STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265491	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on interview and record review, the facility failed to keep all residents free from misappropriation of resident property when the staff could not account for 30 doses of medication for one resident (Resident #14) that had been signed by staff as being received from the pharmacy. The facility census was 53. Review of the facility policy Abuse, Prevention, and Prohibition, revised 10/2022, showed the following: -Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent; -The facility prohibits misappropriation of resident property; -The owner, licensee, administrator, employee or agent of the facility must prohibit the misappropriation of resident property; -The facility employee who becomes aware of alleged misappropriation of resident property, shall immediately report the matter to the administrator; -The facility administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress. 1. Review of Resident #14's face sheet (admission information) showed the following: -admitted [DATE]; -Diagnoses included anxiety disorder. Review of the resident's current physician's orders, on 01/13/25, showed an active order for alprazolam (used to treat anxiety) 0.5 milligram (mg). Staff to administer 0.5 mg by mouth at bedtime for anxiety. Review of the facility's investigation, dated 12/30/24, showed the following: (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's alprazolam 0.5 mg had not been delivered to facility. Staff ordered the medication before 12/19/24. The staff had been pulling this medication daily from the emergency kit) to provide to the resident; -The Director of Nursing (DON) called the local pharmacy who informed the DON the medication was delivered on 12/19/24. Licensed Practical Nurse (LPN) N signed the count sheet. The pharmacy sent a copy to the DON which showed LPN N signed for the medication; -The DON spoke with Certified Medication Technician (CMT) P who said he/she put away the medications that were delivered on 12/19/24, but he/she did not receive any medications for the resident. CMT P said the pharmacy should send a narcotic count sheet with all narcotic medications each time they deliver, however there had been occasions the pharmacy did not do this. CMT P said he/she just created a narcotic sheet and put the medication away when the pharmacy did not send a narcotic sheet with the medication; -The DON and CMT P searched both medication carts, the narcotic box, and the medication room and there was no record of the medication in the facility. The narcotic sheet was not located and the medication was never logged into the narcotic book; -The DON interviewed several nurses who worked on 12/19/24, and no staff were aware of any medication delivered during the day and had not seen any medications left sitting out at the nurse's desk or in the medication room; -The DON notified the Administrator who made a self-report to Department of Health and Senior Services for missing medication; -The DON spoke to LPN N who confirmed he/she signed medications in on 12/19/24. LPN N said he/she did not count the medications individually and did not see any narcotic medications with the white narcotic sheet around the medication. LPN N was unaware there was any narcotic medications delivered on 12/19/24 because that was how he/she identified narcotic medications upon delivery. LPN N said he/she put all delivered medications in the medication room for CMT P to put them away. The DON re-educated LPN N to properly count the medications and check them into the facility. The DON then suspended LPN N for failure to follow policy and procedure; -The DON notified and received approval from the resident's physician to order another card of medication with the facility to pay for the resident's medication and notified the resident's guardian. -The Administrator did made a self-report to the local police department for the missing medication. Review of the pharmacy's delivery log, dated 12/19/24, showed a quantity of 30 alprazolam 0.5 mg delivered to the facility and signed for by LPN N. Review of the written police voluntary statement dated 01/03/25, at 3:15 P.M., showed the following: -On 12/30/24, the DON was made aware of a card of medication missing which was the resident's alprazolam 0.5 mg; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The pharmacy sheet, dated 12/19/24, had this medication listed as delivered to the facility; -The nurse failed to properly check medication in the medication and the nurse signed to accept medications; -There is no record of the alprazolam 0.5 mg 30 tablets medication in the building. During an interview on 01/07/25, at 11:45 A.M., the resident said he/she goes up to the nurses' station to get his/her medications. For a while, the nurses had to get the alprazolam 0.5 mg medication from the e-kit since the medication card did not arrive from the pharmacy. During interviews on 01/09/25, at 10:30 A.M. and 12:16 P.M., CMT P said the following: -The pharmacy makes a delivery between 4:30 P.M. and 5:15 P.M. depending on how they are running. The narcotic medications are delivered with regular medications. They usually have a narcotic sheet wrapped around the narcotic medication card. -About 3 weeks ago, he/she was doing medications with the dinner pass. He/she was working with LPN N. He/She finished the medication pass with dinner and went into medication room and saw medications on the back counter to put away. He/She separated medications by resident name. -He/she was off work a few days and when he/she returned the resident let him/her know he/she wasn't getting his/her alprazolam at night. Some nights they were pulling it from the emergency medical kit. -If the alprazolam was ordered within the week before, it should have been delivered on 12/19/24 and should have been there in the facility. -LPN N always left the medications on the counter in the medication room. During an interview on 01/09/25, at 10:49 A.M., LPN N said the following: -When the pharmacy delivered medications, there was a sheet with all the medications listed. He/She looks at each one to see if all medications were there. He/She signs the sheet and keeps the copy and will sign the other copy and places it into a binder. -Narcotic meds come in the same tub or basket. There is a white sheet wrapped around the medication card usually. -He/She did not remember the particular day on 12/19/24. The pharmacy delivery always come in right after dinner, and they are trying to get residents laid down. -Around 12/19/24, the pharmacy delivered medications in a tub and he/she did not count them. He/she usually takes narcotic medications and puts them in the narcotic drawer and locks them up. He/she didn't remember if he/she laid it on the counter in the medication room, but he/she does not usually set narcotics on counter. He/she usually always counts the medications. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she was the only nurse, and things got busy, he/she would have put it on the counter in the locked medication room. During an interview on 01/09/25, at 11:15 A.M., the DON said the following: -The resident had asked if his/her medication had come in from the pharmacy on 12/30/24, which was 11 days since the resident's medication card of alprazolam went missing and the nurses were taking the alprazolam 0.5 mg medication from the emergency medication kit. -The local pharmacy was to deliver the alprazolam 0.5 mg medication card of 30 tablets on 12/19/24; -The DON looked for the medication and was not able to find it. She found the alprazolam 0.5 mg was pulled each night from emergency medication kit. -LPN N's signature was on the pharmacy delivery paper. -The nurse was to checkmark each medication and he/she did not do this. -The DON called the local pharmacy to confirm the alprazolam 0.5 mg card of 30 was sent out on 12/19/24. During interview on 01/07/25, at 12:34 P.M., the Administrator said they did an investigation and interviewed nurses and CMTs. They were not sure what happened to the resident's alprazolam. MO00247293

