STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265417	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37681 Based on observation and interview, the facility failed to post in a place readily accessible to residents, family members, legal representatives of residents and visitors the results of the most recent survey and complaint investigations. The census was 88. Observations on 6/20/24, 6/21/24 and 6/24/24, showed no survey results maintained at the entrance of the building, in the lobby of the building or at the desk with the receptionist. No signs were posted for the location of the survey results and/or availability of the last survey or complaint investigations. During a group interview on 6/24/24 at 1:55 P.M., eight residents who represented the resident counsel said they did not know where to locate the survey binder. During an observation and interview on 6/24/24 at 3:16 P.M., eight residents from the group meeting approached the receptionist area and requested the survey binder. The binder was not located. The receptionist said he/she was not aware of where the survey binder was located and not sure if he/she ever saw it. The front lobby was under construction and the binder could have been in the storage room. During an interview on 6/24/24 at 3:21 P.M., the Assistant Director of Nursing (ADON) said the binder was normally at the front entrance of the lobby but was not sure where it was. During an interview on 6/26/24 at 1:18 P.M., the Administrator said the binder was usually kept in the front lobby near the receptionist area. He was not sure why the binder was moved. The binder should have been accessible to all residents, visitors, and families.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 Based on observation, interview and record review, the facility failed to notify one resident's (Resident #239) physician timely when there was change in the drainage from a surgical wound and when there was a change in the resident's blood pressure. The sample was 19. The census was 88. Review of the facility's Clinical Protocol: Guidelines for Notifying Health Care Providers (Physicians) of Clinical Problems Policy, dated last approved 1/23, showed: -Purpose: These guidelines are to help ensure that 1) medical care problems are communicated to the health care provider, efficient and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record; -Immediate Notification - Immediate implies that notification should occur as soon as possible, the health care provider or alternate is informed at the time of the event. Immediate notification is used when the resident has sign or symptom that is acute or sudden in onset and a marked change in relation to usual signs and symptoms, or unrelieved by measures already prescribed; -Non-Immediate Notification - The health care provider or alternate is informed of the event during normal business hours, and generally no later than the next regular office day. If a non-immediate event occurs on a weekend or holiday, nursing judgment shall determine if the notification could wait until the next office day or should be made during the weekend or holiday. Non-immediate notification applies when the resident exhibits new or worsening symptoms that do not meet the criteria under immediate notification, as above; -The charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management; -Procedure: The nurse is to: -Notify the resident/resident representative of the change and health care provider orders; -Implement health care provider orders; -Document in the resident's medical record. Review of Resident #239's medical record, showed: -Alert and oriented times three (person, place, and time) to four (person, place, time, and situation); -admitted on [DATE]; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included dependence on renal (kidney) dialysis (a machine that filters the blood in individuals with kidney failure) and right hip fracture with intramedullary nailing (surgery to repair the broken bone). Review of the resident's care plan, in use at the time of survey, showed: -Problem: has impaired skin integrity related to presence of dialysis catheter right chest; -Goal: will be free from signs and symptoms of infection and will demonstrate optimal healing; -Action-monitor insertion site for redness, warmth, swelling and report to medical doctor (MD). Observation and interview on 6/24/24 at 10:05 A.M., showed the resident sat up in the wheelchair and said the nurses changed his/her dressing. The surgical incision site was sore, but he/she did not think there was any drainage. Registered Nurse (RN) A and Certified Nurse Aide (CNA) H assisted the resident into bed. RN A said this was the first time he/she had seen the surgical incision. There was a dressing on the right thigh. The dressing was dated 6/24/24 at 12:42 A.M. The resident said he/she had pain and described the pain 10 out of 10 (0 equals no pain and 10 equals the worse pain imaginable). RN A removed the dressing, there was pink colored drainage on the dressing. RN A described the wound as a surgical incision that was 4 to 5 centimeters (cm) long. The site was well approximated (wound edges together and the wound closed). On both ends of the incisions, there was a small open area where the staple/suture was. There was minimal serosanguinous (yellowish drainage will small amounts of blood) drainage and a scant (small) amount of purulent drainage (thick, milky discharge that comes out of a wound) from where the top staple was. The wound was actively weeping. There was a scrape between the incision line and the knee. The nurse described the scrape as nickel size. The area around the scrape was 6 cm x 8 cm warm and hard. RN A said he/she was concerned about this area, and he/she would call the surgeon. There was another scrape between the groin and the incision. This area was not warm or hard. Observation of the dialysis port showed there was a dressing over the port. There was no swelling, warmth or redness noted around the dressing. Review of the resident's Treatment Administration Record (TAR), dated 6/1/24 through 6/30/24, showed an order for: cleanse right hip with wound cleanser, apply abdominal pads (ABD, gauze pad used to absorb wound drainage) and cover with tape daily and as needed (prn) 11P.M.-7 A.M. before patient gets out of bed. Do not change treatment order or time of treatment. Review of the resident's hard chart progress notes, dated 6/16/24 through 6/21/24, showed: -On 6/16/24 at 2:23 A.M., continues Doxycycline (antibiotic) twice daily until 6/19/24 related to infection of surgical wound site to right hip. Wound to right hip continues to have serous sanguineous drainage in scant amount. Skin around wound appears normal without redness or swelling and is warm to touch. Nine staples remain in place to right hip. Treatment done to right hip. Resident's dialysis port remains in place. Dressing to dialysis site is clean and dry, intact; -On 6/17/24 at 1:05 P.M., no concerns at this time; -On 6/18/24 at 12:30 P.M., the nurse does not have any concerns at this time and will continue to monitor the resident for changes; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/20/24 at 10:50 A.M., resident had orthopedic (ortho) appointment, returned. New order: patients staples removed and steri-stripes (thin adhesive bandages) placed. Monitor incision daily. Discontinue Doxycline but if incision shifts negatively, contact office; -On 6/21/24 at 4:54 A.M., resident complained of pain and discomfort to right hip as nurse changed resident's dressing to right hip. Nurse noted staples were removed but wound continues to drain purulent fluid. Resident has completed Doxycycline. Will notify day nurse of continued purulent drainage and encourage to contact primary care physician (PCP) on day shift; -On 6/21/24, no time documented, resident out to dialysis, dialysis site is clean and dry. Steri-stripes intact. Vital signs within normal limits at this time, no drainage present at incision site at this time. Will continue to monitor. Review of the resident's hard chart copy of vital sign flow sheet, showed: -On 6/19/24, 7 A.M.-3 P.M., Blood pressure (B/P, normal 90/60 through 120/80) was 80/52; -On 6/20/24, 7 A.M.-3 P.M., B/P was 80/46; -On 6/21/24, 7 A.M.