STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to assess 2 of 2 residents (R10, R27) reviewed for the ability to self-administer medications (SAM). Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and transfers. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. R27's electronic medical record lacked an order for diclofenac (medication used to treat mild and moderate pain) and/or Calazinc (medication used to temporarily protect and help manage moisture and relieve minor skin irritations) and documentation about the completion of a SAM assessment for these medications. During an observation and interview on 3/11/24 at 4:21 p.m., a tube of Calazinc Body lotion and a tube of diclofenac sodium were observed in R27's bathroom. R27 stated she applied the Calazinc cream to her bottom and used the diclofenac sodium 1% as the label indicated three times a day for shoulder pain. During an interview on 3/13/24 at 11:10 a.m. registered nurse (RN)-F stated R27 medications were administered by the nurses and did not have an order to self-administer her medications. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/24 at 12:15 p.m. R27 indicated she self-administered the Calazinc and diclofenac and kept both creams in the bathroom. R27 stated she asked the nurses for the Calazinc cream when her tube was almost empty, and used the cream as needed for her bottom. The diclofenac had a pharmacy label with R27's information and prescription directions. R27 stated she applied the diclofenac cream three times a day for pain to her shoulders and left hip. During observation and interview on 3/13/24 at 1:10 p.m., nurse manager/registered nurse (RN)-H verified R27 didn't have a SAM assessment and was not aware R27 was using the creams. RN-H verified R27 had tubes of Calazinc and diclofenac cream in the bathroom. R27 informed RN-H she had been self-administering both creams for as long as she can remember. R27 stated I receive the diclofenac cream and other medications in the mail and gave the package to the nurse on duty. The nurses kept the pills and gave me the creams. During observation and interview on 3/13/24 at 1:20 p.m., RN-F confirmed to RN-H the medicated cream arrived via mail and the nurses had given the diclofenac tubes to R27. During interview on 3/13/24 at 2:04 p.m. director of nursing (DON) stated a SAM assessment needed to be completed to assess residents' ability to self-administer any medication, including medicated creams. 49339 R10 R10's quarterly Minimum Data Set (MDS) dated [DATE], included the following diagnoses for R10: chronic obstructive pulmonary disease (progressive lung disease), heart failure, hypertension (high blood pressure), diabetes, metabolic encephalopathy (problem in the brain caused by a chemical imbalance), and macular degeneration in both eyes (loss of vision). The MDS indicated that R10 has vision which was moderately impaired - limited vision. R10's Brief Interview for Mental Status (BIMS) assessment, dated 10/9/23, moderate cognitive impairment. During observation and interview on 3/11/24 at 4:54 p.m., R10 was observed sitting in her recliner in her room. She had a bedside table immediately to the left of her recliner. R10 stated she was taking her 4 o'clock medications. R10 had empited them onto the bedside table, from the plastic medication cup, to spread them out so I can see them a little. R10 indicated that the nurse brought them in a while ago but I wasn't ready to take them, so they left them with me .I always take them though. R10 was not able to identify the medication tablets on the table. R10 stated the big white ones I call the horse pills because they are so big. R10 was not able to state what the medications were for. R10's nebulizer was on a table to the right of her recliner, within her reach. It contained a clear liquid substance in the nebulizer chamber. R10 was not able to identify what the liquid was but stated she does her nebulizer herself. R10 indicated the nurse sets it up for me so I can use it when I need it I use it when I get a heaviness in my chest I am able to see the black button to turn the machine on and off they [staff] don't usually watch me when I use it .they just put the solution in it so I can use it whenever I want. R10 took the oral tablets while surveyor was in the room during interview. There was no staff present while R10 was taking her oral medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's medication self-administration safety screen, dated 7/7/23, indicated R10 may not self-administer medications. There is a note indicating not a candidate for SAM. R10's care plan, printed 3/13/24, lacked documentaion R10 was appropriate for self-administration of medications. During interview on 3/14/24 at 2:09 p.m., registered nurse (RN)-D stated that R10 is not appropriate for self-administration of medications. They stated that she likes to put the strap on for the mask herself, but they stand in the room with her during the nebulizer treatment. RN-D stated that she sometimes just holds the mask to her face instead of putting the strap on. RN-D stated due to multiple reasons, she needs supervision with oral medications, and they should not be on the table for her to take and staff should stay with her during administration. During interview on 3/14/24 at 2:15 p.m., nurse manager (NM)-E stated R10 would not be appropriate for self-administration of medications. NM-E stated They would expect nurses to stay either in the room or right outside the door (where they can still see her) to observe her use her nebulizer. NM-E verified that R10's SAM indicated she was not appropriate for self-administration of medication. During interview on 3/14/24 at 2:26 p.m., director of nursing (DON) indicated that an assessment needed to be done prior to self-administration of medication to assess if a resident is appropriate. DON verified that R10 should not take medications without being observed and should not be doing nebulizer treatments by herself. A facility policy on self-administration of medication was requested and not provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASARR) was conducted, documented, and retained to ensure mental health needs were appropriately addressed or provided for 2 of 2 residents (R4, R27) reviewed for PASARR. Findings include: R4 R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 with admission to facility on 3/10/21 and diagnoses of bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows), depression, diabetes, and delusional disorder. R4's initial Pre-Admission Screening (PAS) results and attached letter from Senior Linkage Line, dated 3/10/21, indicated The Senior Linkage Line forwarded the PAS to the county/managed care organization for processing. The PAS is not final until the lead agency sends documentation to the nursing facility. The letter went on to list a lead agency and phone number for the facility to follow up with. R4's entire medical record was reviewed and lacked evidence a final determination had been received and/or evaluated by the county or managed care program as directed by the PAS (dated 3/10/21). During interview with medical records clerk (MRC) on 3/12/24 at 11:46 a.m., MRC reviewed R4's Level I PAS document MRC and stated, looks like she had the Level I. [I] Can't see if she got the Level II results. From the looks of it this is incomplete. MRC stated she was responsible for following up on the Level II's but, I gave up after doing it a few times. MRC stated, I know it needs to get done. During interview with administrator on 3/12/24 at 12:23 p.m., the administrator stated his expectation of staff to complete and follow up on PASARRs. Administrator stated, [it is] important to have a completed PASARR done to keep them [residents] assessed for appropriate services if they trigger [or are] needing it. 48065 R27 R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact and had no issues with mood or behavior. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, major depression, and personality disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's Pre-Admission Screening (PAS) results and attached letter from Senior Linkage Line, dated 5/22/23, indicated the Senior LinkAge line received and processed a pre-admission screening (PAS/OBRA Level I). The letter indicated Senior LinkAge Line made a referral for mental illness OBRA level II to lead agency. The letter went on to list a lead agency and phone number for the facility to follow up with. R27's medical record was reviewed and lacked evidence a final determination had been received and/or evaluated by the county. During interview on 3/13/24 at 11:23 a.m., MRC indicated the facility did not follow up the results of the PASARR with the lead agency. During interview on 3/14/24 at 10:05 a.m. administrator stated it was the medical records clerk's responsibility to ensure the PASARR was completed. A policy on PASARR was requested but not received.

