STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265842	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ssm Health Depaul Hospital - Anna House	12284 Depaul Drive Bridgeton, MO 63044

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 40290 Based on observation, interview and record review, the facility failed to ensure residents were assessed to self-administer medications and to ensure staff adequately supervised residents during medication administration (Residents #28, #7 and #17). The sample was 16. The census was 62. Review of the facility's Medication Administration-General Guidelines policy, dated July 2021, showed: -Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so; -Administration: -Residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications (see Self-Administration of Medications); -The resident is always observed after administration to ensure that the dose was completely ingested. Review of the facility's Self-Administration of Medications policy, dated July 2021, showed: -Policy: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so If the facility's interdisciplinary team (IDT) has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer; -Procedures: -If the resident desires to self-administer medications, and assessment is conducted by the IDT of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process; -The results of the IDT's assessment of the resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #28's medical record, showed: -Diagnoses included dementia, multiple sclerosis (MS, disease of the central nervous system) and unspecified symptoms and signs involving cognitive functions and awareness; -No assessment identifying the resident as able to self-administer his/her medications. Review of the resident's Physician Order Summary (POS) and Medication Administration Record (MAR), dated September 2024, showed: -An order, dated 10/23/21, for glucosamine (supplement) capsule 500 milligrams (mg), give 500 mg by mouth (PO) one time a day. AM dose for 9/24/24 initialed as administered by Certified Medication Technician (CMT) D; -An order, dated 10/23/21, for losartan potassium (used to treat high blood pressure and heart failure) tablet 50 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/23/21, for potassium chloride (electrolyte supplement) tablet extended release (ER) 10 milliequivalents (mEq), give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/23/21, for raloxifene (used to treat osteoporosis) hydrochloric acid (HCl) tablet 60 mg, give 60 mg PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/23/21, for lutein (supplement) and zeaxanthin (supplement) tablet delayed release (DR), one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/23/21, for multivitamin tablet, one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 12/2/22, for calcium/vitamin D tablet 600-400 mg-unit, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 1/19/23, for lasix (blood thinner) oral tablet 20 mg, give one tablet PO in the morning. AM dose for 9/24/24 initialed as administered by CMT D; -No physician order for the resident able to self-administer his/her medications. Review of the resident's care plan, in use at the time of survey, showed no documentation the resident able to self-administer his/her medications or take his/her medications without supervision. Observation on 9/24/24 at 8:37 A.M., showed the resident seated at a table in the dining room. CMT D placed a cup of medication on the table in front of the resident, and walked back to his/her medication cart in the dining room. CMT stood at the medication cart with his/her back turned toward the resident, and worked on the computer. At 8:39 A.M., the resident took a sip of water and dumped the cup of pills in his/her hand. He/She placed a pill or two in his/her mouth, took a sip of water, and repeated the process three times until his/her medications were gone. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/26/24 at 8:14 A.M., showed the resident seated at a table in the dining room with a cup of medications next to his/her plate. CMT D stood at the medication cart in the dining room with his/her back turned towards the resident. During an interview, the resident said he/she can take his/her medications on his/her own. CMT D continued to work at the computer on his/her medication cart and administered medications to other residents while the resident remained seated at the table with the cup of medications next to his/her plate. At 8:39 A.M., the resident began taking pills out of the mediation cup and swallowing them with sips of water, one pill at a time, while CMT D stood at the medication cart with his/her back turned towards the resident. 2. Review of Resident #7's medical record, showed: -Diagnoses included dementia, anxiety, depression and bipolar disorder (mood disorder); -No assessment identifying the resident as able to self-administer his/her medications. Review of the resident's POS and MAR, dated September 2024, showed: -An order, dated 4/13/22, for metoprolol tartrate (used to treat high blood pressure and chest pain) tablet 100 mg, give one tablet by mouth two times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 4/13/22, for carbidopa-levodopa (combination medication to treat symptoms of Parkinson's disease (movement disorder)) tablet 25-100 mg, give one tablet PO three times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 4/14/22, for duloxetine (anti-depressant) HCl capsule DR sprinkle 50 mg, give one capsule PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 4/14/22, for lamotrigine (anti-seizure) tablet 100 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 4/14/22, for mirabegron (used to treat overactive bladder) ER tablet ER 24 hour 50 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 6/17/22 for risperidone (antipsychotic) 1 mg disintegrating tablet, give one tablet PO in the morning. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 7/26/23, for Xanax (sedative) oral tablet 0.25 mg, give 0.25 mg PO three times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 8/25/22, for rivaroxaban (blood thinner) tablet 20 mg, give one tablet PO in the morning. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 9/23/22, for losartan potassium tablet 100 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/21/22, for Claritin (antihistamine) tablet 10 mg, one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 10/26/23, for docusate sodium (stool softener) capsule 100 mg, one capsule PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 10/26/23, for meloxicam (anti-inflammatory) oral tablet 15 mg, give 15 mg PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -No physician order for the resident able to self-administer his/her medications. Review of the resident's care plan, in use at the time of survey, showed no documentation the resident able to self-administer his/her medications or take his/her medications without supervision. Observation on 9/24/24 at 8:14 A.M., showed the resident seated at a table in the dining room. CMT D placed a cup of medication on the table in front of the resident and walked away. CMT D got his/her medication cart and pushed it out of the dining room, leaving the resident unsupervised. The resident put a pill in his/her mouth, took a sip of water, and repeated the process until 8:16 A.M., when he/she finished taking all the medications in his/her cup. During an interview on 9/26/24 at 8:11 A.M., the resident said he/she already got his/her medications this morning. The employee gave him/her the medications and left the room. Some staff watch the resident and some do not; it depends on who is working. He/She thinks staff are supposed to watch people take their medications, but isn't sure. 3. Review of Resident #17's medical record, showed: -Diagnoses included anxiety; -No assessment identifying the resident as able to self-administer his/her medications. Review of the resident's POS and MAR, dated September 2024, showed: -An order, dated 5/13/23, for metoprolol succinate (used to treat high blood pressure and chest pain) ER tablet 25 mg, give 25 mg PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 5/13/23, for oyster shell calcium/vitamin D 500-200 mg-unit, give one tablet PO two times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 5/13/23 for Pepcid (antacid) oral tablet 20 mg, give 20 mg by mouth two times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 5/26/23, for sennosides (stool softener) tablet 8.6 mg, give one tablet PO two times a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 7/12/23, for bupropion (antidepressant) HCl oral tablet 100 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 8/23/23, for aspirin 81 mg chewable, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 2/8/24, for duloxetine HCl oral capsule DR particles 40 mg, give 40 mg PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -An order, dated 8/27/24, for oxybutynin chloride (used to treat overactive bladder) ER tablet 10 mg, give one tablet PO one time a day. AM dose for 9/24/24 initialed as administered by CMT D; -No physician order for the resident able to self-administer his/her medications. Review of the resident's care plan, in use at the time of survey, showed no documentation the resident able to self-administer his/her medications or take his/her medications without supervision. Observation on 9/24/24 at 7:45 A.M., showed the resident seated at a table in the dining room, eating breakfast. A cup of medications, containing approximately eight pills, next to his/her plate. CMT D stood at the medication cart in the dining room with his/her back turned towards the resident. At 8:27 A.M., the cup of medications remained on the table next to the resident's plate. At 8:31 A.M., CMT delivered a health shake to the resident and walked away. While CMT D stood at the medication cart with his/her back towards the resident, the resident took the medications from the cup. During an interview on 9/26/24 at 8:16 A.M., the resident said he/she already had his/her medication this morning. Some staff watch him/her take his/her medications and others do not. The employee who gave him/her his medications this morning did not watch the resident take them. 4. During an interview on 9/26/24 at 9:02 A.M., CMT D said during medication administration, he/she verifies he/she has the correct resident and medications, dispenses the medications into a cup, and gives the cup to the resident. Some residents require their medications to be crushed or to have their medications spoon fed, and in this case, the resident must be supervised while they take their medications. Otherwise, CMT D can give the resident their medication and walk away. Residents #28, #7, and #17 are all cognitively intact enough to take their medications without supervision. They might have dementia, but they are all cognitively able to take their own medications. 