-3 P.M., B/P was 79/50. Review of the resident's electronic medical record progress notes, dated 6/22/24 through 6/25/24, showed: -On 6/22/24 at 4:48 A.M., nurse noted resident warm to touch upon repositioning resident and changing resident's dressing during the night. The nurse noted resident's temperature (normal 97.8 through 99.1) was 100.1 and noted resident appeared confused. Nurse continued to talk with the resident and noted resident's face was flush. Nurse also noted resident's inner left thigh was reddened, swollen and warm and hard to touch. Nurse gave resident Tylenol, as needed, for fever. Will notify the day nurse to contact attending physician to report new findings and behaviors; -On 6/23/24 at 4:26 A.M., resident continues to have medium amount of purulent drainage from right hip surgical incision that leaves dressing saturated. Foul odor noted upon removal of dressing to perform treatment. Will notify day nurse to contact attending physician regarding continued drainage from right hip surgical site. Left inner thigh was slightly pink but no fever noted at this time. Upon palpation, area no longer feels harden. Nurse noted was more alert and coherent while dressing changed this shift; -On 6/24/24 at 3:11 A.M., upon changing the resident's dressing, nurse noted purulent drainage continued to drain from wound through a pinpoint hole in distal (furthest from the trunk) part of surgical wound. Foul odor also noted upon changing resident's dressing. Nurse noted skin around surgical wound was not red, swollen, or warm to touch. Will notify day nurse to contact attending physician regarding continuous purulent drainage of surgical wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/24 at 9:00 A.M. and 10:35 A.M., RN A said when he/she received report from the night nurse over the weekend (6/22/24 and 6/23/24) he/she only received part of the report and he/she did not know if the night nurse reported anything to the other nurse. RN A said no one had reported to him/her anything about the resident's surgical site having drainage, or that the resident had an elevated temperature or a period of confusion, or the PCP needed to be called. On 6/23/24, the night nurse reported the dialysis site, in the residents left upper thigh area was warm and swollen and hard. RN A said he/she assessed the area, and he/she did not see any swelling or redness and he/she asked the other day nurse to look at the site to be sure he/she was not missing anything. Today was the first time the night nurse reported to RN A the resident had purulent drainage from the surgical site and the physician needed to be contacted. If the resident did have a fever of 99 or 100 that would be concerning because the resident's baseline temperature was 97 to 98. The resident's blood pressure usually ran low. Review of the electronic medical record progress notes, dated 6/24/24 through 6/25/24, showed: -On 6/24/24 at 11:00 A.M., resident had a surgical wound on right hip. The nurse assessed the wound and noted a 5 to 6 cm long surgical wound to the right hip. The wound was well approximated. The wound was pink and draining at what appeared to be the two staple/suture sites at the top and bottom of the incision before they were removed. The wound ends were draining serosanguinous fluid and scant amounts of purulent drainage. The skin surrounding the surgical wound was warm to touch. The resident stated the surgical incision was painful, rating it a 10 out of 10. The dressing had a half dollar size amount of serosanguinous amount of fluid with scant amount of greenish colored drainage. The nurse noted a second skin wound close to the surgical site. The wound was inferior (below) to the surgical site, appeared as if the skin was scraped off, was pink, approximately the size of a nickel, was warm to touch, and had a large, hard area the size of a credit card under the skin scrape. The resident stated the area also was painful. The skin scrape was approximately 6 cm away from the surgical site. The dressing had a scant, dime size amount of drainage, greenish in color. The nurse noted a third skin wound close to the surgical wound approximately 8 cm superior (above) to the surgical site. The wound appeared as if the skin was scrapped off, was pink, approximately the size of a dime, was warm to touch and the patient stated the site was painful. The dressing covering the wound had a scant, dime size amount of drainage from the wound, greenish in color. The nurse redressed all three wounds and left them clean and dry and intact. The nurse contacted the PCP at 10:00 A.M. who instructed him/her to call the orthopedic surgeon. The nurse contacted the orthopedic surgeon's office at 11:33 A.M. The nurse relayed to the social worker that she will need to call and schedule a follow up appointment for the resident to see the orthopedist stat (immediately); -On 6/25/24 at 12:19 A.M., the nurse received report at 6:45 A.M., and was made aware that the night nurse was concerned about the resident's surgical incision site on his/her right hip and that he/she was concerned it might be infected. The nurse stated he/she did a wound assessment and dressing change on the wound in the night and noted purulent drainage from the wound and drainage on the dressing. The nurse stated there was a foul odor coming from the dressing and recommended the day nurse contact the PCP. The nurse assessed the resident wound and charted a full wound assessment, took vital signs that revealed B/P 78/50 Pulse (normal is 60 through 100) 62, oxygen saturation (SPO2, normal 95% through 100%) unable to obtain a reading, Respiratory Rate (RR, normal was 12 through 18) 18, and temperature 97.4. The nurse called the PCP who gave orders to contact the ortho surgeon and to start Keflex (antibiotic) and florstar (probiotic) in the meantime and to also order a wound culture of the right surgical incision drainage. The nurse completed the orders and got the resident another follow up appointment with ortho for the following day. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic medical record, vital signs section, dated 6/22/24 through 6/24/24, showed, on the following dates/times, the blood pressures were in red, which indicated they were out of range: -On 6/22/24 at 9:13 A.M., blood pressure was 80/40; -On 6/23/24 at 5:08 P.M., blood pressure was 70/42 (sitting); -On 6/23/24 at 6:56 P.M., blood pressure was 70/42 (lying); -On 6/24/24 at 9:04 A.M., blood pressure was 78/52 (sitting); -On 6/24/24 at 9:55 P.M., blood pressure was 78/52 (lying). Review of the facility's investigation, undated, showed: -On 6/24/24, the nurse for the resident worked from 6:45 A.M. to 10:45 P.M. He/ She documented an assessment as well as changed the surgical site dressing prior to the resident going to dialysis. Upon his/her return from dialysis, he/she completed her post-dialysis assessment. The nurse spoke to the orthopedic surgeon and relayed information about the surgical site. In addition, he/she spoke to the Nurse Practitioner (NP) and received orders for midodrine for low blood pressures, a wound culture of the right hip, and Keflex 500 milligrams (mg) twice daily (bid) x 7 days (non-dialysis days) to cover concern for pneumonia from a recent chest x-ray as well as any potential infection. The nurse updated family and continued to monitor the resident and at 10:10 P.M. the resident began shivering and his/ her temperature rose to 99.7. The nurse notified the on-call provider and received orders to send the resident out to the emergency room (ER). During an interview on 6/24/24 at 1:25 P.M., Licensed Practical Nurse (LPN) E said the night nurse did not report anything to him/her about the resident's incision line or that the resident had an elevated temperature, episode of confusion or low blood pressure. The resident's blood pressure was hard to obtain, and his/her blood pressure went up and down. Sometimes he/she would need to change the blood pressure cuff and reposition the resident's arm and recheck the blood pressure. The lowest blood pressure he/she obtained for the resident was 90/50's. If the resident's blood pressure was 70's over 40 or 50's, he/she would call the physician. If a resident's temperature was above 99 or 100, the physician should be called. If the resident had purulent drainage the physician should be called. The only thing reported to her by the previous shift was the dialysis port was irritated and he/she checked the dialysis site and there was only slight redness, there was no warmth, and the site was not hard. During an interview on 6/24/24 at 3:10 P.M., RN B said the last time he/she had seen the resident's incision was shortly after the resident first moved in. Residents with surgical wounds are managed by the facility. Usually, the floor nurse would notify RN B, if the resident had drainage from a surgical site. RN B was not aware the resident's surgical incision had purulent drainage. