomen, severe pain, and fever. UA sent out to (Local Hospital) today at 2pm. Family has been notified and will meet resident at the hospital . Review of Nursing Progress Note dated 2/10/2024 at 2:58 PM, revealed, .Update from (Local Hospital): Resident was admitted late last night for obstructed kidney stone, currently in surgery and will likely stay another 1-2 days . (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Admission Summary dated 2/13/2024 at 5:08 PM, revealed, .Resident admitted to facility on 7/20/2020 from [NAME] Community Hospital r/t Ureterolithiasis .INFECTION STATUS: Resident is being treated for an infection. Bactrim DS as preventative for kidney stone removal Resident is not receiving IV antibiotics . Resident does not have an active MDRO infection. Resident does not require TBP, continue with standard precautions .GUASSESSMENT: Relevant History/Current GU Problems: SP CATH d/t obstructive and reflux uropathy, BPH. Resident has a catheter Catheter Type: suprapubic catheter. Resident is continent of bladder. Urinary symptoms/complaints noted upon admission include: None . Review of Antibiotic Charting dated 2/16/2024 at 11:36 PM, revealed, .Resident is on Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 MG for Urinary Tract Infection,,. Resident has a suprapubic catheter. No adverse reactions noted to antibiotic. No improvement noted to symptoms. Describe symptoms: Emptied foley bag, 700 output at 2248. Noted left flank has large amount of swelling, resident rated pain 5/10. Flushed foley catheter with 60cc. Resident appears relaxed. Afebrile . In an interview on 06/06/24 at 01:29 PM, LPN JJ reported when a resident was sent to the hospital, there was a packet which was sent and it included the bed hold and resident information. The paperwork was handed to the ambulance service. LPN JJ reported the interact form used for transfer was sent with the paperwork. In electronic correspondence received on 06/06/24 from the local Ombudsman, she reported she had not received the transfer notices since 2022. In an interview on 06/06/24 at 01:32 PM, Clinical Manager (CM) E reported the facility would call the resident or the representative about the bed hold. CM E was not sure the resident initiated or facility initiated transfer form was sent with the resident. The interact form was sent with the paperwork. In an interview on 06/06/24 at 01:35 PM, Social Worker (SW) MM reported she does not send the resident emergent transfer information to the Ombudsman. In an interview on 06/06/24 at 01:42 PM, Director of Nursing (DON) B reported the unit clerks gathered the paperwork for a transfer out to the hospital. The admissions coordinator would contact the resident or representative to determine if they would like to go with the bed hold. DON B reported there was no documentation in the medical record the communication had happened. DON B reported she was not familiar with the resident initiated or facility initiated transfer form which would have been sent with a resident at a discharge and that the Ombudsman would need to receive documentation of the transfers.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interview and record review, the facility failed to provide written notification of the bed hold policy upon transfer to the hospital for 1 of 2 residents (Resident #98) reviewed for transfer and discharge requirements, resulting in the potential for residents and/or their representatives to be unaware of their rights in regard to facility bed holds. Findings include: Resident #98: Review of an Admission Record revealed Resident #98 was a male with pertinent diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms (BPH has frequent urination, weak stream, leaking or dribbling of urine), obstructive and reflux uropathy (urine flow is blocked causing urine to back up into the kidneys) and bladder neck obstruction, and cystostomy status (suprapubic catheter). Review of current Care Plan for Resident #98, revised on 10/25/22, revealed the focus, .The resident has a suprapubic catheter: due to BPH, urinary retention related to CVA (stroke), and obstructive and reflux uropathy. He has a history of urinary tract infections .Suprapubic was placed on 1/13/22. New surgical placement on 6/28/22 . with the intervention .Enhanced barrier precautions .Monitor for s/sx of discomfort on urination and frequency .Monitor/document for pain/discomfort due to catheter . Review of Secure Conversations dated 2/9/2024 at 7:06 PM, revealed, .(Licensed Practical Nurse (LPN) OO: Resident sent out to (Local Hospital) for an eval via AMR for severe distention of abdomen, severe pain, and fever. UA sent out to (Local Hospital) today at 2pm. Family has been notified and will meet resident at the hospital . Review of Nursing Progress Note dated 2/10/2024 at 2:58 PM, revealed, .Update from (Local Hospital): Resident was admitted late last night for obstructed kidney stone, currently in surgery and will likely stay another 1-2 days . Review of Admission Summary dated 2/13/2024 at 5:08 PM, revealed, .Resident admitted to facility on 7/20/2020 from [NAME] Community Hospital r/t Ureterolithiasis .INFECTION STATUS: Resident is being treated for an infection. Bactrim DS as preventative for kidney stone removal Resident is not receiving IV antibiotics . Resident does not have an active MDRO infection. Resident does not require TBP, continue with standard precautions .GUASSESSMENT: Relevant History/Current GU Problems: SP CATH d/t obstructive and reflux uropathy, BPH. Resident has a catheter Catheter Type: suprapubic catheter. Resident is continent of bladder. Urinary symptoms/complaints noted upon admission include: None . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Antibiotic Charting dated 2/16/2024 at 11:36 PM, revealed, .Resident is on Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 MG for Urinary Tract Infection,,. Resident has a suprapubic catheter. No adverse reactions noted to antibiotic. No improvement noted to symptoms. Describe symptoms: Emptied foley bag, 700 output at 2248. Noted left flank has large amount of swelling, resident rated pain 5/10. Flushed foley catheter with 60cc. Resident appears relaxed. Afebrile . In an interview on 06/06/24 at 01:29 PM, LPN JJ reported when a resident was sent to the hospital, there was a packet which was sent and it included the bed hold and resident information. The paperwork was handed to the ambulance service. In an interview on 06/06/24 at 01:32 PM, Clinical Manager (CM) E reported the facility would call the resident or the representative about the bed hold. In an interview on 06/06/24 at 01:38 PM, CM D reported the bed hold was in a prepacked envelope. The next day, admissions would call and follow up with the resident/representative. CM D reported there was a checklist the nurse completed when the resident was sent to the hospital. In an interview on 06/06/24 at 01:42 PM Director of Nursing (DON) B reported the unit clerks gathered the paperwork for a transfer out to the hospital. The admissions coordinator would contact the resident or representative to determine if they would like to go with the bed hold. DON B reported there was no documentation in the medical record the communication had happened. Review of policy, Bed Hold reviewed/revised 1/24/2024, revealed, .