STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265193	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Hills Health & Rehabilitation Center	3100 Warrior Lane Poplar Bluff, MO 63901

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the the resident's responsible party for three residents (Resident #32, #37 and #60) out of four sampled residents. The facility census was 73. Review of the facility's policy titled, Notice of a Transfer and/or Discharge, revised on October 2017, showed: - The facility shall provide a resident and/or the resident's representative with a 30-day written notice of an impending transfer or discharge; - Except as specified below, a resident, and/or his/her representative will be given notice as soon as practicable before transfer or discharge when: the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the health of the individuals in the facility would otherwise be endangered; and an immediate transfer or discharge is required by the resident's urgent medical needs; - The written notice to the resident and/or representative will include the following: the reason for the transfer or discharge; the effective date of the transfer or discharge; the location to which the resident is being transferred or discharged ; a statement of the resident's appeal rights, including the name address (mailing and email) and telephone number of the entity which receives such requests and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email), and telephone number of the Office of the state long-term care ombudsman; the name, address (mailing and email), and telephone number of each individual or agency responsible for the protection and advocacy of residents with intellectual and developmental disabilities or related disabilities; for residents with a mental disorder or related disabilities (as applies); and the name and phone number of the resident's current attending physician. 1. Review of Resident #32's medical record showed: - admitted on [DATE]; (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 04/30/24, and returned on 05/03/24; - The resident transferred to the hospital on 07/28/24, and returned on 07/28/24; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party on 04/30/24, and 07/28/24. 2. Review of Resident #37's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 08/15/24, and remained in the hospital; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party. 3. Review of Resident #60's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 05/12/24, and returned on 05/17/24; - The resident transferred to the hospital on 06/18/24, and returned on 06/21/24; - The resident transferred to the hospital on 06/26/24, and returned on 07/01/24; - The resident transferred to the hospital on 07/13/24, and returned on 07/13/24; - The resident transferred to the hospital on 08/19/24, and remained in the hospital; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party on 05/12/24, 06/18/24, 07/13/24, and 08/19/24. Review of the resident's Necessity of Transfer Form, dated 06/26/24, showed: - Did not include an explanation of the right to appeal to the State; - Did not include the name, address (mail and email), and the telephone number of the State entity which received the appeal hearing request; - Did not include information on how to request an appeal hearing; - Did not include information on obtaining assistance in completing and submitting the appeal hearing request; - No documentation the written notification with the reason for the hospital transfer provided to the resident and/or responsible party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 3:45 P.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said the nurses were responsible for completing the transfer/discharge notices, and for contacting the family and the physician. During an interview on 08/21/24 at 4:12 P.M., the Social Service Designee (SSD) said he/she was not aware of the transfer/discharge notices, and did not provide a copy to the family, representative, or guardians. 47445

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide written notification of the bed-hold policy to the resident and/or their representatives at the time of transfer for three residents (Resident #32, #37 and #60) out of four sampled residents. The facility census was 73. Review of the facility's policy titled, Bed-Hold Policy, undated, did not address the facility providing the resident or resident's representative a written copy. 1. Review of Resident #32's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 04/30/24, and returned on 05/03/24; - The resident transferred to the hospital on 07/28/24, and returned on 07/28/24; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the responsible party on 04/30/24, and 07/28/24. 2. Review of Resident 37's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 08/15/24, and remained in the hospital; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the resident's responsible party for the transfer on 08/25/24. 3. Review of Resident #60's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 05/12/24, and returned on 05/17/24; - The resident transferred to the hospital on 06/18/24, and returned on 06/21/24; - The resident transferred to the hospital on 07/13/24, and returned on 07/13/24; - The resident transferred to the hospital on 08/19/24, and remained in the hospital; - No documentation of the written notification for the bed-hold policy provided to the resident and/or the responsible party on 05/12/24, 06/18/24, 07/13/24, and 08/19/24. (continued on next page)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 3:45 P.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said the nurses were responsible for completing the bed-hold notices. During an interview on 08/21/24 at 4:12 P.M., the Social Services Designee (SSD) said he/she was not aware of the bed-hold notices, and did not mail a copy to the family, representative, or guardians. 47445

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide needed care and services in accordance with professional standards of practice for one resident (Resident #12) out two sampled residents who required treatment due to a skin condition. The facility census was 73. The facility did not provide a policy related to treatment of skin conditions. 1. Review of Resident #12's Physician Order Sheet (POS), dated August 2024, showed: - admitted on [DATE]; - Diagnoses of psoriasis (a condition in which the skin cells build up and form scales and itchy dry patches), stroke, and aphasia (a language disorder that affects a person's ability to communicate); - An order for skin observations once a week every Saturday, dated 04/23/24; - No order for a psoriasis treatment. Review of the resident's care plan, last reviewed on 06/13/24, showed: - The resident has dry flaky skin and flare ups of psoriasis, at times has self-inflicted scratches on the face and head: - Resident will have ongoing evaluations and interventions to reduce the incidence of skin breakdown; - Apply ordered creams to face and monitor for effectiveness. Review of the resident's Treatment Administration Records (TAR), dated 07/01/24 - 08/22/24, showed: - On 07/06/24, the resident's skin was clear; - On 07/13/24, the resident's skin was red; - On 07/20/24, the resident's skin was red; - On 07/27/24, the resident's skin was red; - On 08/10/24, the resident's skin was red; - On 08/17/24, the resident's skin was clear; - The facility failed to document the skin description, location, and the interventions for 07/13/24, 07/20/24, 07/27/24, 08/03/24, and 08/10/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the resident on 08/19/24 at 3:44 P.M., 08/20/24 at 8:45 A.M., and 08/21/24 at 8:06 A.M., and 2:26 P.M., showed the resident lay in bed with scaly, crusted patches on his/her forehead, between the eyes, down the nose and under the eyes with numerous small scratches on his/her upper forehead. During an interview 08/22/24 at 11:28 A.M., Registered Nurse (RN) B said the resident had psoriasis breakouts and would refuse treatment at times. During an interview on 08/22/24 at 2:42 P.M., the Assistant Director of Nursing (ADON) said she was sure the resident previously had an order for psoriasis medication, but she was unable to find a current or discontinued order. She would expect a skin abnormality to be addressed in the progress notes or the skin alert, and this was not done for Resident #12. 45693