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 2:07 P.M., LPN D said sometimes he/she received report and sometimes he/she did not receive report from the off going shift. If he/she did not receive a verbal report, he/she would go through the resident's charts and look for pertinent information such as the progress notes and labs. LPN D said he/she made up a report sheet for the 200 hall and they have been using it for the past few days. He/She always gave report to the oncoming shift, which included the highlights of what was going on with each resident. If there was a change in the resident's condition, he/she would assess the resident and if the resident needed to be sent, he/she would send the resident out. If the resident was alert and talking and was at their baseline and their vital signs were stable, he/she would monitor the resident and pass it on to the next shift because in the past when he/she had called the physician, sometimes he/she had to leave a voice mail and it would take a few days for them to get a response back where as if day shift called they can usually get a faster response. The resident had a surgical incision on his/her right hip, and he/she has had blood and drainage from the incision site since he/she had been here. The resident went to the orthopedic office and came back with an order for antibiotics. While the resident was on antibiotics the redness, swelling and drainage decreased. Then, he/she went out to the orthopedic office again and the staples were removed. The incision line had two areas, one at each end of the incision which continued to have drainage. There was a scant amount of purulent drainage, he/she documented it and notified the day nurse to notify the physician and ortho. LPN D did not know if the day shift notified the physician or orthopedic office or not. The resident ran a fever of 100.1 or 99.9. LPN D removed some of the blankets off the resident because the resident did not have an order for Tylenol. He/She did not know if the resident was confused because of a fever or if it was from the pain medication. The resident's left inner thigh, where the dialysis port is located was red, hard, and swollen on the days the resident received dialysis. During an interview on 6/24/24 at 5:50 P.M., the Director of Nursing (DON) and Administrator said each shift the off going nurse gave the oncoming nurse a verbal report and there was a written report which is an additional tool. All nurses have access to the written report. Report should include if there was a change in the resident's condition, if the resident had an appointment, and if there were any new orders. If a resident had a change in condition, the DON would expect for the nurse to check the residents' vital signs and depending on what was going on, notify the physician, responsible party and update the resident. The DON would expect staff to document their findings in the medical record. The physician can be notified 24/7 if a resident had a change in condition. The DON would expect the nurse who found an issue with a resident to own it and to deal with the situation. If a resident had a skin issue, the night shift should notify the physician at the end of their shift. The DON was not aware of the resident's surgical site. The DON would expect for staff to call the physician immediately if the resident had a fever or signs of infection and not pass it on to the next shift. If a resident had a low blood pressure, the DON would expect for staff to rehydrate the resident and attempt to get another blood pressure. The physician would want two blood pressure readings. If the physician was notified the DON would expect it to be documented. During an interview on 6/24/24 at 5:30 P.M., the medical doctor (MD) said he would expect staff to notify him if a resident had purulent drainage. Each resident's blood pressure was different, but he would expect to be notified if a resident's systolic blood pressure was below 80. The MD did not recall the facility calling him regarding the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 2:01 P.M., the Physician Assistant (PA) said the resident was seen in the office on 6/20/24 and his/her surgical site was looking better, there was some serosanguinous drainage from the distal end of the surgical site. A negative shift in the wound would be signs and symptoms of infection such as redness, swelling and drainage. If a resident had purulent drainage, that would be a change. He/She would expect for staff to call the office, the same day they noted the purulent drainage or if it was after 4:00 P. M. they could leave a voice mail or call the next day, because the resident may need to be restarted on antibiotics. The PA said there was no note in the chart to show the facility had notified the office prior to 6/25/24, when someone from the facility called to say they decided to send the resident to the hospital in place of coming in for his/her appointment. During an interview on 6/26/25 at 1:18 P.M., the DON and Administrator said they would expect for the physician to be notified when there is a change in the residents' condition, and they would expect for staff to document if they notified the physician.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 36151 37681 Based on interview and record review, the facility failed to ensure newly hired employees were screened to determine the presence of a federal indicator (used to identify individuals found to have abused, neglected, or misappropriate resident property) with the Nurse Aide (NA) Registry for three of 10 sampled employees hired since the last survey. The facility hired at least 57 new employees since the last survey. The census was 88. Review of the facility's Abuse Prevention policy, approved 6/2022, showed: -Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms; -Policy Interpretation and Implementation: The community's goal is to achieve and maintain an abuse free environment. As part of the resident abuse prevention program, the administrator will provide a safe resident environment and protect the residents from abuse by anyone including, but not limited to, community associates, other residents, consultants, volunteers, associates from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will perform the following: -Screening; -It is the policy of this community to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check. Will not knowingly employ or otherwise engage any individual who: has had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. Review of Employee A's employee file, showed: -Hire date of 10/12/23; -No NA registry check. Review of Employee B's employee file, showed: -Hire date of 6/11/24; -No NA registry check. Review of Employee C's employee file, showed: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hire date of 6/25/24; -No NA registry check. During an interview on 6/26/24 at approximately 10:30 A.M., the Human Resources representative said background checks were completed prior to an employee being hired at the facility. The background checks were uploaded to the computer in their regional office. He was not sure if NA registry checks were completed or if it was a requirement for non-nursing staff. During an interview on 6/26/24 at 1:18 P.M., the Administrator said NA registry checks were not completed. He was not aware NA registry checks should have been conducted on non-nursing staff.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 50366 Based on observation, interview and record review, the facility failed to meet professional service standards when staff did not clarify medication orders and documented the same medication as given in multiple forms and duplicated doses, for one resident (Resident #67). In addition, the facility failed to follow physician orders when staff failed to send one resident (Resident #238) out to the hospital timely. The sample was 19. The census was 88. 