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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** 44656 Based on observation, interview and document review, the facility failed to ensure appropriate infection control techniques were implemented during wound care for 2 of 2 residents (R11, R49) who were reviewed for wound care. In addition, the facility failed to comprehensively assess, monitor, and provide necessary care for 1 of 1 residents (R2) with a intrathecal baclofen pump. Findings include: R11 R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 with intact cognition, diagnoses of diabetes, chronic kidney disease, chronic obstructive pulmonary disease (debilitating lung disease[COPD]), lymphedema (condition that results in swelling of the leg or arm due to blockage in the lymphatic system which is part of the immune system), anxiety, depression, and cellulitis of right lower leg (potentially serious bacterial skin infection). In addition, R11 on oxygen. R11's Diagnosis List, printed 3/14/24, identified R11 with non-pressure chronic ulcer of right lower leg with fat layer exposed, and history of methicillin resistant staphylococcus aureas infection (infection resistant to many antibiotics), and deep vein thrombosis (deep tissue blood clots). R11's physician orders, dated 12/9/23, directed staff to perform, Bilateral leg: apply Aquaphor healing ointment, wrap with kerlix, apply ace wrap daily. R11's care plan revised 12/31/22, informed staff of [R11] has history of infection requiring antibiotics. During observation of R11's wound care with registered nurse (RN)-C on 3/11/24 at 3:44 p.m., RN-C gathered supplies from R11's dresser drawer. RN-C removed four pieces of medical tape from a roll and then adhered them to a bedside nightstand. RN-C removed the dressing from R11's right lower leg using medical scissors that were removed from the dresser drawer. These medical scissors were not wiped down prior to use. RN-C placed a towel under R11's right leg and performed wound care to right leg using uncleaned scissors to trim kerlix wrap and then placed the scissors onto R11's bed sheet. RN-C obtained two of the pieces of medical tape that were attached to the nightstand and secured the dressing. RN-C dated and labeled one piece of medical tape before applying the ace wrap and stockingette. RN-C proceeded to R11's left leg and removed the old compression dressing and ace wrap. RN-C removed the two remaining pieces of medical tape from top of dresser drawer and re-attached them to the handle of R11's wheeled walker which was near the bedside. RN-C sanitized hands and reapplied gloves and picked up the uncleaned scissors from the top of R11's bed sheet and trimmed the old kerlix wrap from R11's left leg. RN-C then lifted R11's left leg and placed the same towel used for R11's right leg wound care procedure, and then set R11's exposed left leg on top of it. RN-C proceeded with wound care to R11's left leg and put the sterile kerlix wrap on top of the unclean towel prior to wrapping R11's left leg. RN-C wrapped the kerlix from the ankle to below the knee and applied the two pieces of medical tape to top of kerlix wrap. RN-C then completed wound care with wrapping the ace wrap on top of the kerlix and applying the stretch wrap from ankle to knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with RN-C on 3/11/24 at 6:05 p.m., immediately after R11's wound care, RN-C stated, Scissors should be cleaned between left leg and right leg [wound care]. Common sense [sic]. And I used the same towel for both legs. In addition, RN-C stated, The paper [medical] tape was attached to the night table which I did not make sure was wiped down with cleaner or a wipe. I also moved two pieces of paper [medical] tape from the nightstand to the handle of the walker which was not cleaned prior to me using it. R49 R49's quarterly MDS dated [DATE], identified R49 with moderate cognitive impairment, diagnoses of epilepsy, combined congestive and diastolic heart failure, venous ulcer of left lower extremity, bipolar disorder (a serious mental illness characterized by extreme mood swings), depression, COPD and oxygen use. In addition, R49 was listed as receiving hospice services. R49's orders dated 2/10/24 directed staff, Wound Care: LLE VLU-cleanse wound daily, place crushed doxycycline in wound bed, cover with calcium alginate and wrap with rolled guaze. R49's care plan revised 2/13/24 indicated, [R49] has an infection of L lower leg trunk requiring antibiotic therapy directory to wound bed. During observation of R49 wound care with registered nurse (RN)-A on 3/12/24 at 2:04 p.m., RN-A stated R49 vulnerable to infection. RN-A gathered supplies from R49 dresser drawer. RN-A removed a piece of medical tape from a roll then dated and labeled it with a permanent marker. RN-A then tore the medical tape off and adhered it to the top of the uncleaned drawer. RN-A performed wound care to left lower leg by removing old dressing, applying cleanser to wound bed, applying medicated powder, and dressing to wound bed, applying kerlix, and then applied the labeled medical tape to dressing. During interview with RN-A immediately after the procedure, RN-A stated, tape should not be touching or attached [sic] to the top of the drawers. [I] do not know if it [dresser top] has germs on it and I did not clean it [dresser top] before attaching the tape. Should not do that. During interview with director of nursing (DON) on 3/13/24 at 1:37 p.m., DON stated, disappointment in staff placing medical tape on uncleaned surfaces and, I expect my staff to utilize proper infection control techniques including wiping down scissors before and after use. DON stated the sharing of a single towel from one leg to another while performing wound care is, not acceptable infection control. DON stated, These residents [R11, R49] are at risk for infection and both have been battling long term infections and wound care. Placing the kerlix on a towel and then using the kerlix to wrap her leg [R11] is not using acceptable infection control techniques. And they [nurses] know better. 49339 INTRATHECAL BACLOFEN PUMP (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2'S quarterly Minimum Data Set (MDS), dated [DATE], identified R2 had intact cognition. Diagnoses included: progressive neurological conditions, multiple sclerosis, anemia, neurogenic bladder, malnutrition, pressure ulcer of unspecified part of back-stage 3, pressure ulcer of right lower back-stage 2. MDS lacked identification in the diagnosis of presence of other specified device. Section O: special treatment and program of the MDS was marked under Z1, indicated resident had none of the above. MDS further indicated, R2 needed set up for eating. R2 was dependent for all other activities of daily living (ADLs) including dressing and bed mobility. R2 had an indwelling foley catheter and always incontinent of bowels. MDS lacked identification of diagnosis of presence of other specified device [baclofen intrathecal pump]. R2's Order Summary Report, printed 3/14/24, included the following diagnoses: presence of other specified devices, multiple sclerosis (autoimmune disorder which damage the insulating covers of the nerve cells in the brain and spinal cord), reduced mobility, pressure ulcer of unspecified part of back-stage 3, and pressure ulcer of right lower back-stage 2. The report lacked evidence of an order for the baclofen pump which indicated the placement, dose, and rate of medication R2 received daily. The report lacked evidence of the last fill of the pump or when it is due to be filled. R2's medication administration record for March 2024, printed 3/13/24, indicated the following orders: -[R2] may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump [surgically implanted pump that delivers medication directly to the fluid surrounding the spinal cord] runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, and/or other life threatening signs like high fever, confusion, rebound spasticity, or muscle rigidity. Administer oral baclofen PRN as ordered. Notify the provider and contact the clinic of neurology [provider name and contact information included] as needed for baclofen pump with a start date of 5/1/22 - baclofen tablet (medication for muscle spasms) 10 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for baclofen withdrawal. [R2] may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, with a start date of 5/5/2022 - Complete Body Audit Assessment in PCC Weekly on Tuesdays PM. Weight and full vitals one time a day every Tue for body audit must complete regardless if resident refuses shower with a start date 7/11/2023 The medication administration record lacked evidence of monitoring of the intrathecal baclofen pump. R2's care plan, printed 3/14/24, indicated [R2] potential for pain with need for medication management R/T history of surgery and history of pressure ulcer /multiple skin issues. Intervention/task included the following: -intrathecal baclofen pump: simple continuous to deliver 27.65 micrograms (mcg)/day. - Offer non-pharmacological interventions for pain relief such as music, repositioning, massage (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Etc. - Observe/document verbal and non-verbal s/sx of pain: Resident reports pain, Weight changes, protective behavior, guarding behavior, facial mask, irritability, self-focusing, restlessness, depression, Atrophy of involved muscle group, Changes in sleep pattern, Fatigue, Fear of re-injury, Reduced interaction with people, altered ability to continue previous activities, Sympathetic mediated responses (e.g., temperature, cold, changes of body position, hypersensitivity), Anorexia. - Report pain or requests for analgesics to nurse R2's care plan lacked indication for baclofen pump, interventions needed, how to monitor, placement of the pump, or management of pump. During observation and interview on 3/11/24, at 12:21 p.m., R2 was observed lying in bed. R2 stated she has a baclofen pump that manages the pain from the muscle spasms from the multiple sclerosis. R2 indicated that it was implanted in her abdomen and had since before moving to the facility. R2 further indicated that staff do not monitor or look at the pump. On 3/11/24 at 11:14 a.m., registered nurse (RN)-F indicated that they were currently working with R2 and frequently worked with R2. RN-F verified they are familiar with her needs and cares. RN-F stated that R2 does not have any type of implanted pump. RN-F stated, it would be important for me to know if a resident did. Upon review of the electronic medical record (EMR) and meeting with R2, RN-F verified that R2 does have an intrathecal baclofen pump. They