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45693 Based on observation, interview, and record review, the facility failed to provide a safe environment when the facility failed to monitor the elopement prevention wander guard system for one resident (Resident #70) out of one sampled resident and one resident (Resident #62) outside the sample. The facility census was 73. Review of the facility's policy titled, Elopement Prevention Policy, undated, showed: - The policy is to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement; - At the time of the screening and/or upon admission, ask the resident, resident representative, family members, referring source and past care givers if the resident has a history of wandering or elopement; - A licensed nurse will complete the Elopement Risk Assessment upon admission to the facility. An interim plan of care for minimizing the risk for elopement will be initiated upon the risk determination; - A facility staff member will take a photograph of the resident. The photograph will be placed in the Medication Administration Record (MAR). Any resident assessed to be at risk for elopement will have their photograph and basic identifying information placed in a special folder or binder to be maintained in a designated location. Responsibility for updating the folder/binder shall be assigned to a designated staff member by the Administrator; - The Interdisciplinary Team (IDT) will initiate a plan of care for any resident determined at risk for elopement. Facility specific measures as well as resident specific measures will be included in each at risk resident's plan of care to minimize risk factors. Individualized care plans that specify how staff should redirect each resident based on their reason for attempted elopements and the ways that are proven to help redirect them. Communication of these interventions will be made to direct care staff through exposure to the resident's plan of care and periodic review and disclosure of the contents of Elopement Binder; - Interventions of personal door alarm devices will be instituted as deemed necessary by the IDT and documented in the individual resident's plan of care. If these devices are in place, they should be checked for placement, function, and expiration date every shift; - Any at risk resident will be promptly and courteously escorted back to the appropriate nursing unit, activity room, dining area or resident room when noted to be near and exit door; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Revision of the Elopement Risk Assessment will be completed quarterly, upon a resident's significant change in condition, when elopement behaviors occur and as needed, determined by the IDT; - The plan of care for minimizing elopement risks will be reviewed each time the Risk Assessment is completed. 1. Review of Resident #62's medical record showed: - Date of admission on 07/18/23; - Diagnosis of dementia (a group of thinking and social symptoms that interferes with daily function, such as memory loss and judgement) and major depressive disorder (a mental health condition that causes a persistent low mood); - Physician Order Sheet (POS), dated August 2024, did not address the wander guard; - MAR, dated August 2024, and the Treatment Administration Record (TAR), dated August 2024, did not address the wander guard to be checked for placement, function, and expiration date every shift; - Nurses note, dated 08/07/2024 at 1:53 P,M., the resident was found outside in the parking lot. The resident said he/she was seeing if his/her family member was still out there. The resident left his/her wheelchair on the inside. The alarm was on the wheelchair and therefore the alarm on the door did not sound to alert staff the resident had went outside. The resident became upset when staff escorted him/her back into the building. The wander guard alarm was taken off the wheelchair and placed on the resident's right ankle. Review of the resident's Elopement Evaluation, dated 07/21/24, showed: - Resident independent with a walker or ambulatory; - Resident had risk factors; - Resident made statements he/she was leaving; - Elopement care plan initiated. Review of the resident's Care Plan, last revised 06/23/24, showed: - An intervention for over the next 48 hours, the resident will need monitoring of an alarm that prevents the resident from leaving the area of safety, dated 07/19/23; - The care plan did not address the elopement risk, with individualized interventions or the continued use of an alarm/wander guard. Observations of the resident showed: - On 08/19/24 at 10:16 A.M., the resident lay in bed with the wander guard on his/her right ankle; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 08/20/24 at 11:22 A.M., the resident propelled him/herself in a wheelchair past the nurses station with the wander guard on his/her right ankle; - On 08/21/24 at 4:41 P.M., the resident propelled him/herself in a wheelchair in the hall with the wander guard on his/her right ankle. 2. Review of Resident #70's medical record showed: - Date of admission on 05/10/24; - Diagnoses of vascular dementia and metabolic encephalopathy (a group of neurological disorders that cause brain dysfunction due to chemical imbalances in the blood); - POS, dated August 2024, did not address the wander guard; - MAR, dated August 2024, and TAR, dated August 2024, did not address the wander guard to be checked for placement, function, and expiration date every shift; - Nurse's Note, dated 07/02/24, the resident attempted to exit the building at the front entrance. The wander guard was placed on the resident and he/she was returned back to C wing. Review of the resident's Care Plan, last revised 05/13/24, showed: - The resident is elopement risk and will be free from elopement; - Did not address the wander guard; Observations of the resident showed: - On 08/19/24 at 11:04 A.M., the resident propelled him/herself in a wheelchair down the hall with the wander guard on his/her right ankle; - On 08/20/24 at 12:15 P.M., the resident propelled him/herself in a wheelchair up to the nurse station on A Hall with the wander guard on his/her right ankle and said he/she was lost. The facility did not provide any documentation that showed the wander guard alarms were checked for placement, function, and expiration date every shift. During an interview on 08/21/24 at 3:46 P.M., Licensed Practical Nurse (LPN) K said the facility had a little machine that was used to check the wander guards, and it was the night shifts responsibility. He/She wasn't sure if the checks were done or where they were documented. During an interview on 08/21/24 at 4:48 P.M. the Assistant Director of Nursing (ADON) said if the wander guards were blinking, it meant they were working. They did not receive orders for the wander guards. They were used as a nursing judgement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 5:10 P.M., Certified Medication Technician (CMT) M, said he/she knew which residents had a wander guard on because the nurses tell the staff when they put one on a resident usually. He/She had no idea how or who monitors the wander guards. During an interview on 08/21/24 at 5:30 P.M., the Administrator said maintenance checked the wander guard bracelets and doors but was unsure how often. The facility followed their policy, but they did not document it. If the wander guard bracelets had a light blinking, they were working. The staff completed hourly checks on the residents with the wander guard bracelets as well to just lay eyes on them.

