STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation and Living Center	1900 Ballington Boulevard NW Rochester, MN 55901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to timely revise the care plan to include an individualized toileting/incontinence plan for 1 of 3 residents (R1) who were reviewed for impaired skin integrity that had impaired skin integrity. Findings include: R1's face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis, hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel.R1's Significant Change Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet.R1's Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows:-Inspect skin daily with cares. (dated 10/31/25)-Follow wound care orders. (Dated 11/11/25)-Weekly skin checks completed by nursing. (dated 12/15/25)-Pressure ulcer care to left heel as ordered. (dated 1/15/26)-Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26)-Gel mattress applied 2/13/26. (dated 2/16/26).R1's care plan did not include an individualized toileting plan.R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a new stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm and contact dermatitis on left and right gluteal fold.R1's IDT Final Post Review Follow Up dated 3/10/26 however was signed on 3/23/26, identified R1's new skin issue (did not identify what skin issue). Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident is that resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect a revision to include any repositioning schedule nor incontinence care increased until 3/17/26 (seven days after the IDT review).Review of R1's care plan from 3/3/26 through 3/16/26 did not identify revisions pertaining to increased incontinence care.R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side. R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. Air mattress was placed on R1's bed. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed as a Kennedy terminal ulcer/End of Life. Progress listed as deteriorating; wound characteristics listed as deteriorated; Pressure ulcer staging as a Stage 4 pressure ulcer; wound in house acquired; increase in exudate (drainage); increase in size and smell; pain described as sharp; measurements recorded as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation. R1's skin focus care plan was revised on 3/17/26 to include the following:-Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown. R1's elimination focus care plan revised on 3/17/26, identified R1 had incontinence due to neurogenic bladder. Goal to cooperate in establishing a routine for urine elimination. Interventions as follows:-Use bedside commode and no longer use the bedpan.-Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance.During an interview on 3/24/26 at 3:57 p.m., nursing assistant (NA)-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing. NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened.During an interview on 3/25/26 at 4:11 p.m., DON stated R1care plan had not been revised to include a turning and repositioning schedule, nor did her toileting care plan revised to not have R1 use the bedpan until 3/17/26. DON explained R1's care plan should have been revised as soon as she heard that R1 was falling asleep while sitting on the bedpan and not waited until 3/17/26 until after R1's pressure ulcer had worsened.Review of the facility's Comprehensive Care Plan Policy dated 4/11/25. Identified The purpose of this policy is to ensure that all residents receive individualized, person-centered care through the timely development, implementation, and ongoing review of comprehensive care plans. This policy ensures alignment with federal regulations and professional standards by outlining processes that assess resident needs and preferences, coordinating interdisciplinary team input, and promoting culturally competent and trauma-informed care.Development of the Care Plan. The comprehensive care plan must be:(a) Developed both: Within seven (7) days after completion of the comprehensive assessment, and Within 21 days after the resident's admission.(b) Prepared by an IDT that includes but is not limited to:The attending physician or, if unavailable, the designated non-physician practitioner (NPP) who is involved in the resident's care, to the extent permitted by state law.A registered nurse with responsibility for the resident.

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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** Based on observation, interview, and document review the facility failed to comprehensively assess an area of moisture associated skin damage and failed to notify the physician for 1 of 1 resident (R3) reviewed for non-pressure skin issues. Findings include:R3's face sheet dated 3/27/26, identified diagnoses of diabetes, Crohn's disease, and kidney transplant.R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and receives dialysis. R3's Wound assessment dated [DATE], identified R3 had a resolved moisture associated skin damage (MASD) to his right gluteus. R3's progress note dated 3/9/26, identified sacral wound cleansed and creams applied to sacrum as well. Sores are still open and present and R3 experienced pain with application of creams. R3's record did not identify measurements of the wounds or any other wound characteristics, nor evident of physician notification.R3's Wound assessment dated [DATE], identified R3 had an open lesion to the right gluteus that measured 0.3 centimeters (cm) x 0.21 cm. R3's wound assessment did not identify the type of wound nor other wound characteristics. R3's record did not identify physician had been notified or any treatment for open lesion. R3's Wound assessment dated [DATE], identified R3 had an open lesion to the right gluteus that measured 0.6 cm x 0.74 cm. No other characteristics were documented.R1's progress note dated 3/20/26, identified nurse practitioner in facility to assess R3's right gluteal fold wound. NP is going to send new orders for wound care via