STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tipton Oak Manor	601 West Morgan Street Tipton, MO 65081

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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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to respect the privacy of two residents (Resident #14 and #4) out of four sampled residents, when staff failed to provide privacy during wound care and medication administration, and posted care signs for on a wall visible to other residents and visitors in the day room. The facility census was 47. 1. Review of the facility's Patient [NAME] of Rights, undated, showed residents shall be treated with consideration, respect and full recognition of your dignity and individuality, including privacy in treatment and in care for your personal needs. 2. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/14/24, showed staff assessed the resident with severe cognitive impairment, and received application of non-surgical dressings other than to feet. Observation on 07/29/24 at 1:50 P.M., showed the Director of Nursing (DON) entered the resident's room and performed wound care to the resident's face, with the privacy curtain and door to the room open to the hallway. Several residents ambulated in the hallway past the room. Staff did not provide privacy to the resident during wound care. 3. Review of Resident #4's annual MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, and has a feeding tube. Observation on 07/29/2024 at 2:24 P.M., showed the DON entered the resident's room, administered medications to the resident via feeding tube, with the privacy curtain and door to the room open to the hallway, as a male resident wandered past the room. Staff did not provide privacy to the resident during medication administration. 4. Observation on 07/29/24 at 10:40 A.M. showed a sign in the day room with two resident (Resident #14 and #4) names, room number and medical reason for the use of Enhanced Barrier Precautions (EBP) (an infection control intervention) with other residents and visitors in the dayroom. Observation on 07/30/24 at 9:29 A.M. showed a sign in the day room with Resident #14 and #4 names, room number and medical reason for the use of EBP with other residents and visitors in the dayroom. (continued on next page)

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

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

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Observation on 07/31/24 at 10:09 A.M. showed a sign in the day room with two Resident #14 and #4 names, room number and medical reason for the use to use of EBP with other residents and visitors in the dayroom. Observation on 08/01/24 at 9:29 A.M. showed a sign in the day room with Resident #14 and #4 names, room number and medical reason for the use of EBP with other residents and visitors in the dayroom. During an interview on 08/01/24 at 123:25 P.M., Certified Nurse Aid (CNA) F said the sign in the dayroom should be in a more private area. During an interview on 08/01/24 at 1:00 P.M., Certified Medication Technician (CMT) G said the list of residents should not be in the dayroom for other residents and visitors to see. During an interview on 08/01/24 at 1:14 P.M., the DON said the sign with residents' personal information should be at the nurses station and not in an open area for others to see.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on interview, and record review, facility staff failed to update care plans in regards to smoking for three (Resident #1, #11, and #13) out of six sampled residents. The facility census was 70. 1. Review of the facility's Care Plan Comprehensive Policy, undated, showed assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition. Review staff were directed to: -Apply current standards of practice in the care plan process; -Update care plans when a significant change in condition has occurred, at least quarterly, and when changes occur that impact the resident's care. 2. Review of the Resident #1's Quarterly Minimum Data Sheet (MDS), a federally mandated assessment tool, dated 05/17/24, showed staff assessed the resident as follows: -Cognitively intact; -Tobacco use, not assessed. Review of the resident's care plan, dated 05/09/24, showed the resident will have supervised smoking in designated areas and will smoke safely throughout the next review. Cigarettes and lighters are kept at nursing station. Observation on 07/30/24 at 3:45 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 8:00 A.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 9:50 A.M., showed the resident in his/her wheelchair in the hallway with a pack of cigarettes and a lighter in the pocket of his/her shirt. Observation on 07/31/24 at 10:23 A.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 10:28 A.M., showed the resident wheeled into the facility with his/her cigarettes and lighter in their pocket and went to the dinning room for lunch. Observation on 08/01/24 at 8:15 A.M., showed the resident outside without staff smoking a cigarette. 