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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** 45693 Based on observation, interview and record review, the facility failed to ensure a physician's order for a catheter (a tube inserted into the bladder to drain urine) which included catheter care for two residents (Resident #10 and #28), failed to ensure a urinary catheter drainage bag was kept off the floor, and failed to ensure proper positioning of the catheter for one resident (Resident #10) out of two sampled residents. The facility census was 73. Review of the facility policy titled, Urinary Catheter Care, revised July 2017, showed; - The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder; - Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility's policy titled, Physician's Orders, dated February 2020, showed: - To complete documentation of an order; clarify the order, transcribe to Medication Administration Record (MAR) or Treatment Administration Record (TAR), document into the physician's order form with the date, time and signature; - Did not address orders that weren't medications. 1. Review of Resident #10's medical record showed: - admitted on [DATE]; - Diagnoses of heart failure, dehydration, and spinal stenosis (spaces inside the bones of the spine get too small) lumbar (lower back region of the vertebral column, made up of five or six vertebrae) region. Review of the resident's Physician Order Sheet (POS), dated August 2024, showed: - No order for a catheter; - No order for catheter care. Review of the resident's Nurse's Notes showed on 08/12/24, a 16 French (measurement of size of the catheter) Foley (a type of indwelling catheter) inserted using sterile technique. Immediate yellow cloudy urine returned. Sample of urine obtained and labeled for lab. Observation on 08/20/24 at 8:40 A.M., showed: - The resident lay in bed while Certified Nursing Assistant (CNA) C and CNA D performed incontinent and catheter care; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA C rolled the resident to his/her right side and the catheter bag fell off the bed to the floor; - CNA C picked up the catheter bag and placed it at the foot of the bed; - CNA D picked up the catheter bag after rolling the resident to his/her back and placed it on the resident's pelvis which was above the resident's bladder; - CNA C and CNA D used the Hoyer lift (a type of mechanical lift) to transfer the resident from the bed to the recliner with the catheter bag in the resident's lap, which was above the resident's bladder, while he/she held on to it; - CNA C and CNA D placed the resident into the recliner, removed the catheter bag from the resident's lap and placed it on the bottom of the recliner where the bottom of the catheter bag touched the floor. Observation on 08/20/24 at 11:00 A.M., and 08/22/24 at 10:37 A.M., showed the resident sat in the recliner and the bottom of the catheter drainage bag touched the floor. Observation on 08/20/24 at 11:19 A.M., showed the resident sat in the recliner and the catheter drainage bag lay on the floor. During an interview 08/20/24 at 3:40 P.M., Registered Nurse (RN) A said a resident should have an order for a catheter. They had a standing order for catheter care anytime a resident had a catheter. During an interview on 08/21/24 at 4:30 P.M., the Director of Nursing (DON) said there should be orders for catheters and catheter care. The catheter bag should be kept lower than the resident's bladder. During an interview on 08/22/24 at 8:34 A.M., RN A said Resident #10 had the catheter about a week now. During an interview on 08/21/24 at 3:30 P.M., RN B said a resident should have an order for a catheter if they had one. During an interview on 08/22/24 at 9:38 A.M., CNA C said Resident #10's catheter was placed on 08/13/24, after he/she declined. The catheter drainage bag and tubing should not ever be on floor. The catheter drainage bag should be kept lower than the resident's bladder. 2. Review of Resident #28's medical record showed: - admitted on [DATE]; - Diagnoses of hemiplegia (paralysis of one side of the body), hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms legs and facial muscles), atherosclerotic heart disease (a buildup of cholesterol plaque in the walls of the arteries causing obstruction of blood flow), and morbid obesity (severe obesity due to excess calories). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's POS, dated August 2024, showed: - No order for a Foley Catheter; - No order for catheter care. Review of the resident's Nurse's Notes, dated 08/20/24, showed the nurse received an order to discontinue the Foley catheter. The balloon was deflated and the catheter removed using clean technique. The resident tolerated the procedure. Observation on 08/21/24 at 4:25 P.M., showed Resident #28 lay in bed with his/her clothing and sheets wet and a strong urine odor. The resident's call light button lay underneath his/her right leg and out of reach for the resident. During an interview on 08/21/24 at 4:26 P.M., Resident #28 said he/she had needed to speak with staff about the call light. The call light button was stuck under his/her leg and help was needed with urination and he/she felt wet. During an interview on 08/21/24 at 4:58 P.M., the ADON said Resident #28 had the Foley catheter placed at the hospital and was discharged with it to the facility. The physician was contacted because there was no diagnosis for the catheter. The physician approved the removal and sent an order to discontinue the catheter. During an interview on 08/21/24 at 5:25 P.M., RN H said Resident #28 came into the facility from the hospital with a Foley catheter with no related or adequate diagnosis. The Foley catheter was removed yesterday. 46521

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	265193	A. Building B. Wing	08/22/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to ensure a physician's order for oxygen was obtained for two resident (Resident #10 and #43) out of two sampled residents. The facility census was 73. Review of the facility's policy titled, Oxygen Administration, revised October 2010, showed staff to verify there is a physician's order and to review the order. 1. Review of Resident #10's medical record showed a diagnosis of heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment to be completed by facility staff), dated 03/25/24, showed the resident didn't receive oxygen. Review of the resident's August 2024 Physician Order Sheet (POS) showed no order for oxygen therapy or to change tubing. Review of the resident's Nurse's Notes, dated 08/16/24 showed: - The resident's vital signs: blood pressure-125/54, heart rate-94, respirations-34, oxygen saturation- 89%; - Oxygen at 2 liters (L) started and the physician notified. Observation of the resident on 08/19/24 at 10:39 A.M., showed: - The resident lay in bed with oxygen on at 1.5 L via nasal cannula (NC); - The oxygen tubing and humidifier canister not dated. Observation on 08/21/24 at 5:45 P.M., showed: - The resident lay in bed with oxygen on at 2 L via NC; - Oxygen tubing and humidifier canister not dated. 