STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parmly on the Lake LLC	28210 Old Towne Road Chisago City, MN 55013

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and document review the facility failed to ensure methods to restrain residents were not used for 1 of 1 residents (R74) reviewed for restraints. Findings include: R74's admission Minimum Data Set (MDS) dated [DATE], indicated R74 was cognitively intact and had diagnoses of lung cancer, repeated falls, and weakness. R74's care plan revised 9/18/24, indicated R74 had alterations in cognition due to brain cancer. Interventions included to provide supervision as needed. Furthermore, R75 had an alteration in mobility related to a history of falls, imbalance, and weakness. Interventions included to assist with movement in and out of bed, concave mattress in place, fall mat, and low bed. R74's provider and nursing orders lacked indication restraints were ordered. R74's fall incident and review analysis dated 8/9/24, indicated R74 had a fall from bed. It was determined R74 was self-positioning in bed when the fall occurred. R74's fall incident and review analysis dated 9/12/24, indicated R74 had a fall from bed. It was determined R74 was reaching for the call light that was attached, but not in reach when the fall occurred. R74's fall incident and review analysis dated 9/17/24 indicated R75 had a fall from bed. It was determined R74 did not put on call light to alert staff prior to getting out of bed when the fall occurred. R74's nursing progress note dated 9/14/24, at 11:20 a.m., indicated R74 was yelling from room. When staff arrived, resident was laying on their stomach with legs out of bed on windowsill. An observation on 9/16/24 at 2:09 p.m., R74 was lying in bed sleeping on his back. The bed was pushed up close to the wall with a window. R74 had a concave mattress in place. In the middle of the mattress where there was a gap in the raised edges of the mattress was a pillow that had been placed under the fitted sheet. The pillow was not positioned underneath R74, but along side of them. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 9/16/24 at 5:43 p.m., nursing assistant (NA)-E entered R74's room to assist R74 with incontinent cares. NA-E donned gloves and pulled down the resident blanket. A pillow was placed under the fitted sheet of R74's concave bed, where there was a gap in the raised edges of the concave mattress. NA-E removed the pillow from underneath the sheet before assisting with the incontinent cares. Upon completion of the cares NA-E went to the head of the bed to pull the draw sheet and boost R74 up in bed. Then NA-E took a pillow and tucked it under R74's fitted sheet beside him in the gap of the raised edges of the concave bed. NA-E finished settling R74 and exited the room. When interviewed on 9/16/24 at 5:59 p.m., NA-E stated R74 was a high risk for falls and had rolled out of bed before. NA-E stated the pillow was placed under the fitted sheet to prevent R74 from rolling out of bed. NA-E further stated they weren't sure if R74 could remove the pillow as it would be in an awkward position and R74 had some weakness. An observation on 9/19/24 at 7:19 p.m., R74 was in bed laying on his back awake. At the edge of R74's bed, the fitted sheet was pulled up some and a pillow was underneath the fitted sheet closer to R74's knees and lower legs. An observation on 9/19/24 at 7:39 p.m., NA-A entered R74's room. NA-A assisted R74 with drinking some water and offered R74 to get up for breakfast. R74 declined. NA-A verified the pillow was tucked under the fitted sheet near R74's lower legs and removed it. When interviewed on 9/19/24 at 7:59 a.m., NA-A stated the pillows were not supposed to be under fitted sheets and it was not a practice of theirs. NA-A stated R74 was a fall risk and had falls from their bed. NA-A further stated the pillow was likely placed to prevent R74 from swinging their legs over the side of the bed and used to help keep him in bed. NA-A stated R74 wouldn't have been able to remove it as it was under the fitted sheet. When interviewed on 9/19/24 at 8:05 a.m., licensed practical nurse (LPN)-A stated pillows should not be placed under fitted sheets as it could prevent them from getting out of bed. LPN-A further stated R74 could have placed it there or the significant other may have. LPN-A further stated R74 may be able to remove it as their strength can vary from time to time. When interviewed on 9/19/24 at 1:22 p.m., the Director of Nursing (DON) expected staff not to place pillows under fitted sheets to help keep residents from rolling or getting out of bed. That would not be an appropriate intervention for falls. DON further stated a concave mattress would be used as an intervention when a resident had rolled out of bed. The consulting nurse stated pillows may be used if the resident was assessed and able to swing their legs or get up with them in, however was unable to provide an assessment showing R74's ability to do so. A facility policy on restraint use was requested however, the facility stated restraints would be followed under the resident rights policy. That policy was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and document