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on interview and record review, the facility failed to implement an abuse/neglect policy that ensured all reported allegations of possible abuse were reported to the State Survey Agency (Department of Health and Senior Services-DHSS) within two hours when staff failed to report a documented allegation of verbal abuse involving two residents (Resident #7 & #35). The facility census was 53. Review of the facility policy titled, Abuse, Prevention, and Prohibition Policy, undated showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. -The facility administrator is designated as the facility abuse coordinator. -Resident abuse must be reported to the administrator immediately. Review of the facility policy titled, Reporting Policy, undated,showed the following: -The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the supervisor. The supervisor will then report to the Administrator or Director of Nursing (DON); -The results of all investigations will be reported to the Administrator or DON and to the other officials in accordance with state and local laws, as well as federal regulations; -Initial report to state certifying agency will be made immediately, but not later than two hours if allegation involves abuse or serious bodily injury, or not later than 24 hours if the allegation does not involve abuse or does not result in serious bodily injury. 1. Review of Resident #7's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder, intermittent explosive disorder (a mental health condition that causes sudden and impulsive episodes of anger, aggression, or violence that are disproportionate to the situation), past history of alcohol use, drug induced myopathy (a disease that affects the muscled that control voluntary movement in the body), and drug induced subacute dyskinesia (a disease affecting the nervous system often caused by long-term use of psychiatric drugs). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 11/03/24, showed the following: -Cognitively intact; -Resident experienced delusions and hallucinations; -Resident had physical and verbal behavior symptoms towards others, which significantly interfere with the resident's participation activities or social interactions and significantly interrupts care or living environment. Review of the Resident #7's care plan, last revised on 01/06/25, showed the following: -Resident has behavior problems which included pulling fire alarm and laughing about it, inappropriate behaviors towards male caregivers, yelling and cursing at staff and others. -Resident will try to intimidate and bully caregivers. -Resident will urinate on the floors and on the beds in his/her room. -Resident will refuse medications and be socially inappropriate. Review of Resident #35's quarterly MDS showed the following: -admitted [DATE]; -Moderate cognitive impairment; -Diagnoses included stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles), depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave correctly), and post-traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -Used a wheelchair; -Independent with most ADL's. Review of the Resident #7's nursing note dated 12/09/24, at 9:40 P.M., showed Registered Nurse (RN) U noted during the smoke break Resident #7 attempted to take a cigarette back inside when Resident #35 saw this and reminded him/her that residents are not allowed to take cigarettes inside. Resident #7 replied stating, I will cut your throat. This threat was head by other residents outside smoking. The resident denied saying this. He/she was advised making threats are very serious and not tolerated. Resident #7 verbalized understanding and again denied saying anything like that. (Staff did not document notifying management or DHSS of the allegation of verbal abuse.) Review of facility records showed staff did not provide documentation of reporting the allegation of possible abuse to DHSS. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of DHSS records show DHSS did not have record of the facility reporting allegation of Resident #7 threatening to cut Resident #35's throat. During an interview on 01/14/25, at 7:59 A.M., Registered Nurse (RN) U said the following: -On 12/09/24, when residents were coming in from the 9:00 P.M., smoke break, Resident #35 reported to him/her Resident #7 was attempting to bring a cigarette into the facility. Resident #35 told Resident #7, he/she was not supposed to bring a cigarette back inside the facility; -Resident #7 then told Resident #35, I will cute your throat; -Another resident reported he/she also heard the threat; -He/she ensured the residents were separated and talked with Resident #7 who denied making the comment; -He/she immediately notified the Administrator and DON via text message and made a nursing note; -He/she considered it to be abusive behavior which needed to be reported to management; -He/she was unsure if the allegation should have been reported to the state; however, abuse allegations are to be reported to the state agency within two hours. -Resident #7 later admitted to making the threat and apologized. During an interview on 01/13/25, at 12:00 P.M., Certified Nurse Assistant (CNA) A said the following: -If a resident threatened to cut another resident's throat, he/she would separate the residents and report immediately to the Director of Nursing (DON) or charge nurse or both; -He/she would consider a resident threatening to cut another resident's throat to be abuse and should be reported to the state within two hours. During an interview on 01/13/25, at 12:08 P.M., Certified Medication Technician (CMT) P said he/she would consider a resident threatening to cut another resident's throat to be abuse, and he/she would report this to the Administrator immediately. The state should be notified within two hours. During an interview on 01/13/25, at 12:17 P.M., RN O said the following: -He/she was not aware of any residents threatening or being abusive to other residents; -He/she would consider a resident threatening to cut another resident's throat to be abusive; -He/she would separate residents and report to Administrator immediately and the state should be notified within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/25, at 12:30 P.M., the Infection Prevention Specialist (IPS) said the following: -She was not aware of any resident-to-resident abuse allegations, including a resident threatening to cut another resident's throat; -She would consider this to be abuse, and would separate residents, report to the DON and Administrator immediately; -The state should be notified within two hours