2. Review of Resident #43's medical record showed: - Diagnoses of heart failure, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), emphysema (a lung condition that causes shortness of breath), and cardiomyopathy (diseases of the heart muscle that can make it harder for your heart to pump blood). Review of the resident's quarterly MDS, dated [DATE], the quarterly MDS, dated [DATE], and the significant change MDS, dated [DATE], showed the resident received oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's August 2024 POS, showed no order for oxygen therapy or to change the tubing. Review of the resident's progress notes, dated 01/04/24 - 08/21/24, showed: - On 04/11/24, the resident returned from the hospital with oxygen; - On 04/24/24, the resident used oxygen at night due to shortness of breath while lying flat; - On 08/21/24, the resident received oxygen via nasal cannula and in place. Review of the resident's care plan, revised 07/28/24, showed: - Resident received oxygen therapy due to: COPD, emphysema, and heart failure. Oxygen per NC continuous; - Interventions included: apply padding to the top of the ears to protect the skin from pressure from the tubing as needed; change the oxygen tubing weekly or as indicated; check for proper fit of the cannula or mask as needed; check the rate of the oxygen flow every shift,; notify the physician as needed for changes or complications; oxygen saturation levels as ordered by the physician; and provide oxygen as ordered. Observations of the resident showed: - On 08/19/24 at 10:32 A.M., the resident lay in bed with oxygen on at 4 L via NC at 4 liters, the tubing and humidification canister undated, and no water in the humidifier canister; - On 08/19/24 at 1:07 P.M., and on 08/20/24 at 8:19 A.M., the resident sat in a wheelchair in the room with oxygen on at 2.5 L via NC, the tubing, and humidifier undated, and no water in the humidifier canister; - On 08/20/24 at 12:45 P.M., the resident sat in the room eating lunch with oxygen on at 2.5 L via NC, the tubing, and humidifier undated, and no water in humidifier canister; - On 08/21/24 at 8:00 A.M., the resident sat on the side of the bed with oxygen on at 2.5 L via NC, tubing, and humidifier undated, and no water in the humidifier canister. During an interview on 08/20/24 at 8:19 A.M., Resident #43 said he/she wore oxygen all the time and it should be at 2.5 L. He/She needed water in the humidifier canister for his/her oxygen. During an interview on 08/21/24 at 3:30 P.M., RN B said a resident should have an order for oxygen as well as for the tubing change. The oxygen tubing should be dated when it was changed. During an interview on 08/21/24 at 3:40 P.M., RN A said a resident should have an order for oxygen. A nurse could start oxygen by using nursing judgement but a physician's order should be received afterwards. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 10:33 A.M., Certified Nursing Assistant (CNA) I said Resident #43 always wore oxygen unless he/she took a shower. During an interview on 08/22/24 at 10:40 A.M., Registered Nurse (RN) B said there should be an order for oxygen if a resident used oxygen, especially continuously. There may be an order to change the tubing and the humidified water. He/She would expect the tubing and the humidifier canister to be dated when changed. During an interview on 08/22/24 at 11:11 A.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said they would expect an order for oxygen. During an interview on 08/22/24 at 11:16 A.M., the Administrator said she would expect an order for oxygen, unless it was an emergent situation and the nurse could make a nursing judgement.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45693 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 48 opportunities with 24 errors made, for an error rate of 50% for three residents (Resident #43, #48 and #179) outside the seven sampled residents. The facility census was 73. Review of the facility's policy titled, Preparation and Administration, Oral Medication, undated, showed staff to remain with the resident until the medication is swallowed. Review of the facility's policy titled, Preparation and Administration, Nasal Medication, undated, showed administer the dosage, insert spray nozzle gently into the nose and spray. 1. Review of Resident #43's Physician Order Sheet (POS), dated August 2024, showed an order for Spiriva with HandiHaler (an inhaled bronchodialator medication) 18 microgram (mcg) 1 inhalation once daily, dated 04/13/21. Review of the resident's medical record showed; - No education and no assessment/competency completed for the resident to self-administer the Spiriva; - Care Plan, dated 07/28/24, did not address self-administration of the Spiriva. Observation on 08/19/24 showed: - At 10:32 A.M., the resident lay in bed with the Spiriva inhaler at his/her bedside; - At 11:30 A.M., the Spiriva inhaler was not at the resident's bedside. During an interview on 08/21/24 at 8:00 A.M., Resident #43 said staff leave his/her Spiriva inhaler on the bedside table for him/her to use and the staff pick it up after breakfast. He/She administered his/her own inhaler without staff present. 2. Review of Resident #48's Physician Order Sheet (POS), dated August 2024, showed: - An order for Cymbalta (an antidepressant medication) 30 milligrams (mg) once a day, dated 01/08/24; - An order for diltiazem (a blood pressure medication 120 mg once a day, dated 12/06/23; - An order for furosemide (a diuretic medication) 20 mg once day, dated 12/06/23; - An order for hydroxyzine (an antihistamine medication) 25 mg twice a day, dated 03/28/24; - An order for levetriracetam (an anticonvulsant medication 500 mg twice a day, dated 12/06/23; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for pantoprazole (a medication used to treat acid reflux) 40 mg once a day, dated 12/06/23; - An order for Tylenol Arthritis Pain 650 mg tablet two tablets twice a day, dated 12/27/23; - An order for Miralax powder (a laxative medication) 17 gram (g) once a morning in applesauce, dated 12/27/23. Observation on 08/21/24, showed: - At 7:47 A.M., Registered Nurse (RN) A poured and mixed Miralax 17 g into an applesauce container with the applesauce; - RN A added the resident's Cymbalta, diltiazem, furosemide, hydroxyzine, levetriracetam, pantoprazole, and two tablets of Tylenol Arthritis) tablets whole into the applesauce; - RN A entered Resident #48's room while the resident ate his/her breakfast; - At 8:06 A.M., RN A sat the resident's applesauce container with the medications in it in front of the resident on the bedside table; - At 8:16 A.M., RN A stopped at the resident's door and asked if he/she had taken the medication yet. The resident's applesauce container with the medications sat in front of him/her; - At 8:19 A.M., RN A stopped at the resident's door and asked if applesauce had been eaten. The resident said yes and the empty applesauce container sat in front of him/her; - At 8:23 A.M., the resident's empty applesauce container and breakfast tray were picked up by the staff; - RN A failed to administer the medications to the resident. 3. Record review of Resident #179's POS, dated August 2024, showed: - An order for adult low dose aspirin 81 mg once tablet daily, dated 08/09/24; - An order for calcium 600 mg + D3 capsule 5 microgram (mcg) once daily, dated 08/09/24; - An order for cetirizine (an antihistamine) 10 mg once daily, dated 08/09/24; - An order for Eliquis (an anticoagulant) 5 mg twice a day, dated 08/09/24; - An order for Florastor (a probiotic) 250 mg twice a day, dated 08/09/24; - An order for furosemide 50 mg once daily, 08/09/24; - An order for isosorbide mononitrate (a heart medication) 30 mg once daily, dated 08/09/24; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for losartan (blood pressure medication) 50 mg once daily, dated 08/09/24; - An order for One Daily Multivitamin one tablet daily, dated 08/09/24; - An order for pantoprazole 40 mg once daily, dated 08/09/24; - An order for Prednisone (s steroid) 10 mg once daily, dated 08/09/24; - An order for sertraline (an antidepressant) 100 mg once daily, dated 08/09/24; - An order for spironolactone (a diuretic) 25 mg once daily, dated 08/09/24; - An order for tamsulosin (a medication used to treat urinary retention) 0.4 mg once daily, dated 08/09/24; - An order for Welchol (a cholesterol medication) 625 mg twice a day, dated 08/09/24. Observation on 08/21/24, showed: - At 8:29 A.M., RN A put Resident #179's aspirin, calcium +D3, cetirizine, Eliquis, Florastor, furosemide, isosorbide mononitrate, losartan, One Daily Multivitamin, pantoprazole, Prednisone, sertraline, spironolactone, tamsulosin, and