STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265325	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41061 Based on observation, interview and record review, the facility failed to prevent further potential abuse, neglect or mistreatment by not investigating an injury of unknown origin for one of three sampled residents (Resident #1). The census was 95. Review of the facility's Injury of Unknown Source - Investigative Protocol policy, undated, showed: -Purpose: The following indicators of abuse/neglect are provided to help determine if abuse/neglect should be suspected. Staff are mandated to report suspected abuse; -Indicators of physical abuse may include injuries of an unknown source; -The attached worksheet and directions are offered to assist facilities in their internal investigation. If a logical/reasonable explanation of the source of the injury cannot be determined, notify your local state agency within 2 hours of discovery. Review of the facility's when to initiate an investigation document, undated, showed: -Contact Administrator and Nursing Administration immediately for the following events included for injury, actual or suspected. Examples included bruise of unknown origin/suspicious bruising or skin tear. Review of the facility's Abuse and Neglect Policy, revised January 2019, showed: -Providing a safe environment for the resident is one of the most basic and essential duties of the facility; -Injuries of unknown source: An injury should be classified as an injury of unknown source when both the source of the injury was not observed by any person or the source of injury could bot be explained by the resident and the injury is suspicious because of the extent or severity or the location of the injury (the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Administrator or designee will be responsible to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately, not later than two hours after the allegation is made, to other officials in accordance with state law including to the state survey and certification agency; -Procedure for investigation: -Administrator or designee on duty will assess the resident (including the size, location, etc. of any injury), and assure proper documentation of the date, time, and location of the reported or suspected incident; -The supervisor will do everything possible to protect the resident's welfare and safety from harm during the investigations; -An incident report will be completed; -The physician and family will be notified as soon as possible; -The Administrator or Director of Nursing is responsible to notify their Regional Nursing Supervisor to report alleged violation of the resident safety policy to assure prompt investigation and corrective action are in place; -Any employee suspected of violation of these resident safety policies, may be suspended pending investigation; -If a family member or other visitor is suspected of violation of these policies, they may not be allowed to visit the resident or in any other way have access to the facility pending the investigation; -The Administrator or designee and/or supervisor on duty will interview the resident as well as any nursing, housekeeping, laundry, dietary, activity, social service staff, any visitors, volunteers or others who may have knowledge of the occurrence or who may have been in the vicinity at the time of the incident. The Administrator or designee on duty will prepare a written summary of each interview; -Summaries of these investigations will be reviewed during quality assurance and assessment committee meetings for re-evaluation of policies and procedures, if warranted to prevent further occurrences. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/6/24, showed: -Sometimes able to make self-understood; -Sometimes able to understand others; -Required max assistance for upper and lower body dressing, putting on/off footwear, showering, and transferring from chair/bed-to-chair; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included non-traumatic brain dysfunction, chronic kidney disease, Alzheimer's disease, epilepsy (seizure disorder) and chronic obstructive pulmonary disease (COPD, lung disease); -No open lesions, or skin tears noted. Review of the resident's progress notes, showed: -On 6/10/24, at 6:23 P.M., the resident slide out of his/her chair and sat on the floor. No injury or pain was noted. The resident was assisted back up with assistance with two staff members. The Medical Director (MD) and resident's responsible party (RP) were notified. Review of the facility's event summary report, dated 4/22/24 through 7/23/24, showed: -On 6/10/24, at 6:18 P.M., a post fall assessment was completed due to the resident sliding out of his/her chair and sat on the floor; -There was no injury or pain noted; -The care plan was not reviewed; -The evaluation was to ensure assistance in and out of recliner; -The event was closed on 6/14/24. Review of the resident's progress notes, showed: -On 6/18/24, at 9:55 P.M., the resident was noted with a dime size skin tear to his/her left inner arm. No pain or drainage was noted. The area was cleansed and covered with a dry dressing. The MD and the RP were notified. Review of the resident's event report, dated 6/18/24, at 9:51 P.M., showed: -Event details: A dime sized skin tear/laceration was located on the resident's left inner arm, with irregular wound edges with out any pain reported from the resident; -Activity during skin tear/laceration occurrence: Post fall; -MD and RP were notified; -Orders included: Apply