fax. Instructed to cleanse, apply skin prep to surrounding tissue, apply Medihoney (an ointment that supports the removal of necrotic tissue and aids in wound healing) to wound bed and cover with foam dressing. R3's nurse practitioner note dated 3/20/26, identified R3 had a stage 3 pressure ulcer on left buttocks that measured 1.0 cm x 0.3 cm x less than 0.2 cm with 100% slough (yellow-tan necrotic tissue) in wound bed. Plan to cleanse daily with wound cleanser, pat dry, apply MediHoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam bordered dressing. Turn and reposition frequently and have dietician evaluate for nutrition support and wound healing. R3's physician orders identified the following order: -Cleanse buttocks and pat dry, apply house barrier cream twice daily and as needed for incontinence cares. (3/5/26 through 3/20/26)-Left buttocks: Cleanse with wound cleanser, apply Medihoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam dressing, change daily and as needed at bedtime. (dated 3/20/26) R1's record did not identify a treatment to the right gluteus wound. R3's progress note dated 3/24/26, identified a nutrition/dietary had a review of R3 due to new wound on gluteus that per registered nurse (RN) was considered a stage 2.R3's progress note dated 3/24/26 at 1:00 p.m., identified an email sent to the nurse practitioner (NP) wanting to follow up on the staging of a previously moisture associated skin damage to R3's right gluteal area that was staged as a stage 3 pressure ulcer. Will wait for a response from NP regarding wound classification. During an interview on 3/26/26 at 1:45 p.m., director of nursing (DON) stated she had sent an image of R3's right gluteal wound to the nurse practitioner to evaluate prior to doing rounds on 3/20/26. DON explained R3's wound had not had a notification or gotten treatment until 3/20/26 and the physician should have been notified as soon as the wound was identified. DON was unaware the NP had labeled R3's wound as his left buttocks when it was his right gluteal area nor that it was classified as a stage 3 pressure ulcer. DON believed the wound may be moisture associated skin damage and was reaching out to a different provider to assist with the determination of the wound. During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated he had received a call from the facility to review an image of R3's right gluteal wound to assist with classification of the wound. MD stated he will be doing a telehealth video visit today (3/26/26) to assess R3's wound on his right gluteal area to see if he (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be able to classify what type of wound it was. During an interview on 3/26/26 at 4:30 p.m., R3 stated he has this recurring area on his right buttocks that is painful. R3 stated he leaked stool ever since he had surgery a long time ago and staff put a special pad near his rectum to try and catch the stool. R3 got a special cushion for his wheelchair seat but a donut cushion for his chair was on order to help his bottom not hurt so bad. Just waiting for it to be delivered. During an observation and interview on 3/26/26 at 4:39 p.m., DON performed a telehealth visit with the medical director (MD) to assess R3's right gluteal wound. DON removed R3's brief where a foam dressing was on R3's right gluteus. DON removed the dressing where an approximately 0.5 cm x 0.5 cm open wound was present over what appeared to be a scar- pink skin was noted at the base of the wound, with maceration (occurs when the skin is exposed to moisture for too long) surrounding the wound. R3 stated he had an anal fistula (a tunnel that develops between the inside of the anus and the outside of the skin) repair over 40 years ago and had leaked stool ever since and believed it was in that same area of the wound. MD then assessed R3's wound and explained that the wound was not pressure related, and he would classify the wound as MASD due to the continued leaking stool and wanted to continue the current treatment and have the certified wound nurse practitioner evaluate the wound the next day to give further recommendations. During an interview on 3/26/26 at 5:15 p.m., registered nurse (RN)-D stated R3's wound was never on his left buttocks, however, the wound orders were for the left buttocks, but she just thought it was a mistake and had been applying the treatment to the right gluteal open area since there was no open area on the R3's left buttocks. During an interview on 3/26/26 at 2:01 p.m., director of nursing (DON) stated R3's right gluteus wound was identified as an open lesion, due to not feeling comfortable in being able to assess the type of wound R3 had on his buttocks. DON stated when the NP assessed the wound on 3/20/26 she identified it on the left buttocks, which was incorrect due to the wound his right gluteus that was assessed and as a stage 3 pressure ulcer and gave orders. DON initially thought the wound was a stage 2 pressure ulcer, but after review of R3's chart identified R3 had a history of MASD in the same areas in February. DON stated she relied on the certified wound nurse to assist with staging or to identify the type of wound, however, had not reached out to get clarification on R3's wound type. During an observation and interview on 3/27/26 at 7:31a.m., certified nurse practitioner wound nurse (CNP-WOC) assessed R3's right gluteal wound and classified the wound as MASD and changed the treatment order to the following: wash with normal saline, pack wound with collagen (wound dressing that promotes healing by stimulating new tissue growth), cover with foam, change daily and as needed soiling, may use barrier cream to surrounding peri wound for redness or irritation. Review of the facility's Wound Treatment Policy dated 1/21/26, identified Residents with wounds will receive necessary treatment and services, in accordance with provider orders and professional standards of practice, to promote healing, prevent infection, and prevent the development