STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bethany	804 Wright Street Brainerd, MN 56401

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview, and document review, the facility failed to ensure a urinary catheter bag was placed in a privacy bag to maintain dignity for 1 of 3 residents (R25) reviewed for dignity. Findings include: R25's quarterly Minimum Data Set (MDS) dated [DATE], identified R25's cognition was severely impaired and diagnoses included Huntington's disease (a rare genetic disorder that affects the brain and causes movement, cognitive and mental health problems). R25 used an indwelling urinary catheter due to having a neurogenic bladder (when the relationship between the nervous system and bladder function was disrupted by injury or disease). R25's care plan revised 2/12/24, identified R25 had an indwelling catheter due to urinary outlet obstruction and neurogenic bladder. The care plan directed catheter care was performed by nursing assistants twice daily with cares and as needed. A non-adhesive secure anchor on leg. However, the care plan failed to direct staff to keep the catheter bag in a privacy bag to maintain dignity. During an observation on 10/14/24 at 5:20 p.m., R25 was lying in bed on his back with a fleece blanket covering R25 to his chest. The room lights were on and R25 was watching a tv program. R25's catheter bed bag was hanging from the bed frame and clearly visible from the hallway. The catheter bag was not in a privacy bag. During an observation on 10/15/24 at 2:18 p.m., R25 was lying in bed in his room. R25's catheter bed bag was hanging from the bed frame and was visible from the hallway. -At 3:16 p.m., activity aide (AA)-A visited with R25 at his bedside but did not cover R25's catheter bed bag before leaving. - At 3:59 p.m., R25's catheter bed bag continued to hang from R25's bed frame without a privacy bag and was clearly visible from the hallway. During an observation on 10/16/24 at 7:14 a.m., R25 was lying in bed with his catheter bed bag hanging from the bed frame without a privacy bag and was clearly visible from the hallway. (continued on next page)

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	- At 8:19 a.m., R25 was assisted into his wheelchair and registered nurse (RN)-C was observed placing R25's catheter bed bag in a privacy bag underneath R25's wheelchair. During an observation on 10/16/24 at 1:12 p.m., R25 was lying in bed with his catheter bed bag hanging from the bed frame. The catheter bed bag was clearly visible from the hallway. During an interview on 10/16/24 at 3:06 p.m., nursing assistant (NA)-D stated it was normal to hang the catheter bed bag from the bed frame on the hallway side of the bed because the catheter tubing was anchored to R25's right leg. NA-D stated she did put R25's catheter bed bag in a privacy bag when he was in his wheelchair but did not even consider it when he was in bed. NA-D stated a privacy bag was important to maintain R25's dignity and privacy. [NAME] needs to know about R25 catheter except R25. During an interview on 10/16/24 at 3:20 p.m., RN-C stated yea, staff hung R25's catheter bed bag from the bed frame without a privacy bag. That's just what we do. A privacy bag was available on the wheelchair, but it was not easily removed from the wheelchair because it was tied on. The facility used to use a different supply company that provided covers, but they no longer used that brand. The facility did not have privacy bags available for the resident's bed. RN-C stated it was much better because the catheter bed bag was always covered to maintain privacy and dignity and now anyone walking past R25's door could see R25's catheter. During an interview on 10/17/24 at 9:07 a.m., RN-B stated a catheter bed bag was supposed to have a privacy bag. Staff knew better. Staff had never been directed to place the catheter bed bag on one side of the bed or the other but had been directed to keep the catheter bed bag always covered because it was a privacy and dignity issue but also an infection prevention issue as well. Staff needed to allow as much dignity as possible because it was nobody's business that R25 had a catheter. During an interview on 10/17/24 at 10:53 a.m., the director of nursing stated all residents should have a privacy bag for their catheter bed bag on their bed and wheelchair. It was important to protect every resident's dignity and privacy as a person. The facility policy Resident Dignity revised 11/16/23, identified the facility would promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed ensure clinical monitoring was completed and documented for 2 of 3 residents (R37, R39) reviewed with recent COVID-19 infections. Findings include: R37's significant change Minimum Data Set (MDS) dated [DATE], identified R37 was [AGE] years old, had a severe cognitive impairment and diagnoses included chronic respiratory failure, atrial fibrillation, and chronic kidney disease. R37's care plan revised 9/26/24, identified R37 had a respiratory infection: COVID-19 and directed staff to observe for symptoms and monitor/document/report new or worsening signs/symptoms of COVID-19. R37's Order Summary Report dated 10/1/24 - 10/13/24, directed staff to obtain clinical monitoring - infection/suspected infection two times a day for 12 days. R37's progress from 9/26/24 through 10/4/24, identified R37 was positive for COVID-19 on 9/26/24 and R37's urine was collected for a urinary analysis and culture on 9/30/24. However, the progress notes failed to identify any monitoring of vitals, conditions, or symptoms during R37's COVID-19 infection and/or why the urine sample was collected. R37's Clinical Monitoring - Infection/Suspected Infection V10 dated 10/4/24 at 2:16 p.m., identified R37 was monitored for a respiratory and urinary infection, weight 189.8 pounds, temperature 97.0 degrees Fahrenheit (F), pulse 70, respirations 20, blood pressure 130/70 and oxygen saturations 98% on room air. R37 was alert and oriented t person and place and exhibited agitation and impaired decision making. R37 had a cough, lung sounds were clear and normal quality. Interventions included monitor/observe and fluids/hydration. However, R37's medical record failed to identify any clinical monitoring starting 9/26/24 through 10/3/24. R37's vitals record failed to identify vitals collected 9/26/24 though 10/4/24. R39's significant change MDS dated [DATE], identified R39 was [AGE] years old with diagnoses that included chronic obstructive pulmonary disease (COPD) (a common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), chronic kidney disease atherosclerotic heart disease, and atrial fibrillation. R39's care plan revised 7/23/24, identified R39 had an altered respiratory status/difficulty breathing related to COPD. Staff were directed to monitor for signs of respiratory distress and report to health care provider as needed: increased respirations; decreased pulse oximetry; increased heart rate (tachycardia); restlessness, headaches, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle usage; skin color changes to blue/grey. Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. However, the care plan did not direct staff to obtain vitals and/or where/how to document nor how frequently to do so, especially in times of illness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's progress notes 9/28/24 through 9/30/24, identified R39 tested positive for COVID-19 on 9/28/24, was hoarse and felt pukey. However, the progress notes failed to identify any monitoring of vitals, conditions, or symptoms during R39's COVID-19 infection. R39's vitals record failed to identify vitals collected 9/28/24 through 9/30/24. R39's medical record failed to identify Clinical Monitoring - Infection/Suspected Infection V10 completed for R39 from 9/28/24 through 9/30/24. During an interview on 10/16/24 at 3:14 p.m., registered nurse (RN)-C stated when a resident had COVID-19, RN-C would get vitals and, at least, lung sounds every shift and that's documented in the Clinical Monitoring - Infection/Suspected Infection V10 in the resident's assessment tab. During an interview on 10/16/24 at 3:59 p.m., RN-F stated, when a resident was ill, but especially COVID-19, RN-F would get vitals every shift and assess the resident for changes. RN-F would document this in the progress notes. RN-F stated she was unaware of the Clinical Monitoring - Infection/Suspected Infection V10 the assessment tab and had never used it. During a telephone interview on 10/16/24 at 7:42 p.m., nursing assistant (NA)-E stated, when a resident showed a possible sign or symptom of COVID-19, she notified the nurse on the unit and then would obtain a set of vitals for the nurse. NA-E would encourage the resident to stay in his/her room until a test was collected. After that, staff needed to be aware of a resident's condition, were they showing signs of COVID-19 and report that to the nurse. During a telephone interview on 10/16/24 at 7:43 p.m., RN-A stated when a resident started to show symptoms of illness, staff collected an COVID-19 antigen test and, if positive, the resident would be placed into transmission-based precautions that sort of thing. Clinical monitoring of the resident depended on symptoms. If the resident was having respiratory issues, nursing staff would listen to lung sounds and clinical monitoring documentation would be triggered in the resident's medical record. Implementation of clinical monitoring depended on the nurse on duty that shift. If it was a seasoned nurse, the unit nurse on duty would implement clinical monitoring. RN-E stated she did work 9/28/24 and 9/29/24. RN-A was aware of positive COVID-19 residents in the facility but did not recall personally assessing residents for illness and/or implementing clinical monitoring documentation in the residents' medical records. During an interview on 10/17/24 at 8:54 a.m., RN-F stated, when a resident was symptomatic for respiratory illness, an antigen COVID-19 test, and vitals were collected to determine if the resident had a fever and/or something else going on. RN-F then would document those findings in the vitals tab of the resident's medical record. After that, vitals would be collected and documented in the vitals tab every shift or more often depending on the resident's condition. RN-F stated she has never implemented the clinical monitoring form in the assessment tab nor put an order into direct staff to assess the resident every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 9:06 a.m., RN-B stated residents symptomatic for respiratory illness, staff were expected to evaluate the resident at least twice a day: lung sounds, vitals, etc. Night shift could also evaluate the resident depending on condition. Staff were directed to do this by implementing the Clinical Monitoring- Infections/Suspected Infections V10 form in the resident's assessments because that provided for the facility's infection control program. During weekend hours, nursing was expected to implement the Clinical Monitoring- Infections/Suspected Infections V10 form and, on Monday, RN-B would ensure this had been implemented. If not, RN-B would implement at that time. During a telephone interview on 10/17/24 at 10:00 a.m., RN-G stated, when a resident was showing symptoms of respiratory illness, the resident was first tested for COVID-19 