and an investigation should be completed. During an interview on 01/13/25, at 1:24 P.M., Social Services Director (SSD) said the following: -She was not aware of any resident-to-resident abuse allegations and no grievances had been filed, including a resident threatening to cut another resident's throat; -She would consider this to be abuse and would report immediately to the DON and Administrator; -The state agency should be notified within two hours and an investigation should be completed. During an interview on 01/13/25, at 1:35 P.M., Business Office Manager (BOM) said the following: -She has no knowledge of any resident-to-resident abuse allegations, including a resident threatening to cut another resident's throat; -She would consider this to be abusive and would report immediately to management; -She would depend on management to report to the state agency within two hours if applicable. During an interview on 01/13/25, at 1:45 P.M., the Administrator said the following: -She had not received any reports of a resident being abusive to other residents; -She would consider a resident threatening to cut another resident's throat to be abusive and should be reported to her and then to the state within two hours; -She was not aware of the progress note from 12/09/24, alleging the resident told another resident he/she would cut the resident's throat; -This allegation was not reported to her.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45190 Based on interview and record review, the facility failed to implement an abuse/neglect policy that ensured staff completed and documented a timely investigation of all reported allegations of possible abuse when staff failed to complete a documented investigation of a documented allegation of verbal abuse involving two residents resident (Resident #7 and #35). The facility census was 53. Review of the facility policy titled, Abuse, Prevention, and Prohibition Policy, undated, showed the following: -Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals; -The facility administrator is designated as the facility abuse coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation; -Resident abuse must be reported to the administrator immediately. The administrator will do a thorough investigation of alleged violations of individual rights and document appropriate action; -A thorough investigation may include notifying resident representatives, provider, medical director, state agency, and even law enforcement if applicable, utilizing the resident abuse investigation teams, complete a report of alleged resident abuse within required timeline, resident assessment by a licensed nurse, thorough chart review, interviews with residents and employees, follow up counseling by social services to victims of abuse or neglect, and review by the regional nurse; -Resident to resident altercations: when another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the provider for a determination regarding treatment and/or discharge options. Residents will be referred for behavior management when indicated. The safety of other residents and employees of the facility is primary concern. 1. Review of Resident #7's face sheet (a brief resident profile) showed the following: -admitted [DATE]; -Diagnoses included schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder, intermittent explosive disorder (a mental health condition that causes sudden and impulsive episodes of anger, aggression, or violence that are disproportionate to the situation), past history of alcohol use, drug induced myopathy (a disease that affects the muscled that control voluntary movement in the body), and drug induced subacute dyskinesia (a disease affecting the nervous system often caused by long-term use of psychiatric drugs). Review of Resident #7's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 11/03/24, showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -Resident experienced delusions and hallucinations; -Resident had physical and verbal behavior symptoms towards others, which significantly interfere with the resident's participation activities or social interactions and significantly interrupts care or living environment. Review of the Resident #7's care plan, last revised on 01/06/25, showed the following: -Resident has behavior problems which included pulling fire alarm and laughing about it, inappropriate behaviors towards male caregivers, yelling and cursing at staff and others. -Resident will try to intimidate and bully caregivers. -Resident will urinate on the floors and on the beds in his/her room. -Resident will refuse medications and be socially inappropriate. Review of Resident #35's quarterly MDS showed the following: -admitted [DATE]; -Moderate cognitive impairment; -Diagnoses included stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles), depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave correctly), and post-traumatic stress disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event); -Used a wheelchair; -Independent with most ADL's. Review of the Resident #7's nursing note dated 12/09/24, at 9:40 P.M., showed Registered Nurse (RN) U noted during the smoke break Resident #7 attempted to take a cigarette back inside when Resident #35 saw this and reminded him/her that residents are not allowed to take cigarettes inside. Resident #7 replied stating, I will cut your throat. This threat was head by other residents outside smoking. The resident denied saying this. He/she was advised making threats are very serious and not tolerated. Resident #7 verbalized understanding and again denied saying anything like that. (Staff did not document notifying management or or beginning an investigation.) Review showed the facility did not provide a written investigation into the allegation of possible abuse. Review of Department of Health and Senior Services (DHSS) records showed a written investigation into the allegation of possible abuse was not received. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/25, at 7:59 A.M., Registered Nurse (RN) U said the following: -On 12/09/24, when residents were coming in from the 9:00 P.M., smoke break, Resident #35 reported to him/her Resident #7 was attempting to bring a cigarette into the facility. Resident #35 told Resident #7, he/she was not supposed to bring a cigarette back inside the facility; -Resident #7 then told Resident #35, I will cute your throat; -Another resident reported he/she also heard the threat; -He/she ensured the residents were separated and talked with Resident #7 who denied making the comment; -He/she immediately notified the Administrator and DON via text message and made a nursing note; -He/she considered it to be abusive behavior which needed to be reported to management; -Resident #7 later admitted to making the threat and apologized. During an interview on 01/13/25, at 12:00 P.M., Certified Nurse Assistant (CNA) A said the following: -If a resident threatened to cut another resident's throat, he/she would separate the residents and report immediately to the Director of Nursing (DON) or charge nurse or both; -He/she would consider a resident threatening to cut another resident's throat to be abuse. During an interview on 01/13/25, at 12:08 P.M., Certified Medication Technician (CMT) P said he/she would consider a resident threatening to cut another resident's throat to be abuse. During an