non-adhering dressing, cover with foam dressing, change every three days; Skin tear: Apply antibiotic ointment, cover with dressing if needed to minor cuts or skin tears. Review of the facility's wound report, dated 4/01/24 through 7/23/24, showed: -There was no wound documentation found on the resident. Review of the facility's event summary report, dated 4/22/24 through 7/23/24, showed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation of a fall between 6/10/24 and 6/18/24; -There was no documentation of the injury of unknown origin, the skin tear found on 6/18/24, located on the resident's left inner arm. Review of the resident's Medication Administration Record (MAR), dated June 2024, showed: -An order dated 8/18/23, for a weekly skin assessment, once a day on Wednesdays. Documentation showed an assessment was completed on 6/26/24, noting the resident had impaired skin, a skin tear on the left elbow; -An order, dated 6/28/24 and discontinued on 6/28/24, for a skin tear; monitor for signs and symptoms of infection on each shift. Documentation showed the facility did not administer per order on the night shift on 6/26/24, due to no area.; -An order, dated 6/18/24 and discontinued on 6/28/24, for a skin tear, to apply antibiotic ointment, cover with dressing if needed, change day; Documentation showed the treatment was not administered on 6/27/24 due to healed. Review of the resident's MAR, dated July 2024, showed: -An order, dated 6/18/24, discontinued on 7/6/24, to apply non-adhering dressing, cover with foam dressing, change every three days was administered as ordered. Review of the resident's care plan, dated 7/17/24, showed: -Problem: The resident was at risk for falls; Interventions included: on 6/10/24, the resident had a fall. Ensure assistance in and out of recliner; -Problem: The resident requires maximum assistance with activities of daily living (ADLs); Interventions included monitor skin for redness and breakdown during ADL care and bathing. Report changes to nurse and MD. During an interview on 7/23/24, at 1:39 P.M., the Assistant Administrator said: -Nurses were expected to complete weekly skin assessments and document completion on the residents' MAR; -Nurses were expected to document any new skin issues in the residents' wound management detail. During an interview on 7/23/24, at 2:35 P.M., LPN D, said: -He/She was assigned to the resident's care; -He/She was not aware the resident had any wounds; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She would report any abuse, suspected or witnessed, including physical, verbal, mental, sexual or theft, to the Administrator, the Director of Nursing (DON), or Assistant Director of Nursing (ADON) so they could investigate the incident for the residents' safety; -He/She expected the facility to investigate any injury of unknown origin to ensure the cause was not due to abuse. Observation on 7/24/24, at 11:19 A.M., showed the Wound Nurse evaluated the resident's skin. The resident had a healed wound to his/her upper left arm. During an interview on 7/24/24 at 11:25 A.M., the Wound Nurse said: -She was not aware the resident had a healed skin tear located on his/her left inner arm and did not know there was a treatment order for the skin tear; -She expected the nurses who initially found the wounds to document the wounds in the wound management document so she could see them when she looked at residents' wound management detail report; -She would have followed up on the skin tear to ensure the appropriate treatments were ordered and the MD and RP were notified. During an interview on 7/24/24, at 10:45 A.M., the Assistant Administrator said the facility's event summary report would include injuries of unknown origin. During an interview on 7/26/24, at 11:26 A.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), said: -They expected nurses, after finding a new skin issue, to assess the wound and document their finding in the resident's wound management document, call the MD, get new orders if appropriate, and tell the Wound Nurse; -The nurses were not required to document new skin issues in progress notes; -The Wound Nurse was made aware of any new skin issues by nurses reporting the new wounds to her verbally or by reading residents' progress notes; -The DON and Night Supervisor also looked at daily notes to see if any new skin issues were noted and they would inform the Wound Nurse of their findings; -They expected the Wound Nurse to assess the residents' new skin issue, make sure there was an appropriate wound order and see if the outside wound management team needed to get involved. They also expected the Wound Nurse to put findings in a progress note and in wound management if not already there; -They expected the Wound Nurse to know if a resident had a treatment order for a wound; -They expected nurses to notify the Wound Nurse when they put in a treatment order for a new wound; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They expected nurses to create an unknown injury event, notify the MD, the Wound Nurse and RP of the injury, and document their assessment, what they did and how they followed up when they find an injury of unknown origin; -They expected staff to report any injury of unknown origin to their supervisors, so they could investigate how if might have occurred by talking to the staff, the resident and family members, do a root cause analysis, and put in proper interventions to try to keep it from happening again after reviewing the resident's care plan; -They would document the conclusion