with an antigen test and vitals were collected. After this, vitals and the resident's condition would be documented in a nursing progress note. This is what was routinely done, but how often really depended on how sick the resident was. RN-G stated R37 was fine on 9/28/24 and 9/29/24. RN-G did not collect vitals and/or assess R37 on 9/28/24 and/or 9/29/24 because R37 wouldn't stay in his room and he kept coming out and screaming at me. During an interview on 10/17/24 at 10:34 a.m., the director of nursing (DON) stated it was very disappointing to not find nursing assessments twice daily for R37 or R39 from 9/26/24 to 10/4/24. The DON expected staff to collect vitals and do a nursing assessment of any ill resident every shift while not feeling well. Any nurse can initiate the Clinical Monitoring- Infections/Suspected Infections V10 form in the resident's medical record. Additionally, the DON expected the unit manager to ensure it was implemented as well; this included the weekend nursing managers. This was the facility infection control process, and it allowed communication between staff. During an interview on 10/17/24 at 11:53 a.m., the administrator stated she expected staff to follow the facility's policies, procedures and/or processes and to also communicate with each other to keep the residents, staff, and visitors safe. The facility policy Emerging Threats - Acute Respiratory Syndromes Coronavirus (COVID) revised 4/19/24, identified residents were monitored for signs and symptoms of COVID-19 per routine practice. However, the policy failed to direct staff on frequency of monitoring and/or how monitoring should be documented. A policy regarding illness monitoring and documentation was requested but not received.

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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** 40948 Based on interview and document review, the facility failed to ensure an appropriate provider's order and rational for use were obtained for an indwelling urinary catheter for 1 of 3 residents (R30) who were reviewed for catheter care. Findings include: R30's significant change Minimum Data Set (MDS) dated [DATE] identified no cognitive impairment and identified R30 was always continent of bladder. R30's urinary/catheter assessment dated [DATE], identified resident was admitted to the unit with indwelling urinary catheter in place. The rational provided was the resident was on hospice. R30's provider's orders dated 9/30/24, identified an order for Foley Cath (catheter) Care dated 9/30/24. The provider's orders lacked any order for insertion or use of a Foley Cath, or the rational for the use of it. During observation on 10/16/24 at 12:25 p.m., R30 sat up in her bed and ate lunch. R30's Foley catheter bag was hanging on the side of her bed. During interview on 10/16/24 at 1:24 p.m., R30 stated she did not know why the catheter was placed. She could not think of a reason why she would need it. During an interview on 10/17/24 at 10:33 a.m., licensed practical nurse (LPN)-A stated R30 was admitted to the unit with the catheter already in place and could not find an order or reason it was placed. During an interview on 10/17/24 at 10:48 a.m., registered nurse (RN)-D stated if a resident needed a catheter there should be a provider's order and a rational for why a catheter was needed. This information would be important as it would drive the plan of care for the catheter. R30's medical record lacked any documentation of why the catheter was inserted. The R30's medical record did not contain an order for the catheter or the rational for why it was needed. During an interview on 10/17/24 at 11:02 a.m., the director of nursing (DON) stated it is the expectation that every resident who had a catheter in place would have had a provider's order for the catheter and the rational for why the catheter was needed. It would not be appropriate for a catheter to be placed just because a resident was on hospice. The facility's Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation and Specimen-LTC policy dated 7/30/24, identified a resident is not to be catheterized unless the clinical condition demonstrates that catheterization is medically necessary and is not used solely for nurse/physician convenience. Also identified Catheters will be utilized only with a physician's order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on observation, interview and document review, the facility failed to ensure staff provided care according to standards of practice and per physician orders for gastrostomy tube feeding for 1 of 1 resident (R15) reviewed for tube feedings. Finding include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of traumatic brain dysfunction, hemiplegia (one-sided paralysis or weakness), and seizure disorder. R15 was dependent on staff for bed mobility and had a gastrostomy tube (g-tube) for feeding. R15's Order summary report signed by the primary Physician on 8/28/24, identified an order for enteral feeding two times a day with Nutren 1.5 at 75 milliliters per hour (ml/hr., to run for 16 hours per 24-hour period. Elevate head of bed (HOB) greater than 30 degrees with tube feeding running, Start at 1700 (5:00 p. m.), end at 0900, for a total of 1200ml/day. Reset count to zero with new bag. R15's care plan dated 5/15/17, identified R15 required a tube feeding related to the inability to swallow. Staff were directed to elevate the head of the bed at least 30 degrees during and 30-40 minutes after tube feeding was stopped. During an observation on 10/16/24 at 8:56 a.m., nursing assistant (NA)-A and NA-B put on gowns and gloves and went to R15's room. R15 tube feeding was