STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44647 Based on observation, interview, and record review the facility failed ensure timely care was provided in a manner to maintain and enhance quality of life for 1 of 2 residents (R64) reviewed for call lights. Findings include: R64's admission Minimum Data Set (MDS) 11/30/24 indicated R64 had mild cognitive impairment and diagnoses of heart failure and sepsis (systemic infection). R64 required extensive assist of one person for bed mobility and transfers. R64's care plan dated 11/29/24, indicated R64 had impaired self-performance with toileting due to weakness and sepsis. R64 was incontinent of bowel and continent of bladder. Interventions included toilet upon rising, after meals and before going to bed as needed. R64 required max assistance from staff for toileting. R64's nursing assistant (NA) care sheet obtained 1/6/25, indicated R64 required toileting via Hoyer lift or bedpan upon rising, after meals and before going to bed as needed. R64's call light report for 1/7/25, indicated R64's call light was placed at 1:52 p.m. and was closed at 1:56 p.m. An observation on 1/7/25 at 2:06 p.m., family member (FM)-B was walking back to R64's room. When nearing the entrance of the room, FM-B stated they haven't gotten him to the bedpan yet? .they were going to get him onto the bedpan. FM-B looked up at the call light outside of R64's door. The call light was no longer on. At 2:14 p.m., nursing assistant (NA)-G and NA-I walked out of a resident room adjacent to R64's room, walked past and down the hallway. At 2:27 p.m., NA-G and TMA-A entered another resident room adjacent to R64's room. At 2:28 p.m., R64's light above the door lit up and indicated assistance was needed. At 2:34 p.m., R64's unanswered call light was now blinking. At 2:35 p.m., TMA-A entered R64's room and FM-B stated R64 had been waiting to use the bedpan. TMA-A started to get R64 ready to transfer with a Hoyer lift and at 2:37 p.m., left to get another staff for transfer help. At 2:39 p.m., TMA-A and TMA-B entered R64's room to assist back to bed and to place a bedpan. At 2:54 p.m., TMA-A and TMA-B exited room to give R64 some time on the bedpan. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A total of 48 minutes had passed since FM-B had re-entered R64's room and a total of 62 minutes had passed since R64's call light was first turned on according to the call light log. When interviewed on 1/6/25 at 1:21 p.m., FM-B stated sometimes the wait is an hour long to get R64 into the Hoyer lift. It takes so long for them to get set up or find another person to help. When interviewed on 1/7/25 at 2:37 p.m., R64 was sitting in the wheelchair waiting for TMA-A to get help. I have to go so bad. R64 stated he was usually continent, but I can't just get up and go and sometimes can't wait. R64 stated he wore a brief. FM-B stated, I guess you are going to miss bingo and R64 just nodded and looked down. When interviewed on 1/7/25 at 2:54 p.m., TMA-A stated change of shift is always a challenge as this time was busy and sometimes hard to find someone. TMA-A verified she was aware R64 needed help toileting and was told by NA-G. TMA-A further stated NA-G answered R64's call light and told R64 and FM-B she would let me know he needed assistance. TMA-A stated R64 was assigned to her and not a NA. TMA-A stated she was in the middle of a medication pass and had to complete the medications first. TMA-A acknowledged it took some time to get to R64 for assistance. TMA-A further stated usually staff tried to work together but change of shift was tricky. When interviewed on 1/8/25 at 1:16 p.m., licensed practical nurse (LPN)-A expected all staff to answer call lights. If there was something that non-nursing staff couldn't address, they should let nursing staff know. If staff were unable to complete the request right away, they should let the residents know when to expect them back and stated toileting needs should be a high priority. LPN-A further stated if a request couldn't happen when the call light was answered, the light should be left on as someone else may have time to answer and assist. LPN-A further stated when staff are in a bind, all have walkie-talkies that can be used to ask for additional staff assistance. A follow up interview on 1/8/25 at 2:47 p.m., LPN-A stated after following up with NA-G, R64 requested to get back to bed and be changed, which NA-G took as R64 had already voided in the brief. Contrary to the initial interview, LPN-A stated it was ok for R64's call light to be turned off and R64's needs to be reported to TMA-A. LPN-A then verified staff do their best however it may take an hour for residents to get back to bed for an incontinent change. When interviewed on 1/9/25 at 12:54 p.m., the Director of Nursing (DON) stated the overall goal is for call lights to be answered in a timely fashion. NA-G communicated to TMA-A R64 needed help who then did get back to R64 to assist. R64 had recently transferred from transitional care and staff were still getting to know and understand his care needs. DON further stated I know his needs were met eventually and acknowledged it took a little bit to do so. A facility policy titled Resident Dignity, choices and preferences revised 11/15/24, directed staff to treat all residents with kindness, dignity and respect which included responding promptly to requests.

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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** 42584 Based on observation, interview, and document review, the facility failed to ensure residents were comprehensively assessed safe for self-administration of medication for 1 of 1 resident (R36) reviewed and observed for self-administration of medications. Findings include: R36's quarterly Minimum Data Set (MDS) dated [DATE], indicated R36 was cognitively intact, was taking high-risk drug class medications, and had diagnoses of type 2 diabetes, neuropathy (damage or disease affecting nerves and may impair sensation and movement), dysphagia (difficulty swallowing), weakness, respiratory disease, and congestive heart failure. R36's provider orders dated 3/27/23, indicated, acetaminophen [OTC] tablet; 500 mg; amt: 1000 mg; oral Three Times A Day 08:00, 14:00 [2:00 p.m.], 20:00 [8:00 p.m.]. R36's provider orders lacked evidence for SAM. R36's SAM observation form dated 10/4/24, indicated whether the resident desired to self-administer medications with a response selected as follows, No-If no, there is no need to answer any more questions. You can stop this assessment. During observation and interview on 1/6/25 at 12:43 p.m., R36 had a small clear medicine cup on her bedside table. The medicine cup contained two caplets. R36 stated the two pills were Tylenol due at 1:00 p. m. and that the nurse had brought then in early and left them. During interview on 1/6/25 at 1:02 p.m., registered nurse (RN)-D stated when she took R36's afternoon dose of Tylenol into her room, R36 was in the middle of something and said she would take them when she was done. RN-D stated she left the two pills in a medicine cup on R36's bedside table. RN-D stated R36 did not have a SAM assessment allowing for self-administration and she should not have left the medication at her bedside. RN-D entered R36's room to observe the administration and R36 stated that she had just taken the medication. During interview on 1/7/25 at 3:28 p.m., licensed practical nurse (LPN)-A stated any resident who requested to SAM would require an assessment and if deemed appropriate, a provider order would be obtained. LPN-A stated R36 had not been assessed appropriate for SAM and medication should not have been left at her bedside. During interview on 1/9/25 at 10:05 a.m., director of nursing (DON) stated expectation that a resident would be assessed safe for SAM and would have had a provider order prior to leaving a medication at the bedside. DON stated that R36 was not assessed safe for SAM and did not have a provider order for SAM. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Self-administration of medications last reviewed 11/5/24, indicated all residents would be asked upon admission if they desired to self-administer their medications and if they did, a full assessment and observation would be completed. The policy further indicated if a resident wanted to self-administer medications and they were assessed to do so safely, then a provider order would be obtained.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure ambulation program was completed daily for 1 of 1 residents (R62) who was reviewed for ambulation. Findings included: R62's annual Minimum Data Set (MDS) dated [DATE], indicated R62 was cognitively intact, required supervision or touching assistance for walking 150 feet in a corridor or similar space, and did not exhibit rejection of care behaviors. R62's diagnoses included type 2 diabetes, major depressive disorder, osteoarthritis, and muscle weakness. R62's care plan last reviewed 11/6/24, indicated, AMBULATION: Resident requires assistance with ambulation due to generalized weakness. Resident will maintain the ability to ambulate. See ambulation program for details. R62's care plan further indicated, Resident has participated well in therapies and has desire to participate in a restorative ambulation program. Resident agrees to participate in this program. Resident will participate in restorative walking program at least 5 days per week. R62's physical therapy (PT) discharge note recommendation indicated, Assistive device for safe functional mobility, re-consult as patient needs/conditions changes [sic], continue ambulation program with staff, and home exercise program as trained. R62's undated nursing assistant care sheet indicated, Ambulate with assist of one using walker and wheelchair [to] follow daily. R62's POC history report dated 10/1/24 - 10/31/24, indicated R62 walked seven times with two refusals. R62's POC history report dated 11/1/24 - 11/30/24, indicated R62 walked four times with seven refusals. R62's POC history report dated 12/1/24 - 12/31/24, indicated R62 walked zero times with one refusal. R62's POC history report dated 1/1/25 - 1/8/25, indicated R62 walked one time with zero refusals. During interview on 1/6/25 at 2:18 p.m., R62 stated PM bill used to walk with me-- but no longer-- supposed to walk everyday- but doesn't happen During interview on 1/7/25 at 12:50 p.m., R62 stated she was supposed to be walking every day but had not been offered to walk in the halls for about a month or two. R62 stated she wanted to walk to keep up her strength and would not refuse to ambulate if offered. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/8/25 at 7:50 a.m., nursing assistant (NA)-H stated he used to be a restorative NA and would walk with all the residents on an ambulation program. NA-H stated the restorative nursing program was discontinued so now the resident's assigned NA was supposed to be completing the ambulation program. During observation on 1/8/25 at 9:57 a.m., NA-E assisted R62 to the toilet in her bathroom with stand-by assistance (SBA) and a walker. On 1/8/25 at 10:04 a.m., NA-E assisted R62 from the toilet back to her recliner with SBA. R62 used a walker and walked very slowly. NA-E did not offer R62 to ambulate in the hallway. During interview on 1/8/25 10:08 a.m., R62 stated no one had offered her to ambulate in the hallways yet today and that she would not refuse if offered. During interview on 1/8/25 at 11:25 a.m., NA-F stated ambulation programs were done by the NA, but nurses could assist as well. NA-F stated R62 was on an ambulation program and should be offered to ambulate in the hallways daily. During interview on 1/8/25 12:44 at p.m., NA-E stated NAs would offer and walk with any resident on an ambulation program which could be found on the NA care sheets. NA-E stated they would document the ambulation in point of care (POC) and should document any refusals. During interview on 1/8/25 1:07 p.m., licensed practical nurse (LPN)-B stated staff typically knew which residents were on an ambulation program and it would be listed in their care plan and NA care sheets. LPN-B stated when a resident was on an ambulation program, the nurse was responsible to ensure it was being done. LPN-B was not aware of a current ambulation program for R62. During interview on 1/8/25 at 2:39 p.m., occupational therapist (OT)-A stated residents were evaluated by physical therapy (PT) and recommendations were made regarding ambulation programs. The recommendations would be sent to the nurse manager who would update the care plan for staff to implement. During interview on 1/8/25 at 3:02 p.m., LPN-A stated the restorative nursing program recently changed, however staff were still required to complete the ambulation program with the residents. LPN-A stated R62 should be offered ambulation daily other than to and from the bathroom and refusals should be documented. During interview on 1/9/25 at 10:05 a.m., director of nursing (DON) stated expectation for staff to assist residents with ambulation daily when the resident was on an ambulation program. DON stated R62 should ambulate daily in the hallways and any refusals should be reported to the nurse and documents. DON further stated continued refusals should be reported to PT so the resident could be re-evaluated. Facility policy Restorative Nursing/Functional Maintenance Program Review last reviewed 3/28/24, indicated, It is the policy of Cassia to provide residents with appropriate programs to achieve skills enabling their highest level of function. The policy further indicated therapy would evaluate and recommend appropriate restorative or functional maintenance programs and the nurse manager would update the resident's care plan with recommendation. Clinical manager and therapy would meet monthly to review progress and determine if the program remained appropriate or required changes or to be discontinued.

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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** 44647 Based on observation, interview, and record review the facility failed to ensure care planned interventions were implemented for 1 of 2 residents (R64) reviewed for pressure injury. Findings include: R64's admission Minimum Data Set (MDS) 11/30/24 indicated R64 had mild cognitive impairment and diagnoses of heart failure and sepsis (systemic infection). R64 required extensive assist of one person for bed mobility and transfers. Furthermore, R64 was at risk for pressure injury. R64's comprehensive skin assessment dated [DATE], indicated R64 was high risk for pressure injury. R64's pressure injury Care Area Assessment (CAA) dated 11/30/24, indicated R64 was at risk for pressure injury due to immobility, poor nutrition, and cognitive loss. R64's care plan dated 11/29/24, indicated R64 was at risk for skin alterations related to sepsis, heart failure, and recent assistance of daily living (ADL) decline. Interventions included elevate heels off the bed with pillows and to position body with supports/pillows to protect bony prominences. R64's nursing assistant (NA) care sheet obtained 1/6/25, lacked indication R64 required their heels elevated off the bed. An observation on 1/7/25 at 8:33 a.m., TMA-A obtained R64's medications before entering the room to administer. R64 was sitting up in bed with both heels were resting on the bed. TMA-A greeted resident and stated she had their medications. R64 stated my left heel is hurting. TMA-A replied, I have some Tylenol here to help with the pain. TMA-A administered R64's morning medications. Without further asking about R64's heel pain or elevating R64's heels off the bed, TMA-A left R64's room. An observation on 1/7/25 at 2:56 p.m., trained medication assistant TMA-A and TMA-B entered to assist R64 with toileting cares. Upon completion of cares, the resident was remained in bed with both heels resting on the bed. An observation on 1/8/25 at 10:17 a.m., R64 