5. During an interview on 9/26/24 at 10:53 A.M., Nurse Supervisor A said during medication administration, staff should verify they have their right resident and right medication, dispense the medications, then supervise the resident while they take the medication. Staff must observe the resident take the medication because the resident might drop them or another confused resident might take the resident's medication. Staff must supervise medication administration for safety and accuracy. If a resident is adamant about taking their medication without supervision, staff should explain it is a regulatory requirement to watch them. Staff could also walk away but remain within eye sight to make sure the resident is taking their medication properly. 6. During an interview on 9/26/24 at 2:17 P.M., the Director of Nurse (DON) and Administrator said when staff are administering medications, they must verify they have the right resident and right dose of medication, and check the MAR. After dispensing the medications, they give them to the resident and watch the resident take the medications. Staff must watch the resident take their medications because the resident might choke or not take the medication. If a resident refuses to be supervised by staff, staff should take the medications back and tell the resident they will come back when the resident is ready. Residents #28, #7, and #17 should be supervised during medication administration and should not self-administer. All residents should be supervised during medication administration.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure a significant change in status assessment was completed within 14 days after a determination was made a significant change occurred for one of two residents sampled for hospice (Resident #27). The facility identified six residents who received hospice services. The census was 62. Review of Resident #27's medical record, showed: -admitted [DATE]; -Diagnoses included neurocognitive disorder with lewy bodies (degenerative brain disorder characterized by dementia, psychosis and features of parkinsonism (movement symptoms)) and dementia; -A hospice admission form, showed the resident admitted to hospice on 7/19/24 with a diagnosis of failure to thrive. Review of the resident's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, records, showed: -An annual MDS dated [DATE]; -A quarterly MDS dated [DATE]; -No significant change MDS assessment completed within 14 days after the resident's admission to hospice. During an interview on 9/26/24 at 9:51 A.M., the MDS Coordinator said a resident's admission to hospice is considered a significant change. Upon a significant change, a significant change MDS must be completed within 14 days. She is notified of a resident's admission to hospice via email, and the facility's daily clinical meetings and weekly risk meetings. When the resident was admitted to hospice, a physician order was not put in the resident's electronic medical record (EMR), so she did not know the resident was admitted to hospice at that time. During an interview on 9/26/24 at 2:17 P.M. with the Director of Nurses (DON) and Administrator, they said all MDS assessments are completed by the MDS Coordinator. A resident's admission to hospice is considered a significant change. It is expected that a significant MDS assessment be completed within 14 days of a resident's admission to hospice.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46888 Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care needs were met for two dependent residents (Resident #13 and Resident #35). The sample was 16. The census was 62. Review of the facility's activities of daily living policy, dated February 2019, showed: -Policy Statement: the facility will provide care to each resident to ensure that a resident's abilities in activities of daily living do not diminish unless decrease in a resident's function may be expected and unavoidable due to the predictable, cyclical patterns of the resident's clinical condition or the resident or his/her representative's refusal of care and treatment to restore or maintain functional abilities. -Activities of daily living include the resident's ability to bathe, dress, groom, transfer, and toilet, eat, and use speech, language or other functions communication systems; -Appropriate treatment and services are provided for all residents to help them maintain and improve their abilities to perform activities of daily living. If a resident is unable to carry out activities of daily living, he/she shall receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. For these residents, care plan goals may not be stated in terms of what the resident is able to achieve, but in terms of the outcome of care and services provided. The resident's plan of care will be reviewed and revised at least quarterly and more often if a decline in function is apparent. 1. Review of Resident #13's electronic medical record (EMR), showed: -Cognitively intact; -Diagnoses included hemiplegia (paralysis or loss of strength on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting right dominant side, major depressive disorder, anxiety and morbid obesity. Review of the resident's care plan, dated 8/21/24, showed: -Need: resident has an ADL self-care performance deficit requiring assistance; -Goal: resident will maintain current level in ADL performance; -Interventions: the resident requires extensive assistance on staff for personal hygiene and oral care. During an interview on 9/23/24 at 4:51 P.M., the resident said staff never assist him/her with brushing his/her teeth. The resident's teeth had a white thick matter on them. The resident's chin had a patch of hair growth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/24/24 at 11:23 A.M., showed the resident in bed. The resident's chin had a patch of hair. His/Her teeth had a white/yellow matter on them. During an interview on 9/26/24 at 8:17 A.M., the resident said he/she would like the chin hair shaved off his/her face. Nursing staff have not assisted him/her with brushing his/her teeth. He/She does not even know if he/she owns a toothbrush. He/She said his/her teeth feel icky. During an interview on 9/26/24 at 9:41 A.M., Certified Nursing Assistant (CNA) G said CNAs are responsible for asking residents if they would like their facial hair shaved and to assist residents with shaving. He/She said any nursing staff can assist a resident with brushing their teeth. During an interview on 9/26/24 at 11:26 A.M., the Director of Nursing (DON) said she expected nursing staff to assist the resident with his/her ADL care needs. She expected staff to brush a resident's teeth and assist with oral hygiene. She also expected CNAs to ask residents if they would like their facial hair shaved in a way that is sensitive to the resident's feelings. 2. Review of Resident #35's EMR, showed: -Moderately impaired cognition; -Diagnoses included Alzheimer's disease and muscle weakness. Review of the resident's care plan, dated 7/1/24, showed: -Need: resident has an ADL self-care performance deficit due to Alzheimer's disease; -Goal: resident will maintain current level in ADL performance through next review; -Interventions: the resident is independent for personal hygiene and oral care after set up of grooming items. Observation on 9/23/24 at 11:39 A.M., showed the resident had a strong odor emitting from his/her mouth. The resident's chin had a patch of hair. Observation on 9/25/24 at 7:38 A.M., showed the resident had a strong odor emitting from his/her mouth. The resident's chin had a patch of hair. During an interview on 9/26/24 at 9:41 A.M., CNA G said when he/she assists the resident with oral care, he/she uses mouth swabs to clean the resident's mouth. CNA G expected staff to be consistently assisting the resident with his/her oral hygiene care. He/She has never thought to ask the resident if he/she wants facial hair on his/her chin. CNAs are responsible for assisting the resident with shaving facial hair. During an interview on 9/26/24 at 11:26 A.M., the DON said she expected nursing staff to assist the resident with his/her oral care and personal hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 46888 Based on observation, interview and record review, the facility failed to ensure weekly skin assessments were completed by a nurse for three residents at risk for skin breakdown or with impaired skin integrity (Residents #7, #27, and #32), failed to complete an admission skin assessment and admission note, obtain a admission weight, and obtain skin tear treatment orders (Resident #155), failed to implement the physician order for thromboembolic deterrent (TEDs. a type of compression stocking applied to legs to prevent blood clots) hose when the resident has a history of edema and blood clots, failed to perform skin assessments, failed to obtain monthly weights and address the resident's weight gain (Resident #6), and failed to ensure wound care was being completed (Resident #1). The sample was 16. The census was 62. Review of the facility's Weight Measurement and Recording, reviewed, February, 2019, showed: -Purpose: To identify changes in the resident's weight and nutritional status and provide availability of weights to appropriated staff by documentation in the medical record. To provide appropriate nutritional interventions to promote health and maintain weight within appropriate parameters; -Policy: Residents will be weighed routinely on admission and re-admission, weekly time for 4 weeks, and then monthly; Residents with weight variations will be weighed more frequently; -Procedure: The community will develop a system for measuring weights on admission, weekly, monthly, and as needed; Monthly weights will be done over a 3-4 day period each month. Weekly weights will be done on a specific day of each week to establish consistence in time between weights; Weights will be reviewed by a qualified individual and re-weights will be obtained; Weights will be entered into the medical record for each resident in a timely manner. Review of the facility's Physician Order policy, revised, February, 2022, showed: -Policy: Resident care will be provided in accordance with physician orders; -Procedure: Orders for a licensed physician can be handwritten, faxed or transmitted electronically; Verbal orders car be given to a qualified nursing staff member; Orders will be entered into the electronic medical record (EMR) and followed accordingly; Nurses are required to follow physician orders unless they are clearly erroneous, dangerous to the resident, or not within the scope of practice; The ordering physician will be contacted with any questions. Review of the facility's wound care policy, dated April 2021, showed: -Policy statement: all residents needing wound care will have wound care provided by nursing staff, in accordance with doctor's orders or wound consultant company; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Procedure: upon notification of a wound, nursing staff will assess the wound and notify physician. Nursing staff will follow doctor's orders to care for the wound, and consult wound consultant company, if directed. If resident removes dressing prior to scheduled dressing change, staff will replace dressing and continue to monitor. 