(Facility) has established the following policy to provide notification of options of holding a bed when a resident is discharged from the facility for hospitalization or leave of absence .C. The responsible party must sign a facility form stating he or she wishes to hold the bed .3. Notice of Bed Hold Policy Before/Upon Transfer .a. At the time the admission contract is reviewed, the resident representative will be provided with written notice of this bed hold policy and Bed Hold Authorization Form (See Admissions Form Bed Hold Authorization) .i. Upon transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice of this bed hold policy. In the case of emergency transfers, the facility will attempt to contact the resident ' s representative to provide notice of the bed hold policy .ii. All attempts to reach the resident ' s representative must be documented .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice for physician orders were obtained/followed for two residents (R91 and R291) of two residents reviewed for professional standards of care, resulting in the lack of documentation, and the potential for the worsening of a condition and a delay in treatment. Findings include: R91 According to the Minimum Data Set (MDS) dated [DATE], R91 scored 14/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), required a fistula/port for dialysis for a medical diagnosis of chronic kidney disease stage V. Review of R91's Summary Order, dated 2/23/23, revealed, Change dressing to hemodialysis site daily. Review of R91's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated February 2023 did not contain the order for Change dressing to hemodialysis site daily on it. Subsequently, the order was not added to the resident's MARs/TARs from February 23, 2023, through June 5, 2024. Review of R91's Care Plan, revised on 5/16/24, revealed, The resident needs dialysis related to renal failure three times a week. The goal, revised on 3/2/24, was for the resident to have no signs or symptoms of complications from dialysis with interventions that included check and change dressing daily at access site. Document. (date initiated 1/16/2023). During an observation and interview on 6/5/24 at 9:28 AM, R91 stated, I go to dialysis Monday, Wednesday, and Friday. I have a port in my right arm. It gets a lot of use. Observed a dialysis port in resident's right arm with no dressing. The skin covering the port had three small openings that were scabbed over. During an interview and record review on 6/5/24 at 2:57 PM, Licensed Practical Nurse (LPN) JJ stated while reviewing R91's medical chart, When (R91) comes back from dialysis the night shift changes his dressing that night. That is what I assume because I've never done a dressing change over his dialysis port. I do not see an order on the MAR to do a dressing change on my shift, 7a-7p. For the night shift, 7p-7a, the order it is not there either. There is no order for R91 to have a dressing change over his port. During an interview and record review on 6/5/24 at 3:02 PM, Clinical Manager (CM) D, reviewed R91's Order Summary, MAR/TAR, and Care Plan stating, I see the order dated 2/23/23 to do a dressing change daily for the dialysis port and it is on the care plan. It is not on his MAR/TAR to be done daily. It should have been a routine schedule to be done and it was not. When the facility does a resident's MDS we look through Care Plans for each department, we look at orders with new orders double-checked. The nurse double-checks with the Provider when they put the order in, and a second nurse double checks the MAR/TAR to make sure the orders are in. (R91's) order was missed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41424 Resident #291: Review of an Admission Record revealed Resident #291 was a male with pertinent diagnoses which included lung cancer, heart failure, pneumonia, asthma, sepsis, MRSA, diabetes, muscle wasting, and low back pain. Review of current Care Plan for Resident #291, revised on 5/30/24, revealed the focus, .The resident has MRSA in his sputum . with the interventions .CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry (follow protocol (policy) .Educate the resident/family/caregivers regarding the importance of hand washing. Use antibacterial soap and disposable towels. Wash hands immediately after ADLs, care tasks, and activities .Give antibiotic therapy as ordered . During an observation on 06/04/24 at 12:05 PM, Resident #291's door was shut to the room. On the door was hanging a personal protective equipment (PPE) pocketed door caddy, a sign which indicated Droplet Precautions and how to don and doff PPE. In an interview on 06/04/24 at 12:57 PM, Licensed Practical Nurse (LPN) Charge Nurse HH reported the resident was on droplet precautions and full PPE would be used when entering the room. LPN HH reported Resident #291 was admitted on [DATE] with pneumonia, sepsis, congestive heart failure, and MRSA. In an interview on 06/06/24 at 11:46 AM, Infection Control Nurse (ICN) YY reported there was no order in the medical record for droplet precautions or contact precautions. ICN YY reviewed the order checks for the admission orders and observed LPN T had completed both the first check and the second check for the admission orders on the same day and at the same time and that should not have happened. ICN YY reported the order checks should have been completed by different nurses, not on the same day, at the same time to ensure the accuracy of the orders. In an interview on 06/06/24 at 12:00 PM, ICN YY reported the resident did not come to the facility with precautions as he didn't need it as he was not productive coughing and he had been on multiple antibiotics for extended lengths of time. ICN YY reported he was on an antibiotic as a prophylactic measure, the resident was not symptomatic, and infectious disease had treated him extensively with multiple antibiotics and basically released him. ICN YY reported she ran an antibiotic report every day and that was how she was aware of Resident #291 being admitted . ICN YY reported the resident would have been on enhanced barrier precautions (EBP). ICN YY reported since EBP had started the nurses see certain diagnoses and get confused and had a hard time with implementing EBP. In an interview on 06/06/24 at 12:37 PM, IFC YY reported she went through the chart and was not sure how the staff decided to implement the droplet precautions. IFC YY reported no one asked her for clarification and she assumed the nurse saw MRSA in sputum and placed the resident on droplet precautions. IFC YY reported the care plan should have been updated for enhanced barrier precautions for Resident #291. IFC YY reported the unit managers have been the ones to update the care plans when they review the admission, as they were responsible for the MDS as well. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/24 at 01:57 PM, Director of Nursing (DON) B reported the admission paperwork came to the nurse and the nurse would take it to the unit clerks who would enter the orders, then the nurses make the updated first check of the orders, the Unit Manager does the other checks. DON B reported the unit managers created the baseline care plans. Once the care plan was created, it was a collaborative effort between members of the interdisciplinary team to update the care plans as it was treated as a working document for the resident and accessed on a frequent basis. DON B reported when there was a new admission the referral was reviewed and complete a work up to see the diagnoses, if any specialty equipment was needed, what the potential residents functional status was, diets needed, etc. DON B reported contact precautions was the option available to the nurses when the care plan was created and she needed to have the other precautions added but there was in there the option to select enhanced barrier precautions (EBP). DON B reported the resident should have been placed on EBP. DON B reported because of the MRSA diagnosis and the antibiotic use, the nurses felt Resident #291 was supposed to be on droplet precautions and the order did not get entered for droplet precautions as it was not on his discharge orders from the hospital. The medical record is a legal document and is used to protect the patient as well as the professional practice of those in healthcare. Documentation of the care you give is proof of the care you provide .Charting is objective, not subjective. This means chart only what you see, hear, feel, measure, and count, not what you infer or assume. All nurses know that if it wasn't charted, it wasn't done the patient's complete and accurate medical record the most reliable source of information on the care of that patient. Proper nursing documentation prevents errors and facilitates continuity of care. (https: //www. asrn. org/journal-chronicle-nursing/341-charting-and- documentation.html) The quality of patient care depends on your ability to communicate with other members of the healthcare team. Regardless of whether documentation is entered electronically or on paper, each member of the health care team needs to document patient information in an accurate, timely, concise, and effective manner to develop and maintain an effective, organized, and comprehensive plan of care. When a plan is not communicated to all members of the health care team. Care becomes fragmented tasks are repeated and delays or omissions in care often occur. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 23982-23986). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to follow orders for monitoring of blood sugars for 1 resident, (R292), and to follow orders for dressing changes for 1 resident, (R119) resulting in the lack of monitoring and the resident not receiving appropriate interventions with the potential of worsening health status. Findings include: Resident #292: The quality of patient care depends on your ability to communicate with other members of the healthcare team. Regardless of whether documentation is entered electronically or on paper, each member of the health care team needs to document patient information in an accurate, timely, concise, and effective manner to develop and maintain an effective, organized, and comprehensive plan of care. When a plan is not communicated to all members of the health care team. Care becomes fragmented tasks are repeated and delays or omissions in care often occur. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 23982-23986). Elsevier Health Sciences. Kindle Edition. Review of an Admission Record revealed Resident #292 was a female with pertinent diagnoses which included gastrostomy status (artifical entrance to the stomach, tube feeding), parkinson's disease, irritable bowel syndrome (IBS), acquired absence of parts of digestive tract, cancer of small intestine, muscle wasting, GERD, disease of the esophagus, kidney disease, and dysphagia (a condition that affects your ability to produce and understand spoken language). Review of current Care Plan for Resident #292, revised on 5/16/2024, revealed the focus, .I am at risk for malnutrition as evidenced by Dx (diagnosis) Parkinson's, depression, GERD, metastatic neuroendodrine tumor of ileum/jejunum (NET) (small bowel tumor that can spread to the liver and regional lymph nodes with symptoms which include weight loss, diarrhea, nausea/vomitting, tired, bloated) s/p (status post) small bowel resection, dysphagia requiring enteral feeding/NPO status . with the intervention .Administer medications per physician orders .Diet per physician order: NPO (nothing by mouth) Jevity 1.5 enteral feeding and flushes per physician order .Obtain labs as ordered and notify physician of abnormal results . Review of Orders for Resident #292 revealed, .Please check BS (blood sugar) Q AM before breakfast and before dinner x5 days dtr says pts BS was low at times .dated 5/13/24 . Review of Resident #292's record revealed there were no blood sugar results taken prior breakfast and prior to dinner. In an interview on 06/06/24 at 11:23 AM, Licensed Practical Nurse (LPN) O the orders for Resident #292 and reported the order was written on 5/13/24, was only to be done for 5 days, before breakfast and dinner. LPN O reviewed the vitals section for Resident #292 and there were no blood sugar results, reviewed the results section for lab work and reported on 6/4/24 the blood sugar results were 78. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/24 at 11:31 AM, Clinical Manager (CM) C reviewed the vitals section on the profile and reported there were no blood sugar results. CM C reviewed the treatment administration record (TAR) and reported there were no results there as well. CM C reviewed the order and reported it was entered by the provider and checked by RN EEE. CM C when an order was entered by a provider, the double check of the order was the nurse who reviewed it. CM C opened the order and discovered the order did not have a routine or schedule attached to it and without that it would not transfer over to the medication administration record (MAR) so the nurse would be prompted to check the blood sugar on their screens. CM C since the provider entered the order, there would only be the two checks and if it was a verbal order then there would be three checks. CM C reported RN EEE should have caught there was no routine/schedule attached to the order when she completed her check. CM C reviewed the Skilled Dcoumentation assessment which would pull over to a progress note to verify if a blood sugar had been documented in the assessment and there were no progress notes with blood sugars noted in them. In an interview on 06/06/24 at 02:11 PM, Director of Nursing (DON) B reported the provider's template did contain a schedule and in review of the medical record for Resident #292 the provider entered the order manually and did not include a schedule which did not prompt the nurses to complete blood sugar checks for Resident #292 as she was a resident who received nutrition through a tube feeding with the potential for variations with her blood sugar levels. Resident #119: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 72648-72650). Elsevier Health Sciences. Kindle Edition.A health care provider's order for changing a dressing indicates the dressing type, the frequency of changing, and any solutions or ointments to be applied to the wound . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20790-20791). Elsevier Health Sciences. Kindle Edition.Nurses are responsible for performing all procedures correctly and exercising professional judgment as they carry out health care providers' orders . Review of an Admission Record revealed Resident #119 was a male with pertinent diagnoses which included cancer of the temporal lobe and brain. Review of current Care Plan for Resident #119, revised on 7/10/2018, revealed the focus, .The resident has wound on his head (right lateral) related to cancer. At times his wife removes the dressing on her own. This was something she did for him at home . with the intervention .Change wound dressings as ordered .EBP (Enhanced Barrier Precautions) .Keep skin clean and dry .Monitor/document locations, size, and treatment of skin injury. Report abnormalities, failur eot heal, s/sx (signs and symptoms) of infection, maceration (excessive moisture, leading to the softening and breaking down of the surrounding skin) . During an observation on 06/04/24 at 02:15 PM, Resident #119 was observed lying in his bed on the phone with the head of the bed at approximately 45 degrees with pillows behind him. There was another male in the room with him. room [ROOM NUMBER]: Sverre [NAME]: was on the phone when attempted to speak to him, had a male visitor in the room. (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 and observation, Hospice Volunteer BBB exited Resident #119's room and informed me the resident was on the phone with his daughter and he was a volunteer with hospice who went to visit residents in the facility. Review of Order dated 4/19/24, revealed, .Dressing Change: change dressing to right skull wound daily. Remove old bandage, lay patient flat on right side in bed with pad underneath head and allow woudn to drain for 10 minutes, cleanse surrounding ares with NS (normal saline), apply 1/3 ABD pad over wound and wrap head with coban (a bandage wrap that adheres to itself with no sticky adhesives) to secure, then secure coban wiht tape .every day shift . During an observation on 06/04/24 at 02:31 PM, Licensed Practical Nurse (LPN) OO had entered Resident #119's room as he was lying in the bed with the head of the bed at approximately 60 degrees. LPN OO was observed to not have a gown or face mask on. LPN OO began to remove the bandages wrapped around Resident #119's head. LPN OO reported she was cleaning the inside of the wound with normal saline and gauze. LPN OO reported it was a chronic surgical wound. Resident #119 reported he had a craniontomy performed due to a lesion on his brain and the wound was from the surgery. LPN OO used a tablet to take a photo of the wound and reported it would upload to the medical record. LPN OO placed a non stick pad to the dressing and wrapped his head with gauze. Note: LPN OO did not allow the wound to drain for 10 minutes prior to changing the dressing and did not wrap the head with coban. In an interview on 06/04/24 at 02:51 PM, LPN OO reported she did not don a gown when she performed a dressing change on Resident #119 and she did not allow the wound to drain for 10 minutes prior to cleaning and applying a new bandage. In an interview on 06/05/24 at 02:37 PM, Registered Nurse (RN) Y reported prior to the dressing change for Resident #119, the bandage had to be removed and allowed to drain, lying on the right side to help it drain, before she could replace the bandage. RN Y reported the wound was opened more due to the tumor started growing again, it opened the wound back open and it has to drain. In an interview on 06/06/24 at 02:15 PM, Director of Nursing (DON) B reported for the wound dressing change for Resident #119, the gown and gloves were appropriate for the dressing change as there was no risk of splashing from the wound care. DON B reported the wound had to be allowed to drain for 10 minutes prior to applying the new dressing. DON B reported the spouse of Resident #119 was permitted to change the dressing on Resident #119 using the supplies per the hospice order. DON B reported this order was entered when Resident #119 was at the facility earlier in the year for respite but was unable to locate it when asked to review the order. DON B reported the facility did not rediscuss the order for allowing the wife to do the dressing change as the wound was draining more and upon his return for long term care. This writer requested the order to allow the sposue to change the dressing and it was not received prior to exit from the facility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interviews, and record review, the facility failed to ensure services to maintain and prevent further decrease in ROM (range of motion) for 1 of 2 residents (Resident #7) reviewed for limited ROM, resulting in the potential for decreased ROM, contractures (hardening of the muscles, tendons, and other tissues) and pain. Findings include: Resident #7 Review of an Admission Record revealed Resident #7 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral palsy (a disorder of movement, muscle tone, or posture). Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 4/18/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #7 was cognitively intact. Review of Resident #7's Care Plan revealed, .Restorative: Active Range of Motion Date Initiated: 08/29/2022. Goal: Maintain ROM to Extremities. Revision on: 11/07/2023. Interventions: Notify nurse if decline or significant change in performance. Revision on: 05/01/2024. Notify nurse if pain is present/increased or presents with performance of plan. Revision on: 05/01/2024. PROM (passive ROM: staff moves the joint) to upper and lower extremity Joints 5 reps each daily with cares. Revision on: 05/01/2024. Review of Resident #7's Kardex (CNA care guide) revealed, .PROM to upper and lower extremity Joints 5 reps each daily with cares. In an interview on 06/04/24 at 01:03 PM, Resident #7 reported concerns with increasing pain and cramps in her legs. Resident #7 reported that she was not getting any type of therapy for her arms and legs and stated, .they are supposed to do it every day, but don't .I wish the therapist would show them how to do it . In an interview on 06/05/24 at 01:59 PM, Resident #7 reported that the CNA's had not done any ROM with her yet that day. During an observation on 06/05/24 at 02:17 PM, CNA Z and CNA III transferred Resident #7 into bed, performed incontinence care and then transferred her back into her wheelchair. There was no observation on ROM activities performed. In an interview on 06/05/24 at 02:32 PM, CNA Z reported that she does ROM with Resident #7 when she gets the resident dressed in the morning, and she had done it that morning. CNA Z reported that when she was educated by the facility, she was told that getting the resident dressed in the morning is considered ROM and stated, .no, I do not bend her arms or legs .I try not to . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/24 at 02:33 PM, CNA III reported that the only time ROM involves repetitions of bending legs and arms is when therapy does it. In an interview on 06/06/24 at 11:09 AM, Clinical Manager (CM) C reported that Resident #7 was very aware of her ROM needs and would prefer to be in therapy all of the time. CM C reported that Resident #7 becomes anxious when she does not have Biofreeze (pain relieving cream) and also if she has a decrease in her ROM abilities. In an interview on 06/06/24 at 11:10 AM, CM D reported that the CNA's should be performing PROM per Resident #7's care plan, which consists of repetitious movement of her arms and legs. CM D reported that she had not heard that Resident #7 had any concerns with her ROM being performed, but that she had not specifically asked the resident about it. In an interview on 06/06/24 at 11:11 AM, CNA Manager (CNA-MA) S reported that the staff that get Resident #7 dressed in the morning are typically who would be expected to perform the PROM, and that she expected that CNA's perform repetitions of moving the residents arms and legs per the care plan, and not just once when they put her arms through her shirt and/or legs through her pants. Review of the CNA Tasks revealed that CNA's were documenting Resident #7's tolerance of PROM exercises to the upper and lower extremity joints 5 reps daily with cares. The documentation over the past 30 days indicated at the resident tolerated well 12 of 30 days, tolerated poorly 10/30 days, resident refused due to pain 1/30 days, and not applicable 5/30 days. Review of Resident #7's Occupational Therapy Evaluation dated 12/28/23 revealed, .Diagnoses: .cerebral palsy, muscle wasting and atrophy .Contracture Functional Limitations Present d/t (due to) Contracture = Yes; Functional Limitations as Result of Contracture(s): ADL tasks; Is skilled therapy needed to address impairment? = No (Staff educated on PROM restorative care) . Review of the facility policy ROM (Range of Motion) dated 12/4/2023 revealed, Policy: To exercise the resident ' s joints and muscles and to maintain function and prevent decline for as long as possible. Guidelines: 1. Review resident ' s Plan of Care for special needs. 2. Support the extremity at the joint as it is being exercised. 3. Move each joint through its range of motion three (3) times unless otherwise instructed. 4. Move each joint gently, smoothly and slowly through its range of motion. 5. Remember to stop an exercise before the point of pain. 6. Include range of motion in dressing and undressing the resident as much as possible. 7. Encourage resident to actively stretch and move joints .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview, and record review the facility failed ensure physician orders were in place for dialysis treatment (the process of removing excess fluid and toxins in people with insufficient kidney function) and monitoring, and post dialysis assessments were documented for 2 residents (Resident #65 and #91) of 2 residents reviewed for dialysis care, resulting in the potential for the resident to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #65 Review of an Admission Record revealed Resident #65 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stage 4 chronic kidney disease. Review of a Minimum Data Set (MDS) assessment for Resident #65, with a reference date of 5/15/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #65 was cognitively intact. In an interview and observation on 06/04/24 at 04:40 PM, Resident #65 reported that he had returned from dialysis about 90 minutes prior. Resident #65 reported that normally he did not go to dialysis on Tuesdays, but that it was a make up day because he wasn't able to finish his treatment the day before. Resident #65 reported that he had not seen any facility staff yet, but was waiting to be laid down. Observed a dressing on Resident #65's right chest, and he reported that it was his port, where they hook up the dialysis. Review of Resident #65's Care Plan revealed, I need dialysis r/t (related to) renal failure. Date initiated 7/3/2023, Interventions: Check and change dressing daily at access site. Document, Do not draw blood or take B/P (blood pressure) in arm with graft . The care plan did not indicate the type of dialysis, when or where the dialysis took place, and/or monitoring of the dialysis port located on the right chest. Review of Resident #65's Physician Orders revealed no current or discontinued orders for Dialysis. Review of Resident #65's Treatment Administration Record revealed no treatments and/or monitoring for a dialysis port. In an interview on 06/06/24 at 08:21 AM, Resident #65 reported that he did not know who was supposed to be changing the dressing that covered his dialysis port and stated, .they have never change it here .when I go to dialysis they change it . In an interview on 06/06/24 at 08:24 AM, Licensed Practical Nurse (LPN) F, who was assigned to Resident #65, reported not normally working on that unit and stated, .I know he (Resident #65) does dialysis, but I don't see orders .not sure where his port is . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/24 at 08:28 AM, Clinical Manager (CM) D reported that based on review of the medical record, she was not able to confirm where or when Resident #65 received dialysis, when he started dialysis, and/or where specifically his dialysis port was located. CM D reported that there were no orders in Resident #65's record related to dialysis and/or monitoring of his dialysis port. CM D reported that the facility nurse should be visually monitoring Resident #65's dialysis port site at least daily, but there was no documentation to support that it was being done. Review of Resident #65's Vital Signs Record indicated that vital signs were not obtained regularly, nor were they consistently recorded on Dialysis days (Monday, Wednesday and Friday). For the month of May blood pressure findings were recorded on 8 days. For the month of May 2024, 4 of the 8 days that blood pressures were recorded, coincided with Dialysis days. Review of the facility policy Dialysis date last reviewed/revised 1/2/2024 revealed, Policy: the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis (dialysis). Purpose: .The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices .7. The nurse will monitor and document the status of the resident's access site upon return from the dialysis treatment to observe for bleeding or other complications .10. The facility will ensure that the physician's orders for dialysis include: a. The type of access for dialysis and location. b. The dialysis schedule .d. The dialysis facility name and phone number .11. The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift . 38384 R91 According to the Minimum Data Set (MDS) dated [DATE], R91 scored 14/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), required a fistula/port for dialysis for a medical diagnosis of chronic kidney disease stage V. Review of R91's Order Summary did not have orders for dialysis including the days of the week or designated dialysis facility. Review of R91's Care Plan, revised on 5/16/24, revealed, The resident needs dialysis related to renal failure three times a week. Further review of R91's Care Plan, did not include the days of the week or which dialysis facility the resident received treatment from. During an observation and interview on 6/5/24 at 9:28 AM, R91 stated, I go to dialysis Monday, Wednesday, and Friday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/5/24 at 3:02 PM, Clinical Manager (CM) D, reviewed R91's Order Summary, stated, I do not see an order for (R91's) dialysis. Staff double-check orders when new orders come in. The nurse double-checks with the Provider when they put the order in, and a second nurse double checks the MAR/TAR to make sure the orders are in. (R91's) order was missed. Review of R91's Patient Transfer admitted [DATE] revealed, .Mon/Wed/Fri (name of Nephrologist) (name of dialysis facility) (address) . Review of facility policy Dialysis dated 1/2/24, revealed, .10. The facility will ensure that the physician's orders for dialysis include: a. They type of access for dialysis .and location. b. The dialysis schedule. c. The nephrologist's name and phone number. d. The dialysis facility name and phone number. e. Transportation arrangements to and from the dialysis facility. f. Any medication administration or withholding of specific medications prior to dialysis treatments. g. Any fluid restriction if ordered by the physician.