was laying on their back with the head of bed slightly elevated. R64's heels were resting on the bed. An observation on 1/9/25 at 7:40 a.m., R64's room door was open, and lights were off. R64 was sleeping on his back with both heels were resting on the bed. At 7:51 a.m., licensed practical nurse (LPN)-D entered with R60's breakfast tray. LPN-D assisted R60 with the bed and was sat up for breakfast. At 7:53 a.m., LPN-D left the room and R64 stated the left heel was still painful. LPN-D entered R60's room again at 7:55 a.m. LPN-D verified R64's heels were not elevated and R64's heels were then assessed. LPN-D verified R64 was at risk for pressure injury and the left heel was red and blanchable. R64 indicated pain in the left heel and LPN-D stated heel boots would be placed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/9/25 at 8:18 a.m., LPN-D stated when a resident complains of heel pain, the nurse should be updated, and an assessment completed. LPN-D sated any interventions in place to prevent breakdown were usually included on the NA care sheet or in the care plan and should be in place. When interviewed on 1/9/25 at 11:59 a.m., LPN-A expected staff to notify the nurse if a resident complained of heel pain and expected the nurse to complete and document an assessment. Staff were also expected to have interventions listed on the care sheets or care plans in place to prevent any pressure injury. When interviewed on 1/9/25 at 12:54 p.m., the Director of Nursing (DON) stated R60 had just transferred to the long-term care side from TCU. DON further stated staff should be assessing the heels if there was pain and hoped interventions listed on the NA care sheets and care plan were updated and followed. A facility policy titled Skin Integrity revised 9/18/24, directed staff to provide cares and services to prevent pressure injury development.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview and document review, the facility failed to ensure a hand splint was used for 1 of 1 resident (R30) reviewed for range of motion (ROM). Findings include: R30's quarterly Minimum Data Set (MDS) dated [DATE] indicated R30 had mild cognitive impairment, required substantial/maximal assistance with most activities of daily living (ADLs), and did not exhibit rejection of care behavior. The MDS indicated R30 did not perform any restorative nursing programs to include splint brace assistance. R30's diagnoses included vascular dementia, muscle weakness and neuralgia and neuritis (inflammation and pain along a nerve path). R30's care plan last reviewed 1/6/25, indicated, Resident to ear yellow splint for 2-3 hours daily, to ensure optimal joint protection and for progression with function. R30's Resident Profile printed 1/10/25, indicated, Resident will wear splint for 2-3 hours .to L wrist .daily as recommended by OT [occupational therapy]. R30's OT note dated 1/3/24, indicated, R30 was being referred to skilled [OT] for splint replacement request and reeducation of staff for safe/proper use. The note continued, OTR prescribing Pt with AliMed Therapy Carrot to mitigate stiffness of forming contractures .and to reduce risk of skin breakdown from pressure in affected area. Pt will continue to use device as instructed in original orders to ensure optimal functional benefit. R30's rehabilitation resident referral dated 5/9/23, indicated, [OT] recommending Pt [patient] wear yellow splint for 2-3 hours each day. R30's OT discharge note dated 5/9/23, indicated, Discharge Recommendations: OTR recommending that Pt wear yellow splint Minimum of 2-3 hours each day. The note continued, Splint and Brace Program Established/Trained: Therapist providing Pt with yellow splint to be work [sic] minimum of 2-3 hours each day to encourage optimal join [sic] protection. Review of R30's point of care (POC) documentation report for 12/1/24 through 12/31/24, lacked evidence R30 wore the splint or utilized a carrot at all during the month. Review of R30's POC documentation report for 1/1/25 through 1/9/25, lacked evidence R30 wore the splint or utilized a carrot. During observation and interview on 1/6/25 at 1:49 a.m., R30 was in his room sitting in his wheelchair. R30's left hand was noticeably contracted, he was not wearing a splint, was not utilizing a carrot, and did not have any other palm protector. R30 stated could not remember ever having a splint, carrot or palm protector (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 1/7/25 at 8:15 a.m., R30 was in bed eating breakfast and leaning awkwardly to the left side. R30 was not wearing a splint, was not utilizing a carrot, and did not have any other palm protector. During observation on 1/7/25 at 11:48 a.m., R30 was sitting in dining room eating lunch independently with right hand. R30 was not wearing a splint, was not utilizing a carrot, and did not have any other palm protector During observation on 1/8/25 at 8:32 a.m., R30 was in bed eating breakfast and leaning awkwardly to the left side. R30 was not wearing a splint, was not utilizing a carrot, and did not have any other palm protector. During interview on 1/8/25 at 10:36 a.m., nursing assistant (NA)-E stated could not recall ever seeing a splint or any other type of palm protector for R30's contracted hand. During interview on 1/8/25 at 1:07 p.m., licensed practical nurse (LPN)-B stated her understanding was that therapy was working with R30 on a splint and had seen NAs place the splint in the past. LPN-B could not recall the last time she saw R30 using the splint. During interview on 1/8/25 at 2:29 p.m., OT-B stated the process was therapy would make a recommendation and send a communication form on to the nurse manager who would then change the care plan to reflect the recommendation. OT-B further stated R30 was provided a hand splint on 5/9/23 to be worn 2-3 hours daily. OT-A joined the conversation and agreed with OT-B and further stated expectation that R30 would be offered to wear the splint as recommended and if the splint was missing or R30 consistently refused, staff should notify OT for re-evaluation or replacement. During interview on 1/8/25 at 2:49 p.m., LPN-A confirmed and stated R30's care plan included instruction to wear a yellow splint 2-3 hours a day. LPN-A stated expectation that R30 still had the splint and that it would be offered daily. LPN-A stated if the splint was missing or R30 refused to wear it, staff should notify OT for re-evaluation or replacement. During interview on 1/8/25 at 3:06 p.m., LPN-A stated she searched R30's room and was unable to find a splint. During interview on 1/9/25 at 10:05 a.m., director of nursing (DON) stated after further investigation, they were able to locate a carrot in R30's room, but still did not find a splint. DON stated expectation that R30 would be offered the splint or carrot daily and that any refusals would be documented and reported to the nurse. DON further stated continued refusals should be reported to OT. During follow up interview on 1/9/25 at 1:31 p.m., OT-A stated R30 was re-evaluated in January of 2024, but a new recommendation would not have been sent since the previous recommendation was still valid and expected to be implemented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Restorative Nursing/Functional Maintenance Program Review last reviewed 3/28/24, indicated, It is the policy of Cassia to provide residents with appropriate programs to achieve skills enabling their highest level of function. The policy further indicated therapy would evaluate and recommend appropriate restorative or functional maintenance programs and the nurse manager would update the resident's care plan with recommendation. Clinical manager and therapy would meet monthly to review progress and determine if the program remained appropriate or required changes or to be discontinued.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to comprehensively assess and implement interventions necessary to maintain continence for 1 of 1 residents (R27) reviewed for bowel and bladder. Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact and diagnoses of cerebral infarction (stroke) with left sided hemiplegia (inability to move one side of the body) and edema. Furthermore, R27's MDS indicated R27 had no rejection of cares, had occasional incontinence of bowel and bladder and no toileting program. R27's comprehensive bowel and bladder assessment dated [DATE], indicated R27 was fully continent of bowel and bladder. Furthermore, the comprehensive assessment lacked review of R27's cognitive awareness, diuretic use, observation of bladder/bowel function, potential voiding difficulties, or toileting patterns. R27's urinary incontinence care area assessment (CAA) dated 3/25/24, indicated R27's was frequently incontinent of bladder and required maximum assist with toileting. R27 was able to request assist with toileting though was not always accurate when asking and directed staff to toilet per care plan and resident request. R27's quarterly bowel and bladder assessment dated [DATE], indicated the bowel and bladder comprehensive observation was reviewed and there had been no changes. R27's current toileting plan was effective. R27's care plan revised 12/4/24, indicated R27 had functional bladder incontinence and was usually continent of bowel. A toileting plan was established per resident preference. R27's interventions included use incontinent briefs, provide peri care after incontinent episodes. R27's nursing assistant (NA) care sheet provided 1/6/25, indicated R27 was incontinent of bowel and bladder and to toilet upon request. When observed on 1/7/25 at 12:11 p.m., NA-G answered R27's call light. R27 had requested to use the bathroom. NA-G assisted R27 to the bathroom with a stand lift (equipment used to stand and move the resident). NA-G assisted R27 to lower pants and removed soiled brief and then lowered R27 onto the toilet to void. NA-G instructed R27 to use the call light when done using the toilet. At 12:19 p.m. , NA-G entered R27's room and assisted R27 with peri cares as R27 had a bowel movement and had voided. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/6/25 at 1:03 p.m., R27 stated it usually took staff a while to answer their call light and she wore a brief because it takes too long for them to help. R27 further stated not getting to the toilet for a bowel movement was upsetting as it was bad enough I have to pee in the brief. R27 stated she takes a medication for edema that makes her urinate a lot and cannot help when she needs to go, and it was usually urgent. R27 stated she wasn't aware of any toileting schedule and staff did not come ask her about using the bathroom. R27 always requested help when needing to go. When interviewed on1/8/25 at 10:11 a.m., NA-H stated the NA care sheets were used to communicate what kind of assistance was needed for residents. NA-H stated R27 was extensive assist with cares and a total assistance with transfers. NA-H stated R27 was continent of bowel most of the time but was usually incontinent of bladder. NA-G was not aware of any toileting plan and stated R27 used the call light and will void when on the toilet, however, was usually already incontinent. When interviewed on 1/8/24 at 11:08 p.m., licensed practical nurse (LPN)-C stated bowel and bladder assessments were completed each quarter and the electronic medical record will prompt their completion. LPN-C wasn't familiar with that assessment as it was completed on a different shift. LPN-C further stated R27 notified staff when needing to go and most of the time will urinate on the toilet and sometimes was incontinent. LPN-C further stated R27 did not have any toileting schedule and had her own routine and would let us know. When interviewed on 1/8/25 at 1:16 p.m., LPN-A stated quarterly assessments were completed by the management staff and verified it prompts to review the comprehensive assessment to identify if there were any changes. LPN-A verified R27's comprehensive assessment stated fully incontinent and verified there was no other parts of the assessment completed. LPN-A stated she was taught if that was the answer, the rest of the form did not need to be completed. LPN-A further verified the quarterly assessment indicated no change from the comprehensive assessment, however the care plan indicated R27 had functional incontinence. LPN-A stated the assessment was not accurate and needed to be updated and the toileting plan reviewed. When interviewed on 1/9/25 at 12:57 p.m., the Director of Nursing (DON) stated they completed the comprehensive bowel and bladder assessment and at that time R27 and the staff indicated they were fully continent. DON stated when the assessment was opened, only a highlighted yellow section needed to be reviewed. Once the fully continent section was completed, no other sections opened to review. DON expected if there were any changes identified during the quarterly assessment, then those changes should be reflected on the assessment. DON stated this was important to ensure changes were identified and acted upon. A facility policy titled Bowel and Bladder assessment revised 3/28/24, directed staff to complete bowel and bladder assessments upon admission and other appropriate clinical times. Furthermore, staff were directed to provide individualized resident centered toileting programs for appropriate residents with interventions and goals to enhance quality of life and functional status.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview and document review, the facility failed to ensure weekly weights were completed for 1 of 1 resident (R32) who was reviewed for nutrition. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], indicated R32 had severe cognitive impairment, required substantial/maximal assistance with eating, and did not exhibit rejection of care behavior. R32's diagnoses included hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) following cerebral infarction (stroke) affecting left non-dominant side, vascular dementia, type 2 diabetes mellitus, and dysphagia (difficulty swallowing). R32's care plan (CP) last reviewed 11/6/24, indicated, Resident requires regular texture without restrictions related to weight loss, quality of life and expansion of choices. Resident needs assistance with eating d/t [due to] vision limitations. R32's CP further indicated a long term goal of No significant weight changes will be observed .wt [weight] gain desirable. R32's CP instructed staff to weigh R32 per provider order and monitor at nutritional high risk. R32's progress note (PN) dated 12/17/24, indicated, Nutrition High risk monitoring NUTRITION DIAGNOSIS: potential for unintentional wt loss r/t [related to] decreased oral intakes AEB [as evidenced by] need for supplementation and hx [history] of weight trending down. The PN further indicated, NUTRITION INTERVENTION .weekly weight and Continue with high risk nutrition monitoring. R32's provider order dated 10/16/24, indicated, Weekly Weight Once a day on Wed. R32's December 2024 medication administration record (MAR) indicated R32's weight as 127.9 on 12/4/24 and 125.6 on 12/11/24. R32's MAR indicated, Not Administered .not done on 12/18/24 and Not Administered .did not get out of bed today on 12/25/24. During interview on 1/8/25 at 11:25 a.m., nursing assistant (NA)-F stated the nurses informed the NAs in the morning which residents needed a weight done on that day. NA-F stated that the NAs would weigh the residents unless they were too busy and then the nurse would assist. The NA would then tell the nurse the weight and the nurse would document it in the electronic health record (EHR). During interview on 1/8/25 at 12:44 p.m., NA-E stated R32 required full assistance with meals and usually ate pretty well and he was also offered beverages and snacks throughout the day. NA-E stated the nurse would notify the NAs at the start of the shift of residents needing weights and the weights were typically done on bath days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/8/25 