1. Review of Resident #67's medical record, showed: -Diagnoses included Alzheimer's disease, unspecified dementia, and gastroesophageal reflux disease (GERD, heart burn); -An electronic physician order dated 10/21/22, for pantoprazole (used to treat heartburn) 40 milligram (mg) tablet delayed release, by mouth (PO), twice a day (BID), for GERD; -A paper chart physician order dated 10/27/22, for pantoprazole 40 mg tab, 1 tablet PO, BID, for GERD; -A paper chart medication administration record (MAR) dated 6/13/24, showed discontinue pantoprazole 40 mg tab, see new order for packets; -An electronic physician order dated 6/15/24, for pantoprazole suspension 2 mg/1 milliliter (ml), administer 20 ml/40 mg, PO, BID, for GERD. Review of the resident's electronic medication administration record (eMAR), showed: -Pantoprazole 40 mg tablet, delayed release 1 tab, PO, BID, for GERD, marked as administered on 6/23/24, 6/24/24, and 6/25/24 at 9:00 A.M. and 5:00 P.M.; -Pantoprazole sodium 40 mg packet, dissolve 1 packet in 5 ml of apple juice, PO, BID a day for GERD, marked as administered on 6/22/24, 6/23/24, 6/24/24, 6/25/24, and 6/26/24 at 6:00 A.M.; -Pantoprazole suspension 2 mg/ml administer 20 ml/40 mg, PO, BID, for GERD, marked as administered on 6/22/24 at 09:00, 6/23/24, 6/24/24, and 6/25/24 at 9:00 A.M. and 5:00 P.M. During an interview on 6/26/24, at 10:08 A.M., with Licensed Practical Nurse (LPN) E and LPN F, they said the resident is getting pantoprazole in liquid form, PO, BID, and they are unsure what date the medication was last given because the liquid medication expired and could not be used. They said it has been reordered but has not arrived as of 6/26/24, at 10:08 A.M. LPN F called pharmacy to verify the medication was to be delivered today. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24, at 11:38 A.M., with the Administrator and Director of Nursing (DON), they said staff should call the physician to verify duplicate orders for the same medications. On the eMAR, the nurse initials in the box means medication has been given. If it was not given there would be no initials. They also said they discovered today, 6/26/24, that there are duplicate orders now in the eMAR because their computer system was down for over a month and went back live on Friday June 21, 2024. They currently have a nurse assigned to go through all resident orders to clean up duplicates. During an interview on 6/26/24, at 1:00 P.M., the Medical Director said staff should call him to verify duplicate orders prior to administering. He verified Resident #67 is high risk for aspiration and the correct order for pantoprazole is pantoprazole suspension 2 mg/1 ml administer 40 mg/20 ml, PO, BID, for GERD. He gave verbal order to LPN E. 2. Review of Resident #238's medical record, showed: -Resident admitted on [DATE]; -The resident is alert and oriented times four (person, place, time, and situation); -Diagnoses included: autism (a serious developmental disorder that impairs the ability to communicate and interact) and history of seventh thoracic (T7) vertebra (middle section of your spine) through tenth thoracic vertebra (T10) laminectomy (surgery in which a surgeon removes part or all the vertebral bone) with mass removal. Review of the resident's care plan, in use at time of the survey, showed: -Problem: resident is status post T7 through T10 laminectomy with resection of mass; -Goal: will not develop complications from surgery so that can discharge to home without requiring outside medical interventions; -Action: assess for post-surgical healing of incision. Provide wound treatment per orders and inform physician of any concerns. Review of the resident's hard chart progress notes, dated 6/21/22 through 6/22/24, showed: -On 6/21/24 at 4:00 A.M., the nurse noted upon turning the resident, resident had a surgical incision to spine that has dehiscence (a partial or total separation of previously approximated wound edges). Wound was 11 centimeters (cm) length X one cm width with slough (yellow/white material noted in the wound bed) noted to wound on back. Area was cleaned with wound cleanser and clean dry dressing was applied. Will notify day nurse to contact Primary Care Physician (PCP) to obtain orders for spinal incision. Nurse also noted spinal incision had scant (small amount) amount of yellow purulent drainage (thick, milky discharge that comes out of a wound) coming from wound bed; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/21/24 at 9:00 A.M., night shift notified nurse that patients back incision had dehisced (to gape or burst open). Nurse went to assess patient, patient noted to have an open surgical site to his/her mid back. Site notes to have a small amount of drainage noted to be yellow and slough present. Nurse attempted to call the surgeon and was unable to reach. Nurse then called physician and made him aware of the new finding. Nurse received orders to send the patient out to the hospital for further evaluation. Nurse instructed patients assigned nurse to send him to the hospital by non-emergency ambulance; -On 6/22/24 at: 8:00 A.M., the nurse received report on the resident and was told he/she had an 11 cm long superficial incision mid back/spinal region on his/her upper back that appeared to be infected with thick green discharge in the wound and the wound had dehisced. The nurse looked at the wound and an approximately 11 cm long surgical incision that dehisced and had green exudate (drainage) coming out of the wound. The wound was red and was swollen on the right side. The resident was afebrile (without fever), denied any pain at the site. The nurse put a bandage/dressing back over the site and notified the physician at 9:17 A.M., the family at 9:13 A.M., and received orders to send he resident out to the hospital for evaluation and treatment. The nurse called the ambulance at 9:18 A.M. Review of the resident's electronic medical records, showed: -On 6/22/24 at 4:38 A.M., the nurse noted no new orders for infected spinal incision. Nurse cleaned area with normal saline and dry dressing applied to reduce infection. Will notify day nurse to contact resident's attending physician to obtain order to treat wound; -On 6/22/24 at 12:09 P.M., the nurse received report that the resident has an infected 11 cm long surgical wound that had dehisced, mid back/spinal area on his/her upper back. The nurse assessed the resident and noted an 11 cm long surgical incision, along the spinal column that had dehisced, was swollen on the right side, and noted green, thick exudate oozing out of the length of the wound. The resident stated the wound was not painful. The resident was afebrile, and alert and oriented x3 (person, place, and time). The nurse recovered the wound with a dressing and notified the physician at 9:17 A.M. the nurse received orders to send the resident to the emergency room (ER) for evaluation. The resident was taken out of the facility via stretcher with two ambulance attendants at 10:30 A.M. During an interview on 6/24/24 at 1:25 P.M., LPN E said he/she was made aware the resident's wound dehisced on 6/21/24. RN B and LPN E assessed the residents wound, the wound was coming apart and was draining. RN B called the physician. The physician said to send the resident out to the hospital and to call the surgeon, they tried to call the surgeon, but we were unable to reach the surgeon. RN B told LPN E to send the resident to the hospital. LPN E said it slipped his/her mind because management came to the desk to do an in-service and he/she was doing orders for other residents. When he/she came back to the facility on [DATE], the resident was at the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/24 at 3:10 P.M., RN B said he/she was made aware the incision was open and he/she assessed the site. The wound size was 11 cm x 1 cm. The tissue was pink with yellow drainage and slough. He/She called the surgeon but was unable to reach him/her and the physician was called and said to send the resident out to the hospital. RN B said he/she documented it in the resident's hard chart. RN B did not send the resident out. He/She delegated the task to the day shift nurse on the 200 halls. If the day shift nurse was unable to complete the task, he/she would expect the task to be completed by the next shift. RN B was not aware the resident did not go to the hospital until the next day when he/she called the floor and talked to the nurse and was told the