Welchol tablets into a medication cup; - RN entered the resident's room with the medication cup and a cup of water and sat them on the bedside table in front of the resident, left the room, and shut the resident's door; - RN A failed to administer the medications to the resident. During an interview on 08/21/24 at 8:22 A.M., CMT E said the residents should not administer their own medications without an order. Medications should not be left unattended with a resident. During an interview on 08/20/24 at 3:00 P.M., CMT F said medications should not be left unattended with a resident. During an interview on 08/21/24 at 4:30 P.M., Registered Nurse A said residents should not administer their own medication unless the physician order says so. There should be documentation showing education and and assessment of the resident's competency to self-administer the medication. During an interview on 08/22/24 at 12:30 P.M., the Administrator and the Director of Nursing (DON) said residents should not administer their own medications unless they had an order, and assessment, and had shown they were safe to do so. Medications should not be left unattended with a resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45693 Based on observation, interview, and record review, the facility failed to store medications in a safe and effective manner when staff left the medication cart unlocked and unattended, leaving the narcotics behind only one lock. This had the potential to affect all residents The facility census was 73. The facility did not provide a policy regarding storage of medication. 1. Observation on 08/19/24 at 9:37 A.M., of the 60 Hall medication cart showed: - At 9:37 A.M., the medication cart was unlocked and faced the hall between the mechanical and the soiled utility rooms. Certified Medication Technician (CMT) F walked past the unlocked medication cart and placed a nystatin (an antifungal medication) bottle on top of the medication cart and walked down the hall; - At 9:41 A.M., a resident propelled him/herself in a wheelchair down the hall past the unlocked and unattended medication cart with the nystatin bottle on top of the medication cart; - At 9:44 A.M., CMT F walked to the medication cart, placed the nystatin bottle in the medication cart, and locked it; - At 11:05 A.M., the medication cart was unlocked and unattended, and faced the hall between the mechanical and soiled utility rooms. Two residents sat in the dining room across from medication cart; - At 11:40 A.M., a resident propelled him/herself in a wheelchair down the hall past the unlocked and unattended medication cart; - At 12:09 P.M., CMT F walked down the hall and locked the medication cart; - At 12:50 P.M., the medication cart was unlocked and unattended, and faced the hall between the mechanical and the soiled utility rooms; - Certified Nursing Assistant (CNA) C sat at the dining room table across from the unlocked and unattended medication cart with seven residents; - At 1:06 P.M., the Minimum Data Set (MDS - a federally mandated assessment to be completed by facility staff) Coordinator walked onto the hall and locked the medication cart. 2. Observations on 08/19/24 at 1:06 P.M., of the A Wing treatment cart showed: - At 1:06 P.M., the treatment cart was unlocked and unattended, and faced the hall across from the nurse's station beside the entrance door and the linen closet; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 1:10 P.M., the MDS Coordinator walked down the hall and locked the treatment cart. During an interview on 08/19/24 at 1:10 P.M., the MDS Coordinator said all treatment and medication carts should be locked when staff were not using them. 3. Observations of the medication pass on 08/21/24, showed: - At 8:18 A.M., CMT E left the medication cart unlocked and unattended, and faced the hallway across from the A wing nurse's station; - At 8:19 A.M., CMT E returned to the unlocked medication cart to continue the medication pass. During an interview on 08/21/24 at 8:22 A.M., CMT E said he/she messed up when he/she left the cart unattended and unlocked. It should stay locked anytime it was left unattended. During an interview on 08/20/24 at 3:00 P.M., CMT F said the medication cart should be locked anytime it was left unattended. During an interview on 08/21/24 at 4:30 P.M., Registered Nurse (RN) A said medication and treatment carts should be locked anytime they were left unattended. During an interview on 08/22/24 at 12:30 P.M., the Administrator and the Director of Nursing (DON) said treatment and medication carts should be locked anytime they were left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46521 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility census was 73. Review of the facility's policy titled, Cleaning and Sanitation - General, revised January 2012, showed: - The kitchen will be maintained in a clean and sanitary condition; the state and/or federal food code will be maintained on file within the food service department and will be the basis of all sanitation and food safety practices; - Hairnets or hair coverings will be worn at all times; - Utensils and dishes will be handled so that food and customer contact surfaces are not touched; Disposables will be opened from the bottom of the package; - Work surfaces will be kept neat and clean during food preparation and service. The department philosophy is Clean as you go. Review of the facility's policy titled, Cleaning Schedule, revised February 2012, showed: - There will be a written, comprehensive cleaning schedule posted and monitored to maintain the cleanliness and sanitation of the food service department; - The food service manager is responsible for developing a cleaning schedule for the department; he/she will also monitor compliance and overall cleanliness and sanitation of the department; - The cleaning schedule will include each piece of equipment, specific position assigned to complete the task; frequency of cleaning, i.e. after each use, daily, weekly; the method and agents to be used for cleaning will be written for each task; a cleaning schedule will be posted and employees will initial and date tasks when completed. 1. Observation on 08/19/24 at 8:51 A.M., 08/21/24 at 1:04 P.M., 08/22/24 at 9:18 A.M., and 9:48 A.M., of the kitchen showed: - No cleaning logs; - Scattered debris below the food preparation table; - Three white plastic food bins with wheels and an oily film substance build up on the handles near the gas range; - Wall board section behind the gas range with splattered food debris and brown grime build-up; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The walk-in refrigeration unit with gray plastic shelving with a black substance on the right-side low section and water on the floor below about one half inch (in.) deep and an area below the doorway with a damp green substance 1 in. by 3 foot (ft.); - A damaged 2 ft. by 4 in. end wall section left of the ice machine and a missing wall board section 2 ft. by 6 ft. with exposed plumbing pipes left of the ice machine, a dark film on the floor below, and the drain with no visible air gap; - One wall mounted metal fan with a gray substance and an oily film blew into the dishwashing area; - A drawer below the metal food preparation area with grime build up and debris in the bottom used for miscellaneous storage; - A 3 ft. by 4 ft. floor basin area with mop storage with a black substance on the back splash area; - Gas range with a pooled, dark brown grease build up with food debris, three chicken nuggets and six potato pieces on the floor beneath; - The commercial style can opener with an oily film; - One 3 ft. by 4 ft. ceiling diffusers (one of the few visible parts of an air conditioning system) with dust buildup and a brown substance on the front exterior surfaces and between the ventilation louvers; - The floor below the reach-in freezer with scattered debris, disposable bowl, and a reusable food container in the front kitchen area; - The Maintenance Director stood by the kitchen range without a proper restraint of exposed hair and facial hair. 2. Observation on 08/19/24 at 8:56 A.M., 08/21/24 at 12:28 P.M., and 08/22/24 at 9:23 A.M., of the dry food storage room showed: - One 6 ft. long section with a peeled vinyl cove baseboard beneath the right side lowest food shelf with a brown substance on the wall area and scattered debris on the floor; - One chest type milk cooler with a one-half in. frost buildup along the upper interior surface; - One 4 in. metal pipe centered in an unfinished ceiling repair area in the dry food storage and a 4 ft. food rack with spices and oatmeal stacked below; - One light fixture without a plastic cover; - One light fixture with a damaged plastic cover. 