of the investigation in a miscellaneous event report and would notify the RP of their findings of the investigation; -They monitored for potential or actual reported allegations of abuse or neglect by depending on residents, family and especially staff to report any potential allegations of neglect; -Staff had not reported any concerns about the manner in which care was provided to the resident; -They were not aware of the resident's skin tear, found by staff on 6/18/24, located at his/her left upper arm; -They could not determine how the skin tear occurred or when as there were no notes in the resident's electronic medical record (EMR) so it was considered an injury of unknown origin; -There were no investigations found on the resident's skin tear located at his/her left upper arm, an injury of unknown origin; -When an injury of unknown origin was not reported to the administrative team, it put the resident at risk of infection and pain if the injury was left untreated; -The facility investigated all injuries of unknown origin to protect residents from possible abuse or neglect. During an interview on 7/26/24 at 3:32 P.M., the Administrator said: -The delivery of care at the bedside by the CNAs was monitored by the nurses on the floor. The care the nurses gave to residents was monitored by the nurse supervisors (Nurse Managers, ADON and DON); -She expected nursing staff to have knowledge of and follow facility policies. MO0023922

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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. 41061 Based on observation, interview and record review, the facility failed to ensure the residents' environment remained free of accident hazards by keeping an un-secured plastic container filled with insulin (used to control high blood sugar) pens (a small lightweight pen that is prefilled with insulin to inject under a person's skin) of 13 residents (Residents #2, #4, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16) on un-attended, unsupervised treatment/medication carts. The facility also had an open plastic tray with auto shield duo pen needles (needles used to inject insulin from the insulin pen) and lancets (a small device with a needle used to prick the surface of the skin to obtain a blood sample) with a sharps container (used to discard used lancets and auto shield duo pen needles) which had an unsecured plastic lid on top of the un-attended, un-supervised treatment/medication carts. The sample size was 16. The census was 95. Review of the facility's Storage of Drugs policy, undated, showed: -Compartments and areas containing drugs are locked when not in use or when left unattended. Such areas include drawers, cabinets, rooms, refrigerators, carts and boxes. 1. Observation on 7/19/24, at 12:20 P.M., showed an un-attended, unsupervised treatment cart, labeled #2, on the 300 hall, with a red, plastic box with four rows of individual drawers which contained insulin pens; -The first row had one drawer labeled with Resident #7's name containing a Humalog (short acting insulin) pen and a Lantus (long acting insulin) pen; a separate drawer labeled with Resident #7's name which contained a Novolog (fast acting insulin) pen; a separate drawer labeled with Resident #8's name which contained a Lantus pen and a Lispro (fast acting insulin) pen, a separate drawer labeled with Resident #9's name containing two Fiasp (fast acting insulin) pens; a separate drawer labeled with Resident #2's name containing a Humalog pen and a Lantus pen; a separate drawer labeled with Resident #10's name containing a Lispro pen and a Lantus pen; -The second row had one drawer labeled with Resident #11's name containing one Soliqua (a long-acting insulin) and a Lispro pen; a separate drawer labeled with Resident #12's name containing one Lantus pen and a Humalog pen; -The third row had one drawer labeled with Resident #13's name containing one Lispro pen; a separate drawer labeled with Resident #14's name containing one Aspart (a fast-acting insulin) pen; a separate drawer labeled with Resident #15's name containing two Basaglar (a long-acting insulin) pens and one Humalog pen; a separate drawer labeled with Resident #4's name containing one Basaglar pen and a Lispro pen; a separate drawer labeled with Resident #16's name containing on Novolog pen; -The fourth row had separate drawers containing lancets and auto shield duo needles; -Each drawer was un-secured and pulled out of the red plastic box. They each were covered with a plastic cover which was also unsecured and easily opened; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was also a plastic basket, that did not have a cover, sitting on top of the treatment cart, filled with lancets and auto shield duo needles; -A small sharps container, half filled with used lancets and duo needles, had an un-secured plastic lid that had a small round opening with an attached round lid. The round lid was not attached to the plastic lid and the opening was large enough for a small hand to reach in and take out the used, dirty sharps or shake dirty, used sharps out of the container. The plastic lid covering the top of the small sharps container was also easily removed completely off of the sharps container to gain access to the dirty, used sharps. The small sharps container was mobile and not secured to the cart in any way; -The large sharps container was not secured to the medication cart. There were residents walking around the area of the un-attended, un-supervised medication cart during the time of observation. During an