3. Review of Resident #11's Annual MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Independent with care and transfers; -Independent with manual wheelchair; -Current Tobacco user. Review of the resident's care plan, dated 06/28/24, showed resident will: -Have supervised smoking in designated areas; -Smoke in designated smoking area at designated times, staff assigned to assist with residents that smoke. Observation on 07/29/24 at 3:15 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/30/24 at 12:30 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/30/24 at 3:45 P.M., showed the resident outside without staff smoking a cigarette. Observation on 07/31/24 at 10:26 A.M., showed the resident outside without staff smoking a cigarette. Observation on 08/01/24 at 8:15 A.M., showed the resident outside without staff smoking a cigarette. 4. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Independent with manual wheelchair; -Tobacco use; not assessed. Review of the resident's care plan, dated 05/16/24, showed resident will: -Have supervised smoking in designated areas; -Smoke in designated smoking area at designated times, staff assigned to assist the resident; -Cigarettes and lighters are kept at nursing station. Observation on 07/30/24 at 12:30 P.M., showed the resident outside without staff smoking a cigarette. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/01/24 at 8:20 A.M., showed the resident outside without staff smoking a cigarette. Observation on 07/29/24 at 10:41 A.M., showed resident in his/her room with cigarettes and lighter in vest pocket. Observation on 07/30/24 at 3:30 P.M., showed resident in his/her room with cigarettes and lighter in vest pocket. 5. During an interview on 08/01/24 at 12:30 P.M., the Care Plan Coordinator said resident care plans are updated quarterly, annually, with significate changes, and regularly when something needs to be added. He/She said Resident #1, #11, and #13 keep their cigarettes and light on themselves. He/She said the residents do not need to be supervised when smoking. He/She said he/she was not aware that their care plan said supervised smoking and cigarettes and lighters are kept at nurses station. He/She said he/she expects the care plans to be updated. He/She said it is his/her responsibility to update care plans. He/She said the policy was just updated about three weeks ago and it just didnt get changed in care plan. During an interview on 08/01/24 at 1:08 P.M., the Director of Nursing (DON) said care plans should be updated weekly because things change so quickly. He/She said care plans should be updated. He/She said he/she does not think the residents are allowed to keep their lighter on themselves. He/She said the residents do not need to be supervised while smoking. He/She said he/she was unaware the care plans said residents have to be supervised while smoking. He/She it is the care plan coordinators responsibly to update care plans. He/she said he/she believes it is his/her job to monitor care plans are being updated. During an interview on 08/01/24 at 1:47 P.M., the administrator said care plans are updated quarterly, significant change in condition, or an event happens. He/She said that residents do not need to be supervised when smoking and they can keep cigarettes and lighters on them. He/She said he/she expects the care plans to be updated. He/She said it is the care plan coordinator responsibly to update care plans. He/She said it is the director of nursing and administrator job to monitor to ensure they are being updated. 50422

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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. 39440 Based on observation, interview, and record review, facility staff failed to maintain professional standards of care, when they failed to check placement of a Gastrostomy Tube ((G-Tube) a tube placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) prior to administration of G-tube feeding, and failed to follow the physician's orders regarding water flushes for one (Resident #4) of one sampled resident with a G-tube. The facility census was 47. 1. Review of the facility's policy for Medication, Administration by Naso-Gastric or Gastrostomy Tube, undated, showed staff are directed: -Wash hands; -Verify the recipient with physician orders and medication administration record; -Check for tube placement; -Give medications only by gravity. Never force with plunger; -At completion of medication administration, flush tube with water as ordered; -If resident is bolus fed, clamp tube and follow physician orders (to include but not limited to amount of formula, amount of water, and time the tube feeding can be off each day). Review of the facility's policy on Physician Orders, undated, showed staff are directed as follows regarding Tube Feeding: -Specify the type of feeding, amount, frequency of feeding, frequency for tube change, and rationale if as needed; -Should always be followed by water. 