running at 75 (ml/hr.). R15's head of the bed was at a 30-degree angle. Staff lowered the head of the bed to do morning hygiene care. NA-A washed R15's face, hands, underarms, and breast, and performed perineal care. NA-A put on new gloves and applied a cream under R15's bilateral breasts. NA-A put a new gown on R15. The head of the bed was raised after the morning activities of daily living (ADL's) were completed around 9:20 a.m. During an interview on 10/15/24 at 9:36 a.m., NA-A stated R15 had a g-tube and R15 did not have negative effects when the head of the bed was lowered for care. Licensed nurses do not stop feeding when ADLs are being performed. During an interview on 10/16/24 at 9:36 a.m., NA-B stated nursing assistants cannot stop the g-tube feedings, and only a licensed nurse can stop a feeding. Lowering R15's head of the bed when doing care had not bothered R15. During an interview on 10/16/24 at 12:26 p.m., registered nurse (RN)-C stated the nursing assistants put the head of the bed down long enough to do care. The nursing assistant had never asked for the tube feeding to be stopped as it had not been an issue. On nights the tube feeding would be paused as R15 has vomited in the past on the night shift. During an interview on 10/16/24 at 2:00 p.m., RN-B stated staff would try to keep the head of the bed up. The nursing assistants did not ask the licensed nurses to put the feeding on hold. Between 2:00 a.m. and 4:00 a.m., R15 has vomited in the morning, and then the licensed staff will turn off the tube feeding and run it later during the day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 3:18 p.m., the director of nursing (DON) stated it would be her expectation that the head of the would be elevated if R15 could tolerate it. If staff needed to perform extensive care, then the feeding could be stopped. The facility Tube-Gastrostomy or Jejunostomy-Enteral Feeding, Care, Placement or Removal policy dated 12/4/24, directed staff to raise the head of the bed 30-45 degrees during feeding and keep elevated for 30-60 minutes after feeding to prevent regurgitation or aspiration unless contraindicated per physician's order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on observation, interview, and document review, the facility failed to ensure a discontinued presciption topical antifungal medication was detroyed and not administered; and failed to ensure only authorizied staff administered prescribed adminstered prescribed creams for 1 of 1 resident (R15) observed to have nursing assistants apply prescribtion creams during cares without an order. Finding include: R15's quarterly Minimum Data Set (MDS) dated [DATE], identified R15 had severe cognitive impairment and diagnoses of traumatic brain dysfunction, non-Alzheimer's dementia, hemiplegia (one-sided paralysis or weakness), and seizure disorder. R15 was dependent on staff for all activities of daily living (ADLs) such as personal hygiene, oral hygiene, bed mobility, and dressing. R15's Order summary report signed by the primary Physician on [DATE], identified Nystatin External Cream 1000 unit/gram (nystatin topical) and appply to under breast topically two times a day for rash related to rash and other nonspecific skin eruption until resolved; however the ordered was discontinued on [DATE]. R15's electronic medical administration record (EMAR) for [DATE] identified no administration for nystatin cream. During an observation on [DATE] at 8:56 a.m., nursing assistant (NA)-A and NA-B donned gowns and gloves and went to R15's room. NA-A and NA-B washed R15's face, underarms, under breasts, and performed perineal care. NA-A changed gloves and picked up a white tube of cream from the bedside table. Tube had a label from the pharmacy, NA-A squeezed out the last of the cream onto a gloved finger. NA-A applied the cream under both breasts. NA-A reported the cream being applied was Nystatin which goes under R15 breasts. The Nystatin tube was placed back on the side table. The pharmacy label was old, and the writing was worn off in some areas and unable to read the date it was filled and the date it expired. R15's name with the name of the medication nystatin was visible. During an interview on [DATE] at 12:26 p.m., registered nurse (RN)-C verified that R15 did not have a current order for nystatin cream. During an interview on [DATE] at 2:00 p.m., RN -B verified R15 did not have a current order for nystatin and the nursing assistants do not apply prescription creams. Prescription creams should be locked in the medication cart. During an interview on [DATE] at 3:18 p.m. director of nursing (DON) stated creams with a prescription like nystatin should be kept in the medication cart unless the resident had an order to keep them at the bedside. The DON's expected there would be an order for the medication being applied. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Medication: Administration including Scheduling and Medication Aids policy dated [DATE], directed the following: A provider's order for any medication is required and must include: diagnosis, name of medication, dose, route, frequency and STOP order if indicated. If the medication order is not legible or does not include the items listed above, the provider is notified for clarification prior to administration of medications. Medications are administered to the resident according to the Six Rights. All employees passing medications are familiar with action and adverse reactions of medications Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, Do not touch the medication with ungloved hands. Do not leave medications at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration.