1. Review of Resident #7's medical record, showed: -Room on the A2 unit; -Diagnoses included dementia and lymphedema (swelling in the body's tissues); -No Braden scale assessments (a tool used to assess a patient's risk of developing pressure ulcers or pressure sores) completed in the past 12 months. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/21/24, showed resident at risk of developing pressure ulcers. Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has potential impairment to skin integrity; -Need: Resident has an activity of daily living (ADL) self-care performance deficit; -Interventions/tasks included skin inspections, the resident requires skin inspections weekly. Review of the resident's skin observation evaluations, completed by licensed nurses, reviewed 9/24/24, showed no skin observations completed after 9/2/24. 2. Review of Resident #27's medical record, showed: -Room on A2 unit; -Diagnoses included dementia and generalized muscle weakness. Review of the resident's scale assessment, dated 7/16/24, showed the resident at risk of developing pressure ulcers. Review of the resident's quarterly MDS, dated [DATE], showed the resident at risk of developing pressure ulcers. Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has potential for impairment to skin integrity related to occasional incontinence of bladder; -Need: Resident has an ADL self-care performance deficit; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions/tasks included skin inspections, the resident requires skin inspections weekly. Review of the resident's skin observation evaluations, completed by licensed nurses, reviewed 9/23/24, showed no skin observations completed after 8/16/24. 3. Review of Resident #32's medical record, showed: -admitted [DATE]; -Room on A2 unit; -Diagnoses included stroke, generalized muscle weakness, and contracture (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement) to left elbow. Review of the resident's Braden scale assessment, dated 8/20/24, showed the resident at risk of developing pressure ulcers. Review of the resident's admission MDS, dated [DATE], showed: -Upper extremity impairment on one side; -Lower extremity impairment on both sides; -Resident at risk of developing pressure ulcers; Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has potential for impairment to skin integrity; -Need: Resident has limited physical mobility; -Interventions/tasks included monitor/document/report as needed, any signs/symptoms of skin breakdown. Review of the resident's skin observation evaluations, completed by licensed nurses, reviewed 9/23/24, showed no skin observations completed after 8/20/24. 4. During an interview on 9/25/24 at 10:34 A.M., Nurse Supervisor A said nurses are expected to complete skin assessments weekly, usually on a resident's shower day. Nurses document their assessments as a skin observation in the electronic medical record (EMR). During day shift, a nurse is scheduled on the facility's A3 and E3 units, but nurses are not scheduled on A1 or A2. Nurse Supervisor A is responsible for completing all skin assessments for A1 and A2; however, it is not possible due to his/her other duties. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 8:45 A.M., LPN T said when a residents develops a skin tear, it should be measured and treatment orders obtained when the nurse calls the physician. A head to toe skin assessment, weight and an admission note should be completed on the resident as soon as they arrive to the facility. During an interview on 9/26/24 at 9:15 A.M., CMT X said admission weights are to be completed when the resident arrives to the facility. During an interview on 9/25/24 at 10:30 A.M., the DON said there was no admission checklist and once the resident is placed in the computer system, all the required assessments auto populate. During an interview on 9/26/24 at 2:28 P.M., the Administrator and the DON said new resident admission weights are expected to be obtained within 72 hours of admission. The skin assessments and an admission note are expected to be completed as soon as possible. The nurse should have obtained treatment orders for the skin tear when he/she notified the physician of the skin tear. 7. Review of the Resident #6's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors or rejection of care; -Requires supervision or touching the resident for putting on or taking off socks and shoes; -Diagnosis include: dementia, hip fracture, arthritis and depression; Review of the resident's EMR, showed diagnoses included left chronic embolism (a blood clot that travels in the blood vessel cause a blockage) and thrombosis (a formation of a blood clot inside the blood vessel) of deep veins of lower extremities. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident had a left hip fracture: -Interventions: Monitor limb for swelling and skin changes; -The care plan did not address resident refusing care. Review of the resident's skin assessment, dated 7/8/24, showed: -Skin intact; -No further skin assessments were available for review. Review of the resident's progress notes on 4/9/24 at 10:24 P.M., showed the Medical Doctor (MD) saw the resident today with new orders for TED hose on in A.M. off in .PM. Health shake and Eucerin cream (a specialized cream to treat dry skin) discontinued due to resident refusing. The orders have been carried out and passed in report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician Order Sheets (POS), dated April, May, June, July, August and September, 2024 did not show orders for TED hose. Review of the resident's progress notes, showed: -On 8/31/24 at 4:23 P.M., the resident's physician visited the resident, no new orders; Review of the resident's physician progress notes, showed: -On 8/31/24 at 4:24 P.M., the resident was seen sitting in his/her chair; Extremities: chronic stasis changes lower extremities; Review of the resident's weights showed: -On 4/9/24: 156.9 pounds (lbs); -On 5/15/24: 165.8 lbs; -On 6/12/24: 165.4 lbs; -No weight recorded dated July, 2024; -On 8/1/24: 169 lbs: -No weight for September, 2024. Review of the resident's progress notes did not show that the resident's weight gain was addressed. During observation and interview on 9/23/24 at 11:00 A.M. and 9/24/24 at 10:30 A.M. the resident sat in his/her chair in his/her room. The resident's bilateral lower extremities had moderate edema. The resident's left leg appeared more edematous than the right. The resident had on white socks that made an indentation into the resident's mid-calf. The resident said he/she had broken his/her hip and was recovering. The left sock appeared to have a yellowish drainage. The resident also had small scabs to his/her left lower leg above the sock line. The resident said he/she had not noticed any drainage from his/her leg and always has swollen legs. The resident did not have TED hose on. During observation and interview on 9/25/24 at 11:01 A.M., the resident sat in his/her chair in his/her room. The resident had his/her feet elevated on a chair. The resident's legs appeared moderately edematous. The resident's left leg was more edematous than the right leg. A yellow stain on the resident's left white sock was present. Certified Nursing Assistant (CNA) Y removed the resident's socks and the resident had indentations where the socks were. Both feet had long toenails approximately one half an inch curling toward the bottom of the resident's toes and both feet were dry. CNA Y said the resident's nails were long and the resident always has edematous legs but refused any type of treatment for them. CNA Y didn't know where the yellow drainage came from that was on the resident's left sock. The resident did not have TED hose on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at approximately 11:15 A.M., Licensed Practical Nurse (LPN) Z said the resident refused treatments to his/her feet and legs. The resident will not even elevate his/her legs. The resident always has lower extremity swelling because he/she has a history of blood clots. LPN Z reviewed the resident's documentation in the resident's EMR progress notes and said there was an order for TED hose on 4/9/24. LPN Z could not locate the order in the POS or the date it was implemented. LPN Z could not locate the TED stocking order under the discontinued orders. LPN Z said he/she doesn't know what happened regarding the TED hose order. During an interview on 9/26/24 at 9:15 A.M., Certified Medication Technician (CMT) X said everyone pitches in to do the weights. The monthly weights are to be completed the within the first 5 days of the month. The Charge Nurse is responsible to review the weights. During an interview on 9/26/24 at 10:00 A.M., LPN Z said skin assessments are weekly, corresponding with the resident's shower. LPN Z pulled out a laminated schedule of showers and skin assessments out of a cabinet at the nursing station on the [NAME] 3 hall. LPN Z said the resident is to have skin assessment every Friday. Weights are completed monthly on residents by the nursing staff and any changes in the resident's weight needs to be reported to the physician. LPN Z was not aware of any weight gain with the resident. During an interview on 9/26/24 at 2:28 P.M., the Administrator and the DON said the resident weights are to be completed monthly. The Charge Nurse is expected to notify the physician of weight changes. The DON was not aware of the physician order for TEDs on the resident. Documentation of the resident refusing treatment should be added to the resident's medical record in a progress note and on the care plan. 8. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Diagnoses of multiple sclerosis (MS, disease of the central nervous system), hemiplegia (paralysis or loss of strength on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left non-dominant side, and neuromuscular dysfunction of the bladder (when the nerves that control the bladder are damaged resulting in bladder dysfunction); -Moderately impaired cognition. Review of the resident's POS, in use at the time of the survey, showed: -Order, dated 9/23/24, for triple antibiotic ointment (TAO, neomycin-bacitracin-polymyxin), apply to right foot 3rd digit topically, every day shift for abrasion. Cleanse area with wound cleanser (WC), apply TAO, and a dry dressing. Change daily until healed; -Order, dated 9/23/24, for TAO, apply to right foot 4th digit topically, every day shift for abrasion. Cleanse area with WC, apply TAO and a dry dressing. Change daily until healed; -Order, dated 9/23/24, for TAO apply to right great toe topically, every day shift for abrasion. Cleanse with WC, apply TAO and dry dressing, change daily until healed; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Order, dated 9/23/24 for triple paste external ointment 2% (miconazole nitrate topical) apply to left foot 4th toe topically every day shift for abrasion. Cleanse area with WC, apply TAO, cover with dry dressing. Change daily until healed. Review of the resident's most recent skin observation tool, dated 9/22/24, showed no documentation of the resident's toe wounds. Observation on 9/25/24 at 7:59 A.M., of the resident's feet, showed: -The right big toe had a scab-like dark red wound on the top; -The right 2nd toe had one dark red pinpoint area; -The right 3rd toe had dark red scab-like area covering the too of the toe; -The underneath of the right 4th toe had a dark, red, flaky wound; -The left 4th toe had a dark, red, flaky area. -No dry dressings were observed on the resident's toes. Observation on 9/26/24 at 8:32 A.M., showed no dry dressings on the resident's toe wounds. During an interview on 9/26/24 at 9:29 A.M., the Clinical Supervisor said the resident has abrasions on his/her toes. She is not sure when the abrasions first appeared on the resident's toes. She was made aware of the abrasions on 9/20/24. She expected the resident's dry dressings to be placed on the resident's toes as ordered by the physician. She said nurses are responsible for wound care. During an interview on 9/26/24 at 3:00 P.M., the DON said she expected the resident's dry dressings to be placed as ordered by the physician and dated. She expected all wounds to be on the skin assessments completed by nursing staff. She is not sure when the abrasions first appeared on the resident's toes.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 40290 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #32) with limited mobility received appropriate equipment and assistance to maintain mobility when staff failed to ensure the resident had a palm protector as recommended by therapy to address a left hand contracture (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement). The sample was 16. The census was 62. Review of Resident #32's medical record, showed diagnoses included stroke, contracture to left elbow, generalized muscle weakness, dementia and cognitive communication deficit. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/26/24, showed: -Severe cognitive impairment; -Upper extremity impairment on one side; -Dependent for upper body dressing. Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has limited physical mobility; -Goal: Resident will maintain current level of mobility through review date; -Interventions/tasks included monitor/document/report as needed any signs/symptoms of contractures forming or worsening, and provide supportive care, assistance with mobility as needed; -No documentation regarding the application of a palm protector. Review of the resident's Occupational Therapy (OT) discharge summary, dated 9/13/24, showed: -Short-term goal: The patient will wear a palm protector in left hand according to wear schedule with 100% accuracy as applied by trained caregivers. Discharge level of functioning: Patient has palm protector but does not wear it consistently; -Summary since last progress report: Patient and caregiver educated on use of palm protector for increasing range of motion in left hand; -Patient discharging from OT to facility where he/she will receive restorative nursing care. Review of the resident's physician order summary, reviewed 9/23/24, showed no order for a palm protector. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/23/24 at 11:24 A.M., showed the resident seated in the dining room. His/Her left hand was contracted with his/her fingers curled into the palm of his/her hand. The resident did not wear a splint. During an interview, the resident used one-word answers and nodded/shook his/her head to respond to simple questions regarding his/her current status. He/She was unable to provide in-depth information regarding his/her status and care needs. Observations on 9/23/24 at 12:39 P.M. and 2:57 P.M., showed the resident with no palm protector on his/her contracted left hand. Observation on 9/24/24 at 8:21 A.M., showed Certified Nurse Aide (CNA) AA propelled the resident down the hall from his/her room to the dining room. The resident's left hand was contracted with fingers curled into his/her palm, and no palm protector on the resident's hand. Observation on 9/24/24 at 1:06 P.M., showed the resident on his/her right side in bed. No palm protector was on the resident's left hand. Observation on 9/25/24 at 7:39 A.M., showed CNA C and CNA B transferred the resident out of bed and into a Broda chair (reclining chair). CNA B brought the resident out to the dining room. The resident's left hand was contracted with no palm protector on the resident's hand. Observation on 9/25/24 at 9:27 A.M., showed Restorative Aide (RA) L provided restorative therapy to the resident in the dining room. The resident's left hand was contracted with no palm protector. RA L moved the resident's left arm and the resident grimaced, closed his/her eyes and winced. RA L apologized to the resident for the discomfort and said he/she did not know why the resident was not wearing his/her brace. RA L said the resident's left hand looked swollen. During an interview on 9/25/24 at 9:31 A.M., RA L said the resident is supposed to wear a brace on his/her left hand every day. The CNA assigned to the resident is responsible for putting the brace on the resident's arm. During the interview, Licensed Practical Nurse (LPN) P approached the resident and assisted RA L in observing the resident's left hand. LPN P said the resident's left hand is slightly swollen and contracted, with indentions in the resident's palm from his/her fingers. The resident should be wearing a brace. During an interview on 9/25/24 at 9:42 A.M., CNA C said the resident cannot use his/her left hand. CNA C had no idea the resident was supposed to wear a brace, no one had told him/her that until today. Nurses make CNAs aware of residents who need splints or braces. During an interview on 9/25/24 at 2:32 P.M., CNA B said he/she did not know the resident is supposed to have a brace or splint. Therapy tells the nurses when a resident is supposed to have a brace, and the nurse tells the CNA. During an interview on 9/25/24 at 9:55 A.M., LPN P said physician orders need to be obtained for the use of a splint or brace. During the interview, LPN P checked the resident's electronic medical record (EMR) and verified the resident did not have orders or documentation to show the resident should have a brace. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 10:34 A.M., Nurse Supervisor A said the resident's left hand is contracted. Therapy has him/her wear a brace on and off. Sometimes therapy will try something like a brace to see if it works and if it does, they will tell nursing if it needs to be ordered by the physician. Nurse Supervisor A was not aware if therapy made someone in nursing aware of a recommendation for the resident to have a brace. During an interview on 9/26/24 at 9:40 A.M., the Therapy Director said the resident was discharged from OT with recommendations for a palm protector. The OT educated nursing staff and documented the recommendation for the palm protector in the resident's discharge summary, but forgot to obtain a physician order for the palm protector. During an interview on 9/26/24 at 2:17 P.M., the Director of Nurses (DON) and Administrator said when a resident is discharged from OT and OT has recommendations for a palm protector, therapy should obtain a physician order for the palm protector and enter in the EMR. Therapy should educate all nursing staff on the floor about application of the palm protector. The RA and CNAs are responsible for applying the resident's palm protector. The DON and Administrator expected residents to have palm protectors as ordered and recommended by therapy to help improve or maintain the resident's range of motion.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42795 Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1) received proper urinary catheter (tube that drains the urine from the bladder) care after an incontinence episode, staff failed to remove the resident's catheter bag off of the floor after providing care and failed to follow the facility's policy of changing the resident's urinary catheter tubing and bag every 30 days. The sample was 16. The census was 62. Review of the facility's Catheter Care policy, review dated February, 2019, showed: -Policy: To keep indwelling catheter free of vaginal discharge and/or crusting, which can cause infections; -Observation and reporting include: -Color and amount of urine; -Check tubing and drainage for sediment; -Attach Foley (a tube that drains the urine from the bladder) to bed frame only; -Change drain bag and tubing every 30 days and as needed; -Change indwelling Foley catheter as indicated based on assessment or per physician order; -Secure urinary drainage bag below the level of the bladder and keep off the floor at all times; -Coil extra tubing and secure. Review of the facility's Perineal Care (cleansing of the genitals) policy, dated July, 2016, showed: -Purpose: To establish routine practices for provide perineal care which will cleanse, reduce the risk of skin breakdown, infection, and odor; -Policy: Residents who are incontinent, have an indwelling Foley (a tube that drains urine from the bladder), or who are identified as requiring perineal care will receive in the morning, every evening, and as needed after bowel movement or urinary incontinence. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/16/24, showed the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of multiple sclerosis (MS, disease of the central nervous system), hemiplegia (paralysis or loss of strength on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left non-dominant side, and neuromuscular dysfunction of the bladder (when the nerves that control the bladder are damaged resulting in bladder dysfunction); -Moderately impaired cognition. Review of the resident's Physicians Order Summary (POS), in use at the time of survey, showed: -Order, dated 5/24/24, catheter care and document output every shift for Foley catheter care; -Order, dated 5/15/24, Foley catheter 18 French (FR, the catheter size) to promote wound healing. Review of the resident's care plan, dated 7/1/24, showed: -Need: The resident has a urinary catheter; -Goal: The resident will be/remain free from catheter-related trauma through review date; -Interventions: position catheter bag and tubing below the level of the bladder and away from entrance room door; Check tubing for kinks each shift; Monitor and document for pain/discomfort due to catheter. Monitor, record, report to Medical Director (MD) for pain, burning, blood-tinged urine, cloudiness, no output of urine, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns; -The care plan failed to address the frequency of indwelling catheter changes, catheter tubing changes or catheter bag changes. Review on 9/25/24 at 11:16 A.M., of the resident's progress notes, showed: -Progress note, dated 5/26/24, said 18 FR Foley catheter was inserted with some difficulty and small amount of blood seen in the urine; -This progress note was the last documented Foley catheter tubing change. Review on 9/26/24 at 10:15 A.M., of the resident's medical record, showed no recent lab work or urinalysis , (UA, a test of urine to check for urinary tract infections, kidney problems, or diabetes). Observation on 9/24/24 at 7:51 A.M., showed the resident's Foley catheter tube appeared cloudy with green residue on the inside of the tubing. The catheter bag had green residue in it with a vertical line of green residue staining the urinary bag. Observation on 9/25/24 at 7:48 A.M., showed the resident's Foley catheter tube looked cloudy with green residue on the inside of the tubing. The catheter bag had green a residue with a vertical line of green residue staining the urinary bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 7:46 A.M., the resident said his/her catheter has not been changed in a long time. Observation on 9/25/24 at 8:02 A.M. showed Certified Medication Technician (CMT) D and Certified Nurse Aide (CNA) J entered the room and explained to the resident they were going to turn the resident for a skin assessment. The resident lay in bed on his/her back. The resident's heel protectors were removed by CMT D. The resident was turned to his/her right side. CNA J removed the resident's brief. The resident had stool in his/her brief. CNA J cleaned the resident's left buttock and rectal area. The resident was then turned to his/her left side. CMT D removed the soiled brief and cleaned the resident's right buttock. The resident had a Foley catheter that became unhooked from the resident's bedframe and fell on to the floor while the resident was turned side to side. The resident's Foley catheter remained on the floor. A clean brief was applied. The resident was repositioned to his/her back by CMT D and CNA J and a clean brief was fastened around the resident. CMT D and CNA J removed their gloves, performed hand hygiene and left the resident's room. Catheter care was not provided. The resident's Foley catheter remained on the floor. Observations on 9/25/24 at 8:26 A.M., 9/25/24 at 8:39 A.M., 9/25/24 at 8:42 A.M., 9/25/24 at 9:01 A.M., 9/25/24 at 9:29 A.M., and 9/25/24 at 10:00 A.M., showed the resident's Foley catheter bag lay on the floor next to the resident's bed. Observation on 9/25/24 at 10:23 A.M., showed CNA G removed the resident's Foley catheter bag off of the floor and placed it back on the resident's bed frame. During an interview on 9/25/24 at 1:15 P.M., Nurse Supervisor A observed the resident's catheter bag and said the bag and tube appeared to have a green residue. He/She said he/she was not sure what the green residue was but that it could be discoloration due to a possible manufacturer malfunction. He/She said the resident's catheter tubing should be changed every 30 days. He/She expected there to be an order for when catheter bags are supposed to be changed. During an interview on 9/26/24 at 9:50 A.M., CNA G said he/she is responsible for making observations of the resident's Foley catheter during care to make sure there are no changes to the resident's urine output, cleanliness and coloring of the catheter tubing and bag. He/She was not aware the resident's catheter bag and tubing had a green residue. He/She said when staff is providing perineal care to a resident who has had a bowel movement, the catheter site should be cleaned. He/She said if a resident's catheter bag is found on the floor, staff is to pick the catheter bag up and place it back on the resident's bed. During an interview on 9/26/24 at 3:19 P.M., the Director of Nursing (DON) said the resident's Foley catheter does not need to be changed at a set date and does not require a physician's order. She said a resident's catheter tubing should only be changed if there is a dysfunction or is causing discomfort. She did not know when the last time the resident's catheter tubing had been changed. She was not aware the resident's catheter tubing and bag were cloudy and had green residue. She said the green coloring could potentially be a medication issue. She said if a staff member walked into a resident's room and found their catheter bag on the ground, she expected the staff member to clean the bag and place it back on the resident's bed. She expected staff to perform catheter care after the resident has a bowel movement. Review of the information provided by the DON via e-mail on 9/30/24, showed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The DON observed the resident's Foley catheter. The catheter was draining clear amber urine with no signs of infection or malfunction. The outside of the tubing was slightly discolored, but the urine inside remained clear and free flowing. Per the Medical Director, Foley catheters are to be changed only for dysfunction or by physician order. 46888

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 42795 Based on observation, interview and record review, the facility failed to ensure respiratory services were provided, consistent with professional standards of practice, for three residents. The facility failed to obtain physician orders for the use of a continuous positive airway pressure (CPAP, a breathing device that delivers air to a mask worn over the nose and mouth) machine for two residents (Residents #3 and #155). The facility also failed to discontinue an order for continuous oxygen use for one resident no longer requiring oxygen therapy (Resident #3) and failed to have physician orders for oxygen for one resident (Resident # 38) who received continuous oxygen. The sample size was 16. The census was 62. Review of the facility's CPAP policy, revision April, 2019, showed it failed to address the requirement of physician orders. Review of the facility's Oxygen Administration policy, reviewed February, 2019, showed: -Purpose: To provide higher concentration of oxygen than is available in room air; -Procedure: Adjust flow to ordered rate. 1. Review of Resident #3's medical record, showed diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), asthma, and obstructive sleep apnea (recurrent episodes of upper airway collapse during sleep). Review of the resident's electronic Physician Order Sheet (ePOS), showed: -An order, dated 6/13/24, for oxygen at 2 liters (L) per minute, per nasal cannula (NC), every shift, at 2L at all times; -No order for CPAP machine. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: -Cognitively intact; -Oxygen therapy not indicated. Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has COPD and asthma; -No documentation regarding the resident's use of a CPAP machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/23/24 at 2:29 P.M., showed a CPAP machine on the table next to the resident's bed. During an interview, the resident said he/she has COPD and was recently in the hospital for pneumonia. He/She does not use oxygen, but does use a CPAP machine at night. He/She is responsible for cleaning it, but doesn't. During an interview on 9/25/24 at 9:55 A.M., Certified Nurse Aide (CNA) C said the resident does not use oxygen. He/She uses a CPAP machine every night. During an interview on 9/25/24 at 10:34 A.M., Nurse Supervisor A said the resident used to wear oxygen after a previous surgical procedure, but has not needed it since. The resident's physician order should have been discontinued since it is no longer needed. The resident does have a CPAP machine. The resident should have a physician order for use of the CPAP machine and the evening nurse should provide care to the CPAP machine. Physician orders are required for all CPAP machines. 2. Review of Resident #155's, face sheet, undated, showed -An admitted [DATE]; -Diagnoses included COPD, obstructive sleep apnea (when breathing slows or stops when sleeping), stroke and weakness. Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's CPAP machine. Review of the resident's POS dated September, 2024, showed no order for a CPAP machine. Observation and interview on 9/24/24 at 8:02 A.M., showed a CPAP machine on the resident's nightstand. The resident said he/she has sleep apnea and wears the CPAP every night. The resident cleans it and applies it by him/herself. During an interview on 9/26/24 at 8:45 A.M., Licensed Practical Nurse (LPN) T said the resident should have CPAP orders that include maintenance and the settings of the machine. 3. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Diagnoses included heart failure and COPD; -The resident receives oxygen and hospice services. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has heart failure and COPD; -Interventions: Oxygen settings as ordered. Observation on 9/23/24 at 12:35 P.M., 9/24/24 at 7:00 A.M. and 9/25/24 at 1:05 P.M., showed the resident lay in bed with an oxygen concentrator set on 3L and the oxygen tubing connected to resident's nares (nostrils). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 8:45 A.M., LPN T said the resident should have oxygen orders when receiving oxygen therapy. 4. During an interview on 9/26/24 at 2:17 P.M., the Administrator and Director of Nurses (DON) said if a resident has orders for continuous oxygen and does not use it or no longer needs it, the order should be discontinued. Oxygen use up to 2L does not require a physician order. Oxygen use at 3L would require a physician order. Residents should have physician orders for the use of CPAP machines. The order should include the settings required for the CPAP machine, but would not include anything specific to cleaning the CPAP machine. Nurses clean CPAP machine masks daily.