of new wounds unless clinically unavoidable. Wound treatment will be delivered using evidence-based practices, individualized to each resident's assessed needs, and documented, monitored, and reviewed to ensure effectiveness and regulatory compliance.I. General Requirements:Based on the comprehensive assessment of a resident, the facility will ensure that residentswith pressure injuries and other types of wounds receive necessary treatment and services,consistent with professional standards of practice, to promote healing, prevent infection,and prevent the development of new wounds unless clinically unavoidable.Wound treatment and monitoring will be:Individualized based on the wound's etiology, contributing factors, and the residents.overall condition, goals, and preferences.In accordance with the residents' comprehensive care plan; andConsistent with professional standards of practice.II. Comprehensive Wound Assessment:A comprehensive assessment will be completed for each wound to determine etiology andcontributing factors. This assessment will include:Underlying causes of the wound (e.g., pressure, shear, friction, vascular insufficiency,moisture, trauma, or other etiology);Contributing conditions or risk factors (e.g., nutrition, hydration, perfusion, mobility,incontinence, comorbidities, medications); andConsistent measurement of wound characteristics, including location, size, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depth,tunneling, undermining, exudate, tissue type, and condition of the peri-wound skin.III. Treatment Orders:Wound treatments will be provided in accordance with provider orders, including:The cleansing method,Type of dressing, andFrequency of dressing changes.In the absence of treatment orders, the licensed nurse will notify the provider to obtain.orders. This may be the designated treatment nurse or the assigned licensed nurse in theabsence of the treatment nurse.Treatment orders will be guided by current evidence-based wound care practices andinterdisciplinary input when needed (e.g., wound specialist, dietician, therapy staff).Pain associated with wound care will be assessed and managed in accordance with provider.orders and pain management policies and procedures.IV. Treatment Decisions:Treatment decisions will be based on:Etiology of the wound:Pressure injuries.Non-pressure wounds (e.g., arterial, venous, diabetic, moisture-related skindamage).Surgical wounds.Incidental injuries/wounds (e.g., skin tear, medical adhesive-related injury).Atypical injury/wound (e.g., dermatological, or cancerous lesion, pyoderma,calciphylaxis).Characteristics of the wound:Pressure injury stage or level of tissue destruction if not a pressure injury.Size, including shape, depth, and presence of tunneling and/or undermining.Volume and characteristics of exudate.Presence of pain.Presence of infection or need to address bacterial bioburden.Condition of the tissue in the wound bed.Condition of peri-wound skin.Location of the wound; andGoals and preferences of the resident or their representative.Guidelines for dressing selection may be utilized in obtaining provider orders.

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F 0686 Level of Harm - 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** Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 3 of 4 residents (R1, R4, R5) reviewed for pressure ulcers.ˆThis caused actual harm to R1 who developed anˆavoidableˆunstageable pressureˆulcer onˆher coccyx which needed surgical debridement and hospitalization.ˆˆ Findings include:ˆˆ Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. i Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R1's face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis (MS), hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel. R1's nursing home nurse practitioner (NP) note dated 2/6/26, identified R2 had a stage 2 pressure ulcer on left buttocks that had resolved and a deep tissue injury to the left heel. R1's hospital Discharge summary dated [DATE], identified R1 had been hospitalized for an insertion of a pain management pump. R1 had a preexisting pressure induced deep tissue damage to the left heel and a new gluteal cleft lesion for which the wound nurse had been consulted.ˆ R1's hospital after visit summary (AVS) dated 2/24/26, identified R1 had irritant contact dermatitis on her bilateral gluteal cleft and had treatment to cleanse area twice daily and apply barrier cream three times per day and as needed.ˆ (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Braden Scale for Prediction of Pressure Ulcer Risk Evaluation dated 2/24/26, identified R1 was high risk for developing pressure ulcers due to being slightly limited to respond to verbal commands, cannot always communicate discomfort or need to be turned, beingˆ constantly moist, chairfast, very limited mobility due to making only slight changes in body or extremity position but unable to make frequent or significant changes independently, probably inadequate nutrition, and potential problem with friction and shear. R1's ADL focus care plan dated 10/31/25, identified R1 triggered in ADL's because she had preferences and other items of need. Goal to maintain current level of ADLs. Interventions as follows: -Assist of two for bed mobility. (dated 2/24/26) -Assist of two using full body mechanical lift for transfers. (dated 2/24/26) R1's physician orders identified an order dated 11/7/25 to frequent every 2 hours repositioning for wound care. R1's Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows: -Inspect skin daily with cares. (dated 10/31/25) -Follow wound care orders. (Dated 11/11/25) -Weekly skin checks completed by nursing. (dated 12/15/25) -Pressure ulcer care to left heel as ordered. (dated 1/15/26) -Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26) -Gel mattress applied 2/13/26. (dated 2/16/26) ˆ R1's Nursing Data Collection Admission/readmission form dated 2/24/26, identified an unstageable pressure ulcer on left heel that was present on admission/readmission, with no measurements or characteristics of the wound. R1 also had contact dermatitis of the left and right gluteal fold, with no measurements or characteristics. Nursing Data Collection identified R1 could not reposition while lying in bed, did not ambulate, not able to reposition when sitting in chair or wheelchair, had a pressure reducing wheelchair cushion in place and had a pressure reducing mattress.