at 1:26 p.m., licensed practical nurse (LPN)-B stated the NAs typically weighed the residents monthly on their bath day. LPN-B stated residents who were at high risk for weight loss would have orders for more frequent weights like weekly or daily. LPN-B stated if a weight was not taken due to resident refusal or some other reason, the NA should notify the nurse. It would be the responsibility of the nurse to notify the registered dietician (RD) with weight loss or continued refusals or inability to obtain weight. It was the nurse's responsibility to document the weight and refusals in the EHR. During interview on 1/8/25 at 1:45 p.m., family member (FM)-A stated R32 required full assistance with meals, and he had lost some weight over the last six months. FM-A stated the facility was monitoring his weight and providing supplements. During interview on 1/9/25 at 8:17 a.m., registered dietician (RD) stated, R32 was on nutrition high risk monitoring and should have weekly weights completed. Residents at high risk were discussed with an interdisciplinary team weekly and could not explain why the weekly weights on R32 were missed. During observation on 1/9/25 at 8:25 a.m., R32 was in bed totally assisted by staff with the breakfast meal. During interview on 1/09/25 at 8:38 a.m., licensed practical nurse (LPN)-A stated R32 should have weekly weights done as ordered unless refused or for some other reason staff was unable to complete. Refusals and missed weights should be re-attempted and documented if unable to obtain. During interview on 1/9/25 at 10:05 a.m., director of nursing (DON) stated expectation that residents would be weighed according to the provider order and if a resident refused to be weighed the nurse should be notified and the refusal should be documented. Facility policy Charting and Documentation last reviewed 3/28/24, indicated, All services provide to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the [IDT] regarding the resident's condition and response to care. The policy further indicated, Documentation of procedures and treatments will include care-specific details, including .Whether the resident refused the procedure/treatment and Notification of family, physician or other staff, if indicated. A facility policy on obtaining resident weights and nutrition high risk monitoring were requested but not provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to identify and monitor new bruising at the fistula site for 1 of 1 residents reviewed for dialysis. Findings include: R60's quarterly Minimum Data Set (MDS) dated [DATE], indicated R60 was cognitively intact and had diagnoses of end stage kidney disease and hypertension. Furthermore R60's MDS indicated R60 was dependent on renal dialysis (treatment to filter the blood when kidneys are not functioning). R60's care plan revised 11/20/24, indicated R60 required hemodialysis three times a week and had a left arm fistula for access. Interventions included staff monitoring access site for bleeding or signs of infection and to notify dialysis/provider pf concerns. A review of R60's provider and nursing orders on 1/7/2025, indicated the following: -on 11/11/24, indicated R60 required fistualgram site monitoring three times a day and to notify the provider for increased pain, redness and/or swelling at site. -on 11/11/24, R60 required staff to collect the dialysis run sheet, write a progress note on the resident condition post dialysis and check the vital signs before and after each dialysis run. R60's provider and nursing orders lacked indication of monitoring of R60's fistula for bruit and thrill post-dialysis. R60's 1/2025 treatment administration record (TAR) reviewed on 1/8/25, indicated the following: -R60's order for fistulagram site monitoring was completed on all shifts except 1/2/25 day shift and 1/7/25 for the evening shift as resident was unavailable. -R60's order for staff to collect the dialysis run sheet, write a progress note on the resident condition post dialysis and check the vital signs before and after each dialysis run was marked as completed for all shifts on dialysis days. R60's nursing progress note dated 12/31/24, indicated R60 had complaints of left upper arm pain and swelling was noted around fistula site. However, the note lacked indication R60 had bruising at the fistula site. R60's nursing progress notes dated1/1/25- 1/7/25, lacked indication R60 had continued swelling, bruising, or pain at the fistula site. R60's weekly skin observation dated 1/5/25, indicated R60 had no new bruising or skin injuries. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's dialysis run sheet dated 1/7/25, indicated treatment was started with complications. R60 had pain, swelling, and bruising at access site in the left arm. R60's central venous catheter (CVC) line was used instead. An observation and interview on 1/6/25 at 5:29 p.m., R60's left arm appeared swollen. R60 stated there had been swelling at the fistula site and the access was not able to be used at dialysis the last time. R60's CVC line was used instead. R60 stated dialysis nurses would look at the site again at dialysis tomorrow. An observation and interview on 1/8/25 at 8:30 a.m., R60 was sitting in bed eating breakfast. R60 stated dialysis was unable to use the left arm and there was new bleeding that started. R60's left upper arm at the fistula site was swollen and had bruising noted to the top and below the fistula site, extending near the backside of the arm. R60 stated the facility nursing staff had not looked at the left arm and stated it was not really their concern. When interviewed on 1/8/25 at 12:55 p.m., licensed practical nurse (LPN)-C stated when residents returned from dialysis their access site was assessed and their vital signs. LPN-C further stated the paperwork that comes back was also reviewed. If paperwork was not sent, staff should notify the dialysis center to fax it over. LPN-C stated she assessed R60's dialysis site already and had not seen any changes. LPN-C stated there were no concerns with R60's dialysis site given in report. LPN-C observed R60's site again with writer and stated it looked the same since R60's last hospitalization . LPN-C asked R60 about the darkened skin/bruising area and R60 stated the bruising was seen at dialysis yesterday. When interviewed on 1/8/25 at 12:31 p.m., LPN-A stated dialysis should always be sending any updates and the run sheets with the resident after dialysis. LPN-A further stated there were problems getting the run sheet and information back sometimes and expected staff to reach out to dialysis and have them fax it over. LPN-A acknowledged R60's dialysis run sheet had to be requested from the dialysis center after writer requested it this morning. LPN-A expected staff to assess the dialysis site and document any changes in a progress note. If there was a change, the provider should also be updated to determine any needed monitoring and interventions. LPN-A then called LPN-C to verify R60's bruising was documented on the 24-hour board. LPN-A stated it was not on the board and LPN-C stated there was no bruising noted on R60's left arm. LPN-A then observed and verified R60's bruising to the left arm. R60 told LPN-A the bruising was noted yesterday at dialysis and the pain was getting better. LPN-A further stated the bruising needed to be measured, documented and the provider updated. When interviewed on 1/9/25 at 12:54 p.m., the Director of Nursing (DON) expected staff to assess the site upon return from dialysis and to obtain the run sheets if not sent with the resident after dialysis. DON stated a new order was placed to ensure to have it looked at and verified there was communication problems with dialysis at times. A facility policy titled Dialysis reviewed 3/28/24, directed staff to provide an ongoing assessment and monitoring for complications before and after each dialysis treatment for residents who require dialysis.