indicated that they were unaware of this. RN-F verified they do not monitor the site or know who fills the pump or when it was last filled. RN-F verified they do not know the current dose of baclofen R2 gets and if the resident was transferred to another facility, this information would be missing. On 3/13/24 at 11:29 a.m., nurse manager (NM)-E indicated that they are familiar with R2. NM-E verified that there are no current orders for the baclofen pump listed on current medication list with current dose. They stated they monitor for withdrawal, would administer as needed (PRN) baclofen, and notify the provider. NM-E indicated they should be monitoring the baclofen pump site. NM-E verified the nurses really don't do anything with the pump and it should it monitored. NM-E stated the company who fills the pump came on a Sunday evening to fill the pump in December. NM-E indicated they were unsure if this was documented. NM-E verified that if the baclofen dose is not listed on the orders, another facility would not know what the current rate is if the resident was transferred. On 3/13/24 at 2:31 p.m., NM-E provided documentation of baclofen pump fill from Medtronic. The report indicated the baclofen pump was refilled on 7/18/23 and the setting currently set at baclofen 27.65 micrograms(mcg)/day. The report indicated the next fill currently scheduled for 1/9/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/24, a copy of Medtronic report from baclofen fill was provided. The report indicated R2's baclofen pump was filled on 1/9/24 at a current rate of 27.65 mcg/day with the next fill date of 6/25/24. On 3/13/24 at 3:29 p.m., nursing assistant (NA)-D verified they are familiar with R2. NA-D verified they frequently are assigned to that wing and care for R2. They verified they are familiar with her current care level. NA-D indicated that she needs assistance with all cares. They stated that R2 does not have a baclofen pump. Upon review, NA-D indicated they would expect this information to be readily available in the computer [EMR] and on the Kardex. NA-D indicated this is important information for everyone who cares for the resident to know. On 3/14/24 at 8:01 a.m., NA-E verified that they worked with R2 within the last week. NA-E verified they are familiar with the needs and care level of R2. NA-E stated they are not aware of R2 having a baclofen pump. NA-E indicated they would expect this to be in report and passed along as this would be important to be monitored. On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated that it is important that staff is aware of R2 intrathecal baclofen pump. DON verified that it needs to be monitored. DON verified there is no dose listed on the current orders for the baclofen pump. DON verified there is no monitoring in place for the pump. On 3/14/24 at 1:51 p.m., administer stated that it is important that we monitor an intrathecal baclofen pump. He further indicated that they would provide education as needed for staff [in regards to intrathecal baclofen pumps]. Facility policy on General Information Prevention and Control-Nursing Standards updated 10/5/2023 state, Reducing and/or preventing infections through indirect contact requires the decontamination (i.e., cleaning, sanitizing, or disinfecting an object to render it safe for handling) or resident equipment, medical devices, and the environment. In addition, the facility Infection Control Manual updated 10/5/2023, documented, If you use scissors-wipe them down with a disinfectant wipe after use. A facility policy on accuracy of records was requested but not provided.

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Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review the facility failed to provide assistance for hearing appliances for 1 of 1 (R17) residents reviewed who had bilateral hearing aides. Findings include: R17's quarterly Minimum Data Set (MDS) dated [DATE], indicated R17 admitted to the facility on [DATE], and had moderate cognitive impairment, diagnoses of Parkinson's (progressive disorder that affects the nervous system and parts of the body controlled by the nerves), encephalopathy (brain disorder that affects its function), chronic pain, anxiety, dementia, diabetes and depression. In addition, R17 received hospice services. R17's Care Area Assessment (CAA) dated 5/22/23, indicated R17 triggered for communication impairment. R17's care plan (CP) dated 1/7/22, indicated, [R17] had impaired hearing compensated well with use of bilateral hearing aides. CP intervention include, [R17] requires the following hearing appliances: (hearing aides bilateral). R17's Kardex with print date of 3/12/24, informed care staff of Communication section stating, [R17] requires the following hearing appliances: (hearing aides bilaterally). During observation and interview on 3/12/24 at 7:51 a.m., R17 was laying in bed positioned on her back. R17 did not have hearing aides in. R17 stated, I don't know where they [hearing aides] are. During observation and interview on 3/12/24 at 2:39 p.m., R17 was laying in bed positioned on her back. R17 stated, I don't know where they [hearing aides] are. They are supposed to be at the front desk. Registered nurse (RN)-A stated she was familiar with R17 care and needs and stated, [R17 hearing aides] are not in nursing cart. Could be in the nightstand, bathroom or around her room. The aide or nurses should be putting them in for her. If she refuses we should document. I do not know anything about her hearing aides. I have not put them in for her. During interview with R17's family member (FM)-A (who is also the primary emergency contact for R17) on 3/14/24 at 2:40 p.m., FM-A stated, Yes. [R17] has hearing aides. Had them for years. FM-A also stated, She [R17] needs them to help her understand what people are saying to her. She can be a little isolated feeling if she doesn't hear well. They [staff] should at least put a battery in them and offer it to them [sic] but I doubt they do. The hearing aides are never in her ears when I visit. During observation and interview on 3/12/24 at 2:44 p.m., nursing assistant (NA)-D stated he was familiar with R17 care needs. (NA)-D looked around R17 room and found two hearing aides in a nightstand drawer along with several small button batteries. I expect to have it [information about hearing aides] on my Kardex to tell me. I would be responsible for putting [them in]. NA-D stated he never put hearing aides in for R17. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with NA-A on 3/14/24 at 7:38 a.m., NA-A stated she was familiar with R17 care needs and, if Kardex says they [residents] are having hearing aides I would look for them in the room. NA-A stated she had never put hearing aides in R17. During interview with NA-C on 3/14/24 at 8:05 a.m., NA-C stated, [R17] hearing [sic]gotten worse progressively. And I have no clue if she has the hearing aides. I have never seen hearing aides [for R17]. It [hearing aides] should be on my Kardex. Also, I have been here almost two years and have never seen those hearing aides. During interview with NA-C on 3/14/24 at 8:05 a.m., NA-C stated, [R17]'s hearing [sic] gotten worse progressively. And, I have no clue if she has the hearing aides. I have never seen hearing aides for [R17]. It [hearing aides] should be on my Kardex. Also, I have been here almost two years and have worked with [R17] and have never seen those hearing aides. During interview with director of nursing (DON) on 3/14/24 at 1:02 p.m., DON stated, hearing is important for her [R17] quality of life. Facility policy on hearing aides was requested but not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was appropriately administered as well as provide Continuous Positive Airway Pressure ([CPAP]- ventilation machine that administers air via an external device at a predetermined level of pressure) therapy for 1 of 1 residents (R47) reviewed for respiratory care. Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated R47 had intact cognition with no behaviors present. The MDS indicated that R47 received oxygen therapy but did not use a CPAP. The MDS indicated R47 required staff assistance for bathing, dressing, and bed mobility. The facility Standing Orders for Skilled Nursing Facilities dated 1/17/22, indicated that nursing staff could initiate and titrate supplemental oxygen from one to four liters per nasal canula (NC) as needed for dyspnea (shortness of breath), hypoxia (oxygen saturation less than 88 percent), or acute angina (chest pain) to keep oxygen saturations at greater than 88 percent. The order indicated that if an increase in supplemental oxygen was needed, nursing staff should immediately update provider with nursing assessment. The order indicated that nursing staff may wean supplemental oxygen per nursing judgment to maintain oxygen saturations greater than 88 percent. R47's hospital Discharge Summary Report dated 8/7/23, indicated that R47 had presented to the hospital with worsening shortness of breath that was likely due to several factors including lack of wearing a CPAP at night. The report indicated that the hospital providers strongly recommend using the CPAP whenever asleep to assist R47 with avoiding future complications. R47's laboratory results dated [DATE], indicated R47's carbon dioxide (a waste product that your body gets rid of with exhale) level was at 34 millimoles per liter (mmol/L) with a reference range of 22-29 mmol/L. R47's Diagnosis Report dated 1/24/24, indicated R47 was diagnosed with obstructive sleep apnea (OSA), depression, heart failure, and chronic obstructive pulmonary disease ([COPD]- incurable lung disease causing breathlessness, frequent coughing, and chest tightness). R47's Order Summary Report dated 2/19/24, indicated an order for as-needed CPAP therapy resumed at