interview on 01/13/25, at 12:17 P.M., RN O said the following: -He/she is not aware of any residents threatening or being abusive to other residents; -He/she would consider a resident threatening to cut another resident's throat to be abusive. During an interview on 01/13/25, at 12:30 P.M., the Infection Prevention Specialist (IPS) said the following: -She was not aware of any resident-to-resident abuse allegations, including a resident threatening to cut another resident's throat; -She would consider this to be abuse, and would separate residents, report to the DON and Administrator immediately; -An investigation should be completed. During an interview on 01/13/25, at 1:24 P.M., Social Services Director (SSD) said the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was not aware of any resident-to-resident abuse allegations and no grievances have been filed, including a resident threatening to cut another resident's throat; -She would consider this to be abuse and would report immediately to the DON and Administrator; -An investigation should be completed. During an interview on 01/13/25, at 1:35 P.M., Business Office Manager (BOM) said the following: -She had no knowledge of any resident-to-resident abuse allegations, including a resident threatening to cut another resident's throat; -She would consider this to be abusive and would report immediately to management. During an interview on 01/13/25, at 1:45 P.M., the Administrator said the following: -She has not received any reports of a resident being abusive to other residents; -She would consider a resident threatening to cut another resident's throat to be abusive and should be reported to her and then to the state within two hours; -She was not aware of the progress note from 12/09/24, alleging the resident told another resident he/she would cut the resident's throat; -This allegation was not reported to her, and the required investigation was not completed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Nursing	914 Chickesaw Street Seneca, MO 64865

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to routinely monitor for edema (swelling caused by too much fluid trapped in the body tissues), failed to notify the physician of changes in weight and edema, and failed to apply interventions as ordered for one resident (Resident #2). The facility census was 53. Review of a facility policy titled Significant Condition Change and Notification, undated, showed the following: -Facility to ensure the resident's family and/or representative and medical practitioner are notified of the following resident changes: new wounds, bruises, or skin tears; abrupt onset of edema; onset of swelling; or a need to significantly alter treatment. When any of the listed situations exists, the nurse will contact the resident representative and their medical practitioner; -Medical practitioner contacted immediately for emergencies. Non-emergency practitioner notifications may be made the next morning if situation occurs late evening or night shift; -Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner; -All significant changes will be recorded in resident record; -Charting will include an assessment of the resident's current status; -Charting will be done each shift for 72 hours; -Change of condition is reviewed by Director of Nursing (DON). 1. Review of the Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included schizophrenia (a mental illness that affects how a person thinks, feels, and behaves), dementia (condition that makes someone unable to remember, think clearly, or make decisions), diabetes mellitus, and chronic venous hypertension (condition in which veins valves in the legs function improperly causing swelling and skin changes) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 12/19/24, showed the following: -Moderate cognitive impairment; -Dependent on one staff for transfers, mobility, dressing, and showering; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident not taking a diuretic (medication to reduce fluid buildup in the body). Review of the resident's care plan, revised on 01/02/25, showed the following: -Dependent on one staff with transfer, dressing, and hygiene; -Monitor, document, and report to physician as needed for edema or weight gain of over two pounds a day; -Notify physician of significant weight loss or gain; -Inspect lower extremities weekly for redness, weeping, edema, tenderness, or puffiness; -Tubi grip (elasticated tubular bandage to assist with edema) stockings to bilateral lower extremities as resident allows. Review of the resident's nursing admission assessment, dated 02/15/24, showed staff noted the resident did not have edema. Review of the resident's admission paperwork, dated February 2024, showed a weight of 230.2 pounds. Review of the resident's Physician Order Sheet (POS) showed an order, dated 08/28/24, for Tubi grips to bilateral lower legs for increased edema as needed. (There was no order for a diuretic.) Review of the resident's weekly skin assessments showed staff did not document related to the resident having edema until 08/29/24. Review of the resident weekly skin assessment, dated 08/29/24, showed resident baseline is high edema to bilateral lower legs. Tubi grips applied to bilateral lower legs to help aid in scant redness and 3 to 4 plus edema noted. Review of the resident's November 2024 weight showed a weight of 235.8 pounds (an increase of 5.6 pounds since admission). Review of the resident's November 2024 progress notes showed staff did not document notification of the physician of the resident's increase in weight. Review of the resident's weekly skin assessment, dated 12/05/24, showed resident had baseline 3 to 4 plus edema in bilateral legs and wore Tubi grips to assist in edema. Review of the resident's weekly skin assessment, dated 12/19/24, showed resident had baseline 3 to 4 plus edema in bilateral legs and wore Tubi grips to assist in edema. Bilateral feet area swollen and red. (Staff did not document physician notification of the new redness noted to the resident's feet.) Review of resident's December 2024 Treatment Administration Record (TAR) showed an order to apply Tubi grips to bilateral lower legs for edema as needed. Staff did not document to indicate Tubi grips used during the month. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's December 2024 weight showed a weight of 245.6 pounds (a gain of 9.8 pounds in one month). Review of the resident's December 2024 progress notes showed staff did not document notification of the physician of the resident's increase in weight, the redness of the resident's feet, or the resident's Tubi grips not being applied. Review of resident's January 2025 Treatment Administration Record (TAR) showed an order to apply Tubi grips to bilateral lower legs for edema as needed. Staff did not document to indicate Tubi grips used during the month. Review of the resident's December 2024 progress notes showed staff did not document notification of the physician of the resident's Tubi grips not being applied. During an observation and interview on 01/13/25, at 9:39 A.M., the resident was in his/her room sitting in a wheelchair with no foot pedals. The resident's ankles appeared swollen, and the resident's pants appear visibly wet on the back side of right calf. No Tubi grips were in place. Resident said the staff were not doing much for his/her legs. During an observation on 01/13/25, at 2:40 P.M., the resident sat in his/her wheelchair with Tubi grips in place and a dressing to the right leg shin dated 01/13/24. Registered Nurse (RN) O said the resident's left leg was red and a little warm on the shin with scattered dried scabs noted. The left leg appeared to have + 1 pitting edema from the ankle to the knee and +2 to 3 pitting edema on the foot. The right leg had a small, popped blister with another small fluid filled blister noted in the middle of the shin. The right leg had + 2 pitting edema from the ankle to the knee and the foot had + 1 pitting edema. The shin area appeared red, but was not warm. During an interview on 01/13/25, at 10:00 A.M., Occupational Therapist Aide (OTA) W said the resident's legs were hot, and the back of his/her legs were wet through the pants. The right leg was swollen, red in color, scaly, and hot to the touch. Staff encouraged the resident to elevate legs due to swelling. The wound nurse puts Tubi grips on the resident sometimes. He/she was unable to find the Tubi grips in the resident room at that time. During an interview on 01/13/25, at 11:00 A.M., Nurse Aide (NA) B said the resident's legs were swollen and red with flaky skin when he/she observed them two weeks ago. During interviews on 01/13/25, at 10:10 A.M. and 2:40 P.M., Registered Nurse (RN) O said the following: -He/she would contact the physician for a resident with pitting edema to obtain an order for diuretics, compression stockings, or Tubi grips; -The wound nurse was responsible for applying Tubi grips to residents; -He/she saw the resident's legs a couple times last month and they had edema; -He/she contacted the physician due to possible cellulitis and was advised to elevate his/her legs and monitor; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she had not observed the resident with weeping edema (swelling that causes fluid to leak through the skin); -Each resident should have a weekly assessment conducted by the nurse; -The resident had an order for Tubi grips, but there is no documentation that they were applied on the TAR. During an interview on 01/13/25, at 10:25 A.M., the Infection Control Specialist said the following: -The resident had non pitting edema; -The resident had weeping edema with red, dry skin to the right leg, and it is possibly cellulitis (bacterial skin infection); -He/she notified the physician due to the resident possibly having cellulitis; -He/she also observed resident had two open areas to the right leg, one on the inner calf measuring 2.2 centimeters (cm) by 1.1. cm by 0.1 cm and one on the shin measuring 1.5 cm by 1.0 cm by 0.1 cm; -He/she cleaned and applied a dressing to the wounds and then applied Tubi grips; -Resident has weeping edema that comes and goes; -Resident is on a diuretic; -He/she was responsible for applying Tubi grips for residents; -The resident can wear Tubi grips continuously, but they were not on today. During an interview on 01/13/25, at 3:30 P.M., the Administrator said staff should encourage interventions such as elevation of extremities for residents with edema. Staff should advise the nurse of any resident with edema. The nurse is responsible for notifying the physician. The nurse should document in the TAR for any treatments such as Tubi grip application. If a treatment is not documented then it was not completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility staff failed to ensure an environment as safe and as free from accident hazards as possible when staff failed to complete a safe transfer, as care planned, for one resident (Resident #46) and when staff failed to care plan and transfer one resident (Resident #38) who was non-weight bearing in a safe fashion. The facility census was 53. Review of the facility policy Safe Lifting and Movement of Residents, reviewed 02/2021, showed the following: -Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of residents; -Manual lifting of residents shall be eliminated when feasible; -Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, slide boards) and mechanical lifting devices. 1. Review of Resident #46's face sheet (admission information) showed the following: -admitted [DATE]; -Diagnoses that included dementia (progressive impairment in memory, thinking, and behavior), polyarthritis (joint pain), anxiety, and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/20/24, showed the following: -Severely impaired cognition; -Upper extremity impaired on one side; -Transfer from bed to wheelchair required substantial/maximal assistance (helper does more than half the effort). Review of the resident's care plan, dated 08/29/24, showed staff to use a gait belt (used to assist with transfer and prevent falls for weight bearing persons) at all times to transfer the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/13/25, at 10:09 A.M., showed Certified Medication Technician (CMT) P and Nurse Aid (NA) B sat the resident up on the edge of the bed to assist the resident to the wheelchair. With one arm, CMT P went underneath the resident's arm on one side and NA B put one arm beneath the resident's arm on the other side. CMT P held on to the back of the resident's pants and lifted the resident up with his/her arms and sat the resident in his/her wheelchair. The resident's feet touched the floor during the transfer. They both washed hands and then NA B wheeled the resident out of the room. (Staff did not use a gait belt to assist with the transfer as care planned.) During an interview on 01/13/25, at 10:59 A.M., CMT P said the resident did bear a little weight like 25%. He/She did not bear weight 75% of the time. Any time they try to use the gait belt, the resident gets upset. He/she should not pull up on the resident's pants to transfer the resident. During interview on 01/13/25, at 1:09 A.M., NA B said he/she did lift beneath the resident and tried not to hold on to back of her pants to transfer, but ended up doing this anyway because the resident did not bear much weight. During an interview on 01/13/25, at 12:39 A.M. Registered Nurse (RN) O said the resident ambulated with a walker when admitted to the facility. He/She fell and broke an arm, had increased pain, and declined. He/She did take part in therapy and was walking with a walker, then became depressed, and dementia had progressed. He/She can stand up and his/her knees won't buckle. He/She can be toileted. 2. Review of Resident #38's face sheet showed the following: -admitted [DATE]; -Diagnoses included hemiplegia (condition that causes paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs, and facial muscles) following a stroke on the right side. Review of the resident's care plan, revised 04/30/24, showed transfer with staff assistance. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Upper/lower extremity impairment; -Resident was dependent on staff for transfer from bed to wheelchair Observation on 01/13/25, at 10:29 A.M., showed Certified Nurse Aide (CNA A) and NA B assisted the resident to sit up on the edge of the bed. NA B asked for a gait belt and CNA A got one from behind the door. CNA A put gait belt around resident. Both CNA A and NA B both took one arm and went under the resident's arm on both sides of him/her, and held on to the gait belt in the back of the resident and then lifted the resident to the wheelchair. The resident's knees were both bent and stiff during the transfer. The resident's feet did not touch the floor. During interview on 01/13/25, at 10:43 A.M., NA B said sometimes the resident will help with his/her left legs but today, most of his/her weight was on his/her arms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 01/13/25, at 10:43 A.M., CNA A said most of the resident's weight was on his/her arms. During an interview on 01/13/25, at 12:39 A.M., RN O said the resident was a two-assist transfer. There was residual (what remains) from his/her stroke on the right side. He/She didn't think the resident bore weight. The resident shouldn't be a gait belt transfer. The resident had not declined or improved. 3. During an interview on 01/13/25, at 12:39 A.M. RN O said a resident's transfer should be in their care plan. There was a sheet that showed if a resident was a two person transfer, gait belt, walker and if there is a change whether they got better or they got worse with how they transferred. If they decline, they speak to therapy to assess them. They do try to do walk to dine. If a transfer is unsafe for residents and staff, they were to use a mechanical hoyer lift. 4. During interview on 01/13/25, at 2:23 P.M., the Administrator said the following: -If staff were to check and a resident was weak, the aide can go get the nurse or get assistance; -If staff were uncertain about how to transfer a resident, they should go ask the nurse; -If there was a change in the residents condition or maybe they had been sick, staff should get therapy involved; -Staff can always get more help if needed and use two staff to transfer the resident; -If a resident was not bearing weight, they should be a mechanical lift; -If the transfer could hurt the resident or staff, they were to use a gait belt.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 49585 Based on observation, interview, and record review, the facility failed to ensure six nurse aides (NA) (NA B, NA G, NA J, NA K, NA L,and NA C) completed a certified nurse aide (CNA) training program and obtained certification within four months of employment at the facility as a nurse aide. The facility census was 53. Review showed the facility did not provide a nurse aide certification or training policy. 1. Review of a facility list of current nurse aides showed NA B had an initial hire date of 03/28/23 and a rehire date of 12/07/24. Review of the facility's October 2024, November 2024, and December 2024, showed NA B scheduled to work. During interviews on 01/09/25, at 2:26 P.M., and on 01/13/24, at 11:00 A.M., NA B said the following: -He/she had worked at the facility for a month; -He/she had previously worked at the facility for a few years, but left and came back; -He/she provided all care to residents by herself unless the task requires two people; -He/she was not in a CNA class now, but planned to be in the next class; -The next class for nurse aides starts in February. Observation on 01/13/25, at 10:09 A.M., showed NA B provided direct care to residents. Review of the state agency CNA registry website, on 01/14/25, showed NA B was not listed as a CNA. 2. Review of a facility list of current nurse aides showed NA G had a hire date of 08/07/24 (over four months prior). Review of the facility's October 2024, November 2024, and December 2024, showed NA G scheduled to work. Review of the state agency CNA registry website, on 01/14/25, showed NA G was not listed as a CNA. 3. Review of a facility list of current nurse aides showed NA J with a hire date of 02/25/24 (over 11 month prior). Review of the facility's October 2024, November 2024, and December 2024, showed NA J scheduled to work. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the state agency CNA registry website, on 01/14/25, showed NA J was not listed as a CNA. 4. Review of a facility list of current nurse aides showed NA K with a hire date of 8/15/24 (four months prior). Review of the facility's October 2024, November 2024, and December 2024, showed NA K scheduled to work. Review of the state agency CNA registry website, on 01/14/25, showed NA K was not listed as a CNA. 5. Review of a facility list of current nurse aides showed NA L with a hire date of 05/15/24 (eights months prior). Review of the facility's October 2024, November 2024, and December 2024, showed NA L scheduled to work. Review of the state agency CNA registry website, on 01/14/25, showed NA L was not listed as a CNA. 6. Review of a facility list of current nurse aides showed NA C with an initial hire date of 07/13/23 and a rehire date of 04/09/24. Review of the facility's October 2024, November 2024, and December 2024, showed NA C scheduled to work. Observation and interview on 01/08/25, at 4:00 P.M., showed NA C provided direct care to residents and said he/she had been working since April and planned to take certification test in January. Review of the state agency CNA registry website, on 01/14/25, showed NA C was not listed as a CNA. 7. During an interview on 01/13/25, at 12:41 P.M., the CNA Instructor said the following: -There are no nurse aide training classes currently at the facility; -He/she completed the last NA class on 09/28/24; -There were no upcoming classes for nurse aide training scheduled; -There are two nurse aides from the September class that have not tested ; -Nurse aides should become certified within 120 days or be reclassified in another position; -Nurse aides should be working with another CNA or licensed nurse staff. 8. During an interview on 01/13/25, at 3:30 P.M., the Administrator said the following: -There are currently two nurse aides working in the facility that are ready to test; -A nurse aide training class just finished within the last two weeks; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There should not be any nurse aides working in the facility for over four months; -Nurse aides should not work on the floor if certification is not obtained in four months; -He/she will relocate staff to another position in the facility if no certification is obtained within four months. 36974

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49585 Based on observation, interview, and record review, the facility failed to ensure all controlled medications were stored per standards of practice when controlled substances were not stored in a locked compartment. The facility's census was 53. Review of the facility policy Controlled Substance Policy, revised October 2022, showed the following: -Controlled substances were subject to special handling, storage, disposal and record-keeping requirements; -Controlled substances in Schedules II, III, and IV were subject to special handling, storage, disposal, and record-keeping requirements. Such drugs were to be accessible only to authorized nursing and pharmacy personnel. The Director of Nursing (DON) was responsible for the control of such drugs; -Drugs listed in Schedules II, III, and IV were to be stored under double-lock conditions; -The key to the separately locked storage area is not the same key that is used to gain access to other drugs; -The medication nurse or certified medication tech (CMT) on duty at the time will maintain possession of the key; -The key must remain the possession of the licensed nurse or CMT that completed the count at all times during their shift. Should it be necessary to give the keys to another licensed nurse or CMT, a count will be