ˆ R1's Significant Change Minimum Data Set (MDS) dated [DATE], identified ˆR1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet. R1's Nursing Weekly Skin Check dated 2/27/26, identified R1 had an unstageable pressure ulcer to the left heel and contact dermatitis to the left and right gluteal fold.ˆ Weekly Skin Check did not identify measurements or other wound characteristics. Review of R1's Treatment Administration Record (TAR) from 2/1/26 through 2/28/26, included a physician order dated 11/7/25 to reposition R1 every 2 hours. Documentation noted one refusal marked on 2/12/26 at 2:00 a.m. Repositioning not signed off on 2/25/26 at 8:00 a.m.; 2/26/26 at 10:45 p.m.; and 2/27/25 at 10:45 p.m. R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm (no depth was documented even though the record identified the wound as stage 2 pressure ulcer.) Additional wound was unstageable pressure ulcer on left heel that measured 2.29 cm x 2.15 cm x 0.1 cm. (no other characteristics included). Contact dermatitis on left and right gluteal fold (no measurements or further description included). Comment of new coccyx pressure ulcer stage 2 and will be seen by wound nurse tomorrow.ˆ R1's record identified a Situation, Background, Assessment, Response (SBAR) dated 3/3/26 to inform physician of stage 2 pressure ulcer on coccyx. Nursing intervention to cleanse with normal saline, place Mepilex (name brand of foam) dressing to area daily (in accordance with facility standing orders) and as needed if soiled or dislodged. Also stated need recommendations for restriction 30 degrees so resident is not bedbound.ˆ SBAR also indicated that will talk with R1 about adding back air mattress.ˆSBAR did not indicate (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measurements of wound, nor any other wound characteristics. During an interview on 3/25/26 at 9:32 a.m., environmental services director (ESD) stated his department moved R1 to a different room on 3/4/26, however, the gel mattress never got moved to her new bed. R1's Interdisciplinary Team (IDT) Team Initial Post Investigation Review dated 3/5/26 at 12:00 p.m., identified a new skin condition from 3/3/26 in which after the review of investigation the IDT's root cause of the incident was that R1 was staying in bed more often, per choice and is incontinent of bowel and bladder and is extensive assistance with bed mobility, unable to make micro-shifts.ˆ R1's care plan was reviewed and root cause identified. R1 was high risk for skin breakdown due to reasoning as the forementioned. Treatment interventions are put in place and carried out. R1's Wound Nurse Practitioner visit note dated 3/5/26, indicated reason for visit was wound follow up of left heel and a new coccyx wound.ˆ R1's heel continues to improve and is nearly closed, has a new open area on her bottom.ˆ R1 spends a lot of time in bed and encouraged to offload when in bed and wheelchair. The area is over a bony prominence and appears to be pressure related. Plan for coccyx wound was to cleanse and pat dry and cover with foam dressing,ˆair mattress, pressure offloading, dietician consult for wound supplement recommendations. Review of R1's record from 3/3/26 through 3/16/26 identified the care plan had not been revised nor evident that an air mattress had been placed on R1's bed per wound nurse recommendations on 3/5/26. Review of R1's TAR from 3/1/26 through 3/20/26, identified a physician order dated 11/7/25 to reposition every 2 hours; did not identify R1 had any refusals of repositioning, however, repositioning had not been signed off as completed on 3/2/26 at 10:45 p.m. R1's Incontinence focus care plan revised on 11/3/25, identified R1 had altered elimination, needed treatment/monitoring/cares due to neurogenic bladder. Corresponding interventions dated 11/12/25 directed to empty Purewick (external urine collection system) and on 12/4/25 directed to Change Purewick cannister per order. R1's IDT Final Post Review Follow Up dated 3/10/26 (signed on 3/23/26), identified R1's new skin issue (did not identify what skin issue).ˆ Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident was documented as resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect revision for any increases in repositioning since 11/7/25, nor did the incontinence care get increased, and not evident an individualized toileting program or schedule was developed and implemented. During an interview on 3/25/26 at 4:11 p.m. director of nursing (DON) explained the 3/10/26 IDT Final Post Review follow up indicated there would be an increase in incontinence care because she had heard R1 had been falling asleep on the bed pan, however, R1's care plan had not been revised to reflect she should not use the bedpan and should be using a commode instead. R1's Skin Issue Wound assessment dated [DATE], identified R1 had a pressure ulcer/injury to middle coccyx that was stable: previously deteriorating; was in house acquired with onset date of 3/2/26.ˆ The assessment identified coccyx wound measurement of 1.79 cm x 4.03 cm which indicated worsening from the previous assessment on 3/3/26 measurement of 1.84 cm by 1.14 cm. The 3/12/26 assessment also described the wound as no tunneling, surrounding skin fragile, and no exudate.ˆThe assessment did not include any other characteristics. R1's coccyx wound's corresponding image taken 3/12/26, identified a large dark purple line on the left buttocks that extended to the right side of the buttocks. An unopened blister was noted on the left buttocks near the lateral part of the purple area.