review, the facility failed to ensure a bowel regimen was initiated for 1 of 1 residents (R18) reviewed for constipation. Findings include: R18's significant change Minimum Data Set (MDS) dated [DATE], indicated R18 was cognitively intact and had diagnoses of a right arm fracture, depression, and diabetes. R18 was continent of bowel and bladder and had frequent pain. R18's bowel evaluation dated 8/27/24, indicated R18 lacked indication R18 had diagnoses or medications that contributed to bowel dysfunction or required any individualized treatment plan. R18's care plan revised 9/10/24, indicated R18 had a potential alteration in elimination due to right wrist and shoulder fracture and weakness and was independent with toileting transferring from the wheelchair. Interventions included to monitor bowel movements (BM) as they occur and administer bowel medications as ordered. R18's follow-up question report for 8/31/24-9/18/24, indicated R18 had four days without a BM between 8/31/24- 9/5/24, and again from 9/13/24-9/18/24. A facility document titled BM list, no date, directed staff to initiate the following: -administer Milk of magnesia (medication to prevent constipation) 30 milliliters (ml) if 3 days from last BM. -administer Dulcolax suppository (medication to prevent constipation) if 4 days from last BM -administer fleets enema (medication to prevent constipation) if 5 days from last BM -administer magnesium citrate (medication to prevent constipation) and update the provider if no BM for 6 days. R18's medical record lacked evidence R18 had been offered or received bowel medications to help with constipation. R18's consultant pharmacist recommendation to physician dated 7/29/24, indicated R18 had requested a stool softener for hard stools and discomfort. R18 received scheduled MS contin (narcotic pain medication) and scheduled hydromorphone (narcotic pain medication) which can cause constipation. CP recommended initiating a bowel regimen as currently none was on file. The provider responded to the recommendation on 9/16/24 and ordered senna (medication to prevent constipation) 8.6 milligrams (mg) daily and senna 8.6 mg daily as needed for constipation. R18's provider and nursing orders reviewed 9/19/24, lacked indication R18 was started on the bowel regimen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 9/16/24 at 5:27 p.m., R18 stated they have trouble with constipation. R18 stated nursing staff don't ask about constipation or frequency of BM. R18 stated they try to drink prune juice at breakfast to help but doesn't always work. R18 had requested some medication to help but has not received any yet. R18 stated the last BM was a few days ago and stated, I am miserable. When interviewed on 9/19/24 at 8:49 a.m., nursing assistant (NA)-A stated when a resident has a BM, it was documented. If it had been a few days, the system will have an alert. NA-A stated if the alert was seen, the nurse would be notified. NA-A hadn't worked with R18 in a while and wasn't aware of any discomfort or complaints of constipation. When interviewed on 9/19/24 at 10:06 a.m., licensed practical nurse (LPN)-A stated every night the night team would complete a BM list. The list included residents who had no BM for greater 3 days and listed a standing order of bowel medication to provide. The day shift would then review the list, do an assessment, and give the medications. LPN-A did not have one for the prior night as the agency staff were not always aware of the process and the lists were not saved. LPN-A stated R18 was a risk for constipation as they were not as mobile with her recent fractures, and she takes scheduled narcotics. LPN-A stated R18 drinks prune juice and usually that worked for her. LPN-A stated when R18 used prune juice it wouldn't necessarily be documented. When interviewed on 9/19/24 at 1:27 p.m., the Director of Nursing (DON) stated the night nurse completed the BM list and the day shift would implement a one-time order for bowel medications. DON verified R18's BM record and noted there were times when standing orders for medications should have been implemented. If R18 had refused the bowel medications, staff were expected to document. A facility policy/procedure for constipation was requested and was informed the standing orders would be followed. Standing orders for constipation, no date, directed staff to -consider rectal check to determine if impaction was present -encourage 2,000 fluid intake unless contraindicated -consult nutrition services for dietary recommendations -give senna 8.6mg two tabs at night as needed for 3 days -bisacodyl suppository 10 mg daily as needed for 3 days -reattempt senna or bisacodyl if no results after 24 hours and notify the provider -monitor for results