done to verify the inventory. A count will be done again when the keys were returned to the original licensed nurse or CMT. 1. Observation on 01/08/25, at 9:20 A.M., of the facility's medication room showed the following; -The medication room refrigerator was unlocked with the lock laying on the cabinet next to refrigerator upon entering the medication room. -The refrigerator contained three 30 milliliter (ml) vials of Ativan Intensol (antianxiety medication/controlled substance) 2 milligram (mg)/ml; -The refrigerator contained four 30 ml vials of morphine sulfate (opioid pain medication/controlled substance) 20 mg/ml. Observation on 01/13/25, at 10:05 A.M., with Registered Nurse (RN) O showed the narcotic refrigerator unlocked with the lock sitting beside refrigerator on the counter and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/25, at 9:25 A.M., Certified Medication Technician (CMT) P said the following: -He/she would advise the DON if the narcotic refrigerator was unlocked; -He/she had seen the refrigerator unlocked, but it does not happen that often; -He/she will lock the refrigerator if it is found to be unlocked. During interviewed on 01/08/25, at 9:30 A.M. and 10:45 A.M., RN O said the following: -Nurses should make sure the narcotics refrigerator is locked; -Refrigerator should only be unlocked when obtaining medication; -There have been times he/she has come in to find refrigerator unlocked; -Narcotics should be kept behind two locks; -He/she counted narcotics this morning with the off going nurse but forgot to lock the refrigerator. 17193

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45190 Based on observation, interview, and record review, the facility failed to ensure food was served in accordance with standards of practice when staff had bare hand contact with food and food contact surfaces while assisting residents with meals. The facility census was 53. Review of the facility policy Hand Hygiene, dated 2019, showed the following: -The purpose was to cleanse hands to prevent the spread of potentially deadly infections; -The purpose was to provide a clean and healthy environment for residents, staff and visitors; -Hand hygiene was the primary means of preventing the transmission of infection. Review of the 2022 Food Code, by the Food and Drug Administration (FDA), showed the following: -Bare hand contact with ready-to-eat foods can contribute to the transmission of food borne illness; -There should be no bare hand with ready-to-eat food. 2. Observation on 01/08/25, at 12:12 P.M., during the lunch meal service, showed the following: -Nurse Assistant (NA) B was in the dining room talking to a resident and touching the resident's clothing while rubbing the resident's shoulder; -NA B did not perform hand hygiene and went to obtain a straw for another resident, opened the straw, and placed the straw in the resident's cup, touching the straw with his/her bare hands; -NA B did not perform hand hygiene and went to talk to another resident and touched the resident's clothing while rubbing the resident's back; -NA B did not perform hand hygiene and returned to the resident with the straw, picked up the cup and gave the resident a drink, touching the straw with his/her bare hand in the process. Observations on 01/08/25, at 12:21 P.M., during the lunch meal service, showed NA C assisting a resident with eating. NA C was giving the resident a bite of chicken by holding a whole piece of chicken with his/her bare hand and placing it near the resident's mouth for the resident to take a bite. During an interview on 01/09/25, at 1:04 P.M., Dietary Aide M said staff should sanitize their hands in between serving each resident food and drink. During an interview on 01/09/25, at 1:07 P.M., the Dietary Manager said staff should sanitize hands after every third plate and drink is passed to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25, at 1:27 P.M., NA B said the following: -Staff should use hand sanitizer between serving residents drinks and between assisting residents with eating; -Staff should wear gloves when assisting residents with eating and should not touch food with bare hands; -Staff should not touch residents' clothing and then assist a resident with drinking or eating without performing hand hygiene first. During an interview on 01/08/25, at 4:00 P.M., NA C said the following: -Staff should perform hand hygiene in between passing drinks to residents; -Staff should wear gloves when assisting residents with eating and should change gloves and sanitize in between residents; -Staff should not touch food with bare hands while assisting residents with eating. During an interview on 01/13/25, at 10:25 A.M., the Infection Control Specialist (ICS) said the following: -Staff should perform hand hygiene between serving residents at meal times; -Staff should not touch resident food unless using silverware. During an interview on 01/13/25, at 12:00 P.M., CNA A said the following: -Staff should perform hand hygiene in between assisting residents with eating; -Staff should wear gloves when assisting residents with eating; -Staff should perform hand hygiene after touching a resident's clothing and before assisting another resident with eating/drinking or passing trays/drinks. During an interview on 01/13/25, at 2:25 P.M., Certified Medication Technician (CMT) P said the following: -Staff should perform hand hygiene after any resident contact; -Staff should not touch resident food, gloves should be used if needed. During an interview on 01/13/25, at 12:17 P.M., Registered Nurse (RN) O said the following: -Staff should perform hand hygiene after touching a resident and before assisting another resident with eating during mealtimes; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should not touch food with bare hands while assisting residents with eating. During an interview on 01/13/25, at 1:45 P.M., the Administrator said the following: -Staff should perform hand hygiene in the dining room in between assisting residents with eating/drinking; -Staff should perform hand hygiene after touching a resident's person and before assisting another resident with eating/drinking; -Staff should not touch food with bare hands when assisting residents with eating,

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when staff failed to perform proper hand hygiene when performing personal cares for two residents (Resident #46 and #38), when staff failed to have an Enhanced Barrier Precautions (EBP-infection control measures used to reduce transmission of resistant organisms) policy, and when staff failed to follow EBP when providing care to one resident (Resident #5) with a wound. The facility census was 53. Review of the facility policy Hand Hygiene, dated 2019, showed the following: -Purpose to cleanse hands to prevent the spread of potentially deadly infections; -Purpose to provide a clean and healthy environment for residents, staff and visitors; -Purpose to reduce the risk to the healthcare provider of colonization (when a microorganism survives on a host without causing disease. This can happen on the skin, in the respiratory tract, or in the gastrointestinal tract) or infections acquired from a resident; -Hand hygiene is the primary means of preventing the transmission of infection. 