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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** 40943 Based on observation, interview and document review, the facility failed to initiate appropriate transmission based precautions according to The Centers for Disease Control (CDC) for 2 of 3 residents (R11, R224) reviewed for transmission based precautions, failed to track and trend potential/actual infections for 6 of 6 residents (R11, R35, R36, R24, R1, R224) identified to have potential/actual infections; and failed to conduct COVID-19 testing per CDC guidelines for 5 of 5 residents (R11, R35, R36, R24, R15) who were identified to have COVID-19 signs and symptoms. This had the potential to affect all 68 residents residing in the facility. Findings include: Transmission-Based Precautions: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 was [AGE] years old, cognitively intact and diagnoses included acute prostatitis (a disorder of the prostate gland associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's care plan revised 7/24/24, identified R11 had an activities of daily living (ADL) self-care performance deficit related to weakness exhibited by inability to complete at baseline level. Staff were directed to provide extensive assistance of 1-2 for all care activities. However, the care plan failed to identify R11's COVID-19 diagnosis and/or need for transmission-based precautions. During an observation on 10/14/24 at 12:41 p.m., R11's room door was shut, and 3 signs were taped to the outside of the door: Enhanced Barrier Precautions, Contact Precautions and Droplet Precautions. In the hallway, to the left of R11's closed room door was a 3-drawer bedside stand next to the door that contained disinfectant wipes, N95 masks, gloves, surgical masks, and face shields. There was a facility laundry bin next to the bedside stand containing reusable gowns and was covered with a folded flat sheet. On the right of R11's closed room door was a covered, red biohazard linen container and a trash container. - At 1:13 p.m., nursing assistant (NA)-A approached R11's door and donned gloves, gown and continued to wear the same surgical mask. NA-A did not don eye protection and entered R11's door. - At 1:32 p.m., NA-A exited R11's room and doffed her gown, gloves and mask throwing the items in the uncovered trash. NA-A used hand sanitizer and donned a clean surgical mask. During an interview on 10/14/24 at 1:35 p.m., NA-A stated R11 had COVID. Staff needed to wear a gown, gloves, and a mask when they went into R11's room. The N95 and/or eye protection wasn't needed but was extra. NA-A stated you could wear it if you wanted to be extra careful. NA-A had never been directed to wear eye protection in a COVID positive room during her employment at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/14/24 at 1:45 p.m., registered nurse (RN)-C was observed exiting R11's room and doffed a gown, gloves, mask, and face shield. RN-C cleaned the face shield with a disinfectant wipe, put the soiled gown in the biohazard linen bin and threw the soiled gloves in the uncovered trash. RN-C stated the biohazard linen bin and trash container should be on the inside of R11's door, but there was no room for it. If it was on the inside of the door it would have to be at least 6 feet inside the room and that defeated the purpose of wearing personal protective equipment (PPE) inside R11's room. Staff were expected to wear a gown, gloves, N95 mask and eye protection whenever entering R11's door. During an interview on 10/15/24 at 12:38 p.m., the director of nursing (DON) stated R11 was placed into Droplet Precautions when he tested positive for COVID-19 on 10/7/24. The signage on the door tells staff what PPE was required. The DON stated no audits had been conducted to determine if staff were following guidance during the facility's COVID-19 outbreak. Because R11 had a suprapubic catheter, R11 was in Enhanced Barrier Precautions prior to getting ill. Having multiple signs on the door would be confusing for staff because which one should staff follow. However, the DON stated staff have been educated what PPE was required for COVID-19 and were expected to use it as directed. Additionally, all biohazard linen bins and trash bins should have been in the R11's room for staff to doff while in the room. There was room in the resident rooms for them. This was important to prevent the potential spread of infection between other residents, staff, and visitors. The Centers for Disease Control and Prevention (CDC) Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions updated 9/20/24, identified severe acute respiratory syndrome (SARS) (COVID-19) required droplet precautions for the duration of illness plus 10 days after resolution of fever, provided respiratory symptoms were absent or improving. R224's 5-day MDS dated [DATE], identified R224 was [AGE] years old and had intact cognition. R224's diagnoses included bacteremia, weakness, acute kidney injury and hypertension. R224 used an indwelling catheter and an antibiotic. The MDS failed to identify R224 had an infection with a multi drug resistant organism (MDRO). R224's Urinary Incontinence and Indwelling Catheter care area assessment (CAA) dated 9/29/24, identified R224 had an indwelling catheter, a urinary tract infection (UTI) and benign prostatic hyperplasia (BPH) (an enlarged prostate). The CAA further identified urinary incontinence and indwelling catheter use would not be addressed on R224's care plan. R224's care plan dated 10/14/24, identified R224 required Enhanced Barrier Precautions (EBP) related to R224's indwelling urinary catheter. Staff were directed to don a gown and gloves when performed high contact care activities including dressing, changing linens, repositioning, check and changing, device care and/or use, and wound care. Staff were directed to doff gown and gloves inside R224's room and perform hand hygiene. R224's physician orders identified R224's indwelling urinary catheter was placed on 9/11/24. R224's progress note dated 10/7/24 at 4:05 p.m., identified R224 had been hospitalized due to hypotension related hypovolemia (a condition in which the volume of blood plasma is too low. This causes a rapid heart beat, weak pulse, confusion, and loss of consciousness); acute kidney injury superimposed on chronic kidney disease, history of Methicillin-resistant staph aureus (MRSA). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R224's hospital discharge summary dated 9/26/24, identified R224 discharge diagnoses included MRSA sepsis and early septic shock due to complicated UTI and MRSA complicated UTI. R224 was to continue vancomycin (an antibiotic) for 4 weeks. During an interview on 10/15/24 at 8:29 a.m., R224's indwelling catheter was in a cloth cover lying on the floor of his room. R224 stated nursing was good about cleaning his indwelling catheter, but R224 never saw factility staff wear a gown like the hospital nurses did. During an observation on 10/15/24 at 11:03 a.m., R224's door was open with an Enhanced Barrier Precautions sign taped to the door.Registered nurse (RN)-H exited R224's room and doffed a gown and gloves. RN-H placed the gown in the red, covered biohazard linen container in the hallway and placed the soiled gloves in the uncovered trash. RN-H did not doff her surgical mask. - At 11:05 a.m., RN-H went approximately 50 feet down the hallway, around the corner to the nurses' station and donned gown and gloves on the way back to R224's room and entered. No PPE supplies were near R224's room. - At 11:10 a.m., RN-I approached R224's door, looked around then walked away asking staff why there were no gowns for R224. RN-I went to the nurses' station and donned a gown and gloves while returning to R224's room. RN-I stated over half the resident rooms required Enhanced Barrier Precautions due to surgical wounds. Because of this, there were not enough carts to go around and the nurses' placed gowns at the nurses' station to be centrally located. - At 11:15 a.m., RN-H exited R224's room with the soiled gown bunched up in her hand and placed the gown in the biohazard linen bin. - At 11:17 a.m., RN-I exited R224's room with a gown bunched up in her hand and placed the soiled gown in the biohazard bin. RN-I did not use hand sanitizer and went to her office with a visitor. During an interview on 10/15/24 at 11:19 a.m., RN-H stated R224 was on precautions due to having an indwelling catheter. RN-H stated she did not know what an MDRO was, but confirmed R224 did have MRSA. Well, R224 should have been on Contact Precautions but what's the difference. Staff were already wearing gowns, gloves, and masks. RN-H then stated she guessed it would depend on the infection, where the infection was and what the precautions should be. However, staff probably weren't even aware R224 had an infection. RN-H stated she was unaware R224 had an infection until asked and a Contact Precautions sign on R224's door may have triggered her to review his chart earlier to see what R224 had and what R224 required to keep other residents, staff, and visitors safe. During an interview on 10/15/24 at 11:45 a.m., laundry aide (LA)-A was observed donning a gown and gloves while walking down the hall from the nurses' station. LA-A stated a huge stack of gowns were delivered in a facility laundry bin on 10/14/24. LA-A had put one bin in each hallway and stated there just was not enough carts for each room, so she had tried to keep them centrally located. During an interview on 10/15/24 at 12:04 p.m., RN-J stated nursing staff moved the gowns to the nurses' station that morning because staff didn't want to run all over to get gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/15/24 at 12:12 p.m., the director of nursing (DON) stated she was not aware R224 had MRSA. R224 did have MRSA in his diagnosis list. However, diagnoses are entered by health information management (HIM) who only input the diagnosis code. Nursing is not alerted to high risk/high alert diagnoses by HIM. The admitting nurse reviewed a potential resident's hospital medical record then would send an email with information. The DON stated the initial review did not identify R224 required Enhanced Barrier Precautions on his initial admission. However, R224 was re-hospitalized and returned on 10/7/24 and Enhanced Barrier Precautions were then implemented. However, the DON stated R224's hospital discharge summary identified R224 had an active MRSA UTI and should have been placed into Contact Precautions when he was admitted to the facility on [DATE]. It was important for the staff to know the differences in the different type of transmission-based precautions and Enhanced Barrier Precautions to prevent the chance to spread infection not only between the residents but the staff as well. During an interview with the DON and RN-I on 10/15/24 at 12:57 p.m., RN-I stated she didn't review resident's charts for MDRO unless she had time to do so. If a resident was admitted on an antibiotic, it would prompt the implementation of Clinical Monitoring- Infections/Suspected Infections V10 form in the resident assessments. If there was an identified history of MDRO, Enhanced Barrier Precautions were implemented as well. After admission, if an infection was diagnosed , any nurse could implement the Clinical Monitoring-Infections/Suspected