interview on 7/19/24 at 12:28 P.M., the Wound Nurse confirmed the observation of the treatment cart, labeled #2, located in 300 hall, of the un-secured, un-attended red plastic box with rows of drawers labeled with residents' names and containing insulin pens, lancets and auto shield duo needles left on top of the cart. She also confirmed the observation of the small plastic tray which contained lancets and auto shield duo needles and the small sharp container which had an unsecured plastic lid with the hole on top of the lid also uncovered. The Wound Nurse confirmed the small sharps container was not secured to the treatment cart. The Wound Nurse said residents and/or visitors could easily taken any of the insulin pens, lancets or auto shield duo needles and inject insulin into themselves which could cause great bodily harm. She also said residents and/or visitors could easily get their hands into the sharps box or take the sharps box off of the cart. There was potential for a resident and/or visitor to prick themselves with the used, dirty sharps and infect themselves with whatever dried blood was on the sharps. The insulin pens and supplies should be locked up for safety. 2. Observation on 7/19/24 at 1:49 P.M., showed the same red plastic container with drawers labeled with residents' names and containing insulin pens, lancets and auto shield duo needles was left on top of a nurses medication cart located in the 300 hall, un-supervised and unattended. There was also the same yellow plastic tray containing lancets and auto-shield duo needles left on top of the red plastic box, There was a large sharps container that was slightly filled with dirty, used sharps. The lid was secure and attached to the top of the sharps container. The large sharps container was not secured to the medication cart. There were residents walking around the area of the un-attended, un-supervised medication cart during the time of observation. 3. Observation on 7/23/24 at 10:24 A.M., showed showed an un-attended, unsupervised medication cart, on the 300 hall, with a red, plastic box with four rows of individual drawers which contained insulin pens; -The first row had one drawer labeled with Resident #7's name containing a Humalog pen and a Lantus pen; a separate drawer labeled with Resident #7's name which contained a Novolog pen; a separate drawer labeled with Resident #8's name which contained a Lantus pen and a Lispro pen, a separate drawer labeled with Resident #9's name containing two Fiasp pens; a separate drawer labeled with Resident #2's name containing a Humalog pen and a Lantus pen; a separate drawer labeled with Resident #10's name containing a Lispro pen and a Lantus pen; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The second row had one drawer labeled with Resident #11's name containing one Soliqua and a Lispro pen; a separate drawer labeled with Resident #12's name containing one Lantus pen and a Humalog pen; -The third row had one drawer labeled with Resident #13's name containing one Lispro pen; a separate drawer labeled with Resident #14's name containing one Aspart pen; a separate drawer labeled with Resident #15's name containing two Basaglar pens and one Humalog pen; a separate drawer labeled with Resident #4's name containing one Basaglar pen and a Lispro pen; a separate drawer labeled with Resident #16's name containing on Novolog pen; -The fourth row had separate drawers containing lancets and auto shield duo needles; -Each drawer was un-secured and pulled out of the red plastic box. They each were covered with a plastic cover which was also unsecured and easily opened; -There was also a plastic basket, that did not have a cover, sitting on top of the treatment cart filled with lancets and auto shield duo needles; -There was a large sharps container that was slightly filled with dirty, used sharps. The lid was secure and attached to the top of the sharps container. The large sharps container was not secured to the medication cart; -There were residents walking around the area of the un-attended, un-supervised medication cart during the ten minutes of observation. 4. During an interview on 7/26/24 at 11:26 A.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), said: -They expected insulin pens be stored inside of a locked medication cart when not in use, as they were a medication and needed protection from direct sunlight; -There was a risk of residents and/or visitors to take un-attended, unsupervised insulin if they were left on top on a medication/treatment cart instead of locked inside of a medication/treatment cart; -It was not appropriate or safe to keep unsecured used sharp containers (in which the lid was not locked on, a hand could fit into it to retrieve used sharps, and used sharps could get poured out of the container) on top of an unattended medication cart because anyone could have access to the used sharp and get stuck by the dirty, used sharps. The residents and/or visitors were at risk of infection; - It was not safe or appropriate to keep lancets and duo needles unsecured and unattended on a medication cart as it posed a risk to residents' safety, they could take and then use the lancets and needles on themselves; -Residents were at risk of harm if insulin pens and auto shield duo needles were left un-attended, as they could inject the insulin into themselves which could cause them harm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview on 7/26/24 at 3:32 P.M., the Administrator said she expected staff to have knowledge of and follow the facility policies.