ˆ R1's skin surrounding the wound was red in color. ˆ During an interview on 3/25/26 at 11:14 a.m., registered nurse case manager (RN-CM) stated she assessed R1's coccyx wound on 3/3/26 and 3/12/26, however, during the 3/12/26 assessment R1's wound appeared stable to her. RN-CM confirmed R1's wound had increased in size and had a change in color which could indicate the wound was beginning to worsen. RN-CM stated the purple discoloration in the image did not appear as purple to her but more of a brown color and appeared more like a scab. RN-CM could not identify the type of wound associated with the purple discoloration she had documented on the 3/12/26 assessment. RN-CM indicated during the assessment she did not identify (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's bed did not have the gel mattress according to the care plan. ^RN-CM reported she did not notify the physician of the increase in size of the wound or the change in color. During an interview on 3/25/26 at 4:11 p.m., DON stated RN-CM described R1's coccyx wound to her on 3/12/26, and by the description she believed that R1's coccyx wound had begun to change. DON explained she had instructed RN-CM to notify the physician; however, DON had not evaluated the wound herself to see what the changes were. ^DON further explained she had not followed up to ensure that the physician had been notified nor evaluated if R1's pressure relieving interventions were effective. DON reviewed R1's record and explained R1's wound assessment that had been completed on 3/12/26 showed a change in R1's wound from previous assessments showing deterioration. DON further explained R1's wound had not been staged in the assessment and should have been identified as a deep tissue injury. DON stated the physician should have been notified and R1's turning and repositioning schedule should have been reevaluated/increased, however, was not completed.^ R1's progress note dated 3/16/26 at 10:25 p.m., identified after R1's bath skin was assessed and noticed that coccyx area was dark purple/black in color with an odor. R1's record did not identify any other characteristics of the wound including measurements nor physician notification of newly identified discoloration.^ R1's progress note dated 3/17/26 at 4:41 p.m., was called to R1's bedside due to change sacral dressing due to soilage. Wound noted to be increased in size and drainage noted. Management updated. R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side (which was the original treatment order dated 11/7/25, identifying no increase in frequency). R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. ^Air mattress was placed on R1's bed.^ During a follow up interview on 3/25/26 at 12:15 p.m., ESD explained a request had been made on 3/17/2 to place an air mattress on R1's bed, however, the maintenance staff mistakenly marked off that it was completed prior to being placed and R1's air mattress had not been placed on her bed until 3/18/26. According to an earlier interview on 3/25/26 at 9:32 a.m. ESD indicated that's when we found out the gel mattress had not moved to the new room with her on 3/4/26. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type listed as a Kennedy terminal ulcer/End of Life stage 4 pressure ulcer that was in house acquired. The note identified the wound was deteriorating (from the previous assessment 3/12/26 noted 1.79 cm x 4.03 cm.) measurements on 3/17/26 documented as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation and pain described as sharp. R1's progress note dated 3/17/26, identified wound assessment dated [DATE], documented as a Kennedy terminal ulcer/End of Life. Upon further clinical review, R1 was not actively dying and did not meet the criteria for a Kennedy terminal ulcer. R1's wound was more consistent with a pressure injury related to immobility, moisture exposure, and high-pressure injury risk.^ The wound will be managed according to the facility pressure injury protocol and wound care recommendations.^ Wound measurements, staging, and treatment orders remain accurate and ongoing monitoring will continue.^ ^ R1's skin focus care plan was revised 3/17/26 to include the following interventions: -Turn and reposition every 2 hours and as needed, with continued staff encouragement and education if declines. -Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown.^ -Provide coccyx wound care as ordered. ^ R1's elimination focus care plan revised on 3/17/26 to include the following interventions: -Use bedside commode and no longer use the bedpan. -Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance. During an interview on 3/25/26 at 4:11 p.m., DON stated on 3/17/26 R1's toileting care plan had been revised to not use the bedpan because she had heard from staff that R1 was falling (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	asleep while sitting on the bedpan and this likely caused the development of a deep tissue injury on 3/12/26. DON explained that R1's care plan should have been revised at the time she heard about R1 falling asleep on the bedpan and not waited until R1's wound worsened on 3/17/26. R1's nurse practitioner note dated 3/18/26, identified nursing had notified NP about wound concerns with a worsening wound to coccyx. New orders to wound to cleanse with normal saline, pat dry, apply skin prep to surrounding intact skin, apply iodosorb (a sterile antimicrobial wound dressing used to remove slough/debris and killing bacteria) mixed with hydrogel to open wound, place foam dressing, change daily and as needed if soiled or dislodged.^ Nursing had implemented a scheduled offloading pressure every 2 hours and will no longer be using a bedpan. R1 now has an air mattress to relieve pressure. Review of R1's care plan identified the additional intervention of the air mattress on 3/18/26. During an interview on 3/25/26 at 4:11 p.m., DON stated she thought the NP was going to physically assess R1's buttock wound on 3/18/26, however, the NP only reviewed image from 3/17/26 and gave orders.