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to implement pressure ulcer interventions for 2 of 3 residents (R25, R68) reviewed for pressure ulcers. Findings include: R25 R25's significant change Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of blister (non-thermal) on left foot, local infection of the skin and subcutaneous tissue, and cellulitis of left lower limb. It further indicated R25 required substantial to maximal assistance with bed mobility, was dependent on staff for all other mobility, always incontinent of bowel and bladder, and was at risk for pressure injury. R25's Care Area Assessment (CAA) worksheet from MDS dated [DATE] triggered pressure ulcer/injury and indicated the following: Staff to follow therapy/care plan recommendations for all activities of daily living (ADL) and mobility. Staff to leave call light within reach and bed at working height. Braden score 16 indicating risk for skin breakdown. Patient has wound to finger-staff to treat as ordered with wound care (WOC) nurse to follow in-house. Patient has a pressure redistribution mattress and wheelchair cushion, turn and reposition schedule, monitoring of skin integrity with morning (a.m.) and hour of sleep (HS) cares and weekly skin inspection with bath/shower. Complications can include potential for skin breakdown, infection and pain. Will proceed to care plan, for interventions to minimize the risk of pressure ulcer/injury. R25's physician's orders indicated: -9/16/24 wound care to blister left heel: clean with wound cleanser, pat dry, skin prep to peri wound, apply Santyl, cover with ABD pad; wrap with kerlix, change every day and as needed. -7/26/24 float heels while in bed to relieve pressure off of heels, every shift. -10/13/23 encourage blue boots to be on except with transferring, every shift. R25's nursing assistant's care sheet (undated) indicated, R25 had a blister on her left heel, encourage blue boots to be on at all times except during transfers, and encourage floating heels. R25's care plan dated 5/16/24, indicated alteration in skin integrity related to a urinary tract infection (UTI), weakness, venous stasis dermatitis, lymphedema to bilateral lower extremities (BLE). Left dorsum venous ulcer 2nd toe. It also indicated the following interventions: -encourage blue boots at all time except with transfers. -lymph therapy. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-monitor skin integrity daily during cares. Weekly skin inspection by nurse.-Treatment to open area per order -turn and reposition or reminders to offload every 2-3 hours and as needed. -pressure redistribution mattress to bed -pressurer redistribution cushion to wheelhair, chair -monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to medical doctor (MD) or physician's assistant (PA). -document on skin condition and keep MD or PA informed of changes -followed by Wound Care. During observation on 9/17/24 at 11:57 a.m., the assistant director of nursing (ADON) verified there was a pillow under the back of R25's lower legs and ankles. The pillow was thin, laying flat on the bed and R25 had bare feet with her heels laying directly on the pillow and not floating. Her left heel/ankle had a dressing. The ADON also verified R25 had one pressure injury to her left heel and was also not wearing blue foam heel protectors/boots. During observation on 9/18/24 at 9:00 a.m., nursing assistant (NA)-A looked at her nursing assistant care sheet and verified R25 was supposed to be wearing heel protectors stating The care sheet says prevalon boots to both feet except during transfers. The surveyor and NA-A went into R25's room and NA-A was unable to locate her blue foam boots and also verified her feet were not floating. There was a pillow laying flat under both ankles but her heels were laying on the bed. NA-A stated if a resident refused cares they should let the nurse know and document it. NA-A stated they would come back to R25's room later, re-position her, and see if she will let them float her heels on a pillow. During observation on 9/19/24 at 8:00 a.m., R25 was laying in bed on her back. The blue foam heel protectors/boots were laying in her wheelchair and both of her heels were laying directly on the bed and not floating. Her left ankle/heel was wrapped in a dressing. R68 R68's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and chronic pain syndrome. It further indicated R25 had an impairment on the left side of her upper and lower extremities, was dependent on staff for most ADL's and mobility, frequently incontinent of bladder and always incontinent of bowel. R25 was at risk for and had (1) unstageable pressure injury (coccyx) present on admission and a wound vacuum assisted closure (VAC). R68's nursing assistant care sheet (undated), indicated R68 had a wound VAC on her coccyx and shouldn't be in her chair longer than 2-3 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's care plan dated 8/12/24, indicated an alteration in skin integrity and risk for further breakdown related to cerebrovascular accident (CVA), altered mental status, dysphagia, obsessive compulsive disorder (OCD), paranoid schizophrenia, hemiplegia and hemiparesis affecting left non-dominant side unstageable coccyx pressure ulcer on admission, and wound vac placed 3/5/24. It further indicated the following interventions: -monitor skin integrity daily during cares. Weekly skin inspection by nurse. -treatment to open areas per order -turn and reposition or reminders to offload q 2-3 hours and as needed -pressure redistribution mattress to bed -pressure redistribution cushion to wheelchair, chair -staff to perform pericare after each incontinent episode and