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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** 41061 Based on observation, interview and record review, staff failed to demonstrate proper use of hand hygiene and proper infection control during wound care for two of three sampled residents (Residents #2 and #4). The census was 95. Review of the facility's Infection Control Policy, dated 12/2016, showed: -Purpose: The community has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; -Develop prevention, surveillance, and control measures to protect residents and personnel from healthcare-associated infections; -Develop specific policies and procedures governing such activities as surveillance, standard and transmission based precautions, hand hygiene procedures to be followed by staff involved in direct resident contact, aseptic technique, outbreak investigation, wound care, catheter care, etc. to be followed to prevent the spread of infections; -Ensure compliance with state and federal regulations related to infection prevention and control. Review of the facility's check list for clean dressing change, undated, showed: -Purpose: To prevent/minimize the transmission of microorganisms in a wound; -Gather equipment; -Prepare a clean surface with equipment onto it; -Wash hands and apply gloves; -Remove soiled dressing and dispose in plastic bag; -Remove gloves and wash hands; -Apply clean gloves; -Clean wound with wound cleanser or prescribed cleanser; -Remove gloves and wash hands; -Apply clean gloves; -Apply ordered treatment to the wound. Cover with secondary dressing if ordered; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Secure with tape. Apply the tape with initials and date on the dressing; -Remove gloves and wash hands; -Apply clean gloves; -Position the resident for comfort with bed in lowest position and call light within reach; -Discard gloves and used supplies in trash bag; -Wash hands. 1. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/2/24, showed: -Cognitively intact; -Impairment on one side of upper extremity; -Impairment on both sides of lower extremity; -Dependent on staff for toileting, upper and lower body dressing, bathing, personal hygiene, rolling left to right and transfers; -At risk for pressure ulcers (localized are of tissue damage or necrosis (dead tissue) caused pressure over a bony prominence); -One Stage IV pressure ulcer (Full thickness tissue loss (damage extends below all areas of the skin into the subcutaneous tissue or beyond with possible areas of slough (non-viable yellow, tan, gray, green or brown tissue) and/or necrosis) with exposed bone, tendon or muscle) that was present upon admission or re-entry; -Diagnoses included non-traumatic brain dysfunction, diabetes mellitus, Alzheimer's disease, dementia, acquired absence of left leg below knee and right below the knee. Review of the resident's Physician Order Sheet (POS), showed: -An order dated 7/3/24, discontinued on 7/17/24, to cleanse the resident's right buttock with soap and water pat dry and apply Triad (zinc oxide based wound paste for wound healing), twice a day; -An order dated 7/3/24 , discontinued on 7/17/24, to cleanse the resident's sacrum (triangular bone at the base of the spine) and left buttocks with soap and water, pat dry, apply collagen to open wound beds, cover with calcium alginate and a foam dressing daily and as needed. Review of the resident's outside wound management report, dated 7/16/24, showed: (continued on next page)

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	265325	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens North	4401 Parker Road Black Jack, MO 63033

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound/Ulcer #1: A Stage IV pressure ulcer located at the resident's sacrum, with scattered open scratches to right and left buttocks. Treatment plan: Cleanse with foam cleanser and water, pat dry, apply sacral hydrocolloid (moisture-retentive dressing) dressing, change twice a week and as needed; -Wound/Ulcer #6: Self Induced scratches on left and right buttocks. Treatment plan: Cleanse with foam cleanser and water, pat dry, apply sacral hydrocolloid (moisture-retentive dressing) dressing, change twice a week and as needed Review of the resident's POS, showed: -An order dated 7/17/24, to cleanse buttocks with cleansing foam, wipe clean with a wet towel, apply two hydrocolloid sacral dressing twice a week on Tuesdays and Saturdays and as needed. Review of the resident's Medication Administration Record (MAR), dated 7/11/24 through 7/24/24, printed for staff to use while electronic medical record system was down, showed: -There were no orders found for the resident's Stage IV pressure ulcer wound located at his/her sacrum; -There were no orders found for the resident's scratches located at his/her left and right buttocks. Observation on 7/19/24 at 10:37 A.M., showed Licensed Practical Nurse (LPN) A performed wound care on the resident: -LPN A sanitized his/hands, donned gloves, pumped wound cleanser on a clean gauze pad and cleansed the resident's