Infections V10 form as well. R224, RN-I stated more than likely RN-I was aware of the MRSA infection but could not verify that. If RN-I wasn't told by admission nurse, RN-I wouldn't go diving for that. RN-I stated she implemented Enhanced Barrier Precautions for R224 on 10/14/24 due to R224's indwelling catheter but R224 should have been in Contact Precautions since his admission on 9/26/24 because he had an active MRSA infection to prevent the spread of infection. Additionally, the soiled bins should be on the inside of the room. The DON stated they clearly had a process problem and needed to educate their staff. The Centers for Disease Control and Prevention (CDC) Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions updated 9/20/24, identified Multidrug-Resistant organisms (e.g. MRSA) required contact precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. The facility policy Multidrug-Resistant Organisms, MRSA, VRE, CRE and ESBL, All Service Lines revised 4/12/24, identified residents colonized with a CDC-targeted [NAME] and select epidemiologically important MDROs at the facilities discretion are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because [NAME] colonization is prolonged and follow-up testing to determine clearance may yield false negatives, CDC does not recommend routine retesting of residents with a history of colonization or infection with a targeted MDRO. Use contact precautions when the resident is infected or colonized with an MDRO and secretions and excretions are unable to be contained. This includes: - Residents with multidrug-resistant organism infected or colonized wounds that cannot be covered fully by dressings or who have drainage that cannot be contained by dressings. Residents with fecal or urinary carriage of multidrug-resistant organisms whose urine or stool cannot be contained in incontinent products, urine bags or ostomy bags. - Residents with a tracheostomy who have colonized or infected respiratory tracts and large amounts of uncontained respiratory secretions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Residents who have been linked to transmission of multidrug-resistant organisms. The policy further directed for infections (e.g., C. difficile, norovirus, scabies) and other conditions where Contact Precautions is recommended see Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions. Surveillance: The Infection Control Report - September 2024, identified the infection rates for the facility, an analysis of the data collected, resident name, room, source, site, comments and dates of infection and a color-coded map. R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 was [AGE] years old, cognitively intact and had diagnoses that included acute prostatitis (a disorder of the prostate gland associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's progress note dated 9/26/24 at 8:30 p.m., identified R11 reported that he was feeling feverish. Temperature 98.3 degrees F. However, R11's medical record failed to identify if R11 was placed in transmission-based precautions until a confirmatory test was collected. The facility's Infection Control Report - September 2024 failed to identify R11's symptoms. R35's annual MDS dated [DATE], identified R35 was [AGE] years old and had diagnoses that included chronic kidney disease and Type 2 diabetes. R35's progress note dated 9/26/24 at 1:48 p.m., identified R36 slept in bed throughout shift. R35 reported feeling run down and achy. The facility's Infection Control Report - September 2024 failed to identify R35's potential infection symptoms. R36's quarterly MDS dated [DATE], identified R36 was [AGE] years old and had diagnoses that included hypertension, heart disease, dysphagia, and congestive heart failure. R36's progress note date 10/2/24 at 1:38 p.m., identified R36 was withdrawn and not eating or drinking much. R36's face was flushed, dry and ruddy. R36 was slow to respond when spoken to. R36's temperature was 98 degrees F. The facility's Infection Control Report - September 2024 failed to identify R35's potential infection symptoms. R24's quarterly MDS dated [DATE], identified R24 was [AGE] years old and had diagnoses that included hypertension and Type 2 diabetes. R24's progress note dated 10/16/24 at 4:33 p.m., identified R24 was warm to touch, diaphoretic (excessive sweating). R24's vitals were as follows: blood pressure 118/73, temperature 98.0 degrees F, blood sugar 129, respirations 18, heartrate 74. R24 complained of increased discomfort to bilateral legs after therapy. Tylenol 650 mg administered x 1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Infection Control Report - September 2024 failed to identify R24's potential infection symptoms. R15's quarterly MDS dated [DATE], identified R15 was [AGE] years old and had diagnoses that included diabetes insipidus and hypertension. R15's progress note dated 10/15/24 at 4:24 p.m., identified R15's skin felt very warm, but her temp was 97.7 degrees F. R15 was frowning and upset when staff approached her. R15 was less irritable when not touched. R15 she pinched and scratched nurse's forearms when nurse attempted to take temperature. The facility's Infection Control Report - September 2024 failed to identify R15's potential infection symptoms. During an interview on 10/17/24 at 10:30 a.m., the DON stated she was responsible for the facility's infection control program. The DON used two processes for the facility's infection surveillance. The first process was the infection dashboard in the facility's electronic medical record system. The nurses entered resident infection data into Clinical Monitoring- Infections/Suspected Infections