2. Review of Resident #4's annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/02/24, showed staff assessed the resident with a feeding tube, received 51 percent (%) or more total calories via tube feeding, and received 501 cc (cubic centimeter) or more average daily fluid intake via tube feeding. Review of the resident's plan of care, last updated 05/07/24, showed staff assessed the resident to be dependent on staff for all fluids and nutrition, and directed staff as follows: -Nothing by mouth related to dysphagia (difficulty swallowing); -Has a G-tube and received all nutrition and fluids per tube. Is dependent on a licensed nurse for this; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received all medications per G-tube; -Ensure patency and placement of G-tube before flushes/feeding by auscultation (using a stethoscope to listen to sounds of the body) or aspiration (withdrawing fluid/substance); -Ensure head is elevated at least 30 degrees before feedings. Review of the resident's Progress Notes, dated 07/18/24, showed the Registered Dietician documented: -Nothing by mouth, received tube feeding for sole nutrition; -Lactose-reduced food with fiber 1.5 bolus six times daily; -Flushes increased per recommendation to 100 mililters (ml) before and after bolus feedings. Review of the resident's Physician's Order Sheet (POS), dated 07/01/24 - 08/01/24, showed a gastrostomy status (presence of a G-tube) and Dysphagia. Review showed nothing by mouth and with tube feedings. Review showed the physician ordered may crush or alter medications unless otherwise indicated. May mix medication and give with feedings. Review showed staff are directed to administer: -Isosource 1.5 Calorie liquid one carton/240 ml via feeding tube every four hours, at 2 A.M., 6 A.M., 10 A.M., 2 P.M., 6 P.M., and 10 P.M.; -Flush tube with 100 ml of water before and after bolus feeding. Every four Hours at 2 A.M., 6 A.M., 10 A.M., 2 P.M., 6 P.M., and 10 P.M. Observation on 07/29/2024 at 2:24 P.M., showed the Director of Nursing (DON) entered the resident's room with the prepared medications, poured a carton of Isosource 250 ml into a graduated container (used to measure liquids), and filled a separate graduated container with 50 ml of tap water. Observation showed the DON attached a syringe to the resident's G-tube, administered the medications and the bolus feeding of Isosource, flushed with the 50 ml of water, and closed the tube. Staff did not check placement of the resident's G-tube and did not flush the G-tube as ordered by the physician. Observation on 07/30/24 at 10:02 A.M., showed Licensed Practical Nurse (LPN) B entered the resident's room with the prepared medications, poured a carton of Isosource 250 ml into a graduated container, and filled a separate graduated container with 300 ml of tap water. Observation showed the LPN attached a syringe to the resident's G-tube, administered the medications, flushed with approximately 50 ml of water, administered the bolus feeding of Isosource, flushed with approximately 50 ml of water, discarded the remaining 200 ml of water in the sink, washed his/her hands and left the room. Staff did not check placement of the resident's G-tube and did not flush the G-tube as ordered by the physician. During an interview on 07/30/24 at 10:02 A.M., LPN B said the resident's Medication Administration Record (MAR) directs staff on how much water to administer, and he/she believed the directions are to give 100 ml. The LPN said he/she had 300 ml of water in the container, but he/she only administered approximately 100 -110 ml of water total (100 ml with the feeding and 10 ml with the medications) and discarded the remainder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/31/24 at 10:50 A.M., showed LPN A entered the resident's room with the prepared medications, retrieved and poured a carton of Isosource 250 ml into a graduated container, filled another graduated container with tap water. Observation showed the LPN checked tube placement by auscultation, administered the medications, flushed with an unknown amount of water, administered the bolus feeding, then flushed with more water, and closed the tube. Staff did not flush the resident's G-tube as ordered by the physician. During an interview on 07/31/24 at 10:50 A.M., LPN A said he/she flushed the resident's G-tube with approximately 250 ml water. During an interview on 08/01/24 12:22 P.M., LPN A said he/she should follow physician's orders all the time. The LPN said staff should check for tube placement by auscultation with about 10 ml of air, to ensure the tube is in the stomach before administering any medications or feeding. The LPN said he/she mis-read the physician's order for the water flushes the day prior, and thought it was 120 ml, but he/she realized after he/she administered the feeding, that the order was for 100 ml before and after the bolus feeding. During an interview on 08/01/24 at 1:23 P.M., the DON said staff does not need to check for placement prior to administering medications or feeding via G-tube. The DON said he/she never checked for placement before feeding via G-tube unless he/she met resistance. However, if he/she met resistance during medication administration or feeding, he/she would stop, close the G-tube, and check for bowel sounds, or use a syringe to aspirate from the tube for gastric contents. The DON said he/she expects staff to follow physician's orders every time they administer medications or tube feedings to residents. The DON said he/she only flushed the resident's G-tube with 50 ml at the time, by default, because he/she did not remember the exact amount, but he/she later confirmed the physician's order is to flush with 100 ml before and after bolus feeding. During an interview on 08/01/24 at 1:45 P.M., the administrator said he/she expects staff to always follow physician's orders. He/She said staff should always follow physician's orders to give medications and feedings via tube to the resident, and if the order is written to flush with 100 ml of water, he/she expects staff to flush the tube with 100 ml of water.