resident was still at the facility. RN B was not given a reason why the resident did not go the hospital. During an interview on 6/24/24 at 10:35 A.M., RN A said the night nurse reported to him/her on 6/22/24, the residents wound dehisced. He/She went in and assessed the resident and called the physician and sent the resident out to the hospital on 6/22/24. During an interview on 6/25/24 at 2:07 P.M., LPN D said sometimes he/she received report from the prior shift and sometimes he/she did not get a verbal report from the prior shift. If no report was received, he/she went through the resident's charts and looked for pertinent information such as progress notes and labs. LPN D said he/she made up a report sheet for the 200 hall and they have been using it for the past few days. He/She always gave report to the oncoming shift, which included the highlights of what was going on with each resident. If a resident needed to go out to the hospital, he/she would send the resident out, but if he/she felt it could wait, he/she would document his/her findings and tell the next shift to notify the physician. The resident was incontinent, and he/she was assisting the resident to turn over in bed and that is when he/she noted the surgical wound had dehiscence. The resident did not have a treatment order for the surgical site, so he/she cleaned the wound and applied a dry dressing and documented it in the chart and reported it to the day shift nurse to call the physician. When he/she came back the next day, the resident was still at the facility and the off going shift was asking him/her questions about the resident's surgical site. LPN D checked the chart and saw there were no new orders. When LPN D assessed the resident, there was a new dressing on the resident. He/She pulled the dressing back and saw calcium alginate (highly absorbent dressing that promotes healing) in the middle of the wound and green drainage. He/She did not have access to the wound nurse's treatment book to know if there was a new treatment in place or not. LPN D reported his/her findings to the day nurse and asked him/her to call the physician. He/She did not call the physician because usually when he/she called the physician during the night, he/she had to leave a voice mail and it usually took a couple of days to get a response whereas if the day shift would call the doctor, they will get a faster response. He/She was not aware the resident had an order to send the resident to the hospital. During an interview on 6/24/24 at 5:30 P.M., the medical doctor said the facility did contact him about two to three days ago about the wound on the resident's back. He gave orders for staff to call the surgeon and to send the resident to the hospital. The facility called him back the next day regarding the resident's wounds, and again he gave orders to send the resident to the hospital. He did not know why the resident was not sent to the hospital the first time he talked to them. The MD would expect for staff to follow his orders and send the resident to the hospital the same day he gave the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/24 at 5:50 P.M., the DON and Administrator said the DON was told on Friday the resident was being sent out to the hospital non-emergent and today she was surprised to find out the resident did not go to the hospital until Saturday. The DON would expect for the day nurse to assess the resident immediately after receiving report from the night shift. Once orders are obtained to send the resident to the hospital, the nurse should send the resident out as soon as possible. For a non-emergent transfer she would expect the resident to be transferred out sometime within the shift. If one shift obtained the order to send a resident out and they were unable to complete the task, the DON would expect staff to pass the information on to the next shift to complete the transfer. On 6/26/24 at 1:18 P.M., the DON and Administrator said they would expect for staff to follow physician orders and to follow the facility's policies and procedures.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36151 Based on interview and record review, the facility failed to obtain a stop date of 14 days or less on an as needed (PRN) psychotropic medication (a chemical substance that changes brain function and results in an alteration in perception, mood, consciousness, or behavior) for one resident (Resident #76). The sample size was 19. The census was 88. Review of the facility's Psychotropic Drugs policy, dated November 2022, showed: -Psychotropic medications may be considered for residents but only after medical, physical, functional psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed; -Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review; -Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective; -Psychotropic medications requirements apply to the four drug categories; (antipsychotic, antidepressant, antianxiety and hypnotic) regardless of the indication for use; -Residents will not receive as needed (PRN) doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record; -The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The specific duration of the PRN order will be indicated in the order. Review of Resident #76's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/28/24 showed: -Moderately impaired cognition; -Behaviors: rejection of care and wandering, occurred 1-3 days per week; -Diagnoses included stroke, dementia, and malnutrition Review of the resident's Physician's Order Sheet, showed an order dated 4/5/24, for Lorazepam (used to relieve anxiety) 2 milligram (mg)/milliliter (ml). Give 0.25 ml by mouth every three hours as needed for anxiety, agitation. End date, not applicable. Review of the resident's medical record, showed PRN Lorazepam was administered; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-April 2024, 6 times; -May 2024, 0 times; -June 2024, 2 times. During an interview on 6/26/24 at 1:24 P.M., the Director of Nursing said there is 14 day stop date on PRN antianxiety medications. During an interview on 6/26/24 at 9:34 A.M., the administrator said PRN medications are supposed to have a stop date. The standard rule is a 14 revaluation and reorder. The facility policy dictates the PRN stop dates. MO00235258

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 45083 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored appropriately. The facility identified five medication/treatment carts and two medication rooms. Three of the five carts and both medication rooms were checked for medication storage. Issues were found in both medication room medication refrigerators. Staff failed to discard an expired bottle of Pantoprazole suspension (used to treat heartburn) for one resident (Resident #67) and failed to date an opened vial of tuberculin purified protein derivative (PPD, used to diagnose silent (latent) tuberculosis (TB) infection) solution. In addition, the staff failed to check the refrigerator temperatures and keep the log sheets updated. The census was 88. Review of the facility's Storage of Medications policy, dated 12/2017, showed: -The nursing associates shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; -The community shall not use discontinued, outdated, or deteriorated drugs or biologicals; -Refer to Discarding and Destroying Medication policy. Review of the facility's Discarding and Destroying Medication policy, dated 12/2019, showed: -Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances; -Non-controlled and schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications; -Associates shall contact the provider pharmacy if they are unsure of proper disposal methods for a medication. 