3. Observation of the meal preparation on 08/21/24 at 12:19 P.M., and 12:24 P.M., showed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Dietary Aide (DA) N stood near the steam table without a proper restraint of exposed facial and chest hair as food was scooped on to trays; - DA N prepared pot pies in the microwave without a proper restraint of exposed facial and chest hair. During an interview on 08/21/24 at 12:47 P.M., the Dietary Manager (DM) said DA N should have worn a beard net and his/her chest hair covered. During an interview on 08/21/24 at 1:05 P.M., DA N said he/she was not told to put a beard net on unless the beard was longer. He/She should have had a beard net on to cover his/her facial hair and a shirt that covered his/her chest hair. 4. Observation of the dining room on 08/19/24, showed: - At 12:27 P.M., DA O did not perform hand hygiene, used bare hands to touch the rim of two cups filled with tea, and then handed the cups to the Administrator who handed the cups to a resident; - At 12:28 P.M., DA O did not perform hand hygiene, used a bare hand to touch the rim of a coffee cup, sat it down, and filled the cup with sugar and creamer for a resident; - At 12:31 P.M., DA O did not perform hand hygiene, used a bare hand to touch the rim of a cup filled with tea, then touched a resident's wheelchair and shoulder with his/her bare hand; - At 12:33 P.M., DA O did not perform hand hygiene, used a bare hand to touch the rim of a cup filled with a flavored drink, and handed it to a resident; - At 12:35 P.M., DA O did not perform hand hygiene, used a bare hand to touch the rim of a cup filled with tea, and sat it down in front of a resident; - At 12:44 P.M., DA O did not perform hand hygiene, used bare hands to touch the rim of two cups filled with flavored drink and tea, and sat them near two residents. During an interview on 08/22/24 at 9:40 A.M., the DM said the water had backed up in the floor through the floor drains this week and a plumber had been called to make a repair. The plumber had looked at the damaged area beside the ice machine yesterday. There were no cleaning logs kept for deep cleaning under the appliances. The range should be clean and not have oil build up puddled below it. The mop basin should be clean with no black substance build up. The walls should be in good repair, the appliances should be kept clean, and floors should not have build-up or debris. The dietary and maintenance workers should have worn hair/beard nets and have body hair covered appropriately when they visit the kitchen. Dietary workers should be using better hygiene and not handle the tops of cups. The floor below shelves should be clean in the dry storage and the ceiling should be painted and sealed if it had been repaired. The walk-in refrigerator should be clean and not have water standing or a black substance on the shelves. (continued on next page)

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	265193	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Hills Health & Rehabilitation Center	3100 Warrior Lane Poplar Bluff, MO 63901

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/22/24 at 9:50 A.M., the Administrator said the range should be clean and not have an oil spill below. It will need to be pulled out and cleaned below. The walls should be in good repair and the appliances should be kept clean. The floors should not have build-up or debris. The dietary and maintenance workers should be wearing hair or beard nets. Body hair should be covered appropriately when workers were in the kitchen. DA's should be using better hygiene and not handle the tops of cups. The floor below the shelves should be clean in the dry storage and the ceiling should be painted and sealed if it had been repaired. The walk-in refrigerator should be clean and not have water standing. During an interview on 08/22/24 at 10:13 A.M., the Maintenance Director said he/she oversaw cleaning under the kitchen appliances like the refrigerator and range. A log wasn't kept when he/she cleaned. He/She worked on the floor in the kitchen last week and had cleaned, but nothing was deep cleaned. He/She hadn't noticed the grease spilled on the floor beneath the range, but it might be from the deep fryer leaking. It was a problem to keep the large 3 ft. by 4 ft. ceiling vent clean in the kitchen near the door. An outside contractor oversaw the refrigeration equipment, and the contractor didn't clean it. He/She wasn't aware of a missing baseboard in the dry food storage. The kitchen should be cleaned, including under appliances and food shelves.

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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** 37575 Based on observation, interview and record review, the facility failed to maintain proper infection control practices during incontinent care for four residents (Residents #4, #10, #38, and #50) out of four sampled residents and one resident (Resident #34) outside the sample, during wound care for two residents (Residents #50, and #57) out of three sampled residents, and during the medication pass for two residents (Residents #48 and #69) out of four sampled residents. The facility failed to disinfect the glucometer (a machine used to test how much sugar is in a blood sample) for three residents (Residents #24, #45, and #46) out of three sampled residents. The facility also failed to follow enhanced barrier precautions (EBP) for two residents (Residents #10 and #50) out of three sampled residents during care. The facility census was 73. Review of the facility's policy titled, Handwashing, revised April 2015, showed: - All staff thoroughly cleanses hands with friction, soap, and water to control infection and reduce transmission of organisms; - Hands should be thoroughly washed before and after providing resident care. Proper handwashing techniques must be followed at all times; - Hand antiseptic/hand sanitizer is a supplement or alternative to the use of soap and water when hands are not visibly soiled. Review of the facility's policy titled, Equipment, Supplies and Cleaning, dated 02/03/21, showed if equipment must be used for more than one resident, it will be cleaned and disinfected before use on another resident, according to the manufacturer's recommendations using the Environmental Protection Agency (EPA) - registered disinfectant. Review of the facility's policy titled, Preparation and Administration, Oral Medications, undated, showed: - Wash hands or antibacterial hand cleanser; - Assemble equipment, organize medication in order, wash hands if contaminated; - Prepare medication; - Administer resident the medication; - Wash hands. Review of the facility's policy titled, Insulin Vial Injection Administration, dated June 2020, showed: - Proper hand washing before and after administration of insulin; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Apply gloves. Review of the facility's policy titled, Isolation Precaution/EBP, dated 04/04/24, showed: - EBP is used in combination with standard precautions and expand the use of personal protective equipment (PPE) to putting on of gown and gloves during high contact resident care activities that provide opportunities for transfer of multidrug resistant organisms(MDRO) to staff hands and clothes; - EBP will be used for any resident who meets the following criteria: infection with a Center of Disease Control (CDC) targeted MDRO when contact precautions do not otherwise apply; chronic wounds, such as pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin), unhealed surgical wounds, diabetic ulcers (an open sore or wound that occurs in diabetic patients) and venous stasis ulcers (a wound on the leg or ankle caused by abnormal or damaged veins); and indwelling medical devices; - Resident who meet the above criteria, EBP are recommended when performing the following high contact care activities: dressing, providing hygiene, bathing, showering, transferring, changing linens, changing briefs or assisting with toileting, indwelling medical device care, and chronic wound care. The facility did not provide an incontinent care policy. 