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39644 Based on observation, interview, and record review, facility staff failed to complete or post required nurse staffing information, which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis in an area readily accessible to residents and visitors. The facility census was 70. 1. Review of the facility's policies showed staff did not provide a policy for the daily nurse staff posting. 2. Observations on 07/29/24 at 2:00 P.M., showed the facility staff did not post the nurse staffing information. Observation on 07/30/24 at 10:00 A.M., showed the facility staff did not post the nurse staffing information. Observation on 07/31/24 11:00 A.M., showed the facility staff did not post the nurse staffing information. During an interview on 08/01/24 at 12:15 P.M., Licensed Practical Nurse (LPN) A said he/she is aware the nurse staff information should be posted but has not seen it in this facility. The LPN said he/she believes it is the night shift staff that update the posting information. During an interview on 08/01/24 at 12:25 P.M., the Director of Nursing (DON) said he/she was not aware the nurse staff posting needed to be updated and posted daily. He/She is unsure if it is his/her responsibility. The DON said he/she is aware that it is important for it to be posted so they know what staff are in the building each day. During an interview on 08/02/24 at 1:40 P.M., the administrator said it is ultimately his responsibility to make sure the nurse staff posting is updated and posted. No one has been designated to do this duty, there were a couple staff members who would do this, but they stopped and did not inform him.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 39440 Based on observation, interview, and record review, facility staff failed to store medications in a safe and effective manner when staff failed to date and label insulin pens (to treat high blood sugar). The facility census was 47. 1. Review of the facility's Labeling Drugs and Medication policy, undated, shows facility staff were directed as follows: -All drugs and biologicals must be properly labeled and legible at all times; -Labels must be permanently affixed to each container; -Medications in container having no labels must be destroyed in accordance with the facility procedures governing the destruction of medications; -Labels for individual drug containers must contain: Resident's full name and room number, expiration date (when applicable), and other appropriate information; -No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. Review of Lantus Insulin Pen Instruction insert, dated ,d+[DATE], shows Lantus Insulin pens can only be used up to 28 days after it's first used and throw away the Lantus pen after 28 days, even if it still has insulin left in it. Review of Novolog Insulin Pen Instruction insert, dated ,d+[DATE], shows Novolog insulin pens should be thrown away after 28 days of opening, even if it still has insulin left in it. 2. Observation on [DATE] at 7:56 A.M., showed the 100 hall medication cart contained: -Five opened and undated Lantus Insulin Pens; -One opened and undated Novalog Insulin Pen; -One opened and undated Tresiba Insulin Pen. During an interview on [DATE] at 8:10 A.M., Certified Medication Tech (CMT) E said when he/she opens a medication he/she labels with open date. He/She said if medication is not dated then you will not know when medication is no longer good. He/She said if medication is not dated it's a risk for the medication to not be effective if it's expired. 3. Observation on [DATE] at 1:32 P.M., showed the Memory Care unit medication cart contained: -Two Fiasp insulin pens without an open date; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-One Humalog insulin pen without a patient identifier or an open date; -One Lantus Solostar insulin pen without a patient identifier or an open date. 4. Observation on [DATE] at 1:55 P.M., showed a sign in memory care unit medication room directed staff all insulin bottles need to be dated when opened and all insulin expire 28 days after opening, regardless of expiration date on bottle and goes by date opened. 