as neeed -low air loss air bed, pressure redistribution -heel lift boots. -dietary interventions, including encourage supplements as ordered -weekly measurements and assessment of wound -monitor for skin breakdown for signs/symptoms of infection. Report signs/symptoms to MD or PA. -document on skin condition and keep MD or PA informed of changes -followed by wound care. -encourage repositioning every 1-2 hours side to side staying off coccyx -up in chair for no longer than 1-2 hours During continuous observation on 9/17/24 at 12:32 p.m., R68 was sitting in her wheel chair in the dining room eating lunch at a raised bedside table. -12:50 p.m. nursing assistant (NA)-D asked R25 if she was finished eating, R25 responded yes. so NA-D removed her clothing protector and her meal tray. Then LPN-A came in and administered her medication. NA-D brought her out to the common/TV area and put her in front of the TV. -1:02 p.m. LPN-A took her vital signs. -1:07 p.m. R68 fell asleep in her wheelchair. -1:21 p.m. R68 dozed off/on in her wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1:34 p.m. same as above -1:49 p.m. therapeutic recreation (TR) staff (unknown) brought her back to the dining room to play black jack, adjusted her wheelchair to a sitting position to play cards. -1:54 p.m. R68 started yelling/calling out for Tylenol, so TR staff (unknown) brought her back to the nursing station. -2:04 p.m. R68 received Tylenol -2:06 p.m. staff (unknown) brought her back down to the dining area to play black jack. -3:07 p.m. TR brought her back to the common/TV area. -3:12 p.m. R68 fell asleep in her wheelchair. -3:21 p.m. LPN-A and NA-F took her to her room and transferred her using the Hoyer lift from her wheelchair to her bed. Staff failed to offer R68 to re-position or lay down in bed from 12:32 p.m. to 3:21 p.m. during the continuous observation. During interview on 9/17/24 at 3:17 p.m., LPN-A stated R68 had been up in her wheelchair since 11:50 a.m. and was supposed to be repositioned every 2 hours and shouldn't be in her wheelchair more than 2 hours at a time. LPN-A further stated there may be times R68 was in her wheelchair longer then 2 hours if she was participating in an activity. During interview on 9/18/24 at 8:27 p.m., NA-D stated they got R68 up for lunch yesterday (9/17/24) at 11:50 a.m. and she can be in her wheelchair as long as she can tolerate it. NA-D further indicated they should ask the residents if they want to lay down and complete rounds every 2 to 2.5 hours to re-position, check/change their brief, see if they need anything, etc. During interview on 9/19/24 at 9:54 a.m., licensed practical nurse (LPN)-C stated R25 should wear blue foam heel protectors/boots at all times except during transfers. If she refuses to wear the heel protectors then staff should be floating her heels off the bed which means her heels shoudn't be laying on the mattress. If a resident refuses treatment or care, the NA's should let the nurses know and the nurses should be documenting the refusal. LPN-C verified both R25 and R68 lacked documentation of any refusals of care (specifically regarding pressure ulcer interventions). R68 should not be in her wheelchair for longer 2 hours and staff was responsible for offering and to document if she refused. During interview on 9/19/24 at 11:30 a.m. the director of nursing (DON) should stated nursing staff should be following care planned interventions and verified R68 should only be in her wheelchair for 1-2 hours. The DON also stated when floating a resdent's heel they need to be off of the mattress and not laying directly on it. If a resident refuses cares, staff should reapproach 3 times, try having a different staff reapproach the resident, notify the nurse, and the nurse should document it as well as the NA. The facility's policy on skin assessment and wound management dated 3/2024, indicated guidelines for assessing and managing wounds which included the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. 3. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. 4. Staff will perform routine skin inspections (with daily care). 5. Nurses are to be notified if skin changes are identified. 6. A weekly skin inspection will be completed by licensed staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 R69's quarterly Minimum Data Set (MDS) dated [DATE] indicated intact cognition and diagnoses of traumatic subarachnoid hemorrhafe with loss of consciousness of 30 minutes or less, adjustment disorder, and nicotene dependence. It further indicated R69 was independent with all activities of daily living (ADL) and mobility and had no history of falls. R69's Smoking Evaluation dated 8/20/24, indicated resident currently Identifies as a smoker. Resident was aware of smoking policy to store all smoking materials in the cart, sign out before leaving facility, and to leave facility grounds when smoking. Assessment will continue and updates will be made to nurse practioner (NP)/medical doctor (MD). R69's smoking evaluation lacked documentation that staff had observed him while smoking. R69's care plan dated 8/20/24, indicated R69 identified as smoker. Independent to leave property safely, following LOA policy. It further