V10 form in the resident assessments. Every morning that information was pulled into the infection log. The DON stated the facility's infection surveillance log was dependent on nursing to enter the data or it would not be reflected on the surveillance reports. When reviewing the infection control dashboard in the electronic medical record system, each individual resident would need to be reviewed. For an example, when a resident tested positive for COVID-19, Clinical Monitoring- Infections/Suspected Infections V10 form was completed every shift until the resident's illness resolved. If the form was not completed, the data would not be pulled into the log. The second process was a paper log. The DON was taking information from the dashboard and entered the data in the paper log. The DON stated she did not know how to print any reports from the dashboard, and this eased tracking and trending. The DON stated resident illness needed to be tracked to determine trends in the facility and for the prevention of possible spread of infection. A facility policy regarding infection control surveillance was requested but not received. A copy of the facility's dashboard surveillance was requested but not received. A copy of the facility's Infection Control Report - October 2024 was requested but not received. COVID-19 Testing: The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 3/18/24, identified the decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- If using NAAT (molecular) (A Nucleic Acid Amplification Test is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs detect genetic material (nucleic acids). NAATs for SARS-CoV-2 specifically identify the RNA (ribonucleic acid) sequences that comprise the genetic material of the virus), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT. - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. - If a patient suspected of having SARS-CoV-2 infection is never tested , the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions. R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 was [AGE] years old, cognitively intact and had diagnoses that included acute prostatitis (a disorder of the prostate gland associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's progress note dated 9/26/24 at 8:30 p.m., identified R11 reported that he was feeling feverish. Temperature 98.3 degrees F. COVID test repeated with negative results. R11's medical record failed to identify if R11 had a confirmatory COVID-19 test and/or if/when R11 had been placed in isolation. R35's annual MDS dated [DATE], identified R35 was [AGE] years old and had diagnoses that included chronic kidney disease and Type 2 diabetes. R35's progress note dated 9/26/24 at 1:48 p.m., identified R36 slept in bed throughout shift. R35 reported feeling run down and achy. Covid swab was negative. R35's medical record failed to identify if R35 had a confirmatory COVID-19 test and/or if/when R35 had been placed in isolation. R36's quarterly MDS dated [DATE], identified R36 was [AGE] years old and had diagnoses that included hypertension, heart disease, dysphagia, and congestive heart failure. R36's progress note date 10/2/24 at 1:38 p.m., identified R36 was withdrawn and not eating or drinking much. R36's face was flushed, dry and ruddy. R36 was slow to respond when spoken to. R36's temperature was 98 degrees F. R36's Covid Swab test was negative. R36's medical record failed to identify if R36 had a confirmatory COVID-19 test and/or if/when R36 had been placed in isolation. R24's quarterly MDS dated [DATE], identified R24 was [AGE] years old and had diagnoses that included hypertension and Type 2 diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R24's progress note dated 10/16/24 at 4:33 p.m., identified R24 was warm to touch, diaphoretic (excessive sweating). R24's vitals were as follows: blood pressure 118/73, temperature 98.0 degrees F, blood sugar 129, respirations 18, heartrate 74. Rapid Covid screen negative. R24 complained of increased discomfort to bilateral legs after therapy. Tylenol 650 mg administered x 1. R24's medical record failed to identify if R24 had a confirmatory COVID-19 test and/or if/when R24 had been placed in isolation. R15's quarterly MDS dated [DATE], identified R15 was [AGE] years old and had diagnoses that included diabetes insipidus and hypertension. R15's progress note dated 10/15/24 at 4:24 p.m., identified R15's skin felt very warm, but her temp was 97.7 degrees F. R15 was frowning and upset when staff approached her. R15 was less irritable when not touched. R15 she pinched and scratched nurse's forearms when nurse attempted to take temperature. R15 was tested for COVID-19 and R15's antigen test was negative. R15's medical record failed to identify if R15 had a confirmatory COVID-19 test and/or if/when R15 had been placed in isolation. During an interview on 10/17/24 at 10:30 a.m., the DON stated she tracked positive COVID-19 residents and staff. Also, a list of residents and staff tested due to outbreak testing was available. However, residents who were tested due to symptoms were only tracked by the progress note in each resident's medical record and were not tracked. Additionally, symptomatic residents who had an antigen test negative result were not placed into transmission-based precautions and/or a confirmatory test collected. The facility policy Emerging Threats - Acute Respiratory Syndromes Coronavirus (COVID) revised 4/19/24, identified residents were monitored for signs and symptoms of COVID-19 per routine. practice. Residents with symptoms of COVID-19 will be isolated and tested immediately. Removal from isolation will follow current CDC guidelines.