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure dietary preferences were accommodated for 1 of 1 resident (R17) reviewed for food preferences. Findings include: R17's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have behaviors, did not reject cares, required setup or clean-up assistance with eating, had malnutrition or was at risk for malnutrition, morbid obesity, diabetes, did not have signs or symptoms of a swallowing disorder, did not have weight loss or gain, was not on a therapeutic or mechanically altered diet. R17's care plan dated 11/12/24, indicated R17 required a regular diet, had a history of gastric bypass in 2004, malabsorption, and was open to additional weight loss or maintenance and interventions included, R17 requested small portions, and wanted just milk and cereal/breakfast bar for the morning meal. R17's physician's orders form indicated the following orders: 11/10/24, weekly weights for 4 weeks then change to monthly unless otherwise specified by the physician. 11/22/24, regular diet. 11/22/24, ondansetron (a medication for nausea) disintegrating tablet 4 milligrams (mg) every 6 hours as needed for nausea and vomiting. 12/9/24, monthly weights on the first of the month. 12/18/24, vanilla ensure Plus 8 ounces daily. R17's history and physical dated 11/4/24, indicated R17 had a history of gastric bypass, (a surgery that reduces the size of the stomach) and unspecified intestinal malabsorption. R17's Nutritional Assessment form dated 11/11/24, indicated R17 had inadequate oral intakes related to decreased appetite and some intentional weight loss as evidenced by resident report of weight loss of 26 pounds in 4 months and the diet ticket was updated with preferences. R17's Malnutrition Screening Tool (MST) dated 11/12/24, indicated R17 lost 24 to 33 pounds without trying and had been eating poorly due to a decreased appetite and had a malnutrition score of 4 indicating R17 was at risk for malnutrition. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's nutrition progress note dated 12/24/24, at 8:59 a.m., indicated R17 was on a regular diet, was monitored at high risk nutritionally, and had special requests on the diet ticket. R17 mostly consumed 50 to 100% of meals and occasionally had a bedtime snack and weighed 239.9 pounds on 12/22/24. The note further indicated R17's weight was stable for 30 days with a weight loss of 2.5% based on the admission weight of 246 pounds and the dietician spoke with R17 the week prior regarding changing the breakfast order to just cold cereal with fruit and grape juice. Further, the note indicated R17 wanted smaller portions because she could not eat much due to her history of gastric bypass surgery. During interview and observation on 1/7/25 at 8:33 a.m., R17 stated she was having trouble getting the food she wanted and spoke with the dietician about receiving breakfast bars and stated she preferred breakfast bars and received cereal, milk, and juice. R17's breakfast tray was in the room and contained dry cheerios, cranberry juice, and a glass of milk. The tray lacked any type of breakfast bar. R17's meal ticket undated, indicated R17 had a regular diet, had small portions and under the heading, Notes, indicated the following, ONLY: CEREAL/BREAKFAST BAR AND DRINKS. During interview on 1/7/25 at 8:42 a.m., nursing assistant (NA)-A stated R17 usually ate cold cereal and milk and saw R17 received cold cereal and stated R17 did not eat well and at times would not touch breakfast and verified R17 did not receive a breakfast bar. During interview on 1/7/25 at 8:45 a.m., NA-B stated R17 usually ate a breakfast bar. During observation on 1/7/25 at 8:49 a.m., social worker (SW)-A had three breakfast bars in her hand and at 8:50 a.m., went into R17's room with the breakfast bars. During interview on 1/7/25 at 8:51 a.m., nursing assistant (NA)-C stated she delivered R17's meal that morning and R17 had a glass of milk, juice, and cheerios and did not have a breakfast bar. NA-C further stated the kitchen provides what is on the ticket and the aides go thru it and called if something was missing. During interview on 1/7/25 at 8:55 a.m., NA-B stated R17 only wanted a cereal bar. During observation on 1/8/25 at 9:34 a.m., R17 was in bed and her breakfast tray was on the bedside table next to the bed and R17 had dry cheerios and a breakfast bar located on the meal tray. During interview on 1/9/25 at 8:32 a.m., the registered dietician (RD) stated she managed weight loss and followed residents at nutritional risk and spoke with residents to learn their preferences to provide an individualized approach to nutrition and helped make sure resident's needs were met and further stated if their intake started to decline, knowing preferences helped to determine accommodations that could be made. Further, R17 had a gastric bypass and a smaller stomach, required smaller meals, and wanted a lighter breakfast because she thought it would help with her nausea. RD stated in the beginning of December, R17 wanted eggs, sausage, and fruit, and at the end of December just wanted cold cereal and when RD spoke with R17 last on 1/3/25, R17 only wanted a cereal bar and stated she updated the diet ticket and clarified that R17 did not want cereal and only wanted a cereal bar for breakfast. RD stated she expected staff to follow the meal ticket and stated it was best practice to honor a resident's preference. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/9/25 at 8:16 a.m., NA-A stated R17 does not eat breakfast and R17 will state she doesn't feel well, but will take a breakfast bar and stated she did not know why R17 did not want to eat but had been approximately two weeks since resident hadn't been eating breakfast. During interview on 1/9/25 at 8:53 a.m., registered nurse (RN)-B stated R17 occasionally had nausea and expected meal tickets to be followed according to a resident's preferences. During interview on 1/9/25 at 2:03 p.m., the director of nursing (DON) stated she hoped the dietary department put the meal requested on the tray and stated nursing staff should check for correct food consistency and textures and don't always have time to look for preferences and further stated it was important to have preferences because the residents may be more likely to eat. A policy, Resident dignity, choices and preferences, dated 11/15/24, indicated the facility would put protocols in place to honor resident's choices and preferences as able.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to follow transmission based precautions (TBP) based on signage located outside resident's doors for R29, R45, R17, R14. This had the potential to affect all residents. Additionally, the facility failed to ensure hand hygiene was completed during 3 of 6 residents (R14, R55, R47) observed for medication administration. Findings include: According to the Centers for Disease Control (CDC) website, transmission based precautions are the second tier of basic infection control and are to be used in addition to standard precautions (standard precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents) for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. The CDC website provides recommendations for personal protective equipment (PPE) use for various precautions. Contact precautions are used for patients with known or suspected infections that represent an increased risk for contact transmission and a gown and gloves are worn for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. Droplet precautions is used for patients with known or suspected to be infected with pathogens transmitted by respiratory droplets generated by a patient who is coughing, sneezing, or talking. A mask is donned upon entry into the patient room or space. Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities and may be indicated when contact precautions do not otherwise apply. R17's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have behaviors, did not reject cares, and had an indwelling catheter. R17's Facesheet form indicated R17 had the following diagnoses: fracture of metatarsal bone(s) to the right foot, calculus (stones) of ureter (a tube that carries urine from the kidney to the bladder), pyelonephritis (kidney infection), hydronephrosis (a condition where urine builds up in the kidney) with renal and ureteral calculus obstruction. R17's care plan dated 11/12/24, indicated R17 transferred with assist of one and a slide board from the bed to wheelchair and staff used an EZ stand for transfers to the toilet. R17's care plan dated 11/11/24, indicated R17 was at risk for altered skin integrity and interventions included monitoring skin under nephrostomy tubing. Additionally, a short term goals included R17's right foot surgical incision would show signs of healing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R17's care plan dated 11/11/24, indicated R17 had a left nephrostomy tube placement (a tube that drains urine from the kidney into a bag outside the body) with sepsis (the body's reaction to an infection), was continent and incontinent of urine, and continent of bowel, and interventions directed staff to provide nephrostomy care per their policy. R17's care plan lacked information R17 was on any kind of TBP. R17's Active Orders form indicated the following orders: 11/22/24, surgical wound care, R17 has a surgical wound and the wound is protected from injury and germs. Follow physician orders for wound care, when applying new dressing, use an aseptic, non-touch technique and avoid touching the inside of the dressing. Discontinue this nursing order when the surgical wound is healed. 12/16/24, wound care keep splint intact and dry, keep pin to toe intact and do not remove. R17's orders lacked information R17 was on any kind of TBP. During observation on 1/7/25 at 8:50 a.m., R17's door to her room indicated R17 was on contact precautions and social worker (SW)-A went into R17's room with three breakfast bars and did not donn any personal protective equipment (PPE). During interview and observation between 11:51 a.m., and 11:56 a.m., physical therapy assistant (PTA)-C pushed R17 in her wheelchair down the hallway towards R17's room and took out a gown and gloves from the bin next to the door and brought the items into the room without first applying the PPE and closed the door. The signage on the door indicated R17 was on contact precautions and contained signage for sequence of application of PPE. PTA-C verified signage outside R17's door indicated contact precautions and stated they had it in their system that R17 was on EBP and looked in R17's bin that contained the gowns and gloves and located a sign with information on EBP and stated if the sign falls down, they just shove it in the bin and placed the EBP signage on top of the bin outside the door. During interview and observation on 1/7/25 at 11:59 a.m., registered nurse (RN)-A stated they looked in the electronic medical record (EMR) in the orders to know what type of precautions a resident was on and viewed R17's chart and verified the EMR lacked information regarding what precautions R17 was on. RN-A stated R17 was on EBP due to having a nephrostomy, but stated R17 had VRE (vancomycin resistant enterococci, a bacteria resistant to antibiotics) in her urine and was placed on contact precautions. RN-A stated PPE was donned on residents who were on contact precautions with cares and stated for therapy it was advisable to wear gowns if outside of the room per their orientation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 1/9/25 at 12:31 p.m., the infection preventionist (IP)-D stated she initiated precautions and during admission, they had a sheet that indicated if a resident was on precautions. IP-D stated it was up to the IP-D, nurse manager, or the director of nursing to add the PPE bins and correct signage. IP-D stated floor staff were notified of precautions because it was located on the EMR, a resident would have orders for precautions. IP-D stated signage went up prior to the new admission arriving or as soon as a resident was diagnosed with an infection and went down when precautions were over. IP-D stated if signage indicated contact precautions, she expected staff to follow the signage and further stated contact precautions required PPE to be worn whenever staff were in contact with the environment or the resident and included donning gloves, gowns. IP-D stated she expected staff don a gown, gloves, faceshield, and a mask for residents on droplet precautions. IP-D further stated they have noticed staff have had confusion and they were trying to monitor adding it started when enhanced barrier precautions went into effect and was something they were working on. Further, IP-D stated she expected staff wash hands in the sink with soap and water when leaving the room. A policy, Infection Control dated 8/12/22, indicated handwashing and hand sanitizing using alcohol based hand sanitizer is the cornerstone of the program. Transmission based precautions and enhanced barrier precautions will be provided for residents requiring additional precautions if the facility is able to meet the resident's needs and infection control recommendations. 42584 R45 R45's quarterly Minimum Data Set (MDS) dated [DATE], indicated R45 was cognitively intact, required partial/moderate assistance with upper body dressing, substantial/maximal assistance with toileting, and totally dependent for transfers, mobility and taking on and off footwear. R45 did not exhibit rejection of care behavior, had recent major orthopedic surgery, and required dialysis. R45's diagnoses included traumatic brain dysfunction (condition affecting how the brain works as a result of external trauma), end stage renal disease (kidney failure), dependence on renal dialysis, type 2 diabetes mellitus, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right sided paralysis and weakness following a stroke). R45's care plan last reviewed 1/7/25, indicated, Infection-Resident with s/s of respiratory illness .Isolation precautions per policy. R45's progress note dated 1/4/25 at 9:11 p.m., indicated, Resident had flu/cold-like symptoms. R45's progress note dated 1/5/25 at 9:16 p.m., indicated, Resident still has the flu/cold-like symptoms. R45's progress note dated 1/6/25 at 10:02 a.m., Resident noted to be coughing this morning with some mucus production. During observation on 1/7/25 at 12:00 p.m., an infection control isolation cart sat in the hallway next to R45's door. A sign on R45's door indicated, CONTACT and DROPLET precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 1/07/25 01:58 PM activity staff (A)-A walked past R45's room. R45 yelled out for assistance, A-A entered R45's room without donning any PPE. R45's door was open, and A-A was observed to pick up R45's trash can without gloves, held out for R45 to dispose of his mask and then placed it back on the floor. During interview on 1/7/25 at 2:01 p.m., A-A stated being unsure of R45's precautions and did not understand what the sign on the door meant. A-A stated understanding the PPE was only for staff coming in contact with the resident and doing direct patient care. During observation on 1/7/25 at 2:04 at p.m., R45's door was open and was coughing loudly. During interview on 1/7/25 at 2:07 p.m., nursing assistant (NA)-D stated thinking R45 had tested negative for Covid and influenza and just had a cold, but the PPE was to prevent any respiratory symptoms to other residents. During interview on 1/7/25 at 2:49 p.m., registered nursing (RN)-D stated R45 had been placed on precautions due to his symptoms and while various testing occurred. RN-D stated unsure why R45 was on both contact and droplet since he had tested negative for Covid and influenza, however, with the signage in place, it should be followed. RN-D stated staff should be donning appropriate PPE when entering R45's room. During observation on 1/7/25 at 4:07 p.m., signage on R45's door indicated only droplet precautions. During observation on 1/8/25 at 