previous settings unless otherwise instructed, notify the provider if the resident had increased shortness of breath (SOB), and one liter of oxygen via NC as needed to keep oxygen saturation at greater than 90 percent. R47's medication/ treatment administration record (MAR/TAR) dated 3/1/24- 3/14/24, indicated R47's oxygen saturation and supplemental oxygen level were ordered to be assessed and documented three times a day. The record indicated assessment was missed four times and oxygen was administered at a rate of two liters per minute (LPM) on each assessment except for two occasions (not applicable and three). The correlating oxygen saturations were between 92 percent and 97 percent. The record indicated that the nurse practitioner (NP) was to be notified as needed for increased shortness of breath (SOB) and lacked documentation that it had been completed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R47's oxygen saturation summary dated 3/1/24- 3/14/24, indicated oxygen saturation levels ranging between 94 and 97 percent, with 92 and 93 percent observed on 3/13/24 and 3/14/24. R47's care plan dated 3/10/24, indicated that R47 had the potential for an altered respiratory status or difficulty breathing related to COPD and heart failure. The care plan indicated that any change in breathing patterns or any signs of difficulty breathing should have been documented and reported to the medical practitioner. The care plan indicated that oxygen should have been given as ordered by the medical practitioner. R47's medical record was reviewed and lack documentation that a CPAP study had been scheduled/attempted to be scheduled and/or R47's refusal of this study. The medical record also lacked documentation indicating need for oxygen increase or that the provider had been updated regarding this increase. During an observation and interview on 3/11/24 at 1:03 p.m., R47 was observed lying in bed with her eyes closed with a NC applied and observed to administer oxygen at a rate of three LPM with her eyes closed. R47 stated that she did not have any shortness of breath but was often tired as she didn't sleep that well at night. R47 stated that when she was at the hospital, she had been using the CPAP and had also been using it before admittance to the facility and wanted to use one now. R47 stated she had not used a CPAP at the facility since she was admitted in 2021, as her machine had been misplaced. R47 stated that after she had gone to the hospital last fall, the facility was supposed to help her get set up with a new machine. R47 stated that someone had talked with her once about it and had never gotten back to her with more information. During an observation and interview on 3/12/24 at 8:24 a.m., R47 was observed lying in bed with a NC applied with supplemental oxygen running at a rate of three LPM. R47 stated she had told an unknown aide a few days ago that she was short of breath, so they had increased her oxygen to three LPM, but they had forgotten to come back and turn it down. R47 stated she hadn't seen anyone look or change it since then. During an interview and observation on 3/12/24 at 12:08 p.m., registered nurse (RN)-H, the nurse manager for long-term care, stated that she had never observed R47 using a CPAP machine. RN-H stated that when someone was admitted to the facility with CPAP use, they would continue their home settings on admittance unless the provider decided new settings were needed. RN-H stated she was unsure why R47 had not been started on CPAP therapy or reassessed for its appropriateness. RN-H stated that R47 was supposed to have her oxygen administered at one LPM and if R47 had respiratory distress and increased oxygen was needed, the staff member should have reached out to the NP. RN-E stated that it was important that R47 was not receiving too much supplemental oxygen, so her blood gases were maintained within normal limits. RN-H stated that the nurses should have been checking R47's supplemental oxygen level at least every shift because occasionally R47 would ask aides to increase her oxygen and that was completed inappropriately. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 3/12/24 at 12:19 p.m., R47's supplemental oxygen was observed at three LPMs and confirmed by RN-H. RN-H stated that R47's supplemental oxygen never should have been increased to three liters. RN-H stated that if R47's oxygen saturation was low leading to the increase that should have been recorded in the progress notes, the provider should have been notified, and they should have titrated the oxygen back down to one liter as able. RN-I, the floor nurse, stated that she was unaware that R47's supplemental oxygen was running at 3 LPM and R47 had not reported any respiratory symptoms to her nor did the previous shift. RN-I stated she was unsure how long it had been running at three LPM as she had not checked the level but agreed with RN-H stating it should not have been running at three LPM. RN-I was observed to measure R47's oxygen saturation with a result of 97 percent which RN-H stated was too high for R47 to require three LPM. RN-H then lowered the oxygen to two liters and stated she would return to recheck the oxygen and titrate the oxygen back down to one liter as able as should have been completed before now. During an interview on 3/12/24 at 12:32 p.m., the medical records clerk (MRC) stated that normally residents will come in already using a CPAP and she has never scheduled an appointment for new CPAP settings including R47. During an observation and interview on 3/13/24 at 7:03 a.m., R47's supplemental oxygen was observed at one LPM and R47 stated that she had not had any shortness of breath or other respiratory symptoms since her oxygen was decreased. During an interview on 3/13/24 at 12:41 p.m., the nurse practitioner (NP) stated that she had just put in an order to discontinue the CPAP therapy. The NP stated that R47 needed updated CPAP machine settings so a sleep apnea test needed to be completed before R47 could start using a CPAP again as the old settings were outdated. The NP stated that R47 had morbid obesity hypoventilation and the CPAP was an important intervention for her health. During an interview on 3/13/24 at 12:58 a.m., the NP stated that it was important that R47's oxygen was administered as ordered and if an increase was needed, that staff notify her so she could further assess and determine the cause and appropriateness of the increased oxygen. The NP stated she was unaware that R47 was receiving oxygen at three LPMs as she did not recall notification of this. The NP stated that she would have been worried because of the COPD history, R47 would have an increase in her carbon dioxide levels leading to possible free radical damage if oxygen was administered inappropriately. The NP stated when R47 was receiving oxygen at three LPM, this could have led to a decrease in respirations and essentially shutting down R47's respiratory system. During an interview on 3/14/24 at 1:03 p.m., licensed practical nurse (LPN)-A, the NP's care coordinator, stated that the resident had asked her about getting a new CPAP in 2/24. LPN-A stated that R47 had wanted more information regarding the testing required to get a new CPAP before making her decision on whether she wanted to move forward with this, and preferred testing done in the facility if possible. LPN-A stated she had not been able to follow up with R47 to give her any additional information as she only visited the facility once a month. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/24 at 1:38 p.m., the director of nursing (DON) stated the facility had not been aware of R47's need for a CPAP machine. The DON stated that she expected the nurse manager and the admitting nurse to review hospital notes with facility admissions and readmissions to ensure R47 received the respiratory care she needed. The DON stated that she did not think that a CPAP had been offered to R47 because they were unaware of this need. The DON stated that if an appointment was scheduled it would have been completed by the MRC. The DON stated that R47 should not have been receiving supplemental oxygen above the rate ordered in the order summary without provider notification and increased monitoring. The DON stated that this increased oxygen use could have an adverse effect on R47's health. A policy regarding respiratory care was requested and not received.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49339 Based on observation, interview, and document review, the facility failed to ensure nurse staffing information was posted on the weekend and in a timely manner at the start of the shift. This had potential to affect all 69 residents, staff, and visitors who could wish to review this information. Findings include: During entrance to the nursing home, on Monday, 3/11/24 at 11:30 a.m., a clear plastic holder was observed attached to the wall to the left of the main reception desk. This contained a document titled, Daily Staff Posting - Woodlyn Heights Health Care Center. However, the document displayed was dated, 3/7/202 [four days prior]. The form contained the actual and total hours of registered nurses, licensed practical nurses, trained medication aides, and certified nursing assistants which was broken down into each respective shift (i. e., day shift, evening shift, night shift). There was no visible nurse staffing information posted or displayed for Friday, 3/8/24, Saturday, 3/9/24, Sunday, 3/10/24, or Monday, 3/11/24. During interview on 3/11/24, at 11:35 a.m., administrative assistant (AA)-A, verified the posting was dated 3/7/24. They verified there were no other nurse staff information postings present. They indicated the staffing coordinator managed the staff posting. On 3/14/24 at 7:30 a.m., the staff posting posted was noted to be dated 3/12/24. On 3/14/24 at 10:31 a.m., staffing coordinator (SC)-A indicated they are responsible for creating the staff posting. They indicated they will typically post it when they arrive to work otherwise the charge nurse on night shift will post it. They indicated that sometimes I get the dates mixed up. They indicated if the wrong date was posted it might look like we have less staff or the census is wrong. On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated it is important to have the correct staff posting posted. Further, DON stated the posting depicts the staffing in the building, and the intention was to give the right representation of staffing in the building. DON verified there was only one staff posting posted which is located to the left of the reception desk by the main entrance. On 3/14/24 at 1:51 p.m., the administer was interviewed and indicated that the staff posting gives staff, residents, and families an account of how many residents are residing in the facility. Further, administrator stated it also shows how many residents the staff are responsible for. A facility policy for staff posting was requested but not received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed provide appropriate side effect monitoring with psychotropic medication consumption for 1 of 5 residents (R24) reviewed for unnecessary medication use. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], indicated R24 had severe cognitive impairment and was dependent on assistance with activities for daily living (ADLs). The MDS included diagnoses of hypertension (high blood pressure), epilepsy (seizure disorder) and renal insufficiency/renal failure/end-stage renal disease (kidneys no longer adequately filtering waste from the blood). The MDS indicated R24 had hallucinations, delusions and no physical or verbal aggression. R24's physician note, dated 2/7/24, included the following diagnoses; personal history of traumatic brain injury (TBI), chronic kidney disease, major depressive disorder recurrent severe with psychotic symptoms, restlessness and agitation, unspecified fall, hypertensive heart disease without heart failure and generalized anxiety disorder. R24's Order Summary Report dated 3/14/24, identified R24 had physician orders for several medications including the following: -duloxetine HCL (medication to treat major depressive disorder) delayed release capsule: give 80 milligrams (mg) by mouth one time a day related to major depressive disorder, recurrent, severe with psychotic symptoms with a start date of 8/3/23 -Seroquel (medication to treat certain mental/mood disorders) 100 mg tablet: give 100 mg by mouth two times a day related to major depressive disorder, recurrent, sever with psychotic symptoms with a start date of 11/27/23 -trazodone HCL (medication to treat major depressive disorder) oral tablet: give 150 mg by mouth one a day for trouble sleeping with a start day of 8/3/23 R24's medication administration record (MAR) for March, printed 3/13/24, lacked evidence of monitoring of monthly orthostatic blood pressures, side effects of psychotropic medications, non-pharmacological interventions for sleep or behaviors or indication of target behaviors. R24's care plan, dated 1/13/24, identified R24 has the potential for falls related to impaired balance, weakness, impaired cognition, organic brain dysfunction, history of TBI, fall history, psychotropic medication use, and incontinence. R24's care plan identified R24 is on antipsychotic medication. Interventions listed included: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-attempt non-pharmacological intervention and observe effectiveness -observe/record target behaviors/symptoms and document per facility protocol -psychoactive med: monitor for possible side effects (document abnormal findings in progress notes) decreased appetite, dry mouth, difficulty voiding, constipation, dizziness, unsteady jittery, restless, headache, stiff neck, tense muscles, stiff muscles, tremors, slow movement, dyspnea, shortness of break, blood pressure changes. - Observe/document/report to medical practitioner PRN signs/symptoms of psychotropic drug complications: altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, withdrawal, decline in ADLs & continence & cognition, suicidal ideations, constipation, impaction, urinary retention, shuffling gait, rigid muscles, syncope, accidents, dizziness, vertigo, Motor agitation, Tremors, tardive dyskinesia, poor balance, Diarrhea, fatigue, insomnia, loss of appetite, weight loss, N&V - Develop a behavior management program with alternatives to medication use. R24's care plan identified R24 was on an antidepressant medication. Interventions listed included: - Observe/document/report to medical practitioner prn [as needed] ongoing signs/symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety - Monitor for possible side effects (Document abnormal findings in Progress Notes) Decreased Appetite, Dry Mouth, Difficulty Voiding, Constipation, Dizziness, Unsteady, Jittery, Restless, Headache, Stiff Neck, Tense Muscles, Stiff Muscles, Tremors, Slow Movements, Dyspnea, Shortness of Breath, BP Changes - Attempt non-pharmacological interventions and observe effectiveness. - Report to Nurse prn ongoing signs/symptoms of depression: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's care plan lacked evidence of non-pharmacological interventions attempted in the past or present and effectiveness. It also lacked non-pharmacological interventions for sleep. R24's progress notes, printed 3/14/24, reviewed for the last 90 days lacked evidence of monitoring for side effects of psychotropic medication or monitoring of sleep. R24's vital signs summary, printed 3/13/24, lacked evidence of orthostatic blood pressure monitoring in the last 6 months. The package insert for Seroquel dated 1997, indicated metabolic changes (increase in cholesterol, weight gain, increased risk of diabetes), seizures, hypothyroidism (thyroid gland does not produce enough thyroid hormone), potential for cognitive and motor impairment (partial or total loss of function of a body part), dysphagia (difficulty swallowing), falls, orthostatic hypotension (a drop in blood pressure while standing), dizziness, and syncope (fainting) could lead to falls. The insert also indicated Seroquel should be used with particular caution in patients with known cardiovascular disease such as heart failure. Seroquel's drug classification is an antipsychotic medication. The package insert for duloxetine dated 2004, indicated the following side effects: orthostatic hypotension, activation of mania/hypomania, increases in blood pressure, seizures. Duloxetine's classification is a serotonin and norepinephrine reuptake inhibitor (SNRI). The package insert for trazodone, reviewed 2024, indicated the following side effects: cardiac arrhythmia (heart rhythm that isn't normal), activation of mania or hypomania, and orthostatic hypotension. Trazodone's drug classification is selective serotonin reuptake inhibitor (SSRI). The insert further indicates that using more than one SSRI or SNRI increases the risk for serotonin syndrome. Serotonin syndrome signs and symptoms may include mental status changes (e.g., agitation, hallucinations, delirium, and coma), autonomic instability (e.g., tachycardia, labile blood pressure, dizziness, diaphoresis, flushing, hyperthermia), neuromuscular symptoms (e.g., tremor, rigidity, myoclonus, hyperreflexia, incoordination), seizures, and gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). On 3/14/24, at 10:23 a.m., nurse manager (E) stated that monitoring of side effects of antipsychotic behaviors is done in the MAR. NM-E was not able to locate lab results since R24's admission for a lipid panel (blood test to check cholesterol levels). They stated the doctor would have to order that if that was something they wanted. On 3/14/24 at 11:17 a.m., director of nursing (DON) stated it is important to monitor for side effects for psychotropic medications and must intervene. She indicated you want the person to be comfortable and want to eliminate the side effects if you can. She indicated that side effect monitoring for anti-psychotic and anti-depressant medications is found on the MAR. She indicated it is important to monitor orthostatic blood pressures with any psychotropic medications. DON verified that R24 does not have side effect monitoring in place the anti-psychotic or anti-depressant medication R24 is receiving. DON verified R24 has not been getting orthostatic blood pressures completed. DON verified R24 sleep is not being monitored on the MAR. DON verified that there are currently no non-pharmacological interventions in place on the MAR for R24. On 3/14/23 at 1:51 p.m., administrator stated it is important to be monitoring for side effects of psychotropic medications. The monitoring is done on the MAR in the EMR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy PRN Psychotropic Medication Process dated 11/7/22, was provided. The policy indicated non-pharmacological approaches and techniques must be implements. The policy lacked information of monitoring for side effects/effectiveness of psychotropic medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review the facility failed to ensure 1 of 1 residents (R27) reviewed for medication errors were free of significant medication errors whenwhen R27 didn't receive ordered metoprolol (medication to treat high blood pressure and control heart rate) for 30 days and in addition, R27 didn't receive ordered atorvastatin (medication to treat high blood cholesterol) between 2/13/24 and 3/13/24. Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and transfers. R27's Medical Diagnosis report printed 3/13/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. R27's facility's Medical Orders printed on 3/13/24, did not include orders for metoprolol (a medication prescribed to treat hypertension) or atorvastatin (a medication prescribed to treat high cholesterol). R27's clinic Medication Reconciliation report dated 2/13/24 indicated to take metoprolol tartrate 50 milligrams (mg) by mouth twice a day for hypertension. Orders also indicated R27 take half a tablet of atorvastatin calcium 80 mg tablet by mouth every day. R27's medical record lacked documentation concerning the clinic's Medication Reconciliation report, received on 2/13/24, was reviewed by the nursing staff. Review of R27's facility medical record did not indentify orders for metoprolol and atorvastatin following the clinic visit. R27's Medication Administration Record for the months of February and March 2024 lacked documentation for or administration of metoprolol and/or atorvastatin. R27 was not documented as having been administered either medication between 2/13/24 and 3/13/24. During interview on 3/13/24 at 1:10 p.m., nurse manager/register nurse (RN)- H verified the orders for metoprolol and atorvastatin were not included in facility's physician orders and verified R27 had not received either medication between 2/13/24 and 3/13/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/13/24 at 2:04 p.m. director of nursing (DON) stated she expected the nurses to check medication orders received from a provider the same day and compared them to the R27's facility's physician orders. DON stated the nurse on duty should have contacted the provider if the medication orders didn't match. DON stated the medication list needed to be reconciled following a provider clinic visit to assure the facility had the correct orders and to prevent negative outcomes for the resident. A facility policy on medication management was requested and but not provided.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure dental needs were appropriately acted upon for 1 of 1 residents (R47) reviewed for dental care. Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated R47 had intact cognition with no behaviors present. The MDS indicated R47 was diagnosed with heart failure, diabetes, and depression and required setup assistance with oral hygiene. R47's dental progress note dated 1/4/24, indicated that the doctor of dental surgery (DDS) recommended that R47 have five teeth extracted prior to moving forward with a partial denture. R47's dental General Referral dated 1/4/24, indicated that the DDS recommended R47 to see an oral surgeon for extraction of five teeth related to fractured teeth/ root tips that were not restorable. The note also indicated that these teeth were causing R47 pain. R47's progress note dated 2/27/24 at 5:33 p.m., indicated that R47 had obvious or likely cavity or broken natural teeth. R47's care plan dated 12/16/23, indicated R47 was independent after set up help for oral care. During an interview and observation on 3/11/24 at 12:41 p.m., R47 was observed lying on her back in bed with two missing front bottom teeth. R47 stated that she was supposedly going to see an oral surgeon to have teeth pulled and then hopefully she would get dentures made for her missing bottom teeth. R47 stated no one had followed up with her regarding this potential appointment. R47 stated that she had mouth pain related to the missing teeth and cavities so she had to avoid these areas while eating, which bothered her. During an interview on 3/12/24 at 12:08 p.m., nurse manager (NM)-E stated that R47 saw the dentist every six months and it looked like R47 was recommended to get five teeth extracted after her last visit in 1/24. NM-E stated that the medical records clerk (MRC) oversaw taking these referrals and setting up the related appointments and she was unsure if this had been completed. During an interview on 3/12/24 at 12:28 p.m., the MRC stated that she oversaw setting up dental and other out-of-facility appointments for the residents in the facility. The MRC stated that this was the first time she was seeing the dental referral for R47 and therefore an appointment with the oral surgeon had not been scheduled. During an interview on 3/14/24 at 1:39 p.m., the director of nursing (DON) stated that the MRC oversaw setting up out-of-facility resident appointments and it was important that these appointments were scheduled. A policy regarding dental needs was requested and not received.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to maintain accurate medical records to ensure accurate medication lists, nurse/licensed professional monitoring and interventions were implemented for 2 of 2 residents (R2 and R27) reviewed. Findings include, R27's quarterly Minimum Data Set (MDS) dated [DATE] indicated R27 was cognitively intact and had no issues with mood or behavior. MDS indicated R27 needed assistance to set up her meals, supervision with showers, and was independent with dressing, toileting, bathing, and transfers. R27's Medical Diagnosis report printed 3/13/24 indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), unspecified psychosis (a mental disorder characterized by a disconnection from reality), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), generalized anxiety, idiopathic chronic gout (a condition caused by too much uric acid in the body which causes swelling and pain around the affected joint), chronic pain, type II diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), hypertension (high blood pressure), major depression, and personality disorder. During R27's record review on 3/12/24, several discrepancies were noted between a list titled current med list dated 2/13/24 from R27's clinic provider and the facility's Medical Orders. R27's Facility's orders did not include the following orders which were listed on the clinic provider medication list: Atorvastatin calcium (treats high cholesterol levels) 80 milligrams (mg) tablet, take one-half every day for cholesterol. Diclofenac (used to treat mild to moderate pain) NA 1% topical, apply 2 grams topically three times a day as needed for shoulder pain **Use dose card in box to measure dose. Lidocaine (anesthetic cream used to treat pain) 4% topical cream, apply a moderate amount to right foot at bedtime for pain. Metoprolol tartrate (treats high blood pressure) 50 mg, take one tablet twice a day for hypertension. R27's facility's orders didn't match the clinic orders for Melatonin (sleeping aid) 3 mg cap/tab. Take 2 tablets (6 mg) by mouth at bedtime for sleep. The facility's orders indicated to administer 3 tablets (9 mg). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/13/24 at 1:10 p.m. nurse manager/registered nurse (RN)-H verified the discrepancies between the facility's medication orders and the clinic's current medication list. RN-H was unable to provide documentation when the atorvastatin, metoprolol, lidocaine and/or diclofenac orders were discontinued. RN-H stated R27 went to her clinic on 2/13/24 R27. On 2/13/24 at 3:45 p.m. the clinic sent a fax containing the alleged current medication list. RN-H stated the nurse on duty did not reconcile the medication orders as expected. During interview on 3/13/24 at 1:50 p.m. the medical director stated, the facility's medication list often doesn't match the clinic records. Medical director stated it would be concerning if the lists didn't match. The nurse manager should ask the provider to review the medications and reconcile the orders. During interview on 3/13/24 at 2:04 p.m. director of nursing (DON) stated she expected the nurses checked any orders or current medication list received from a provider on the same day and compare them to the facility's physician orders. DON stated the nurse on duty should have contacted the providers if the medication orders didn't match. The medications needed to be re-conciliated to assure the facility had the correct orders and to prevent negative outcomes for the resident. 49339 R2 R2's Order Summary Report, printed 3/14/24, included the following diagnoses: presence of other specified devices. The report lacked evidence of an order for the intrathecal baclofen pump [surgically implanted pump that delivers medication directly to the fluid surrounding the spinal cord] which indicated the placement, dose, and rate of medication R2 received daily. The report lacked evidence of the last fill of the pump or when it is due to be filled. R2'S quarterly MDS, dated [DATE], identified R2 had intact cognition. Diagnoses included: progressive neurological conditions, multiple sclerosis (autoimmune disorder which damage the insulating covers of the nerve cells in the brain and spinal cord), anemia (low red blood cells), neurogenic bladder (lack of bladder control due to nerve problems), malnutrition, pressure ulcer of unspecified part of back-stage 3, pressure ulcer of right lower back-stage 2. MDS lacked identification in the diagnosis of presence of other specified device. Section O: special treatment and program of the MDS was marked under Z1, indicated resident had none of the above. R2's medication administration record for March 2024, printed 3/13/24, indicated the following orders: -[R2] may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations, and/or other life threatening signs like high fever, confusion, rebound spasticity, or muscle rigidity. Administer oral baclofen (medication used to treat muscle spasms) PRN (as needed) as ordered. Notify the provider and contact the clinic of neurology [name of provide and number included] as needed for baclofen pump with a start date of 5/1/22 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- baclofen tablet (medication for muscle spasms) 10 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for baclofen withdrawal. R2 may develop the following withdrawal symptoms when the battery for the internal