wound located on his/her sacrum; -LPN A threw the dirty gauze pad away, and without changing his/her dirty gloves, picked up a clean gauze pad and cleansed the wounds located on the resident's right buttock; -LPN A threw the dirty gauze pad away, and without changing his/her dirty gloves picked up a clean gauze pad and cleansed the wounds located on the resident's left buttock; -LPN A threw away the dirty gauze pad, and without changing his/her dirty gloves, opened a packet of skin prep and applied it to the resident's peri wound (area surrounding the wound) of his/her sacrum; -LPN A threw the dirty skin prep pad away, and without changing his/her dirty gloves, opened a new packet of skin prep and applied to the peri wound of the resident's right buttock; -LPN A threw the dirty skin prep pad away, and without changing his/her dirty gloves, opened a new packet of skin prep and applied to the peri wound of the resident's left buttock; -LPN A threw the dirty skin prep pad away, and without changing his/her gloves, opened a package containing a foam dressing and applied it to the wound on the resident's sacrum; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A then doffed his/her dirty gloves, sanitized his/her hands, donned new clean gloves, picked up a tube of Triad cream, squirted some on a gauze pad and used the gauze pad to apply the ointment using an up and down, round and round motion, to the wounds located on the resident's right and left lower buttocks and the resident's perineum (area between the anus and genitals); -LPN A failed to treat each wound separately, using the same gauze pad to treat multiple wounds. -LPN A failed to sanitize his/her hands and don new, clean gloves between each task. During an interview on 7/19/24 at 12:45 P.M., LPN A said: -There were no orders for the resident's wounds on the printed MAR given to him/her to use while the facility's EMR was down; -The Wound Nurse told him/her what type of treatment to use on the resident's wounds; -He/She should have changed his/her gloves and sanitized his/her hands between each dirty to clean task for infection control; -He/She should have treated each wound separately for infection control; -He/She put the resident at risk of infection, cross contamination and delayed wound healing by failing to follow infection control measures. 2. Review of Resident #4's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Cognitively intact; -Impairment on both sides of lower extremity; -Required maximal assistance from staff for toileting, bathing, lower body dressing, putting on and off footwear and transfers, -Required moderate assistance from staff to roll left to right, sit to lying and lying to sitting on side of bed; -At risk for pressure ulcers; -No unhealed pressure ulcers; -Diabetic foot ulcer present; -Diagnoses included heart failure, peripheral vascular disease (PVD, poor circulation), chronic kidney disease, diabetes mellitus and malnutrition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's POS, showed an order dated 7/9/24, to cleanse the back of the resident's left foot with wound cleanser, apply Iodosorb gel (treats wet ulcers and wounds) and collagen powder (helps maintain a moist wound environment for healing), cover with heel foam. Change daily and as needed. Review of the resident's outside wound management wound report, dated 7/16/24, showed: -Wound /Ulcer #1: Arterial ulcer (ulcer due to inadequate blood supply to the area) full thickness with bone exposed; Treatment plan: Cleanse with wound cleanser, apply Iodosorb and collagen, gauze, cover with adhesive heel foam, change daily and as needed. Observation on 7/19/24 at 11:08 A.M., showed LPN B performed wound care on the resident's wound located on his/her left heel: -LPN B removed wound solution, a plastic baggy containing gauze pads, a packet of Iodosorb gel, a packet of collagen pellets and a packet containing a foam dressing from his/her treatment cart and placed them on top of the cart; -LPN B failed to sanitize the top of the cart with visibly dirty and dried, unidentifiable substances before placing the resident's wound treatment supplies on top; -LPN B gathered the wound supplies, entered the resident's room and placed wound supplies on top of the resident's bare mattress, visibly dirty with debris and dried unidentifiable substances; -LPN B failed to put the wound supplies on a clean, sanitized surface and/or a barrier cloth; -LPN B sanitized his/her hands and donned gloves; -LPN B twisted the cap off of the Iodosorb tube, held it in his/her left hand and pressed his/her gloved second finger on his/her right hand to the top of the tube, and squirted the gel onto his/her gloved finger, then applied the gel to the perimeter of the resident's pressure ulcer on his/her left heel; -LPN B then took his/her dirty gloved second finger, located on his/her right hand, touched the top of the Iodosorb tube and squeezed more gel from the tube onto his/her dirty gloved second finger, then used that same dirty, gloved finger and applied the gel into the resident's wound base; -LPN