indidcated the following interventions: -smoking evaluation per facility policy and PRN -smoking materials will be stored safely with nursing staff. During interview on 9/17/24 at 12:59 p.m., R69 stated he had to go to the street to smoke and he kept his smoking materials in the seat of his walker during the day but at the end of the day he gave them to the nurse. R69 further stated he disposed of the cigarette butts in the trash can when he came back to the facility. He used to live on the golf course and you weren't allowed to leave trash on the ground. During observation on 9/17/24 at 4:30 p.m., R69 was walking out of the building with his walker. He walked to the side of right side of the building when coming out of the facility and started smoking in the parking lot. 43007 During observation on 9/18/24 at 11:36 a.m., R69 ambulated independently with walker out the front door and into the facility parking lot. R69 sat down on the seat of the walker and lit a cigarette and proceeded to smoke. During an interview on 9/18/24 at 11:44 a.m., the director of nursing (DON) verified R69 was not in the designated smoking area (off-campus) and reminded R69 regarding the policy to sign out in the leave of absence book and to go off-campus to smoke since the facility is a non-smoking facility. During observation on 9/18/24 at 11:46 a.m., R69 ambulated to the front door, rolled the cigarette between his two fingers and thumb and threw the cigarette in the trash can which had a clear plastic trashcan liner and several different pieces of paper products in the trash. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/18/24 at 11:51 a.m., noted inside the top of the trash can was black however, did not note any melted plastic or burns. Noted black/grey ashes on the lip of the trash can at the opening. Also, noted melted plastic in a circular shape by the opening of the trash can. During review on 9/18/24 at 12:03 p.m., noted R69 had not signed out to go off campus to smoke. The DON verifieed R69 did not sign out. During interview on 9/18/24 at 12:18 p.m., licensed practical nurse (LPN)-D stated they didn't know who was responsible for filling out smoking assessments but it was probably the nurse who was admitting the resident. During interview on 9/18/24 at 12:20 p.m. the assistant director of nursing (ADON) stated residents should be asssed for smoking on admission, with any MDS assessments, and as needed. The staff who is compelting the assessment should actually observe the resident smoking to ensure they are safe to do so. During observation on 9/18/24 at 12:50 p.m., R69 went outside and ambulated with walker off the property, sat down on a bench and lit a cigarette. Noted a cigarette butt receptacle by the bench at this time. The facility's smoking policy dated 5/2019, indicated Parmly on the Lake is a smoke free campus. Policy prohibits smoking in any part of the building or on any part of the grounds. This includes the sidewalks, parking lots and driveways.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on interview and document review the facility failed to ensure the provider's response to the monthly medication review was followed for 1 of 4 (R18) residents with identified medication irregularities. Findings include: R18's significant change Minimum Data Set (MDS) dated [DATE], indicated R18 was cognitively intact and had diagnoses of a right arm fracture, depression, and diabetes. R18 was continent of bowel and bladder and had frequent pain. R18's consultant pharmacist (CP) recommendation to physician dated 7/29/24, indicated R18 had requested a stool softener for hard stools and discomfort. R18 received scheduled MS contin (narcotic pain medication) and scheduled hydromorphone (narcotic pain medication) which can cause constipation. CP recommended initiating a bowel regimen as currently none was on file. CP also recommend the loperamide (medication to minimize loose BM) be discontinued if no longer needed. The provider responded to the recommendation on 9/16/24 and ordered senna (medication to prevent constipation) 8.6 milligrams (mg) daily and senna 8.6 mg daily as needed for constipation. R18's provider and nursing orders reviewed 9/19/24, lacked indication the facility had discontinued R18's loperamide order or implemented R18's provider orders for senna. When interviewed on 9/19/24 at 10:06 a.m., licensed practical nurse (LPN)-A stated nursing does not do much with the pharmacy recommendations. They go into a folder for the provider to review but wasn't sure what was done after the provider reviewed them. When interviewed on 9/19/24 at 1:27 p.m., the Director of Nursing (DON) verified R18's pharmacy recommendation to start a bowel regimen was provided on 7/29/24 and the provider completed a response on 9/16/24. The nurse consultant stated the providers have 60 days to respond or the CP will re-issue the recommendation. The nurse consultant verified the provider had written orders do discontinue the loperamide and to start senna daily and as needed, however the orders were not transcribed. DON stated the pharmacy recommendations were printed and given to the provider to review. After review from the provider, the DON expected the health information manager to transcribe the orders. The nurses do a second check and then the form was scanned into the medical record. An interview was attempted on 9/19/24, at 10:24 a.m., with the CP. There was no answer, and a voicemail was left. During a returned call on 9/20/24 at 11:05 a.m., the CP expected a provider to respond within 30-60 days of a recommendation. Furthermore, the CP expected the facility to implement the provider's response per their normal process for order entry. A facility policy titled Consultant Pharmacist Reports dated 5/2022, directed Recommendations are acted upon and documented by the facility staff and/or the prescriber.