1. Observation of Resident #4's incontinent care on 08/20/24 at 10:28 A.M., showed: - Resident #4 lay in bed; - Certified Nursing Assistant (CNA) I and Nursing Assistant (NA) H did not perform hand hygiene and put on gloves; - CNA I and NA H removed the resident's urine soiled brief: - CNA I cleaned the resident's abdominal crease, the groin, the inner thighs and hips with a clean wipe for each area; - CNA I did not change gloves, did not perform hand hygiene, and cleaned the resident's buttocks and rectal area; - CNA I and NA H removed the gloves, did not perform hand hygiene, put on gloves, and put a clean brief on the resident; - CNA I and NA H removed the gloves, did not perform hand hygiene, put on gloves, and dressed the resident; - CNA I and NA H removed the gloves, did not perform hand hygiene, put on gloves, and transferred the resident to his/her wheelchair. 2. Observation of Resident #10's incontinent and catheter care on 08/21/24 at 9:45 A.M., showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Sign on the resident's door showed the resident required EBP; - CNA C and CNA D did not perform hand hygiene, put on gloves, and did not put on a gown; - CNA C cleaned the resident's front peri area; - CNA C did not change gloves, did not perform hand hygiene, unfastened and removed the soiled catheter (an indwelling tube inserted into the bladder to drain urine) leg band; - CNA C did not change gloves, did not perform hand hygiene, and cleaned the catheter from the insertion point down the tube; - CNA C did not change gloves, did not perform hand hygiene, cleaned the resident's buttocks, changed gloves, and did not perform hand hygiene; - CNA C touched the resident's right and left hips, the Hoyer lift (a mechanical lift) pad, and the Hoyer lift; - CNA C and CNA D removed gloves and performed hand hygiene. During an interview on 08/21/24 at 4:30 P.M., the Director of Nursing (DON) said hands should be sanitized and gloves changed between dirty and clean care and when changing sites. During an interview on 08/21/24 at 3:30 P.M., Registered Nurse (RN) B said gloves should be changed and hands sanitized anytime going from dirty to clean care or changing care areas. Hands should be sanitized between incontinent care and catheter care. During an interview on 08/20/24 at 3:40 P.M., RN A said gloves should be changed and hands sanitized between incontinent care and catheter care due to them being different care areas. Gloves and gowns should be worn for EBP when performing care. Gloves and hands sanitized should be done with incontinent care at the beginning, end, anytime they become soiled or care areas were changed, and/or going from dirty to clean care. During an interview on 08/22/24 at 9:38 A.M., CNA C said hands should be sanitized between glove changes. Glove changes should occur when going from dirty to clean care and to a new task or body part. 3. Observation of Resident #38's incontinent care on 08/20/24 at 9:35 A.M., showed: - CNA I and RN B entered the room, did not perform hand hygiene, and put on gloves; - RN B wiped fecal material from the resident, changed gloves, did not perform hand hygiene, applied lubricant to his/her finger, and inserted the finger into the resident's rectum to check for fecal material, did not change gloves, did not perform hand hygiene, and continued wiping the resident's buttocks with fecal material on the glove; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN B changed gloves, did not perform hand hygiene, cleaned from the front groin area to the anus with fecal material on the wipe, wiped the same area again with the same soiled area of the wipe, changed gloves, did not perform hand hygiene, opened the bathroom door, retrieved the bed pan, and removed the soiled brief from under the resident; - CNA I placed the bed pan under the resident; - RN B touched the resident's hand, pants, shirt, and adjusted the bedpan; - CNA I and RN B changed gloves, did not perform hand hygiene, and repositioned the resident in bed; - CNA I touched the pillow under the resident's head, touched the top sheet, and removed the unused clean brief from the bed; - RN B touched the second pillow to position the resident, touched the call light, and touched the bottom sheet; - CNA I removed gloves, performed hand hygiene, and left the room; - RN B removed gloves, did not perform hand hygiene, exited the room, took the trash bags to the soiled utility room and performed hand hygiene. 4. Observation of Resident #38's incontinent care on 08/20/24 at 10:09 A.M., showed: - RN B entered the room, did not perform hand hygiene, and put on gloves. CNA I performed hand hygiene and put on gloves; - RN B touched the resident's call light and pillow; - CNA I cleaned the resident's front peri area, touched the resident's wrist, and removed the bed pan from under the resident; - CNA I did not change gloves, did not perform hand hygiene, cleaned the buttocks and the gluteal cleft, rolled the Hoyer lift pad and incontinent pad soiled with fecal material under the resident, removed the gloves, performed hand hygiene, put on gloves, and assisted the resident to roll to the left side; - RN B removed the Hoyer lift pad and the incontinent pad soiled with fecal material from the bed, placed in a bag, did not change gloves, did not perform hand hygiene, used a wipe to clean fecal material from the resident's leg and buttock, did not change gloves, did not perform hand hygiene, and wiped the front of the resident's leg; - CNA I placed a clean brief under the resident, applied barrier cream to the buttocks, changed gloves, did not perform hand hygiene, retrieved clothing from the closet, put clean pants on the resident, and touched the resident's pillow; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN B did not change gloves, did not perform hand hygiene, assisted CNA I with placing the clean brief under the resident, touched the resident's left leg, fastened the brief, removed the pants soiled with fecal material, removed the pillow from the bed, assisted CNA I to roll the resident, pulled up the pants, and repositioned the resident in bed; - RN B removed the glove from his/her right hand, did not perform hand hygiene, and touched the call light; - Both CNA I and RN B removed gloves, and performed hand hygiene. 