intrathecal baclofen pump runs down or not working: baseline muscle spasticity, itching without a rash, twitching, low blood pressure, abnormal sensations with a start date of 5/5/22. The medication administration record lacked evidence of monitoring or assessment of the intrathecal baclofen pump. R2's care plan, printed 3/14/23, had a sentence indicating intrathecal baclofen pump: simple continuous to deliver 27.65 micrograms (mcg)/day. Care plan lacked any indication of how to monitor, placement of the pump, or management of pump. Review of R2's progress notes, dated from 9/13/23 to 3/12/24, lacked monitoring of intrathecal baclofen pump. The notes lacked evidence of coordination with agency who fills the baclofen pump or note of the last fill. During observation and interview on 3/11/24, at 12:21 p.m., R2 was observed lying in bed. R2 stated she has a baclofen pump that manages the pain from the muscle spasms from the multiple sclerosis. R2 indicated that it was implanted in her abdomen and had it since before moving to the facility. R2 further indicated that staff do not monitor or look at the pump. R2 stated she thinks the pump was filled in December. On 3/13/24 at 11:14 a.m., registered nurse (RN)-F verified that they were currently working with with R2 and frequently worked with R2. Rn-F verified there are no orders in the electronic medical record (EMR) that indicate what dose of baclofen R2 gets from the intrathecal baclofen pump. RN-F verified that this would be important to know as they administer medications as there could be a reaction and for coordination of care when the resident goes to the hospital. RN-F verified they do not know the current dose of baclofen R2 gets and if the resident was transferred to another facility, this information would be missing. On 3/13/24 at 11:29 a.m., nurse manager (NM)-E indicated that they are familiar with R2. NM-E verified that there are no current orders for the baclofen pump listed on current medication list with current dose. They stated they monitor for withdrawal, would administer PRN baclofen, and notify the provider. NM-E indicated they should be monitoring the baclofen pump site. NM-E verified the nurses really don't do anything with the pump and it should be monitored and assessed. NM-E stated the company who fills the pump came on a Sunday evening to fill the pump in December. NM-E indicated they were unsure if this was documented. NM-E verified that if the baclofen dose is not listed on the orders, another facility would not know what the current rate is if the resident was transferred. On 3/13/24 at 2:31 p.m., NM-E provided documentation of baclofen pump fill from Medtronic. The report indicated the baclofen pump was refilled on 7/18/23 and the setting currently set at baclofen 27.65 mcg/day. The report indicated the next fill was currently scheduled for 1/9/24. On 3/18/24, a copy of Medtronic report from the baclofen fill was provided. The report indicated R2's baclofen pump was filled on 1/9/24 at a current rate of 27.65 mcg/day with the next fill date of 6/25/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 11:17 a.m., director of nursing (DON) indicated that it is important that staff is aware of R2 intrathecal baclofen pump and the dose of baclofen R2 is receiving. DON verified the pump needs to be monitored and there is currently no monitoring in place. DON verified there is no dose listed on the current orders for the baclofen pump. A facility policy on medication management was requested and not provided. A facility policy on accuracy of records was requested but not provided.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure binding arbitration agreements were clearly communicated in a form and manner that they understood prior to signing the forms for of 2 of 2 residents (R2, R47) reviewed for binding arbitration agreements. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had intact cognition and diagnoses of multiple sclerosis (A disease that affects central nervous system creating difficulty with sending brain signals to the rest of the body [MS]). Review of R2's signed Arbitration Agreement dated 2/3/22 indicated, Resident and Facility will not be able to bring or start a lawsuit in any court and are giving-up all rights to a jury trial to decide any disputes that Resident may have against Facility or Facility may have against Resident. During interview with R2 on 3/14/23 at 8:45 a.m., R2 was unable to recall signing admission paperwork informing her that she was not required to enter into the binding arbitration agreement as a condition of admission. R2 stated, I am sure I did sign a lot of paperwork [when admitted to facility]. I can do it. I am my own person [competent]. I do not recall anything about the arbitration agreement and giving up my right to go to court. R47's quarterly MDS dated [DATE] indicated R47 had intact cognition and diagnoses of heart failure, diabetes, and depression. Review if R47's signed Arbitration Agreement 10/25/21 indicated, Resident and Facility will not be able to bring or start a lawsuit in any court and are giving-up all rights to a jury trial to decide any Disputes that Resident may have against Facility or Facility may have against Resident. Additional review of the agreement did not include evidence the binding arbitration agreement was explained in a form, manner and language that the resident or his or her representative understood. During interview with R47 on 3/14/24 at 9:34 a.m., R47 was unable to recall signing admission paperwork informing her that she was not required to enter into the binding arbitration agreement as a condition of admission. R47 stated, I don't recall them [facility] explaining it [arbitration agreement] to me. And no one explained it in a way I understood. During interview with social worker (SW) on 3/14/24 at 10:12 a.m., SW stated the arbitration agreement is included into the forty six page admission packet provided and reviewed by SW with resident and family or guardian at all facility admissions. SW stated the admission packet is provided by corporate and she had no input or training in what the arbitration agreement includes. SW stated, we go over each page [with the resident or guardian]. Additionally, SW stated her process to determine competency includes decision about, if they seem a little off or based on [their] diagnosis. SW stated, I don't have anything to do with the legal aspect of the document when it come to it. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with administrator on 3/14/24 at 10:47 a.m., administrator stated, [the] arbitration paperwork comes from our corporate office. And, I don't play a great deal in [arbitration] but ensure that it is in admission paperwork and discussed in admission. Facility policy titled Voluntary Binding Arbitration Agreement Policy updated 10/25/2022 state, Obtain the resident or his/her representative's acknowledgement the Voluntary Binding Arbitration Agreement (VBAA) was explained in a manner and form they understand, and that he/she/they understand the VBAA.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to offer a neutral and fair arbitration process by ensuring both the resident or his or her representative, and the facility agree on the selection of a neutral arbitrator, and that the venue is convenient to both parties for 11 of 17 residents (R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48) reviewed for binding arbitration. Findings include: Review of document titled Residents with Arbitration Agreements provided by facility on 3/11/24, documented R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48 with signed binding arbitration agreements with the facility. Review of R1, R2, R4, R5, R15, R17, R22, R28, R42, R47, and R48 Arbitration Agreements indicated, The arbitration shall be administered by the American Health Lawyers Association (AHLA) in accordance with its Rules of Procedure. In addition, The Arbitration will be conducted at a site selected by Facility. R47's quarterly MDS dated [DATE], indicated R47 had intact cognition and diagnoses of heart failure, diabetes, and depression. During interview with R47 on 3/14/24 at 9:34 a.m., R47 stated she did not understand that she was giving up her right to litigation in a court proceeding when she signed the arbitration agreement or that the arbitrator and location of arbitration were decided by the facility. No, I did not know. During interview with social worker (SW) on 3/14/24 at 10:12 a.m., SW stated the arbitration agreement is included in a forty six page admission packet provided and reviewed by SW with residents and family/guardian at all facility admissions. SW stated the admission packet is provided by corporate and she had no input or training in what the arbitration agreement included. SW stated, we go over each page [with the resident or guardian]. During review of R17's signed arbitration agreement SW stated, it is important to have a neutral arbitrator to mediate so you are not taking sides and [the site of arbitration] should be agreed upon site [sic] you don't want either party to feel pressured or [have] ill feelings due to the setting [location][which] recause [sic] trauma. Also, SW stated, I don't have anything to do with the legal aspect of the document when it comes to it. During interview with business office manager (BOM) on 3/14/24 at 10:31 a.m., BOM stated corporate is responsible for any changes or updates to the admission packet. During review of R17's signed arbitration agreement BOM stated the arbitration agreement failed to include a neutral arbitrator or neutral site. BOM stated, it is important to have neutral arbitrator that does not know either side [sic] will be more understanding [of] the dispute. BOM stated the facility chosen arbitrator, will side with the facility and not be neutral. BOM also stated the importance of a neutral site due to, coming back into the facility might [NAME] up more feelings of stress for the family or resident. (continued on next page)