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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** 42586 Based on observation, interview and document review the facility failed to ensure staff performed the recommended hand hygiene for 1 of 2 residents (R77) reviewed who was on enteric precautions; and failed to ensure personal protective equipment (PPE) was utilized for 2 of 3 residents (R68 and R281) reviewed who had enhanced barrier precautions (EBP) in place. Additionally, the facility failed to ensure staff performed hand hygiene after changing soiled gloves for 1 of 1 residents (R74) reviewed for standard precautions with personal cares; and failed to ensure linens were covered during storage in the resident hallway. The uncovered linen had the potential to affect the 11 residents (including R82 and R83) residing in the southside transitional care unit. Findings include: R77 R77's admission Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition. R77 had diagnoses of enterocolitis due to clostridium difficile, which is commonly known as c-diff, a bacterium that causes an infection of the colon; other fecal abnormalities, diarrhea, and dementia. It further indicated R77 required partial to moderate assistance with toileting, frequently incontinent of bladder, and always incontinent of bowel. R77's physician's orders dated 8/30/24, indicated Vancomycin HCl oral capsule 250 milligrams (mg). Give 250 mg by mouth four times a day for 14 Days and give 250 mg by mouth two times a day for 14 Days and Give 250 mg by mouth one time a day related to C-diff, for 14 Days. R77's physician's orders lacked an order for contact enteric precautions. R77's care plan 8/18/24, indicated Isolation Precautions - enteric precautions related to c-diff Infection control precautions per protocol. It further included the following interventions; -sign on resident's door. -treatment for current infection per order. R77's progress note dated 9/18/2024 indicated the following: Infection Note-C-Diff Antibiotic Use: Vancomycin 250mg BID Stools including but not limited to Consistency, Frequency, Odor, Abdominal pain, cramps, signs/symptoms, dehydration: Resident continues to have loose stools, no other GI symptoms observed or reported. Number of loose stools: 1 large, loose (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Side effects of antibiotic use: : n/a Notification of change to provider, family/responsible party if applicable: not applicable During observation on 9/16/24 at 5:45 p.m., R77 was attempting to self transfer, surveyor went to get nursing assistant (NA)-G, who went into R77's room and assisted her into the bathroom. NA-G did not put on a gown or gloves before entering the room. After assisting R77 into the bathroom, NA-G exit the room and used hand sanitizer. Then NA-G went to the nursing station, wrote something down, and then went into R39's room (who was not on precautions) to answer her call light. She entered the room, adjusted the bedside table, and spoke to her for a few minutes before exiting the room. At 5:59 p.m. NA-G went back to R77's room and put on gloves and a gown before entering. NA-G assisted R77 out of the bathroom, removed gown and gloves, brought a bag of into the soiled utility room, and washed hands with soap and water. During interview on 9/16/24 at 6:09 p.m. NA-G verified R77 was on contact enteric precuations for C-diff, was still having loose stools, and wasn't wearing a gown or gloves. NA-G stated the reason for not wearing gown and gloves was because R77 was unable to self transfer and needed to get in the room quickly. NA-G also verified R77 had a sign on the door that indicated staff are required to wash their hands with soap and water when leaving R77's room but forgot and used hand sanitizer instead. R68 R68's quarterly MDS dated [DATE], indicated severe cognitive impairment and diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and chronic pain syndrome. It further indicated R25 had an impairment on the left side of her upper and lower extremities, was dependent on staff for most activities of daily living (ADL) and mobility, frequently incontinent of bladder and always incontinent of bowel. R25 was at risk for and had (1) unstageable pressure injury (coccyx) present on admission and a wound vacuum assisted closure (VAC). R68's physician's orders dated 7/19/24, indicated staff to follow EBP due to wound vacuum active closure (VAC). R68's care plan dated 4/30/24 indicated R68 was currently on EBP related to a wound. Staff to follow EBP. It further