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40290 Based on interview and record review, the facility failed to post nurse staffing information on a daily basis, for two out of four days of survey. The sample was 16. The census was 62. Review of the nurse staffing information on 9/24/24 at 9:00 A.M., 11:13 A.M. and 12:34 P.M., showed the direct care staff daily report was dated 9/23/24. Review of the nurse staffing information on 9/25/24 at 7:26 A.M. and 11:46 A.M., showed the direct care staff daily report was dated 9/23/24. During an interview on 9/26/24 at 11:15 A.M., the Staffing Coordinator said the nurse staffing information has to be posted on a daily basis. She is responsible for doing this, but she was out sick for the past two days. She will try to figure out who will post the staffing information on days she is not in the building. During an interview on 9/26/24 at 2:17 P.M., the Director of Nurses (DON) and Administrator said they expected nurse staffing hours to be posted on a daily basis. The Staffing Coordinator is responsible for posting the staffing hours. Currently, nobody has been responsible for posting the staffing information on days the Staffing Coordinator does not work and going forward, it will be the night shift supervisor.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 42795 Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5%. Out of 28 opportunities observed, ten errors occurred, resulting in a 35.71% error rate. (Resident #161, Resident #163 and Resident #162). The census was 62. Review of the facility's Medication Administration policy, dated July, 2021, showed: -Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so; -Medication are administered in accordance with written orders of the prescriber; -The resident is always observed after administration to ensure that the dose was completely ingested. Review of the facilities Electronic First dose Kit policy, dated, July, 2021, showed: -The facility may use electronic first dose kits for first dose and emergency medications, where permitted by regulation or law; -The resident is always observed after administration to ensure that the dose was completely ingested. -Upon receipt of a new medication order, facility staff should remove doses for the electronic first dose kit at each administration time until the order is available from the pharmacy. 1. Review of Resident #161's electronic medical record (EMR), showed: -An admitted , 9/23/24; -Diagnoses included urinary tract infection, atrial fibrillation (a fib, irregular heartbeat), heart failure, kidney disease, major depressive disorder, and heart disease; -An order, with a start date, 9/24/24, metoprolol succinate extended release (ER) (medication to treat high blood pressure) 12.5 milligrams (mg), give one time daily; -An order, with a start date, 9/24/24, amiodarone (medication used to treat irregular heartbeat) 200 mg, give one time daily; -An order, with a start date, 9/24/24, Symbicort inhalation (medication used to treat lung disease) 160-4.5 micrograms (mcg), 2 puffs twice a day; -An order, with a start date, 9/24/24, bupropion extended release (ER) (used to treat depression) 300 mg, give one tablet daily; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, with a start date, 9/24/24, furosemide (medication to treat heart failure) 20 mg, give one tablet daily; -An order, with a start date, 9/24/24, gabapentin (used to treat nerve pain), 300 mg, give by mouth three times a day; -An order, with a start date, 9/24/24, nitrofurantoin microcrystals (used to treat UTI) 100 mg, give one capsule twice a day. During observation and interview on 9/24/24 at 9:10 A.M., Certified Medication Technician (CMT) V said some of the resident's medications are not available. CMT V searched the medication cart and could not locate the resident's metoprolol, amiodarone, Symbicort, bupropion, furosemide, gabapentin and nitrofurantoin in the medication cart. CMT V informed the resident that he/she would have to wait until the evening shift to get his/her medications when pharmacy delivered the medications. 2. Review of Resident #163's EMR, showed: -An admitted , 9/18/24; -No diagnosis available to review; -An order, with a start date, 9/19/24, docusate sodium (stool softener) 100 mg, give once a day; -An order with a start date, 9/19/24, Systane complete ophthalmic solution (eye drops) 0.6%, instill one drop into both eyes three times a day. During observation and interview on 9/24/24 at approximately 9:40 A.M., CMT W assisted the resident with his/her medications by providing yogurt to help the resident swallow his/her medications. The resident's docusate sodium remained in the resident's medicine cup on his/her bedside table. CMT W left the resident's docusate sodium at the bedside and then left the resident's room. CMT W searched the medication cart for his/her eye drops and said he/she could not find the resident's Systane eye drops. Observation on 9/24/24 at 10:32 A.M., showed the resident sleeping in his/her recliner in his/her room. The resident's docusate sodium remained in a clear medicine cup on the resident's bedside table. 3. Review of Resident #162's EMR, showed; -An admitted , 9/5/24; -Diagnoses included high blood pressure, heart disease, fracture of left foot and muscle weakness; -An order, with a start date, 9/6/24, Omega 3 fatty acids (a supplement), give one capsule daily. During an interview on 9/24/24 at approximately 10:00 A.M., CMT W said the resident's Omega 3 fatty acids was not available to be administered. CMT W said the facility will probably have to go to Walgreens and purchase the supplement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 9/24/24 at approximately 10:00 A.M., CMT W said every CMT and nurse has access to the emergency kit and if they don't have access, they need to find a staff member who does have access or notify the Charge Nurse. New admission medications should be pulled from the emergency kit. 5. During an interview on 9/26/24 at 9:57 A.M., CMT X said new admission medications can be pulled from the emergency kit if available. If the resident's medication is not available, staff is expected to call the pharmacy to determine when the medication is expected to arrive. It is unacceptable to tell the resident they have to wait. If there is a problem getting the medication or it has been missing for several days, staff should notify the nurse or the Director of Nursing (DON). CMTs must watch the resident swallow their pills every time in case they may choke or they might drop the medication. That is the first thing you learn in CMT school is to watch the resident take their medication. 6. During an interview on 9/26/24 at 2:28 P.M., the Administrator and the DON said they expected staff to follow physician orders accurately and correctly. Staff are expected to utilize the emergency kit for newly admitted residents if the medications are not available. The resident should be informed why the medication is not available and should not be told they will have to wait. They expected staff to watch the resident take their medications. If medications are not available, the staff are expected to call the pharmacy and find a solution.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 46888 Based on observation, interview and record review, the facility failed to ensure residents were provided food that was at a safe and appetizing temperature for three residents (Residents #3, #11 and #13). The sample was 16. The census was 62. Review of the facility's checking food temperatures from the main kitchen policy, dated 3/24/24, showed: -Policy statement: the neighborhood team members will check the temperature of hot and cold foods prepared in and delivered from the main kitchen; -Policy interpretation and implementation: upon arrival of the food from the main kitchen, the neighborhood team member will test the temperature of all foods. Hot foods must maintain a temperature of 140 degrees F (Fahrenheit) or greater. Cold foods must maintain a temperature of less than 40 degrees F. The temperatures will be recorded on the food temperature sheet transported with the cart. Any hot food found to be below 140 degrees F will be sent back to the main kitchen. Any cold food found with a temperature more than 40 degrees will be sent back to the main kitchen. Any questions or concerns related to food temperature will be directed to Food Service Director. 1. Review of Resident #3's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/24, showed: -Cognitively intact; -Diagnoses include depression and anxiety. During an interview on 9/23/24 at 2:50 P.M., the resident said the food is not always hot when it is supposed to be hot. Staff bring the food to the hall from the main kitchen and by the time the food is served, it can get pretty cold. 2. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses of type 2 diabetes mellitus and major depressive disorder. During an interview on 9/23/24 at 12:33 P.M., the resident said sometimes when his/her food is served to him/her it is cold when it should be hot. 3. Review of Resident #13's admission MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of major depressive disorder, anxiety and morbid obesity. During an interview on 9/23/24 at 4:50 P.M., the resident said the food is sometimes cold by the time it is delivered to his/her room. 4. During the resident council meeting on 9/24/24 at 2:05 P.M., six residents whom the facility identified as alert and oriented, said that food is often cold when it is served on the first floor [NAME] hallway. 5. Observation on 9/24/24 at 12:22 P.M., of lunch trays served on the first floor [NAME] hallway, showed the following: -Buttered potatoes measured at 114.2 degrees F; -Cornbread casserole measured at 112 degrees F. 6. Observation on 9/25/24 at 11:57 A.M., of lunch trays served on the first floor [NAME] hallway, showed the following: -Baked ham measured at 118 degrees F; -[NAME] sprouts measured at 136 degrees F. 7. During an interview on 9/26/24 at 10:37 A.M., Dining Service Associate H said that food should be served to residents at a safe and palatable temperature to prevent bacteria and health issues. 8. During an interview on 9/26/24 at 10:40 A.M., the Dining Service Manager said he expected staff to serve residents food that is at a safe and palatable temperature to prevent poor quality of food. 9. During an interview on 9/26/24 at 10:45 A.M., the Director of Dining Services said she expected food to be served at a safe and palatable temperature. 