5. Observation on [DATE] at 10:45 A.M., showed a sign in the main medication room refrigerator directs staff: -Date all insulin when it is opened; -Good for 28 days, then it must be destroyed; -Insulin expire after it is open and you can not give it after 28 days open. 6. During an interview on [DATE] at 1:32 P.M., CMT C said insulin pens expire ,d+[DATE] days after they are opened, and any staff who administers insulin to a resident is expected to, and should always check the expiration/discard date prior to administering insulin to a resident. The CMT said any staff who removes the insulin from the refrigerator and opens it, should label the pen with the resident's name, date of birth, open date, and expiration/discard date, there should be someone that does audits, and there should be a system to double check for those things. During an interview on [DATE] at 12:20 P.M., CMT D said when opening a new insulin pen, you put the open date on pen. He/She said the insulin pen is usually labeled with resident's name already on pen or if the pens come in a box the label is on the box, a sharpie is used to write the residents name on the insulin pen. He/She said whoever opens the pen is responsible for dating and labeling the pen. He/She said a pharmacy comes in once a month to check for expired medication and make sure medication are labeled. He/She said insulin pens are only good for 28 days after opening. He/She said if insulin is given after 28 days the insulin is expired and the insulin would not be effective. He/She said if he/she found an insulin pen opened and not dated, he/she would discard the pen and get a new on and label and date it. During an interview on [DATE] at 12:25 P.M., License Practical Nurse (LPN) A said when opening a new insulin pen it needs to have open date and expiration date. He/She said the insulin pens should have the resident's name on the pen and the pen cap. He/She said whoever opens the pen is responsible for labeling and dating the pen. He/She said insulin is only good for 28 days after opening. He/She said after the 28 days the insulin may not be effective and not at its full potential. He/She said if insulin pen found with no date or label, he/she would notify the Director of Nursing and the insulin pen would have to be wasted because he/she would be unsure of how long the insulin had been opened. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 1:12 P.M., the Director of Nursing (DON) said when opening an insulin pen the date that it was opened should be written on the insulin pen along with resident name. He/She said he/she expects that if insulin pens are taken out of original box that it is labeled with resident's name. He/She said it is the CMT's responsibility to make sure insulin pens are dated and labeled. He/She said he/she is unsure of how long insulin pens are good for after opening. He/She said if past expiration date, the insulin would lose its potential and not be effective. During an interview on [DATE] at 1:51 P.M., the administrator said insulin pens should be dated when opened and have Resident's name. He/She said its pharmacy's responsibility to label the Insulin pens and the Nurses and CMT's responsibility to ensure open dates are on insulin pens. He/She said after expiration the insulin weakens its effect. He/She said if staff can not verify when insulin pen was opened, not to given insulin and get a new insulin pen. He/She said a pharmacist comes in monthly and checks medication to check expiration dates. He/She said the DON should be monitoring the insulin pens to ensuring dating and labeling of insulin pens are being done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265748	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tipton Oak Manor	601 West Morgan Street Tipton, MO 65081

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to change gloves and wash/sanitize hands during wound care for one resident (Resident #14), during medication administration for one resident (Resident #4) and failed to implement the enhanced barrier precautions (EBP) (an infection control intervention) policy developed and educate staff who required EBP and place appropriate personal protective equipment (PPE) in close proximity for two out of four sampled residents, one resident (Resident #14) with a wound and one of one resident (Resident #4) with an indwelling gastrostomy tube ((g-tube) surgically placed tube that enters the stomach to deliver fluids and nutrition, that required EBP). The facility census was 47. 1. Review of the facility's policy on Handwashing, undated, showed the purpose of handwashing is to reduce transmission of organisms from resident to resident, nursing staff to resident, and resident to nursing staff. Review of the facility's policy on Hand Cleanser (Antiseptic), undated, showed the purpose is to cleanse the hands between resident contacts during care and to prevent the spread of infection. Review of the facility's policy on Perineal Care, undated, showed the purpose is to cleanse the perineum (area between genitals and anus), to prevent infection and odor, and directed staff: -Wash hands; -Provide male/female perineal care; -Remove gloves and wash hands; -Position resident comfortably. Review of the facility's EBP to infection Control Guidance policy, dated March 2024 showed: -To prevent broader transmission or multidrug-resistance organisms (MDRO), bacteria resistant to antibiotics and/or antifungals, and to help protect residents with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have