included the following interventions: -use appropriate communication to follow EBP. -explain reason for use of enhanced barrier precautions -staff to don/doff PPE per EBP when providing high contact cares. R68's nursing assistant care sheet (undated) indicated R68 was on EBP due to a wound on her coccyx. During observation on 9/16/24 at 3:21 p.m., licensed practical nurse (LPN)-A and NA-F brought R68 to her room to transfer her from her wheelchair to her bed. Upon entering the room, both staff applied gloves but did not don gowns. They proceeded to transfer R68 from her wheelchair to her bed using the Hoyer lift and then they changed her brief. (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 9/17/24 at 3:48 p.m., NA-F stated R68 was on EBP because she had a wound. NA-F verified not wearing a gown while transferring R68 from the wheelchair to the bed (using the Hoyer lift) and changing her brief stating I know she was on precautions, but I just spaced it (forgot). During interview on 9/17/24 at 3:50 p.m., LPN-A verified R68 was on EBP but forgot to put on a gown because she didn't have a isolation cart outside her room. LPN-A stated they should have being wearing a gown while transferring R68 from her wheelchair to her bed and changing her brief. During interview on 9/18/24 at 8:27 a.m., NA-D stated staff are required to wear a gown and gloves when performing cares for residents on EBP. 49893 R281 R281's admission MDS dated [DATE], identified moderately impaired cognition. R281's undated diagnoses list included pneumonitis (inflammation of the lungs), dysphagia (abnormal swallowing), sepsis (infection of blood stream), gastronomy tube (tube inserted into stomach for feeding and medication administration). R281's careplan dated 9/18/24, identified assist of two for incontinence cares and ADLs, and EBP due to having gastronomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/18/24 at 8:50 a.m., NA-C stated they were about to begin morning cares for R281. NA-C wore a yellow isolation gown and gloves. NA-C washed R281's face with wet wash cloth. NA-C opened tabs of incontinence brief and pulled top of brief down exposing R281's peri area. NA-C sprayed cleansing spray on wash cloth and performed catheter/peri care using a clean area of the washcloth for each area. NA-C then removed gloves and applied new gloves without performing hand hygiene. NA-C then grabbed a package of disposable cleansing cloths and cleansed R281's groin area. NA-C removed gloves and, without sanitizing hands, activated call light to get assistance with positioning R281 on their side. NA-C then applied a new pair of gloves without sanitizing hands. A second staff member entered the room wearing yellow isolation gown and gloves to assist NA-C with repositioning R281. The 2nd staff member assisted with positioning R281 on their right side. While stabilizing R281 with left hand, NA-C noticed R218 had a bowel movement and pulled several disposable cleansing cloths out of the container. While the 2nd staff member stabilized R281 on their side, NA-C used right hand to spray cleansing spray onto disposable cloth in left hand. NA-C provided incontinence care using a clean area of disposable cloth with each wipe. Used disposable cloths were placed in incontinence product. NA-C continued providing incontinence care using right hand to spray cleansing spray into new wipe in left hand. NA-C removed gloves and, without performing hand hygiene, applied new gloves. Barrier cream was applied to R281's buttocks. NA-C removed gloves and donned new gloves, without hand hygiene. NA-C and 2nd staff member applied and fastened new brief. NA-C then grabbed dirty brief and disposed of it in the garbage. NA-C then removed gloves and applied new gloves without hand hygrine. NA-C and 2nd staff member then repositioned R281 in bed, placed a pillow under knees, and straightened R281's catheter and gastronomy tube. NA-C removed gloves and asked surveyor if it was permissible to wash their hands in a resident's bathroom. NA-C then washed hands and applied new gloves. NA-C performed oral care for R281 using a cup of tap water and mouth swab. The second staff member then removed isolation gown and gloves before leaving the room. During interview, NA-C stated hand hygiene should be performed when entering and leaving a resident's room and confirmed they should have performed hand hygiene between glove changes however there was no sanitizer in R281's room and they did not have any on their person. They confirmed they should have used soap and water in absence of hand sanitizer. 