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41027 Based on observation, interview, and record review, the facility failed to post required nurse staffing information on a daily basis, for all 135 residents in the facility, resulting in a lack of available staffing information for residents and visitors. Findings include: During multiple observations on 06/04/24 from 10:30 AM-5:30 PM throughout the facility halls and common areas, there were no postings found indicating the daily nurse staffing hours. During an observation on 06/05/24 at 08:10 AM there were no postings found indicating the daily nurse staffing hours. In an interview on 06/05/24 at 8:15 AM, Director of Nursing (DON) B reported that she did not know anything about the nurse staffing hours posting. In an interview on 06/05/24 at 8:20 AM, Nursing Home Administrator (NHA) A reported that he did not know anything about the nurse staffing hours posting. In a subsequent interview on 06/05/24 at approximately 10:00 AM, DON B reported that the daily nurse staffing hours posting was the responsibility of the scheduler, but that she had not been working in the facility for approximately 8 weeks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: 1. During the initial tour of the main kitchen, at 11:09 AM on 6/4/24, observation of the Blueair Refrigeration unit found the digital thermometer on the outside stated it was 34F. Upon opening the door it was noticed that the ambient temperature of the unit felt warm and there was no ambient air thermometer in the unit. A temperature of an open half gallon of fat free milk was taken with a digital rapid read thermometer and found to be 55F. When asked how long it had been since the last temperature of the unit was taken, Kitchen Supervisor BB stated that a temperature of 39F was logged at 8:00 AM this morning, when asked if they would have used the outside digital thermometer to record that that temp, KS BB stated yes. When asked what was going to happen to the drinks and the food product in the unit, KS BB stated they would be discarded. According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: .(2) At 5C (41F) or less. 2. During the initial tour of the kitchen, at 11:23 AM on 6/4/24, it was observed that eight packages of beef roasts were thawing in the wash compartment of the three compartment sink. The drain line from the wash compartment was found to be directly connected to the waste water line. When asked about thawing in the wash compartment, KS BB stated it should be done in a different location. According to the 2017 FDA Food Code guidelines section 4-501.16 Warewashing Sinks, Use Limitation. If the wash sink is used for functions other than warewashing, such as washing wiping cloths or washing and thawing foods, contamination of equipment and utensils could occur. According to the 2017 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . 3. During the intial tour of the kitchen, at 11:35 AM on 6/4/24, it was observed that a green mechanical scoop with stuck on food debris was found stored with clean utensils. During a tour of Rachels' and Davids' Kitchens, starting at 12:48 PM on 6/4/24, it was observed that the underside of the juice dispensers were found with an accumulation of dried on sticky orange debris in the corners and underside of the spouts. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the Borsma Cottage kitchen, at 1:25 PM on 6/4/24, it was observed that the resident silverware drawer was found with an accumulation of food crumbs and debris inside the drawers plastic insert. Further observation found that some of the utensil drawers in this area are pitting and chipping on the inside, no longer making it a smooth and easily cleanable surface. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 4. During the initial tour of the kitchen, at 11:44 AM on 6/4/24, it was observed that the mop sink on the kitchen was found left on, putting undue back pressure on the faucet's internal vacuum breaker. Although a wasting tee was installed, it had failed and was not working properly. During a tour of the Cottages, at 1:15 PM on 6/4/24, it was observed that the janitors sink, used by kitchen staff for getting sanitizer, was found to be left on, putting undue back pressure on the faucets internal vacuum breaker. The device has a wasting tee that is clogged and not working. According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: .(B) Maintained in good repair. 5. During a tour of Rachels' Kitchen, at 12:48 PM on 6/4/24, it was observed that a container of a dozen shake supplements was found in the refrigeration unit. Most shakes had a smeared writing and could not be identified with a legible discard date. A couple that were legible had discard dates of 6/3. The product information states it has to be used within 14 days of thaw. When asked what she was going to do to the product, KS BB stated discard it. Further review of the refrigeration unit found a couple containers of thickened water and juice. These items were found dated with receive by dates, but not dated for discard once opened. A review of the thickened water product found it was to be used within seven days of opening. During a tour of the [NAME] kitchen area, at 1:05 PM on 6/4/24, it was observed that front fridge had a package of sliced ham with a smeared date. It was also found that two ready care shakes were found with no date to indicate discard (item is good 14 days from thaw). Observation of the back pantry fridge found an open package of red skin potatoes dated 5/11 to 8/11, staff and KS BB was unsure why it was dated this way and was discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . 6. During an observation of the [NAME] pantry refrigeration unit, at 1:10 PM on 6/4/24, it was observed that a container of shell eggs was found stored on the middle shelf of the unit, over ready to eat product (including shredded cheese and cooked potatoes). According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on observation, interview, and record review the facility failed to: 1.) ensure resident shared equipment was properly cleaned and sanitized between each use, 2.) ensure personal protective equipment (PPE) was worn by staff and visitors in care units where required and by staff when caring for 1 (Resident #119) of 29 sampled residents, 3.) ensure clean laundry bins used for transport were free from dirt and debris; and 4.) ensure 1 (Resident #91) of 2 residents sampled for dialysis had a dressing applied to their dialysis access site (an indwelling device). These deficient practices resulted in the increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility. Findings include: Resident Shared Equipment During an observation on 6/5/24 at 1:21 PM, noted Licensed Practical Nurse (LPN) LL in the activity room near the front entrance of the facility taking vitals on a resident. After LPN LL had finished taking vitals on the first resident, a second resident in the activity room requested LPN LL take her vitals as well. LPN LL did not clean and sanitize the vitals machine after taking vitals on the first resident before taking vitals on the second resident. LPN LL finished taking vitals on the second resident, exited the activity room with the vitals machine, and took the vitals machine into a third resident's room to take their vitals. LPN LL did not clean and sanitize the vitals machine after taking vitals on the second resident before taking vitals on the third resident. In an interview on 6/5/24 at 1:29 PM, LPN LL reported the vitals machine was supposed to be cleaned and sanitized between each use to prevent the spread of infection. LPN LL reported she had not cleaned nor sanitized the vitals machine between use on the three residents but should have. In an interview on 6/6/24 at 1:03 PM, Infection Control Nurse (ICN) YY reported resident shared equipment (including vitals machines) should be cleaned and sanitized between every resident every time. ICN YY reported that practice was important to prevent the spread of infection. Personal Protective Equipment Review of signage posted on the wall outside the entry to the Good [NAME] Home (GSH) locked memory care units (Rachel's House and David's House) revealed, NOTICE WE ARE EXPERIENCING A RESPIRATORY INFECTION ON GSH. OUR MASKS MUST BE WORN BY ALL FAMILY, VISITORS AND EMPLOYEES WHEN VISITING. IF YOU HAVE RESPIRATORY SYMPTOMS, WE ASK THAT YOU CONSIDER NOT VISITING AT THIS TIME. THANK YOU, FOR SUPPORTING OUR EFFORTS TO KEEP OUR RESIDENTS, EMPLOYEES AND VISITORS SAFE. Review of signage posted at eye level directly on the double door entry to the GSH revealed, Notice: MASKS ARE REQUIRE (sic) FOR VISITORS AND EMPLOYEES UPON ENTERING GSH, [NAME] AND [NAME] Visitation is not restricted however our masks are required when visiting. Thank you, for your support We appreciate your support and understanding as we all work together to protect our residents and one another. We will keep you informed, and again Thank you. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 6/5/24 at 2:28 PM, noted two visitors standing at the signage posted on the wall outside the entry to the Good [NAME] Home (GSH). They appeared to be reading the signage. There was hand sanitizer and a box of surgical masks on a tray table underneath the signage on the wall. The visitors did not don (put on) surgical masks prior to entering the GSH. During an observation/interview on 6/5/24 beginning at 2:33 PM in GSH David's House, noted the two visitors, still not wearing surgical masks, seated at a table in the common area with two residents. Licensed Practical Nurse (LPN) N was conversing with the visitors. LPN N did not direct the visitors to don surgical masks. During this observation, Clinical Manager (CM) EE walked past the visitors, into the nursing office. CM EE then walked back out of the nursing office and again past the visitors. CM EE did not direct the visitors to don surgical masks. CM EE and LPN N then walked over to this surveyor. CM EE was queried as to whom should be wearing surgical masks and why. CM EE reported all visitors and staff were required to wear surgical masks when in GSH, regardless of whether they were in Rachel's House or David's House, because residents in Rachel's House had parainfluenza (a respiratory virus) and the facility was trying to prevent the spread of the virus to all resident's of GSH. This surveyor queried CM EE and LPN N if the two visitors should be wearing surgical masks and LPN N reported she had caught other visitors earlier that were not wearing masks and directed them to put masks on but had not noticed the current visitors were not wearing masks. LPN N reported she should have educated the visitors and directed them to don surgical masks. In an interview on 6/6/24 at 1:03 PM, Infection Control Nurse (ICN) YY reported all staff and visitors were expected to wear surgical masks when in GSH. ICN YY reported if anyone, including visitors, entered through the double doors and into one of the houses (David's or Rachel's), any staff who saw them should educate them on the importance of wearing the surgical masks and then provide them with a surgical mask at that time. 46999 During an observation on 6/4/24 at 11:01am signage was posted on the wall, at eye level outside the memory care unit that stated, We are experiencing a respiratory infection on (name of locked unit) our masks must be worn by all family, visitors, and employees. Hand sanitizer and masks were provided on a raised table under the sign. The same sign hung at eye level on the double doors leading into the unit. During an observation on 6/4/24 at 11:03am, Kitchen Supervisor (KS) XX and Dining Room Supervisor (DRS)WW, walked past the signage, table, and PPE, and entered the locked memory care unit without donning a surgical mask or completing hand hygiene. During an observation on 6/4/24 at 11:05am, KS XX and DRS WW were observed completing rounds in the kitchen area of the locked memory care unit. Neither staff member wore any personal protective equipment (PPE). During an observation on 6/4/24 at 11:07am, KS XX and DRS WW worked in the kitchen area that was open and easily seen by those passing by. Several other staff members passed by but did not alert KS XX or DRS WW about the need to wear PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview at 6/4/24 at 11:07am, KS XX and DRS WW reported they were not aware that the use of a surgical mask was required on the locked memory care unit at this time. Both staff members denied awareness of a suspected infectious illness outbreak on the unit. In an interview on 6/4/24 at 11:46am, Infection Preventionist (IP) YY reported all staff were required to use a surgical mask while on the locked memory care unit because the unit had 1 confirmed case of parainfluenza 3 and 2 more suspected cases of the illness. When further queried about how staff were educated on the need to wear masks, IP YY reported staff were educated by the signage present, a message sent on the electronic medical record and by their supervisors. IP YY reported masking throughout the unit was important to reduce the risk of spreading the illness, especially since some of the residents who were suspected of being ill could not comply with staying in their rooms. In an interview on 6/6/24 at 11:17am, KS XX reported on 6/4/24 she was told by her supervisor to come to the locked memory care unit to do her weekly rounding of the kitchen. KS XX reported her supervisor did not tell her about the infection prevention precautions underway on the unit. KS XX reported she quickly went to the unit to complete her assigned task. KS XX stated To be honest, I was in a hurry and didn't notice the signage. When further queried about the areas in which she worked, KS XX reported she was primarily in the administrative office at this time but could go to any of the company's facilities/kitchens as needed. 