5. Observation of Resident #34's incontinent care on 08/19/24 at 9:37 A.M., showed: - CNA J and NA L entered the resident's room, did not perform hand hygiene, and put on gloves; - CNA J and NA L assisted the resident off of the bedside commode; - CNA J used wipes to clean the buttocks and gluteal cleft, changed gloves, did not perform hand hygiene, and did not clean the front peri area or groin; - CNA J and NA L assisted the resident to the side of the bed; - CNA J removed the pan with urine from the bedside commode, disposed of the urine and sprayed out the pan, changed gloves, and did not perform hand hygiene; - CNA J assisted NA L to reposition the resident in bed; touched the sheet, the blanket and the call light; removed the gloves; did not perform hand hygiene; placed a liner in the trash can; touched the wipe package and the resident's water cup; picked up a coffee cup; exited the room, took the coffee cup to the dining area, placed it on a cart, and performed hand hygiene; - NA L removed the gloves, removed the trash bag with the trash, touched the door knob, exited the room, took the trash bag to the dirty utility room, touched the outside door knob, disposed of the trash, touched the inside door knob, and performed hand hygiene. 6. Review of Resident #50's Physician's Order Sheet (POS), dated August 2024, showed: - admitted [DATE]; - An order to cleanse the left hip, then apply honey bordered foam dressing daily and as needed, dated 07/04/24. Observation of the resident's wound care on 08/20/24 at 10:14 A.M., showed: - EBP PPE cart next to the resident's door due to the resident's wound; - Certified Medication Technician (CMT) G did not perform hand hygiene, and put on a gown and gloves before entering the room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident lay in bed, CMT G removed the resident's dressing, removed gloves, and placed in a red bag; - CMT G performed hand hygiene, put on gloves, used wound cleanser to clean the wound, removed gloves, and did not perform hand hygiene; - CMT G put on gloves out his/her pocket, applied honey to the dressing, and placed on the left hip wound; - CMT G removed gloves, did not perform hand hygiene, removed the gown, and disposed of gloves and gown in a red bag; - CMT G exited the resident's room, took the red bag to the soiled utility room, and performed hand hygiene. 7. Observation of Resident #50's incontinent care on 08/20/24 at 02:01 P.M., showed: - EBP PPE cart next to the resident's door due to the resident's wound; - CNA I and CNA J did not perform hand hygiene, put on gloves, did not put on gowns, and entered the resident's room; - CNA I and CNA J performed incontinent care for the resident. 8. Review of Resident #57's medical record showed an order for skin prep (forms a barrier on top of the skin to help protect it) to the resident's left heel, dated 05/20/24. Observation on of the resident's treatment on 08/19/24 at 11:01 A.M., showed: - CMT E did not perform hand hygiene and put on gloves; - CMT E removed the resident's socks and wiped the left heel with skin prep; - CMT E did not remove the gloves and did not perform hand hygiene; - CMT E applied pressure reduction boots to the resident's feet; - CMT E removed gloves and performed hand hygiene. 9. Observation on 08/21/24, of the medication pass showed: - At 7:47 A.M., RN A prepared and administered medications to Resident #48, and did not perform hand hygiene before or after the medication administration; - At 8:07 A.M., RN A prepared and administered medications to Resident #69, and did not perform hand hygiene before or after the medication administration. 10. Observation on 08/21/24, of the medication pass showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 12:05 P.M., CMT E did not perform hand hygiene, put on gloves, did not clean and disinfect the facility glucometer, obtained Resident #24's blood sugar, did not change gloves, did not perform hand hygiene, and drew up three units of Humalog insulin. CMT E changed gloves, did not perform hand hygiene, and administered the insulin. CMT E did not clean and disinfect the facility glucometer when finished obtaining the resident's blood sugar; - At 12:20 P.M., CMT E did not perform hand hygiene, put on gloves, did not clean and disinfect the same facility glucometer, obtained Resident #45's blood sugar, did not change gloves, did not perform hand hygiene, and drew up eight units of Humalog insulin. CMT E pushed the resident into his/her room from in front of the A Wing door with the syringe needle uncapped, administered the insulin, removed gloves, and did not perform hand hygiene. CMT E did not clean and disinfect the facility glucometer when finished obtaining the resident's blood sugar; - At 12:29 P.M., CMT E did not perform hand hygiene, put on gloves, did not clean and disinfect the same facility glucometer, obtained Resident #46's blood sugar. CMT E changed gloves, did not perform hand hygiene, drew up two units of Novolog insulin, and administered the insulin. CMT E did not clean and disinfect the facility glucometer when finished obtaining the resident's blood sugar. During an interview on 08/22/24 at 11:30 A.M., CMT E said glucometers should be cleaned and disinfected with the wipes between residents. He/She failed to do that yesterday. Hand hygiene should be performed between residents and between glove changes. During an interview on 08/22/24 at 11:35 A.M., RN A said glucometers should be cleaned and disinfected between residents with the disinfectant wipes. Hand hygiene should be performed between residents. During an interview on 08/22/24 at 12:30 P.M., the Administrator and Director of Nursing (DON) said glucometers should be cleaned and disinfected between residents. Each cart should have two glucometers so one can be disinfected while using another one. Staff should sanitize hands between residents when administering medications, doing finger sticks, and insulin. During an interview on 08/19/24 at 9:45 A.M., CNA J said wash or sanitize hands upon entry, put gloves on, use clean wipes, wipe front to back, change gloves, empty pan (bed pan or bedside commode container), spray out the container, change gloves, provide comfort and call light. Should clean front peri area and groin if brief was wet. CNA J said he/she should have washed or sanitized hands with each glove change. During an interview on 08/22/24 at 10:43 A.M., RN B said for incontinent care, go into the room, put bag and supplies on the bed, pull the privacy curtain, put gloves on, designate who will provide clean and who will provide dirty care, remove brief, assist to one side, have clean person provide wipe, wipe front to back using one wipe one swipe method, continue until resident was clean, assist resident to back, clean the front peri area, clean the middle, groin and inner thighs, remove gloves, get clean brief situated under the resident, apply barrier cream if needed, remove the gloves, put on clean gloves, secure the brief, tie off the soiled linen and trash bag to be removed from the room, remove gloves, reposition the resident for comfort, call light in place, personal items in reach, walk dirty linens and trash to the soiled utility room, and wash hands. Change gloves when soiled, and sanitize or wash hands with each glove change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 1:33 P.M., CNA I said for incontinent care, he/she should gather supplies, get a partner, wash hands, gloves, have one dirty/one clean staff, the clean person hands wipes to the person completing the dirty care, clean the front peri area with a wipe, throw away, the clean person turns the resident towards themselves, the staff completing the dirty care would clean the resident's butt, wipe until clean using a new wipe each wipe, roll and tuck the brief, remove gloves, sanitize hands, put on gloves, roll the resident toward their self, hand the second person wipes to clean the other side, the staff completing dirty care removes tucked pads, change gloves, tucks in clean pad, rolls the resident toward themselves, he/she would unroll the pad and brief flat under the resident, apply barrier cream if needed, change gloves, and fasten the brief. Reposition the resident for comfort, provide the call light, tie the bag of dirty items, remove gloves, walk the soiled items to the dirty utility room to discard, and wash or sanitize hands. Should sanitize or wash hands with each glove change. 45693 47445