1. Review of Resident #67's physician orders, showed an order dated 6/15/24, for Pantoprazole suspension 2 milligrams (mg)/1 milliliter (ml), administer 20 ml (40 mg) by mouth two times a day for gastroesophageal reflux disease (GERD, heart burn). Review of the resident's Care Plan, in use at time of survey, showed: -Category: Gastrointestinal (GI); -Focus: Gastrointestinal distress: resident has potential for complications due to gastrointestinal distress related to GERD; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: The resident will not experience complications due to gastrointestinal distress related to the diagnosis of GERD; -Interventions: Administer medication as ordered, and monitor response. Observe for side effects, and advise physician of concerns, and as needed (PRN). Observation on 6/21/24 at 8:00 A.M., showed the medication Pantoprazole suspension 2 mg/1 ml, for Resident #67, with an expiration date of 6/19/24 in the medication storage refrigerator, in the medication storage room, on [NAME] Hall. During an interview with the Administrator and the Director of Nursing (DON) on 6/26/24 at 11:38 A.M., they said expired medications should not be given to residents. Expired medications should be disposed per facility policy and procedure. The nursing staff is responsible to check for expired medications and to order refills. 2. Observation on 6/21/24 at 6:43 A.M., of the 200-hall medication room, showed the medication refrigerator had one open vial of PPD in a box. There was no date on the box or vial, Licensed Practical Nurse (LPN) D said he/she did not see a date on the medication, and he/she did not know when the medication was opened. The medication should be dated when it was opened. The medication is good for 90 days after opening. Further observation of the medication room, showed no medication refrigerator log. LPN D said they have not been keeping a temperature log since they moved back onto the 200-hall. He/She was not sure when they reopened the 200-hall. 3. Review of the facility's Medication Fridge Temperature Log sheet, showed temperatures are logged daily, temperatures out of range 2-8 degrees Celsius and 36-46 degrees Fahrenheit (F) are re-checked, and action is logged. Review of the facility's May 2024 temperature log sheet in [NAME] hall, reviewed on 6/25/24, showed the following dates and temperatures logged: -5/1/24 - 40 degrees F; -5/2/24 - 40 degrees F; -5/25/24 - 36 degrees F; -5/26/24 - 30 degrees F; -5/30/24 - 38 degrees F; -The remaining dates of May were blank; -The month of June 2024 sheet showed a logged temperature on 6/1/24 only. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 6/25/24 at 9:23 A.M., LPN J said night shift nurses are responsible for medication refrigerators temperature log sheets. He/She provided a different [NAME] hall log sheet for the month of June 2024, which showed logged and signed temperatures up to 6/21/24, except for weekend dates of 6/1/24, 6/2/24, 6/8/24, 6/9/24, 6/15/24, 6/16/24, which were blank. 6/7/24 and 6/18/24 were out-of-range at 32 deg F. LPN F said blank dates signifies they were not done. 4. During an interview on 6/25/24 at 8:59 A.M., LPN F said night shift is responsible for checking and logging the refrigerator temperatures. Nurses are responsible for checking expired medications in the medication rooms. Certified Medical Technicians (CMT) and nurses are responsible for their medication carts. 5. During an interview on 6/26/24 at 9:40 A.M., the Administrator said nurses and CMTs are responsible to check expired medications for their own carts. Nurses and nurse managers are expected to check medication rooms, including medications in the refrigerators and to check medication room refrigerator temperatures and log them in the log sheets available. The Administrator said blank dates in the log sheet mean they were not done. He was not aware temperature log sheets were not available in 200-hall. The Administrator said he expected the staff to discard expired medications, date opened medications, and log refrigerator temperatures daily. 50366

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on observation and interview, the facility failed to provide and offer snacks at bed time, when snacks were only offered mid-day, between lunch and dinner, and not at bedtime. The census was 88. During an interview on 6/20/24 at 11:53 A.M., the Dietary Manager said breakfast was served at 7:30 A.M., lunch was served at 12:30 P.M. and dinner was served at 5:30 P.M. During a group interview on 6/24/24 at 1:55 P.M., eight residents, who represented the resident counsel, said the facility did not offer snacks anymore. One resident said they got nothing to eat after 5:00 P.M., his/her sugar was low the other night, and he/she was given some pudding. The facility would give residents a snack if their blood sugar was low. During an interview on 6/25/24 at 3:14 P.M., the Activity Director said they pass snacks at 3:00 P.M., and it's called [NAME]. It was pretty much every day unless they had socials. [NAME] was at 3:00 P.M., and they take the cart around and hand out snacks, drinks and talk to the residents. If residents want snacks after dinner, they ask the Certified Nursing Assistants (CNA)s. No one goes around and passes out snacks after dinner. Snacks consist of soft foods, pudding, applesauce, sometimes Cheeto puffs, fig bars, cheese crackers and trail mix. In the morning, they passed water. Observation and interview on 6/26/24 at 11:49 A.M., showed CNA I walked by the [NAME] Hall nurse's station and said activities comes around with a cart of snacks at 4:00 P.M. If the residents ask for snacks, they would get them for them. Snacks were kept in the cabinets by the nurse's station and only staff knew they were stored there. Observation of the [NAME] Hall refrigerator showed it contained only a tray of health shakes, and the storage cabinets contained no snacks. During an interview on 6/26/24 at 1:49 P.M., the Dietary Manager said nursing lets them know about the need for snacks, and the dietary department tried to stock each nursing station. They try to do it every other day. If the cabinets were empty, she was not sure if the staff or residents were getting them. They asked whoever was taking the lunch trays to the halls to check if snacks needed refilled so residents would have them overnight. Today, snacks were not mentioned as needing stocked. During an interview on 6/26/24 at 1:25 P.M., the Director of Nursing said snacks are to be given after dinner/bedtime and they are available. 37681

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42247 50366 Based on observation, interview and record review, the facility failed to follow acceptable infection control and prevention practices when staff brought the treatment cart into an isolation room and did not clean and disinfect the cart before taking the cart into another resident's room. In addition, staff failed to perform hand hygiene between glove changes, disinfect a clean field, and disinfect scissors for one resident during wound care (Residents #61 and #238). Staff failed to wear appropriate personal protective equipment (PPE), in accordance with the facility's policy, during high-contact activities with residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for three residents (Residents #84, #240 and #73). The sample was 19. The census was 88. Review of the facility's Transmission-Based Precautions policy, last revised 5/23, showed: -Standard precautions assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other residents; -Transmission-Based Precautions (TBP, also referred to as Isolation Precautions) are added to Standard Precautions when needed to manage specific, highly transmissible, or epidemiologically important pathogens based on the mode of transmission; -TBP should be implemented for residents known or suspected to be infected with an infectious agent requiring additional control measures based on the mode of transmission; -Contact isolation: used for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact with the resident or the resident's environment. This includes touching environmental surfaces or handling resident care items. -Resident care equipment, when placed on precautions, the resident will have their own dedicated equipment, when possible, to be used during their precaution period; -Re-usable equipment will be terminally cleaned (a procedure required to ensure that an area has been cleaned/decontaminated following discharge of a patient with an infection) or disinfected upon removal from the resident's room. Review of the facilities Pressure Injury (pressure ulcer, injury to the skin as a result of pressure or friction) Assessment/Treatment policy, dated last revised 1/2018, showed: -Purpose: The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and prevention of acquiring additional pressure injuries; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Steps in wound care procedure: -Clean bedside stand. Establish a clean field; -Place the clean equipment on the clean field. Arrange the supplies so they can be easily reached; -Tape a biohazard or plastic bag on the bedside stand or use a waste basket below clean field; -Wash and dry your hands thoroughly; -Put on clean gloves. Loosen tape and remove soiled dressing; -Pull gloves over dressing and discard into plastic or biohazard bag; -Wash and dry your hands thoroughly; -Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface; -Using clean technique, open other products (example, prescribed dressing, clean gauze); -Perform hand hygiene. Put on clean gloves; -Cleanse the wound with ordered cleanser. Use dry gauze to pat the wound dry; -Apply the ordered dressing and secure with tape or bordered dressing per order; -Discard disposable items into the designated container; -Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly; -Reposition the bed covers. Make the resident comfortable; -Clean the bedside stand; -Perform hand hygiene. 