^ R1's progress note dated 3/18/26 at 8:51p.m., identified R1's wound had an increase in foul smelling odor and pain increased since yesterday assessment. R1 continues to have blanchable redness to surrounding skin, wound bed with 90% necrotic (dead, non-viable tissue) tissue and 10% slough (yellow or white, soft that delays healing). Call placed to on-call physician to update on wound characteristics and will await call back.^ R1's Emergency Department (ED) Telemedicine (the use of delivery of healthcare services from a distance using a computer) note dated 3/18/26 at 9:38 p.m., identified R1 had been seen due to a sacral wound that has changed significantly in the past 48 hours with concern for infection as well as the skin around the wound seems red.^ Noted foul smell to the wound, normal vital signs, and not complaints related to the wound. Assessment identified that the wound was the size of the palm, wound itself is dark which was consistent with an eschar, surrounding redness that is blanchable.^ Area feels firm to nursing at bedside and wound itself is dry.^ The wound itself is expanding which is a concern given R1's ambulatory status, but it is difficult to ascertain whether the surrounding tissue is due to expansion of the wound and is not a stage 1 versus infection.^ Given the wound is dry and the patient remains clinically stable, elected not to transfer to the ED and will have wound assessed by the in-house provider tomorrow morning.^ ED note stated if the provider is not able to arrange for a provider to assess R1 at bedside in the morning, she will be transferred to the ED for evaluation at that time.^^ ^ R1's progress note dated 3/19/26 at 10:17 a.m., identified that a call placed to physician asking to have a provider to assess R1's wound.^ Note received from physician assistant regarding response from situation, background, assessment, and recommendation (SBAR) that was sent on 3/19/26. Electronic health record reviewed to include photo of wound taken 2 days prior (3/17/26), telehealth ED visit and phone call with an on-call provider.^ Response to SBAR sent was as followed: known difficulties assessing skin condition with telehealth visits, therefore, given lack of symptoms and photo from two days ago does show surrounding redness, not of concern at that time, will not send to the ED at this time.^ Orders to continue current wound treatment as ordered on 3/18/26. Continue scheduled offloading.^ Check vital signs every shift for 5 days.^ R1's progress note dated 3/19/26 at 10:22 a.m., identified writer talked with R1 regarding providers decision to wait until tomorrow and nursing to continue monitoring.^ Wound culture had been requested due to foul smelling odor, eschar to the wound with black/mixed purulent drainage, increase drainage and increase in pain from 3/17/26. During an interview on 3/25/26 at 4:00 p.m., DON stated on 3/19/26 she had sent an SBAR to see if a physician could assess R1's wound in person as per the Tele ED recommendations because the certified wound nurse practitioner had not been available to assess R1's buttocks wound.^ DON explained that the physician assistant sent back a response to continue to monitor in facility and not send R1 to the ED for evaluation.^ DON explained she felt R1's wound appeared infected and needed to be seen in the ED, but since the physician assistant declined to give an order to send to the ED, they continued to monitor R1 in the facility.^ DON confirmed that the facility had an order to send R1 to the ED if a physician could not see R1 in person on 3/19/26, however, did not send her to the ED for her possible (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	infected wound and she should have just been sent.ˆ ˆ R1's nurse practitioner note dated 3/20/26, identified R1 had been seen for assessment of an unstageable (deep tissue injury) pressure wound that was contiguous (sharing a common border, touching, or being in proximity) site of back buttocks and hip. Nursing was concerned for infection and over the past 3 days the wound had increased in size and was malodorous (having an unpleasant, foul, or stinky smell). R1was afebrile (without fever)ˆand declined pain.ˆ Dressing removed and had a large amount of purulent malodorous drainage; peri-wound was erythematous (redness) with area of eschar expanded in the past 3 days. Concern for infection and gave orders to send R1 to emergency department (ED) for further evaluation and management.ˆ R1's progress note dated 3/20/26, identified R1 left facility at 11:20 am with emergency management services.ˆ R1's ED note dated 3/20/26, identified R1 presented for concerns for an infected coccygeal wound. ˆR1 had a large irregular wound over the coccyx with eschar and a little bit of slough. Redness to the left glute that is warm and firm. Yellowish drainage that was foul smelling on the dressing. R1 was afebrile and hemodynamically stable. R1 was admitted for consideration of wound debridement and antibiotics.ˆ Computed tomography (CT) did not identify a discrete abscess or suggestion of osteomyelitis.ˆ Impression was sacral decubitus ulcer with associated left gluteal soft tissue phlegmons (a severe, spreading, non-encapsulated bacterial inflammation of soft tissue) with no evidence of osteomyelitis.ˆˆ R1's hospital History and Physical Hospital note dated 3/20/26, identified R1 was admitted for concerns for an unstageable pressure ulcer. A couple of days ago, nursing staff had a ED telemedicine activated and recommended short term in-person follow up.ˆ Evaluation revealed the wound note to be foul smelling with a large necrotic area surrounded by erythema (redness). R1 will need debridement of this large wound. R1 was treated empirically with intravenous antibiotics. R1's hospital note dated 3/21/26, identified R1 had surgical debridement on 3/21/26. R1 had new and worsening anemia with studies consistent with anemia or chronic disease. R1's A1C was markedly elevated which although confounded her anemia may explain the fast worsening of her wound.