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	245320	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with administrator on 3/14/24 at 10:47 a.m., administrator stated, [the] arbitration paperwork comes from our corporate office. And, I don't play a great deal in [arbitration] but ensure that it is in the admission paperwork and discussed during admission. The administrator stated, [it is] important that both parties [resident/family and facility] can mutually select an arbitrator to work both sides like the ombudsman. Then every one feels like they are treated fairly and without bias. During review of R17's signed binding agreement, administrator stated, the arbitrator the facility is choosing and [sic] controlling the procedure and in control and location on this form means it will be determined [by the facility]. Facility policy titled Voluntary Binding Arbitration Agreement Policy updated 10/25/2022 directed facility to Provide for the selection of a neutral arbitrator, agreed upon by both parties, and a venue convenient for both parties.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview, and record review, the facility failed to ensure community use glucometers were properly cleaned and disinfected between patient use for 4 of 4 residents (R10, R47, R42, R35) to have their blood glucose checked with the devices. This had the potential to affect 25 of 69 identified in the facility with orders to obtain blood glucose monitoring. In addition, the facility failed to ensure a wound vac machine was kept off the floor for 1 of 1 residents (R176) reviewed for wound care. Glucometer disinfecting between residents Per manufacturer's instruction for use of Even Care G3 Blood Glucose Monitoring System in the Cleaning and Disinfecting section highlighted the EVENCARE G3 Meter should be cleaned and disinfected between each patient and to avoid wetting the meter test strip port. The document further indicated, the approved and recommended Environmental Protection Agency (EPA) direction included using Medline Micro-Kill+ (Trademark) Disinfecting wipes. According to Medline manufacturer guidelines, Medline Micro-Kill+ has a one-minute contact time, meaning the surface must remain wet with the product to achieve disinfection. During observation on 3/13/24, at 7:28 a.m., medication administration was observed with registered nurse (RN)-D present. RN-D prepared R10's oral medications. When finished, RN-D picked up the plastic caddy that contained an Even Care G3 glucometer along with R10's prepared oral medications and entered R10's room. Inside the room, RN-D removed an Even Care G3 glucometer from it. RN-D donned a pair of gloves and inserted a new strip into the device to test R10's blood glucose. RN-D then used a lancet to [NAME] R10's finger exposing a visible blood flash. RN-D touched the exposed blood droplet to the strip which had been inserted into the glucometer. A reading was obtained with RN-D stating aloud, 115. RN-D removed the strip from the glucometer and disposed of it in the trash. RN-D then placed the glucometer back into the plastic caddy without any attempt to clean or sanitize the device. RN-D returned to the medication cart with the caddy and placed it on top of the cart. RN-D prepared and administered R10's insulin, and then again returned to the cart to complete documentation. There was no attempt to remove or clean the used glucometer. The caddy did not contain any disinfectant wipes. During observation on 3/13/24, at 8:14 a.m., RN-D was observed to carry the caddy into R47's room and return to the medication cart and write down the blood glucose. There was no attempt observed to remove or clean the used glucometer. At 8:18 a.m., RN-D entered R42's room carrying the caddy to obtain a blood glucose. RN-D exited the room at 8:20 a.m., and unidentified staff approached them stating that a resident was waiting for their blood sugar to be checked. RN-D went directly into R35's room, carrying the same caddy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 3/13/24 at 8:25 a.m., RN-D verified that it is important to disinfect all communal resident equipment to stop the transmission of viruses. They verified that they had disinfected the glucometer at the beginning of the shift. They verified they had checked blood glucose levels for residents listed above and did not disinfect the glucometer between uses. They stated, I should have done that. They indicated they should be using the sani-wipes in-between uses. RN-D indicated they should use the Medline Micro-Kill+ disinfectant wipes. According to an order listing report, printed 3/14/24, the residents listed have the following orders for blood glucose (BG) monitoring: -R10: blood glucose monitoring: obtain blood sugar via meter and record result one time a day for DM [diabetes mellitus] -R35: blood glucose monitoring: obtain blood sugar via meter and record results before meals and at bedtime notify provider if two BG results are ,70 or <400 in a 24-hour timeframe and/or change in condition; if no condition change, notify provider on the next business day -R42: blood glucose monitoring: obtain blood sugar via meter and record results before meals and at bedtime related to type 2 diabetes mellitus with hyperglycemia -R47: blood glucose monitoring; obtain blood sugar via meter and record results prior to breakfast and supper two times a day for DM type 2. During medication observation, the community use glucometer was observed to be wrapped in a dried cloth in a plastic caddy on the top of the medication cart. During interview on 3/13/23 at 8:49 a.m., RN-F stated that they wipe down the community use glucometer between each resident use. RN-F stated they then wrap it in a sani-cloth to help clean it more and place the glucometer that is wrapped in a wet sani-cloth back into the caddy. RN-F stated they were trained to clean the glucometer this way. RN-F stated it is not always dry between uses and further indicated that it was wrapped with a wipe, so it is clean. RN-F indicated they use the Medline micro-kill disinfectant wipes. During interview on 3/14/24 at 11:17 a.m., director of nursing (DON) indicated any community use device needs to be cleaned after each resident use as this helps stop the spread of infections. DON indicated they must follow the manufacturer guidelines. DON stated that the facility recently had their skills fair and this was covered at the skills fair. DON indicated it is the expectation that equipment is cleaned between resident uses by following manufacturer guidelines. During interview on 3/14/24 at 1:51 p.m., administrator stated infection control is very important. He indicated it is important to ensure all communal use equipment is cleaned between resident use. A facility policy titled general information prevention and control- nursing standard, dated 10/5/23, blood glucose meters can become contaminated with blood and, if used for multiple residents, must be cleaned, and disinfected after each use according to manufacturer's instructions for multi-resident use. 48065 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R176 R176's admission Minimum Data Set (MDS) dated [DATE], indicated R176 was cognitively intact, had no behaviors, did not refuse cares, and needed moderate assistance with transfers, turning and repositioning. MDS also indicated R176 was independent with oral care, eating and personal hygiene. R176 needed substantial assistance for toileting, bathing, and lower body dressing. R176's MDS indicated diagnoses of stage 4 pressure ulcer on the left buttock (sores extend below the subcutaneous fat into muscles, tendons and/or bones), hypertension (high blood pressure), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), neurogenic bladder (lack of bladder control due to spine or nerve injuries), and neuralgia (pain caused by damaged or irritated nerves). R176's physician orders printed 3/11/24, included orders to clean wound with wound cleanser, and standard wound vac (vacuum-assisted closure is a method of decreased air pressure around a wound to assist the healing). R176's treatment administration record (TAR) printed 3/12/24, indicated wound/dressing every Tuesday, Thursday, and Sunday. During observation on 3/11/24 at 2:44 p.m., R176's wound vac machine was observed on the floor next to R176's bed. The wound vac was turned on and was connected by a drainage tube to R176's left buttock's wound dressing. During interview on 3/11/24 at 4:29 p.m., registered nurse (RN)-A verified the wound vac machine was on the floor. RN-A stated the floor is dirty and bacteria could travel up to her wound. A wound vac should not be on the floor, this an infection control issue. During interview on 3/14/24 at 9:10 a.m., nurse manager/registered nurse (RN)-G stated the wound vac machine should be kept in the bag provided by manufacturers and should hang on the bed, away from the floor. RN-G added placing a wound vac on the floor was an infection control concern. During interview on 3/145/24 at 9:22 a.m., infection preventionist/director of nursing (DON) stated all wound vacs had a bag in which to be carried or hung away from the floor. DON stated, the machine [wound vac] should never touch the floor because the floor is full of germs and represented a risk for infection for an already compromised patient [R176]. Facility's policy titled Surveillance and Monitoring dated 10/5/23 indicated It is the protocol of this facility that routine surveillance and monitoring of the workplace be conducted to determine if compliance with work practices and care of protective clothing and equipment is maintained.