10:58 a.m., occupational therapist (OT)-B knocked on R45's door, announced self and entered the room. OT-B failed to don any PPE prior to entering R45's room. Signage on R45's door indicated droplet precautions and an isolation cart sat next to his door. During interview on 1/8/25 at 11:02 a.m., OT-B stated she did not stop to read the sign on R45's door and just assumed it indicated enhanced barrier precautions (EBP) which would only require PPE when direct contact was expected to occur. After confirming the signage indicated droplet precautions, OT-B stated should have donned PPE prior to entering his room. R29 R29's quarterly MDS dated [DATE], indicated R29 had severe cognitive impairment, was dependent on staff for toileting, and required substantial/maximal assistance with most other ADLs. The MDS indicated R29 had one unhealed stage 3 pressure ulcer and 1 unhealed venous or arterial ulcer, and did not exhibit rejection of care behavior. R29's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, morbid obesity, and muscle weakness. R29's care plan last reviewed 11/6/24, indicated, Resident requires enhanced barrier precautions related to: MRSA .Follow enhanced barrier precautions per policy. R29's active orders included: -11/18/24 Wound care: Rt. [right] great toe ulcer .once a day on Sun, Wed, Fri. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-12/20/24 Wound care: Coccyx .once a day on Sun, Wed, Fri. During observation on 1/8/25 at 7:26 a.m., an infection control isolation cart sat in the hallway next to R29's door. A sign on R29's door indicated enhanced barrier precautions (EBP). NA-G entered R29's room to assist her in morning cares. NA-G performed hand hygiene and donned gloves. NA-G failed to don a gown. NA-G assisted R29 with her pants, socks, and shoes. LPN-C entered to assist with transfer from the recliner into a wheelchair. LPN-C donned gloves and a mask, but does not don a gown. R29 was physically assisted to a sitting position, sling placed behind her, and sling attached to the Hoyer. The Hoyer was pushed into the bathroom and R29 was lowered onto the toilet and the sling disconnected from the Hoyer. LPN-C left the room. NA-G assisted R29 to remove her night shirt and wash her upper body. NA-G removed R29's old brief and replaced it with a new one. NA-G left to find assistance and returned with LPN-C. NA-G and LPN-C donned gloves but neither donned a gown. The sling was reattached to the Hoyer and R29 lifted off the toilet. NA-G wiped R29's bottom, removed gloves, performed hand hygiene and secured the new brief. NA-G pulled up R29's pants. R29 was transferred back into the wheelchair. During interview on 1/8/25 at 8:24 a.m., NA-G confirmed R29 had signage indicating EBP. NA-G stated R29 had wounds and staff should wear a gown when doing wound care and it was not required during regular personal cares. During interview on 1/8/25 at 8:28 a.m., LPN-C confirmed R29 had signage indicated EBP on her door and stated staff were required to wear a gown only if doing wound care and not required during any other personal care or transfers. During interview on 1/9/25 at 8:38 a.m., LPN-A stated expectation for staff to follow the signs when a resident was on any precautions. LPN-A stated EBP indicated staff should don gown and gloves with any personal cares, transfers, wound cares, catheter cares, or any other close contact with the resident. LPN-A stated staff should gown and glove appropriately when performing cares and transfers with R29. During interview on 1/9/25 at 10:05 a.m., director of nursing (DON) stated expectation for staff to follow any precautions signage on a resident's door instructing for PPE use. DON stated staff should don a mask before entering a room with droplet precautions as with R45 and gown and gloves when toileting, transferring and completing cares for residents on EBP as with R29. 44647 R14 R14's quarterly MDS dated [DATE], indicated R14 was cognitively intact and had diagnoses of lumbar fracture, absence of right lower leg, and diabetes. R14's provider order dated 11/1/24, indicated R14 required contact precautions due to norovirus and loose stools. An observation on 1/8/25 at 8:22 a.m., TMA-C was delivering R14's breakfast tray. TMA-C walked into R14's room and without donning a gown or gloves. R14's tray was set near the sink and then TMA-C exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 1/8/25 at 8:22 a.m., TMA-C stated R14 required a gown, gloves, and mask for cares. TMA-C verified they entered the room without donning a gown or gloves and was just dropping off the tray. TMA-C verified the contact precautions sign outside of the room and then further stated a gown and glove was needed if going past the entrance area of the room into the main room. Medication administration R14's quarterly MDS dated [DATE], indicated R14 was cognitively intact and had diagnoses of lumbar fracture, absence of right lower leg, and diabetes. R14's provider order dated 11/1/24, indicated R14 required contact precautions due to norovirus and loose stools. R55's annual MDS dated [DATE] indicated R55 was cognitively intact and had diagnoses of diabetes and heart failure. R47's annual MDS dated [DATE], indicated R47 had moderate cognitive impairment and diagnoses of diabetes and atrial fibrillation (irregular heartbeat). An observation on 1/6/25 at 4:53 p.m., trained medication assistant (TMA)-B brought R14 their medication. Outside of R14's room was a sign indicating R14 required contact precautions. The sign directed staff to don a gown and gloves upon entering the room. A handwritten sign was posted directly under the contact isolation sign directing all staff to wash hands with soap and water upon exiting the room. TMA-B performed hand hygiene and donned a gown, gloves, N-95 facemask, and face shield before entering R14's room. TMA-B entered R14's room and administered the medication. When finished, TMA-B removed the face shield, facemask, gown, and gloves and disposed of them inside R14's room. TMA-B did not wash hands with soap and water upon exit of R14's room and instead used hand sanitizer and returned to the medication cart. TMA-B stated R14 was on contact precautions for norovirus. TMA-B further stated a gown, gloves, mask, and face shield was required to enter. TMA-B stated hand sanitizer was ok to use when exiting the room, however after verifying the sign directing staff to wash with soap and water, TMA-B stated with norovirus, soap and water should be used when exiting. TMA-B then continued to prepare medication for R55 without washing hands with soap and water. TMA-A took the R14's pill cup and proceeded to her room. TMA-B knocked and entered R14's room without performing hand hygiene and administered R14's medication. Upon exit, TMA-B performed hand hygiene with sanitizer and returned to the medication cart. TMA-B prepared R47's medications and obtained supplies to check a blood glucose. TMA-B brought R47 back to their room to obtain the blood glucose and administer medications. Upon entrance to R47's room, TMA-B did not perform hand hygiene and donned gloves. TMA-B performed the glucose test and obtained an error message. TMA-B then removed gloves, washed hands, and donned new gloves. TMA-A performed another glucose test and obtained a reading. TMA-B then removed gloves and without hand hygiene pushed R47 out of the room for NA staff to bring to the dining room. TMA-B then returned to the medication cart. When interviewed on 1/6/25 at 5:26 p.m., TMA-B verified they had not performed hand hygiene upon entrance of R47's room and after completing R47's blood glucose. TMA-B further stated sometimes just get busy in the moment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 1/9/25 at 12:45 p.m., the Director of Nursing (DON) stated hand hygiene should be used upon entrance and exit of all rooms and with any glove removal. Furthermore, the DON stated hand washing with soap and water was required when indicated on signage outside of the room.