ˆ R1's hospital general surgery consult note dated 3/21/26, identified R1 had been admitted for management of an unstageable pressure ulcer. R1's wound in the sacral area was malodorous and had necrotic eschar with surrounding induration and erythema. R1's wound will need to be surgically debrided and would require multiple return trips to the operating room, dressing changes versus wound VAC placement.ˆ The operative note report dated 3/21/26, identified R1 had a debridement and irrigation of ulcer to the ischium/sacrum. Findings included necrotic fat with pockets of foul-smelling purulence, R1 had an excisional debridement of sacral wound down to healthy bleeding tissue that measured 11.5 cm x 9.5 cm x 3.0 cm. Pale muscle fibers at the base of the wound were left.ˆ R1's infectious disease hospital note dated 3/24/26, identified R1 had been admitted due to a necrotic sacral wound that was debrided on 3/21/26 with culture that grew Proteus, Staphylococcus epidermidis, and Enterococcus. Plan to treat R1 for 2 weeks using broad spectrum antibiotics while in hospital and switching to oral antibiotics.ˆ During an interview on 3/25/26 at 2:55 p.m., nursing assistant (NA)-B stated she had not been aware R1 was supposed to be on a gel mattress and relies on looking at the resident's care plan to identify if they were on a special mattress.ˆ NA-B indicated she was unaware of R1's current care plan that directed no bedpan and to use commode at bedside. NA-B stated she had heard R1 had fallen asleep on a bedpan and that was the reason her bottom had gotten worse but was not aware when or who left R1 on a bedpan for an extended period of time.ˆ During an interview on 3/24/26 at 3:57 p.m.,ˆ NA-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing.ˆ NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened.ˆˆ During an interview on 3/24/26 at 3:44 p.m., NA-E stated he was not aware of which residents were at risk for skin breakdown, because his paper care guide did not identify those residents were on a repositioning program.ˆ NA-E stated he had not repositioned any resident since he came on shift at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6:00 a.m. NA-E explained he had not received any recent education on pressure ulcer prevention and if he had a resident with a new open area on a resident's skin he would make sure to clean the area, apply a barrier cream, and then tell the nurse next time he saw them.^^ During an interview on 3/25/26 at 4:11 p.m., DON stated she had not been aware that R1's gel mattress had not been moved to her new bed on 3/4/26 until she assessed R1's wound on 3/17/26 and identified R1's wound had deteriorated. DON identified R1 should have had an air mattress put in place on her readmission on [DATE] due to spending more time in bed than she had before.^^ DON stated the IDT team had reviewed R1's coccyx pressure ulcer on 3/5/26 and 3/10/26, however, had not amended R1's pressure reduction intervention to mitigate the risk of her pressure ulcer from worsening. DON explained she had been informed prior to the 3/10/26 IDT meeting R1 had been left on a bedpan for an undetermined amount of time, however, had not made any changes to her not using the bedpan until R1's buttocks pressure ulcer worsened on 3/17/26. DON confirmed she had completed the wound assessment of R1's coccyx wound on 3/17/26 and initially identified her ulcer as a [NAME] Ulcer/End of Life Ulcer and then changed her ulcer to a stage 4 pressure ulcer.^ DON stated R1's ulcer at the time of the assessment had been incorrectly identified as a stage 4 pressure ulcer when it should have been identified as an unstageable pressure ulcer.^ DON believe the root cause of R1's getting a pressure ulcer was due to being left on the bedpan for an extended period of time and not have a gel mattress on her bed since 3/4/26. During an interview on 3/26/26 at 4:07 p.m., physician assistant (PA) stated she had been informed via SBAR to see if she was available to assess R1's worsening buttocks wound in person on 3/19/26, however, there was not physician available to assess R1's wound in person, so she gave recommendation for monitoring in the facility until her ^wound could be assessed on 3/20/26. PA stated she was aware of R1's pressure ulcer and had been informed by the NP that the likely cause was due to R1 sitting on a bedpan for an undetermined time.^ PA stated her expectation for the facility was to put pressure relieving measures in place immediately to prevent a pressure ulcer and/or to avoid deterioration of an existing pressure ulcer.^ During a return phone call on 4/1/25 at 11:36 a.m., NP stated when he had assessed R1's wound on 3/20/26 it appeared to be infected and had a large amount of purulent drainage and had foul odor and proceeded to send R1 to the ED for further evaluation of her wound.^ NP stated she had been informed at an earlier time that R1 had been left on the bedpan for an unknown amount of time and this likely caused the unstageable pressure ulcer. NP stated R1's toileting plan should have been changed as soon as it was identified she had been sitting on the bedpan for a long time and that she had not been informed R1's gel mattress had not been in place on her bed since 3/4/26. NP explained that by R1 not having her gel mattress in place could have likely caused R1's buttocks wound to deteriorate, and her pressure ulcer could have been avoided if all of the interventions had been in place. ^ During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated it is his expectation for the facility to ensure all residents who are at risk for pressure ulcers have interventions put in place immediately to mitigate the risk of developing a pressure ulcer.^ If the resident develops a pressure ulcer the treatment/interventions need to be continually evaluated to ensure the pressure ulcer does not deteriorate.^ R1 not having a gel air mattress, by not altering pressure reducing interventions could have caused deterioration in her pressure ulcer thus making the pressure ulcer avoidable.^ During an interview on 3/24/26 at 2:29 p.m., administrator stated during the facility investigation of R1's worsened