41424 Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: *Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . Effective Date: April 1, 2024 . Resident #119: Review of an Admission Record revealed Resident #119 was a male with pertinent diagnoses which included cancer of the temporal lobe and brain. Review of current Care Plan for Resident #119, revised on 7/10/2018, revealed the focus, .The resident has wound on his head (right lateral) related to cancer. At times his wife removes the dressing on her own. This was something she did for him at home . with the intervention .Change wound dressings as ordered .EBP (Enhanced Barrier Precautions) .Keep skin clean and dry .Monitor/document locations, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration (excessive moisture, leading to the softening and breaking down of the surrounding skin) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 06/04/24 at 02:15 PM, Resident #119 was observed lying in his bed on the phone with the head of the bed at approximately 45 degrees with pillows behind him. There was another male in the room with him. room [ROOM NUMBER]: Sverre [NAME]: was on the phone when attempted to speak to him, had a male visitor in the room. During an interview and observation, Hospice Volunteer BBB exited Resident #119's room and informed me the resident was on the phone with his daughter and he was a volunteer with hospice who went to visit residents in the facility. Review of Order dated 4/19/24, revealed, .Dressing Change: change dressing to right skull wound daily. Remove old bandage, lay patient flat on right side in bed with pad underneath head and allow wound to drain for 10 minutes, cleanse surrounding areas with NS (normal saline), apply 1/3 ABD pad over wound and wrap head with coban (a bandage wrap that adheres to itself with no sticky adhesives) to secure, then secure coban with tape .every day shift . During an observation on 06/04/24 at 02:31 PM, Licensed Practical Nurse (LPN) OO had entered Resident #119's room as he was lying in the bed with the head of the bed at approximately 60 degrees. LPN OO was observed to not have a gown or face mask on. LPN OO began to remove the bandages wrapped around Resident #119's head. LPN OO reported she was cleaning the inside of the wound with normal saline and gauze. LPN OO reported it was a chronic surgical wound. Resident #119 reported he had a craniotomy performed due to a lesion on his brain and the wound was from the surgery. LPN OO used a tablet to take a photo of the wound and reported it would upload to the medical record. LPN OO placed a non stick pad to the dressing and wrapped his head with gauze. Note: LPN OO did not allow the wound to drain for 10 minutes prior to changing the dressing and did not wrap the head with coban. In an interview on 06/04/24 at 02:51 PM, LPN OO reported she did not don a gown when she performed a dressing change on Resident #119. In an interview on 06/05/24 at 02:37 PM, Registered Nurse (RN) Y reported prior to the dressing change for Resident #119, the bandage had to be removed and allowed to drain, lying on the right side to help it drain, before she could replace the bandage. RN Y reported the wound was opened more due to the tumor started growing again, it opened the wound back open and it has to drain. In an interview on 06/06/24 at 01:04 PM, LPN V reported Resident #119's wife was in today and she completed the wound dressing change for his chronic surgical wound on his head. In an interview on 06/06/24 at 02:15 PM, Director of Nursing (DON) B reported for the wound dressing change for Resident #119, the gown and gloves were appropriate for the dressing change as there was no risk of splashing from the wound care. DON B reported the wound had to be allowed to drain for 10 minutes prior to applying the new dressing. DON B reported the spouse of Resident #119 was permitted to change the dressing on Resident #119 using the supplies per the hospice order. DON B reported this order was entered when Resident #119 was at the facility earlier in the year for respite but was unable to locate it when asked to review the order. DON B reported the facility did not rediscuss the order for allowing the wife to do the dressing change as the wound was draining more and upon his return for long term care. This writer requested the order to allow the spouse to change the dressing and it was not received prior to exit from the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of policy, Enhanced Barrier Precautions reviewed/revised on 4/15/24, revealed, .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) .even if the resident is not known to be infected or colonized with a MDRO.3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident ' s room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care) . 38384 R91 According to the Minimum Data Set (MDS) dated [DATE], R91 scored 14/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), required a fistula/port for dialysis for a medical diagnosis of chronic kidney disease stage V. Review of R91's Summary Order, dated 2/23/23, revealed, Change dressing to hemodialysis site daily. Review of R91's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated February 2023 did not contain the order for Change dressing to hemodialysis site daily on it. Subsequently, the order was not added to the resident's MARs/TARs from February 23, 2023, through June 5, 2024. Review of R91's Care Plan, revised on 5/16/24, revealed, The resident needs dialysis related to renal failure three times a week. The goal, revised on 3/2/24, was for the resident to have no signs or symptoms of complications from dialysis with interventions that included check and change dressing daily at access site. Document. (date initiated 1/16/2023). During an observation and interview on 6/5/24 at 9:28 AM, R91 stated, I go to dialysis Monday, Wednesday, and Friday. I have a port in my right arm. It gets a lot of use. Observed a dialysis port in resident's right arm with no dressing. The skin covering the port had three small openings that were scabbed over. During an interview and record review on 6/5/24 at 2:57 PM, Licensed Practical Nurse (LPN) JJ stated while reviewing R91's medical chart, When (R91) comes back from dialysis the night shift changes his dressing that night. That is what I assume because I've never done a dressing change over his dialysis port. I do not see an order on the MAR to do a dressing change on my shift, 7a-7p. For the night shift, 7p-7a, the order it is not there either. There is no order for R91 to have a dressing change over his port. During an interview and record review on 6/5/24 at 3:02 PM, Clinical Manager (CM) D, reviewed R91's Order Summary, MAR/TAR, and Care Plan stating, I see the order dated 2/23/23 to do a dressing change daily for the dialysis port and it is on the care plan. It is not on his MAR/TAR to be done daily. It should have been a routine schedule to be done and it was not. The port is direct access to the resident's blood and should have a dressing after dialysis if there are open wounds from access for infection control. 38905 (continued on next page)

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