been resolved or indwelling medical devices have been removed; -Residents who require EBP are those with an indwelling medical device including a feeding tube (g-tube) regardless of their MDRO status and residents with a wound, regardless of their MDRO status; -Staff should use EBP when providing high contact resident care activities such as: bathing/showering, transferring residents from one position to another, providing hygiene, changing briefs or toileting, caring for or using an indwelling medical device, and performing wound care; -EBP includes the use of gloves and a gown; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Residents who are placed on EBP should have personal protective equipment (PPE) in close proximity outside the door and a trash can in the resident's room for disposal prior to leaving the room. Review of the Centers for Disease Control (CDC) website https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html article, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, dated June 2021, showed: -Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities; -Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room). 2. Review of Resident #4's Annual Minimum Data Set (MDS), a federally mandated assessment, dated 05/02/24 showed staff assessed the resident as follows: -Severely cognitively impaired; -Use of a feeding tube. Observation on 07/29/2024 at 2:24 P.M., showed the Director of Nursing (DON) entered the resident's room with prepared medications, did not wash his/her hands, put on a gown and applied gloves, administered the medications/feeding via G-tube, and wiped up spilled liquid from the bedside table with paper towels. The DON continued to wear the same soiled gloves and administered a medication under the resident's tongue. The DON removed his/her gloves, gown, and bagged the dirty supplies. The DON did not wash his/her hands before he/she left the resident's room. Observation on 07/30/24 at 9:26 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 07/30/24 at 10:02 A.M., LPN B entered the resident's room and administered medication, feeding, and fluids to the resident via G-tube with a gown on. Observation on 07/31/24 at 9:41 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 08/01/24 at 9:27 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. During an interview on 08/01/24 at 1:23 P.M., the DON said he/she should have changed gloves and washed/sanitized hands between the tube feeding and administration of the sublingual medication. 3. Review of Resident #14's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively impaired; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Open Lesion; -Application of non surgical dressing. Observation on 07/29/24 at 1:50 P.M., showed the DON entered the resident's room to provide wound care. Observation showed the DON washed his/her hands, placed a gown on and gloves. The DON cleansed the wound on the residents right side face. With the same soiled gloves the DON, cleansed a wound on the residents left side of face, used a clean cotton-tipped applicator to apply vaseline to both wounds and covered both wounds with a dressing. The DON did not wash his/her hands before he/she left the resident's room. Observation on 07/30/24 at 9:26 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 07/31/24 at 9:37 A.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. Observation on 08/01/24 at 12:20 P.M., showed the resident's room did not have PPE in close proximity outside the door as directed per the facility EBP policy. During an interview on 08/01/24 at 1:23 P.M., the DON said he/she did not realize he/she did not change gloves during wound care and he/she knew better. 5. During an interview on 08/01/24 at 12:19 P.M., Certified Medication Technician (CMT) G said he/she did not know what resident's required EBP. The name plates don't have yellow dots. If they do, it might mean the resident is a fall risk. He/She said, it is just a smiley sticker. During an interview on 08/01/24 at 12:25 P.M., CNA F said the name plates don't have yellow dots. He/She said no one has told him/her about it or what it means. He/She did not know which resident's required gloves and gowns. During an interview on 08/01/24 at 1:14 P.M., the DON said anyone with an open area, wounds, residents with tube feedings, and anyone with a catheter should be on EBP. Staff should wear gowns and gloves and there should be a stop sign on the door so staff know. The sign at the nurses desk and in the dayroom with only two residents names is incorrect. The sign in the dayroom should not be out in the open. The DON said staff should wear gloves anytime they perform perineal care, wound care, and tube feeding to residents. The DON said staff should change gloves in between dirty and clean tasks, wash hands, dry and apply clean gloves. During an interview on 08/01/24 at 1:45 P.M., the administrator said he/she expects staff to wear gloves when doing cares and treatment to residents, change gloves between dirty & clean tasks, and when switching residents. The administrator said staff should wash hands after they remove gloves, and when hands are visibly soiled.