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 3 residents (R3) observed during wound care. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were utilized during a transfer for 1 of 3 residents (R3).Findings include:R3's face sheet dated 3/27/26, identified diagnoses of diabetes, non-pressure chronic ulcer of right lower leg, and kidney transplant.R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and received dialysis. R3's care plan dated 7/24/25, identified R3 needed EBP. Goal that staff will maintain enhanced barrier precautions when performing high contact resident care activities. Interventions as follows:-Don (apply) gown and gloves during wound care. (dated 7/24/25)-Don gown and gloves for the following high-contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief or assisting with toileting, catheter care.) (dated 7/24/25)R3's Wound assessment dated [DATE], identified R4 had an open lesion on his right gluteus (group of muscles in the buttocks) that measured 0.5 centimeters (cm) x 0.74 cm.During an observation on 3/26/26 at 3:20 p.m., R3' room had a sign near the door that indicated R3 needed EBP for high contact care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief, or assisting with toileting, catheter care.During an interview on 3/26/26 at 3:22 p.m., nursing assistant (NA)-G stated R3 needed EBP (gown and gloves) for high contact care activities because he had a wound on his right buttocks. During an observation and interview on 3/26/26 at 4:39 p.m., director of nursing (DON) was outside of R3's room, performed hand hygiene and applied a gown prior to entering R3's room. DON then entered R3's room where R3 was lying in bed. R3 was informed that a physician wanted to assess R3's right gluteal wound via a telehealth (video visit) in which R3 agreed. DON then placed the computer on R3's bed, went into the bathroom and applied gloves, without performing hand hygiene. DON then removed R3's brief and proceeded to remove a foam dressing that was near R3's right gluteal area. R3's foam dressing had stool on the left corner of the dressing. DON then placed the dressing in the trash, removed gloves, then applied new gloves, without performing hand hygiene prior to application of the new gloves. Surveyor intervened and asked DON when should hand hygiene/hand washing be done in which the DON stated hand hygiene should be done when hands/gloves are visibly soiled, before and after removing/applying gloves. DON confirmed she had not performed hand hygiene each time she had removed/applied gloves. DON then removed her gloves, performed hand hygiene, and applied new gloves. DON then completed the wound dressing change and performed hand hygiene appropriately. During an observation and interview on 3/27/26 at 7:31 a.m., R3 was seated in his chair in his room. An unknown nursing assistant (NA) who had a gown and gloves on then entered R3's room with a sit-to-stand mechanical lift. DON then applied the lift harness under R3's arms, cinched the waist strap while encountering R3's clothes in the process. DON then hooked up the harness to the machine, moved R3's left hand toward the handle on the lift with ungloved hands. DON and NA then transferred R3 to the bed when DON then pulled R3's pants down. R3 was then removed the harness while touching R3's clothes. Certified Nurse Practitioner Wound Nurse (CNP-WOC) then removed the dressing on R3's right gluteal area with gown and gloves on and assessed R3's wound and applied a new dressing. Hand hygiene was performed during the dressing change. DON then sat up R3 on the edge of the bed, touching his upper body with gown but no gloves, applied the lift harness under his arms and around R3's waist with a gown, but no gloves. R3 was then hooked up to the lift and as R3 stood, DON pulled up R3's pants and adjusted R3's shirt. Upon exiting R3's room, DON stated EBP was (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only needed if performing catheter or wound care and was not needed during transfers. DON then read the EBP sign that was outside of R3's room and identified that EBP was needed during any high contact resident care activities including transfers.Review of the facility's Enhanced Barrier Precautions Policy undated, identified It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employees' hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include:DressingBathing/showeringTransferringProviding hygieneChanging linensChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube.Wound care: any skin opening requiring a dressing. ProcedureStandard Precautions should be applied to all residents at all times.Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission.Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions when other Transmission-Based precautions do not apply, when facility identifies any resident with:MDRO infection or colonization when Contact Precautions do not otherwise apply. If resident is infected or colonized with any MDRO and has secretions or excretions that are unable to be covered or contained, the resident should be placed on contact precautions.Wounds or skin openings such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers Shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage would not need Enhanced Barrier PrecautionsAny indwelling medical device, regardless of MDRO colonization status, for example: Central linesPeripheral intravenous line is not considered an indwelling medical device for the purposes of EBP.2Urinary cathetersFeeding tubesTracheostomy/ventilatorPersonal Protective equipment is required for all staff providing high-contact resident care activities to include: Gown and gloves with: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care:any skin opening requiring a dressing.