1. Review of Resident #61's medical record, showed: -Diagnoses included end stage kidney disease (final stage of kidney failure) and type 2 diabetes with diabetic peripheral angiopathy (long term inadequate control of blood sugar levels lead to narrowing in arteries and undersupply of blood and oxygen that leads to long term leg damage); -An order, dated 6/22/24, cleanse left heel with Vashe (wound cleanser), apply Santyl (ointment used to remove dead tissue) to wound bed, apply calcium alginate (dressing used for wounds with drainage) to wound bed only, and wrap with Kerlix (gauze wrap) once a day; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 6/22/24, cleanse right lateral foot with Vashe, apply Santyl to wound bed, apply calcium alginate to wound bed only, and wrap with Kerlix once a day. Review of the resident's Plan of Care, in use at time of survey, showed: -Focus: The resident has impaired skin integrity related to open area on left inner heel; -Goal: The resident will be free from signs and symptoms of infection and will demonstrate optimal healing; -Interventions included: Provide treatment as ordered. Keep skin clean and dry; -Focus: The resident has impaired skin integrity related to open area on right outer foot; -Goal: The resident will be free from signs and symptoms of infection and will demonstrate optimal healing; -Interventions included: Provide treatment as ordered. Keep skin clean and dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/25/24 at 9:22 A.M., showed License Practical Nurse (LPN) F prepared and administered the ordered dressing changes for the resident. He/She retrieved a small treatment cart from a cubby hole by the nurse's station and rolled it down hall, to just outside of the resident's room, next to large treatment cart that contained wound care supplies. He/She prepared the small treatment cart by placing a clean trash bag down to top of cart to establish a clean field without sanitizing the top of the cart. He/She secured one bag to the side of cart for trash and soiled items. He/She did not sanitize his/her hands prior to establishing a clean field. He/She continued to prepare the top of treatment cart by removing supplies from large treatment cart. He/She retrieved calcium alginate dressing, Vashe wound solution, two cotton swabs, a stack of gauze bandages, and medical tape. He/She initialed, dated and timed the tape for both wounds then obtained two gauze rolls and placed Santyl into a plastic disposable medication cup. He/She grabbed scissors from his/her scrub top pocket. He/She did not sanitize the scissors after removing them from the pocket and placed the scissors and the rest of the supplies on top of the clean field on the small treatment cart. He/She applied gown, mask, and gloves without sanitizing his/her hands. He/She rolled the small treatment cart into the resident's room. The resident sat in a wheelchair in the room. LPN F bent down to remove the resident's heel protector boots from both feet and placed a wedge to elevate the left heel, removed his/her glove, did not hand sanitize, and applied new gloves. He/She unwrapped all of the gauze bandages and place them directly on the clean field on top of the treatment cart. He/She applied Vashe to four gauze, opened the calcium alginate dressing and left it in the packaging on top of the clean field. He/She removed hand sanitizer from the top drawer of cart and sat it on the clean field. LPN E removed gloves, hand sanitized and applied gloves. He/She bent down and adjusted the resident's left foot on top of the wedge and used the non-sanitized scissors to cut off the old dressing, then placed the scissors on the clean field. He/She removed old gloves, cleaned left heel wound with Vashe soaked gauze, removed gloves, did not apply new gloves or hand sanitize, cut calcium alginate dressing with non-sanitized scissors, applied new gloves without hand sanitizing, and cut the new calcium alginate dressing with the non-sanitized scissors and gloved hands and laid the rest of dressing directly on the clean field along with the non-sanitized scissors. He/She removed his/her gloves and did not sanitize his/her hands, and applied new gloves. He/She applied nickel thick Santyl from the medication cup with a cotton swab to the wound bed, applied calcium alginate dressing, covered with two gauze pads, wrapped with rolled gauze and secured with medial tape with initials, date, and time on tape. LPN E removed his/her gloves and sanitized his/her hands. He/She applied gloves, moved the wedge from left foot to right to elevate right foot, cut off the old dressing from the right foot with the non-sanitized scissors used for the other wound, and placed the non-sanitized scissors on top of the clean field. He/She then cleansed the right lateral foot wound with Vashe, applied nickel thick Santyl to the wound bed, cut the Calcium Alginate dressing with the non-sanitized scissors, applied Calcium Alginate dressing to right side of the foot, covered with two gauze pads, wrapped with rolled gauze and applied medical tape with initials, date, and time on tape. He/She removed the wedge, applied heel protector boots to both feet, handed the resident the call light, cleaned up small treatment cart by placing all used items in the trash can on the side of cart, placed non sanitized scissors back in his/her pocket without cleaning them, removed gloves and used soap and water for hand hygiene. He/She then pushed the small treatment cart back to the original placement in a cubby hole by the nurse's station. He/She did not clean top of cart with sanitizer after he/she exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and Director of Nursing (DON) on 6/26/24 at 11:38 A.M., They said staff should clean the small treatment cart with facility Cadi wipes, (sanitizing wipes) prior to applying clean barrier such as a paper towel and it should be cleaned with Cadi wipes after use. They expect staff to follow wound care policy when performing wound care. Hand hygiene should be performed prior to and after wound care and with each glove change. They said staff should sanitize scissors prior to and after each use. 2. Review of Resident #238's medical record, showed: -Alert and oriented times four (person, place, time, and situation); -The resident had a urinary catheter and was incontinent of bowel movement; -Diagnoses included autism (a serious developmental disorder that impairs the ability to communicate and interact) and clostridium difficile (C-diff, contagious from of diarrhea caused by bacteria); -A progress note dated 6/19/24 at 10:20 P.M., result received from c-diff testing: results are positive for c-diff. Call was placed to the on-call, new orders were received for isolation precautions. Observation and interview on 6/20/24 at 10:50 A.M., showed, the door to the room was closed. There was a caddy on the door with PPE on it. There was no signage on the door. Registered Nurse (RN) A said, generally the PPE caddies would have a sign showing what type of isolation the resident was on, but they took down all the signs and ordered new ones. RN A said he/she told all the staff/family so everyone knew if the residents were on isolation or EBP The resident was on contact isolation for c-diff. During an observation on 6/20/24 at 11:24 A.M., showed the resident lay in bed, his/her catheter drained to gravity. The wound company Nurse Practitioner (NP) and the facility nurse put on a gown and gloves, and took the treatment cart into the resident's room. The wound company NP and facility nurse provided wound care to the resident. After care was provided both removed their PPE and performed hand hygiene and removed the treatment cart from the room without cleaning and disinfecting it. Then, they took the treatment cart into another resident's room. Observation on 6/20/24 at 11:45 A.M., showed there was a handwritten contact isolation sign on the door. Observation on 6/20/24 at 4:00 P.M., of the yellow contact isolation sign on the door, showed: -Family/Visitors: Please see the nurse before entering; -Everyone must: clean hands before entering and when leaving room; -All healthcare personnel must: wear gloves when entering room and remove before leaving room; -Wear a gown when entering room and remove before leaving; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Use resident-dedicated or single-use disposable equipment. If shared equipment is used clean and disinfect between residents. -The signage failed to show if shared equipment was used, clean with an appropriate disinfectant. During an interview on 6/24/24 at 3:06 P.M., Registered Nurse (RN) B said the treatment cart can go into residents' rooms, it just cannot come in contact with the wounds. 