B then took the Iodosorb tube, placed it centimeters away from the resident's open wound and squirted more gel into the wound base; -LPN B twisted the cap back on the Iodosorb tube and placed the tube back onto the resident's dirty mattress; -LPN B doffed his/her gloves, failed to sanitize his/her hands and donned new gloves; -LPN B opened the packet of collagen pellets, poured them onto a gauze pad and then pressed the gauze pad into the resident's wound; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN B used one hand to hold the gauze, pressed into the wound base, and took the foam dressing from its packet and adhered it to the resident's left heel, covering the gauze pad and wound; -LPN B doffed his/her gloves, failed to sanitize his/her hands, gathered up the wound supplies from the resident's dirty mattress and put them back into the treatment cart; -LPN B then sanitized his/her hands. During an interview on 7/19/24 at 11:30 A.M., LPN B said: -He/She should have changed his/her gloves and sanitized his/her hands between each dirty to clean task for infection control; -He/She should have put the resident's wound treatment supplies on a sanitized area or on a barrier cloth for infection control; -He/She should have squirted the Iodosorb gel to a clean applicator instead of his/her dirty gloved finger for infection control; -He/She potentially introduced germs or bacteria into the resident's Iodosorb tube by touching the top of the applicator with his/her dirty gloved finger and by placing the tip of the applicator so close to the resident's open wound base; -He/She should have discarded the Iodosorb tube as it was potentially contaminated with germs and bacteria for infection control; -He/She should not have put the dirty wound treatment supplies back into the treatment cart as the products had the potential to touch and contaminate other supplies for infection control; -He/She put the resident at risk of infection, cross contamination and delayed wound healing by failing to follow infection control measures. 3. During an interview on 7/19/24 at 11:53 A.M., the Wound Nurse said: -She expected nurses to sanitize their hand and don new gloves when going from a dirty to clean task for infection control; -She expected nurses to put wound treatment supplies on a clean surface or barrier cloth for infection control; -The risk of cross contamination and introduction of bacteria to other items increases when nurses put dirty supplies back into their supply cart; -She expected nurses to squeeze gels and ointments onto a sterile gauze to apply to a wound, to discard the dirty gauze pad and use a new gauze pad for a different area of the wound for infection control; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Touching the top of the application on a tube of medication with a dirty, gloved finger that had touched a wound could contaminate the entire tube of medication; -Squeezing medication straight out of a tube of medication into a open wound increases the risk of cross contamination and contaminating the entire tube of medication; -Failing to follow infection control measures increased the risk of cross contamination, infection of wounds and delayed wound healing. 4. During an interview on 7/26/24 at 11:26 A.M., the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), said: -They expected nurses to sanitize hands and change gloves during wound care before starting the treatment, between dirty to clean tasks and after wound care is completed; -They expected nurses to put wound care supplies on a sanitized area or on a barrier cloth due to risk of contamination of clean supplies, risk of infection of the wounds, and cross contamination; -It was not appropriate for nurses to put medication on their gloved finger, touching the tip of the tube, smear it on the resident's wound, use same dirty gloved finger, touch the tip of the tube again squirting medication on the dirty gloved finger, then spread the medication into the resident's wound bed due to increased risk of cross contamination for wound, risk of contaminating the tube of medication, risk of infection of wound and delayed healing of wounds; -It was not appropriate for nurses take a tube of medication and take it up to the wound bed and squirt the ointment into the wound bed due to increased risks of cross contamination to the wound, and contamination of the tube of medication. They expected the nurse to discard the tube of medication for infection control; -They expected nurses to use one piece of gauze for each wound site due to increased risk of cross contamination of wounds, risk of infection and risk of delayed wound healing; -They expected nurses to clean a wound from the inside out to decrease the risk of cross contamination, risk of infection and risk of delayed wound healing. 5. During an interview on 7/26/24 at 3:32 P.M., the Administrator said: -The delivery of care at the bedside by the nurses was monitored by the nurse supervisors (nurse managers, ADON and DON); -She expected nursing staff to have knowledge of and follow facility policies.