10. During an interview on 9/26/24 at 3:17 P.M., the Administrator and Director of Nursing (DON) said they expected food to be served at a safe and palatable temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 46888 Based on observation, interview and record review, the facility failed to ensure the main kitchen floors, appliances and food storage areas were clean and free from debris, and that the ceiling was free from dust accumulation. The facility also failed to ensure the [NAME] 2nd floor (A2) dishwashers were in working order, affecting two residents (Resident #24 and Resident #3). The sample was 16. The census was 62. Review of the facility's cleaning rotation policy, undated, showed: -Guideline: Equipment and utensils will be cleaned and sanitized according to the following guidelines, or manufacturer's instructions; - Items cleaned daily: Stove top, grill, kitchen and dining room floors, and exterior of large appliances; - Items cleaned weekly: Storerooms, shelves, and ovens; -Items cleaned monthly: Refrigerators, freezers, and ingredient bins; -Items cleaned annually: Ceilings. 1. Observation on 9/23/24, of the main kitchen, showed: -At 10:18 A.M., the walk in refrigerator had food debris and food substance build up on the main part of the floor and under the storage racks. A dirty white towel lay on the floor next to the back storage rack; -At 10:19 A.M., the walk in freezer had food debris and trash debris on the main floor and on the floor under the storage racks; -At 10:21 A.M., the bulk bins had food debris and white powder substance on all three lids and bins; -At 10:22 A.M., the deep fryer had grease and food debris on the inside. The outside of the deep fryer had sticky grease streaks and build up; -At 10:23 A.M., the freezer next to the deep fryer, had a sticky grease substance on the left side. The right side of the freezer had substance debris and liquid streaks; -At 10:24 A.M., above the main food prep station, two light fixtures and eight ceiling tiles surrounding the light fixtures had dust accumulation and build up; (continued on next page)

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	265842	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ssm Health Depaul Hospital - Anna House	12284 Depaul Drive Bridgeton, MO 63044

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 10:25 A.M., the main floor of the kitchen had food debris and trash wrappers in various areas; -At 10:26 A.M., the floor under the prep station had a dirty towel; -At 10:27 A.M., above the spice rack prep station, two lights and three ceiling tiles had dust accumulation and build up; -At 10:29 A.M., the oven doors were caked with substance and food debris; -At 10:31 A.M., the dry storage room floors had food, trash, and food debris on the ground under all of the storage racks. The floor was sticky. Observation on 9/24/24, of the main kitchen, showed: -At 8:08 A.M., the oven doors were caked with substance and food debris; -At 8:09 A.M., the deep fryer had grease and food debris on the inside. The outside of the deep fryer had sticky grease streaks and build up; -At 8:10 A.M., two light fixtures and eight ceiling tiles surrounding the light fixtures had dust accumulation and build up. The light fixtures and ceiling tiles were above the main food prep station where open containers of eggs, bacon, and gravy were located; -At 8:11 A.M., the freezer next to the deep fryer had a sticky grease substance on the left side. The right side of the freezer had substance debris and liquid streaks; -At 8:13 A.M., the dry storage room floors had food, trash, and food debris on the ground under all of the storage racks. The floor was sticky; -At 8:14 A.M., the walk in refrigerator had food debris and food substance build up on the main part of the floor and under the storage racks. A dirty white towel was on the floor next to the back storage rack; -At 8:17 A.M., the walk in freezer had food debris and trash debris on the main floor and on the floor under the storage racks; -At 8:18 A.M., the bulk bins had food debris and white powder substance on all three lids and bins; -At 8:19 A.M., above the spice rack prep station, two lights and three ceiling tiles had dust accumulation and build up; -At 8:36 A.M., the refrigerator by the walk in freezer had food debris and liquid spills on the bottom shelf. Observation on 9/25/24, of the main kitchen, showed: -At 7:23 A.M., the bulk bins had food debris and white powder substance on all three lids and bins; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 7:24 A.M., above the spice rack prep station, two lights and three ceiling tiles, had dust accumulation and build up; -At 7:28 A.M., the refrigerator next to the ice cream storage had food and liquid spills on the bottom shelf; -At 7:29 A.M., the deep fryer had grease and food debris on the inside. The outside of the deep fryer had sticky grease streaks and build up; -At 7:30 A.M., two light fixtures and eight ceiling tiles surrounding the light fixtures had dust accumulation and build up. The light fixtures and ceiling tiles were above the main food prep station where open containers of breakfast food were located; -At 7:31 A.M., the freezer next to the deep fryer had a sticky grease substance on the left side. The right side of the freezer had substance debris and liquid streaks; -At 7:33 A.M., the walk in refrigerator had food debris and food substance build up on the main floor and under the storage racks. A dirty white towel was on the ground next to the back storage rack; -At 7:35 A.M., the walk in freezer had food debris and trash debris on the main floor and on the floor under the storage racks; -At 7:36 A.M., the oven doors were caked with substance and food debris; -At 7:37 A.M., the dry storage room floors had food, trash, and food debris on the ground under all of the storage racks. The floor was sticky. During an interview on 9/26/24 at 10:37 A.M., Dining Service Associate H said the dish washing staff clean the refrigerators and freezers. The cooks were responsible for cleaning the kitchen appliances. All kitchen staff were responsible for cleaning the floors. During an interview on 9/26/24 at 10:40 A.M., the Dining Service Manager said cooks were responsible for cleaning kitchen appliances daily. The dish washing staff were responsible for cleaning the floors. Maintenance staff were responsible for cleaning the ceiling annually or as needed. He/She would expect the entire kitchen top to bottom to be clean. During an interview on 9/26/24 at 10:45 A.M., the Director of Dining Services said she would expect for the kitchen to be clean at all times. The refrigerators and freezers should be cleaned every Monday and Thursday. The dish washing staff were responsible for cleaning the floors and appliances. Maintenance staff were responsible for cleaning the ceiling annually. 2. Review of Resident #24's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, showed: -Room on the A2 unit; -Severe cognitive impairment; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Diagnoses included anxiety and depression. During an interview on 9/23/24 at 10:52 A.M., the resident said the dishwasher has been on the [NAME] for a month now, so sometimes the utensils served with meals were dirty. 3. Review of Resident #3's significant change MDS, dated [DATE], showed: -Room on the A2 unit; -Cognitively intact; -Diagnoses included anxiety and depression. During an interview on 9/23/24 at 2:29 P.M., the resident said the dishwasher is broken so all dishes were hand washed and they are not as clean. He/She gets served meals with dirty forks that still had food on the tongs. The dishes were not sanitized because the water does not get hot enough when washing by hand. 4. Observation of the A2 unit on 9/24/24 at 8:16 A.M., showed two dishwashers in a kitchenette with handwritten notes on the front of both dishwashers, showing Not working. Dining Service Associate M placed dishes into the top rack of the dishwasher on the left side, and pressed the start button. He/She rinsed a divided plate in soapy water in the sink, rinsed it with running water, and placed the divided plate on a drying rack on the counter. He/She rinsed a cup under running water, opened the dishwasher on the left side, placed the cup in the top rack of the dishwasher, closed the dishwasher, and pressed the start button. He/She rinsed two more divided plates in soapy water at the sink, rinsed them with running water, and placed them on the drying rack. Observation of the A2 unit on 9/24/24 at 1:12 P.M., showed Dietary Service Associate M with a cart of dirty dishes from lunch, and a bucket of soapy water. He/She dunked several cups into the bucket of soapy water, placed them in the top rack of the dishwasher to the far left of the sink, then turned the dishwasher on. He/She used a rag to wipe regular and divided plates in the bucket of soapy water, rinsed them in the sink, then placed them on the drying rack next to the sink. He/She removed a handful of utensils from the bucket of soapy water and placed them in the top rack of the dishwasher on the left side, then turned the dishwasher back on. The needles on the temperature gauges on the front of the dishwasher did not move during the cycle. Observation on 9/26/24 at 8:27 A.M., showed Dining Service Associate N turned on the dishwasher to the far left of the sink. After running for five minutes, Dining Service Associate N placed a thermometer into the water at the bottom of the dishwasher, and the temperature reached 102.7 degrees Fahrenheit (F). 5. During an interview on 9/24/24 at 1:29 A.M., Dietary Service Associate M said the dishwashers in the A2 kitchen were broken. He/She washes the dishes by hand, then runs them through the dishwasher to sanitize them, and then they dry before being put away or used at the next service. 6. During an interview on 9/26/24 at 8:27 A.M., Dining Service Associate N said the dishwashers in the A2 kitchen were broken. Dishes for the unit have to be washed by hand, but that was not sanitary enough. Dishes can also be taken to the main kitchen to be washed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. During an interview on 9/26/24 at 9:32 A.M., the Dining Service Manager said the dishwashers were broken in the A2 kitchen. New dishwashers have been ordered and in the meantime, staff should rinse the dishes in the A2 kitchen, then bring them to the main kitchen to be run through the main kitchen dishwashers. Dishes need to be run through the dishwasher to address germs. Handwashing will not sufficiently clean the dishes. 8. During an interview on 9/26/24 at 2:17 P.M., the Administrator said the dishwashers on A2 were broken, and on 9/12/24, an order was placed for new dishwashers. The new dishwashers should arrive in a few weeks and until then, staff should wash the dishes in the A2 kitchen, then take them to the main kitchen to be washed in the main kitchen dishwasher to ensure proper sanitation.