3. Review of the facility's Enhanced Barrier Precautions Policy, dated last approved 5/24, showed: -Purpose: to prevent opportunities for the transfer of MDROs to associate's hands and clothing during care; -EBP are indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Infection or colonization with a targeted MDRO; -EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; -Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line (a flexible tube that is inserted into a large central vein), urinary catheter (a sterile tube inserted into the bladder through the urinary tract to drain urine); -Wound care: Wounds generally include chronic wounds which include, but are not limited to, pressure ulcers (bed sore), diabetic foot ulcers (caused by a combination of poor circulation, susceptibility to infection and nerve damage from high blood sugars levels), unhealed surgical wounds, and venous stasis ulcers (a wound on the leg or ankle caused by abnormal or damaged veins) Shorter-lasting wounds, such as skin breaks or skin tears that can be covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing do not require EBP. Review of the Enhanced Barrier Precaution sign, undated, showed: -Everyone must clean hands before entering and upon leaving the room; -All Healthcare Personnel must wear gloves and gown for the following high-contact resident care activities: changing linens, changing briefs, or assisting with toileting, device care or use (intravenous line, urinary catheter) wound care (any skin opening requiring a dressing). 4. Review of Resident #84's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 5/16/24, showed: -Moderately impaired cognition; -Diagnoses included stroke, high blood pressure, obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow) and diabetes; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Used a urinary catheter. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident needs assistance with activities of daily living (ADL): -Goal: Resident will have daily care needs met through next review period; -Action: Resident used an indwelling catheter. Observation on 6/21/24 at 6:20 A.M., showed a PPE caddy on the resident's door with a blue EBP sign on the door. The resident lay on his/her side in bed. CNA G assisted the resident with care and straightened out the pad on the bed and the brief, then the resident rolled onto his/her back. CNA G said he/she had already washed the resident as he/she fastened the brief. CNA G removed the top sheet from under the resident's head and placed it over him/her and covered him/her with a blanket. Then, CNA G emptied urine from the catheter bag. CNA G did not wear a gown while providing care or when emptying the catheter bag. 5. Review of Resident #240's medical record, showed: -Diagnoses included: osteomyelitis (inflammation or swelling that occurs in the bone) of vertebra, cervical (neck), cognitive communication deficit and high blood pressure. Review of the care plan in use at the time of survey, showed: -Problem: Resident has ordered IV medication for osteomyelitis; -Goal: Will not develop complications from IV medication or fluid through duration of treatment and will not require outside medical intervention. Review of the physician order sheet dated 6/26/24, showed: -An order for intermittent flush peripherally inserted central catheter line (PICC, a long, thin tube that is inserted into a deep vein): five milliliters (mL) normal saline before and after medications, then followed by five mL of heparin (blood thinner) IV every eight hours for IV. Observation on 6/21/21 at 7:15 A.M., showed the resident sat in his/her wheelchair in his/her room. LPN D performed hand hygiene and put gloves on, then he/she flushed the residents PICC line with normal saline and heparin, LPN D removed his/her gloves and performed hand hygiene. LPN D did not wear a gown. 6. Review of Resident #73's medical record, showed: -Resident was alert and oriented times four (person, place, time, and situation); -Diagnoses included heart failure and chronic reoccurring diabetic ulcer to left heel, diabetes, and Parkinson's disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician order sheet, for 6/2024, showed: -An order for Vashe wound therapy solution-cleanse left heel, apply Santyl followed by gentamicin ointment (topical antibiotic), cover with ABD (gauze pad used to absorb wound drainage) and wrap with kerlix, one time a day. Start date 6/13/24 and discontinue date 6/23/24. Review of the care plan in use at the time of survey, showed: Problem: Resident had an impaired skin integrity related to pressure wound to left heel; Goal: Will be free from signs and symptoms of infection and will demonstrate optimal healing; Actions: Provide treatment as ordered. Observation and interview on 6/20/24 at 11:09 A.M., showed no PPE on the door and no EBP sign on the door. The resident was sitting in a chair with the feet elevated and the wound company NP sat on the floor and performed wound care on the resident's foot. The facility nurse stood on the side of the resident assisting the NP. The NP nor the nurse wore a gown while providing wound care. 7. During an interview on 6/24/24 at 10:30 A.M. CNA D said he/she knew if a resident was on EBP or isolation because the resident would have PPE outside their door, and they would have a sign on their door saying what they needed to do. If there was no sign on the door, he/she would ask the nurse. 8. During an interview on 6/24/24 at 1:25 P.M., LPN E said residents who have wounds, catheters and IVs should be on EBP. Staff should wear PPE when they go into their rooms to provide personal care. Staff know which residents needed EBP/isolation because they would have a PPE caddy on their door and a sign showing what precautions are needed. 9. During an interview on 6/24/24 at 3:06 P.M., RN B said residents who have wounds, catheters and PICC lines should be on EBP. Staff should wear PPE (gown and gloves) when they provide wound care and personal care. The wound company NP wears PPE when she provides wound care. 10. During an interview on 6/25/24 at 12:00 P.M., the Assistant Director of Nursing (ADON) said residents who are on isolation or EBP should have a caddy on their door with signage showing what PPE is needed. EBP are used for residents who have chronic wounds, catheters and PICC lines. Staff should wear gown and gloves while providing personal care such as making a bed, toileting, wound care, and flushing IV lines. The treatment cart should not be brought into the room if a resident had a diagnosis of c-diff and if the cart was brought into the room, it should be cleaned and disinfected after exiting the room. The rooms should have signage on them, so staff know what precautions to use. The residents recently moved back onto the 200 halls, and they probably did not have the signs on the hall. 11. During an interview on 12/26/24 at 1:18 P.M., the Administrator said he would expect for staff to follow the Center for Disease Control and Prevention (CDC) guidelines for infection control prevention, and he would expect for staff to follow the facility's policies and procedures.