1. Review of Resident #46's face sheet (admission information) showed the following: -admitted [DATE]; -Diagnoses included dementia (progressive impairment in memory, thinking, and behavior), polyarthritis (joint pain), and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/20/24, showed the following: -Severely impaired cognition; -Toileting and personal hygiene required substantial/maximal assistance. Review of the resident's current care plan showed the resident was incontinent of bladder at times. (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 01/13/25, at 10:09 A.M., showed the resident lying in bed as Certified Medication Technician (CMT) P and Nurse Aide (NA) B washed their hands and put on gloves. CMT P and NA B removed the resident's incontinence brief. CMT P took several wet wipes and performed perineal care, then they turned the resident to his/her side, and took thick white barrier cream and applied it between and on the resident's buttocks which were red. The resident's brief was wet with urine. CMT P removed gloves, did not wash or sanitize hands, then put on a new pair of gloves. The CMT then put the incontinence brief, the resident's slacks, and then shoes on the resident. The CMT and NA sat the resident up on the edge of the bed and then transferred the resident to the wheelchair. CMT P then removed his/her gloves and washed his/her hands at the sink. NA B removed his/her gloves and washed his/her hands. During an interview on 01/13/25, at 10:59 A.M., CMT P said they were to wash hands when they go into the resident's room and when they leave the room. They were to wash hands after removing gloves and before putting on gloves. 2. Review of Resident #38's face sheet showed the following: -admitted [DATE]; -Diagnoses included hemiplegia (condition that causes paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect arms, legs, and facial muscles) following a stroke on the right side. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Upper/lower extremity impairment; -Toilet hygiene-dependent. Review of the resident's care plan, revised 4/30/24, showed the resident was incontinent of bowel and bladder. (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 01/13/25, at 10:29 A.M., showed Certified Nurse Aide (CNA) A and NA B washed their hands at the sink and put on gloves. NA B pulled the privacy curtain. The resident was in bed. His/her incontinence brief was fully saturated and wet with urine. NA B used the cleansing wipes and wiped down the inner right leg with white barrier cream, then turned the wipe and wiped down the left inner leg that had the white barrier cream on the resident. Both inner legs were deep red in color. NA B cleansed the front perineal area which was covered with the white barrier cream. They turned the resident to his/her side. NA B used several cleansing wipes front to back between the buttocks. There was bowel movement smears inside the buttocks. NA B applied a little barrier cream inside buttocks and along the edge of both buttocks, then applied the cream on the front perineal area and inner right and left leg. CNA A removed gloves and applied a new pair of gloves and then removed the soiled brief. NA B removed gloves, did not sanitize or wash hands, then put on new gloves. The CNA and NA put pants on the resident after applying the incontinence brief. CNA A removed his/her gloves, and put on new pair of gloves without sanitizing or washing hands. NA B assisted CNA A to sit the resident up on the edge of the bed, put a gait belt on the resident, and transfer the resident to the wheelchair while wearing the same pair of gloves. They then removed gloves and washed their hands at the sink. During an interview on 01/13/25, at 10:44 A.M., CNA A said they were to wash hands before and after entering room. If staff take their gloves off, the should wash hands. It doing perineal care, staff will remove gloves and wash hands. He/She changed gloves at times because his/her hands sweat. During and interview on 01/13/25, at 11:09 A.M., NA B said they were to wash hands when they enter and leave a resident's room. He/she should have washed hands after removing gloves after peri care. 49585 4. Review showed the facility did not provide a policy regarding enhanced barrier precautions (EBP). Review of the Centers for Disease Control and Prevention's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 04/02/24, showed the following: -MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs; -EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities; -EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, infection, or colonization with an MDRO; -Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care; -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Make PPE, including gowns and gloves, available immediately outside of the resident room. Review of the Resident #5's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic lung disease that blocks airflow and makes it difficult to breathe), diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose)), and muscle weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Dependent on one staff for transfers, mobility, dressing, and showering; -Had a diabetic ulcer. Review of the resident's care plan, revised on 01/02/25, showed the following: -Dependent on one staff with transfer, dressing, mobility, and hygiene; -Had an abrasion on the left foot at the toe amputation site on 12/29/2024. During an observation on 01/09/25, at 1:40 P.M., the Infection Control Specialist (ICS) entered the resident's room to view a wound on the left foot. The room had no EBP signage. The ICS washed his/her hands and applied gloves, but did not don a gown to provide direct care to resident's wound. During an observation on 01/13/25, at 10:10 A.M., Registered Nurse (RN) O entered the resident's room to observe the wound on the left foot. The room ad no EBP signage. RN entered the resident room's and donned gloves, but did not don a gown to assess wound on resident's foot. During an interview on 01/13/25 at 10:25 A.M., the ICS said EBP are used to protect residents due to an increased risk of infection. EBP should be used for residents with multidrug resistant organisms (MDRO - type of bacteria that is resistant to multiple antibiotics), foley catheters (a thin flexible tube that drains urine from the bladder), tube feeding (a small tube inserted in body to provide nutrition for residents unable to eat or drink by mouth) and intravenous lines. Wounds would be included in EBP if there was significant drainage or an infection present. During an interview on 01/13/25, at 11:00 A.M., Nurse Aide (NA) B said if a resident was on EBP there should be a sign posted on the door. The resident is on EBP because of a wound and has gowns in the room, but no sign. EBP is used to protect residents from bacteria and staff should wear gowns and gloves. During an interview on 01/13/25, at 2:00 P.M., NA D said EBP is when staff wear a gown to protect residents. Staff use EBP for residents with wounds. EBP residents should have a sign in front of room with PPE stored in the room. The resident was on EBP and had a PPE cart in the room, but he/she did not know why. (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 on 01/13/25, at 2:25 P.M., Certified Medication Technician (CMT) P said staff use EBP for residents with open wounds. EBP signage is posted outside of the door and there is a cart with PPE, such as gowns in gloves to be used. 36974 45190