44647 R74 R74's admission MDS dated [DATE], identified intact cognition and diagnoses of lung cancer, repeated falls, and weakness. R74 was incontinent and required assist of one for toileting. During an observation on 9/16/24 at 5:43 p.m., NA-E entered R74's room. NA-E performed hand hygiene and donned gloves. R74's blankets were pulled down. R74 was assisted to pull down pants and NA-E unfastened R74's brief. R74's brief was soiled with urine. NA-E tucked R74's brief down and a wipe was used to clean R74 from the front. NA-E then assisted R74 to turn towards the window removed R74's soiled brief and cleaned R74's backside. Without glove exchange or hand hygiene, NA-E took the clean brief and tucked it under R74. R74 was then assisted to turn back onto their back. R74 was able to adjust himself so NA-E could finish pulling the brief through. NA-E fastened the brief and assisted with clothing and blankets. NA-E then removed their gloves and without performing hand hygiene moved to the head of the bed and pulled R74's draw sheet to boost R74 up. NA-E lowered R74's bed down, gave R74 the call light and adjusted R74's bedside table. NA-E then picked up R74's dinner tray and walked out of the room down the hallway to the dish cart before entering a staff area to obtain R74's tacos out of the fridge as requested. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 9/16/24 at 5:59 p.m., NA-E verified they had not removed gloves and performed hand hygiene after removing R74's soiled brief. NA-E also verified they had not performed hand hygiene after exiting R74's room. NA-E further stated if they would have changed gloves if R74 had a bowel movement however wasn't aware they needed to for just urine and usually we just wrap up the wet brief and keep going. 42579 LINEN STORAGE R82's face sheet dated 9/17/24, identified she required EBP due to wound care, and enteric precautions due to c-diff. R83's face sheet dated 9/17/24, identified she required EBP due to a history of MRSA, which stands for methicillin-resistant staphylococcus aureus; an infection from a type of staph bacteria resistant to many antibiotics. During an observation on 9/16/24 at 2:25 p.m., R82's room door was open, contact enteric precautions signage was present outside her room along with a covered PPE bin. Outside R82's door to her room in the hallway was a blanket warmer on a metal cart. There were several blankets stored uncovered on the middle shelf of the blanket warmer. During an observation on 9/17/24 at 1:40 p.m., two unknown staff donned PPE in the hallway outside R82's room, later exited the room and disinfected their transfer equipment in the hallway near the blanket warmer with uncovered blankets on the shelf. During an observation on 9/17/24 at 2:24 p.m., R82 had family members walking in and out of the room near the blanket warmer. Additionally, R83 had unknown therapy staff entering and exiting the room, which was also near the blanket warmer with uncovered blankets on the shelf beneath the warmer. During an interview 9/17/24 at 3:00 p.m., NA-B stated only staff restocked the blanket warmer and retrieved blankets it. NA-B stated she had not seen the blanket shelves covered. During an interview on 9/18/24 at 10:35 a.m., LPN-B verified the blankets were uncovered in the hallway, and stated it was not covered but should be. LPN-B stated laundry stocked the blankets on the shelf. During an interview on 9/19/24 at 10:50 a.m., the contracted housekeeping manager (HM) verified the blankets were stored uncovered in the hallway. The HM stated linens stored in the hallway should be covered to ensure cleanliness of the linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/19/24 at 12:57 p.m., the infection preventionist (IP) stated she expected staff to wear a gown and gloves when entering a resident's room who is on isolation precautions. Staff were expected to use soap and water for hand hygiene upon exit of residents room who was positive for c.diff as hand sanitizer was not effective. IP further stated residents with wounds required staff to use EBP with any close contact care. Close contact care included transferring residents back to bed, repositioning and any personal cares and staff were expected to wear a gown and gloves when performing these cares for residents on EBP. Clean linens should be stored in clean storage rooms or were required to be covered if in the hallways. If not covered when in hallways, there was potential for the linens to come in contact with unclean items, residents, or visitors. The IP stated following these practices were important to minimize the risk of infections in the facility. A facility policy regarding handwashing as it pertains to C-diff was asked for but not received. The facility would follow the center for disease control (CDC) guidelines. A facility policy titled Transmission-Based Precautions revised 7/2023, directed staff to comply with TBP as per the guidance of the Centers for Disease Control (CDC). Contact precautions required the use of a gown and gloves upon entering the room or making contact with the resident or resident environment. Proper hand hygiene remained a key preventative measure regardless of the type of TBP needed. A facility policy on Enhanced Barrier Precautions dated 4/1/24, indicated Enhanced barrier precautions refer to the use of gown and gloves for use during highcontact resident care activities for residents known to be colonized or with a multi drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). A facility policy titled Handwashing Policy revised 2/2024, directed staff to use proper handwashing to prevent the spread of infection. This included after changing incontinent products and after glove removal. The facility's policy titled Infection Prevention and Control Program dated 3/13/23, lacked direction for linen storage.