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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** 40290 Based on observation, interview and record review, the facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and as required by the Centers for Medicare and Medicaid Services (CMS) for residents with central lines to include catheters and wounds requiring treatments (Residents #1, #28, #157 and #155). The facility failed to exhibit appropriate infection control practices when staff left the catheter bag for one resident (Resident #1) on the floor with no protective barrier, and when staff dropped gloves on the floor and placed them back in the box, where they were later removed and used on one resident during personal care (Resident #1). In addition, the facility failed to ensure hand sanitizer dispensers were functional and filled on one unit of the facility. The sample was 16. The census was 82. Review of the facility's Transmission-Based Precautions policy, dated 2023, showed: Transmission-based precautions (also known as Isolation Precautions) refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission in order to prevent or control infections; -Additional Precautions: -Enhanced Barrier Precautions: expand the use of personal protective equipment (PPE) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization; -It is essential both to communicate transmission-based precautions to all health care personnel and for personnel to comply with requirements. Pertinent signage (i.e., isolation precautions in place, PPE instructions) and verbal reporting between staff can enhance compliance with transmission-based precautions to help minimize the transmission of infections within the facility. Signage must comply with the resident's right to privacy and confidentiality. PPE must be available near the entrance to the resident room in order for PPE to be donned prior to entry. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/16/24, showed the following: -Diagnoses of multiple sclerosis (MS, disease of the central nervous system), hemiplegia (paralysis or loss of strength on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left non-dominant side, and neuromuscular dysfunction of the bladder (when the nerves that control the bladder are damaged resulting in bladder dysfunction); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderately impaired cognition. Review of the resident's Physician Order Summary (POS), in use at the time of the survey, showed: -Order, dated 9/23/24, for triple antibiotic ointment (TAO, neomycin-bacitracin-polymyxin), apply to right foot 3rd digit topically, every day shift for abrasion. Cleanse area with wound cleanser (WC), apply TAO, and a dry dressing. Change daily until healed; -Order, dated 9/23/24, for TAO, apply to right foot 4th digit topically, every day shift for abrasion. Cleanse area with WC, apply TAO and a dry dressing. Change daily until healed; -Order, dated 9/23/24, for TAO apply to right great toe topically, every day shift for abrasion. Cleanse with WC, apply TAO and dry dressing, change daily until healed; -Order, dated 9/23/24, for triple paste external ointment 2% (miconazole nitrate topical) apply to left foot 4th toe topically every day shift for abrasion. Cleanse area with WC, apply TAO, cover with dry dressing. Change daily until healed. Review of the facility's EBP list, showed the resident is on EBP precautions due to wound care and Foley catheter (a thin, flexible tube that drains urine from the bladder into a collection bag) care. Observation on 9/25/24 at 7:58 A.M., showed an EBP sign posted outside of the resident's room. Certified Medicine Technician (CMT) D put on a pair of gloves and walked into the resident's room. He/She lifted the resident's blanket to expose the resident's feet and removed the resident's heel protector cushions. He/She lifted each of the resident's feet and then put the resident's heel protector cushions back on. He/She was not wearing an isolation gown. Observation on 9/25/24 at 8:02 A.M. showed CMT D and Certified Nurse Aide (CNA) J entered the room and explained to the resident they were going to turn the resident for a skin assessment. The resident lay in bed on his/her back. The resident's heel protectors were removed by CMT D and wounds were noted to both feet on the resident's toes with no dressing present. The resident was turned to his/her right side. CNA J removed the resident's brief. The resident had stool in his/her brief. CNA J cleaned the resident's left buttock and rectal area. The resident was then turned to his/her left side and CMT D removed the soiled brief and cleaned the resident's right buttock. A dressing to the resident's right buttocks was noted. A clean brief was applied. The resident was repositioned to his/her back by CMT D and CNA J and the clean brief was fastened around the resident. CMT D and CNA J removed their gloves, performed hand hygiene and left the resident's room. CMT D and CNA J did not wear isolation gowns while providing care. Observation on 9/25/24 at 10:23 A.M., showed CNA G removed a pair of gloves from the glove box located outside the resident's room, put the gloves on, and entered the resident's room. He/She touched the resident's Foley catheter bag to pick it up off the ground and placed it back on the resident's bed frame. He/She was not wearing an isolation gown. Observation on 9/26/24 at 8:32 A.M., showed CNA K performed hand hygiene and put on gloves. He/She entered the resident's room and removed the resident's blanket and lifted up the resident's heel protector cushions. He/She was not wearing an isolation gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #28's medical record, showed: -Diagnoses included MS, hereditary and idiopathic (disease of unknown cause) neuropathy (nerve damage), and dementia; -An order, dated 7/11/24, to cleanse right malleolus (prominent bone on the outer side of the ankle) with wound cleanser and apply dry dressing, change every other day and as needed, every day shift for open area; -No documentation of the resident on EBP. Review of the resident's skin and wound evaluation, dated 9/19/24, showed a venous wound (lower leg wound that develops when the leg veins fail to return blood back toward the heart normally) to the resident's right lateral (side) malleolus. Review of the resident's care plan, in use at the time of survey, showed: -Need: resident has potential for impairment to skin integrity due to impaired mobility and occasional incontinence of bladder. Area with treatment to right malleolus; -Interventions/tasks included treatment as ordered to right malleolus; -No documentation of the resident requiring EBP. Review of the facility's list of residents on EBP, undated, showed the resident on EBP due to wounds. Review of the sign on the resident's door on 9/23/24 at 11:11 A.M., showed: -Contact Precautions: -Providers and staff must also: -Put on gloves before room entry. Discard gloves before room exit; -Put on gown before room entry. Discard gown before room exit. Observation on 9/23/24 at 11:11 A.M., showed the resident seated in a wheelchair in his/her room. CNA B was in the resident's room with gloves on, but no gown. CNA B used both hands to adjust the resident's feet and smooth the resident's bedspread. During an interview, CNA B said no one in the resident's room is on any type of precautions. He/She did not know why there was a Contact Precautions sign on the resident's door. A gown is not necessary to wear in the resident's room. (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 9/24/24 at 7:43 A.M., showed the resident seated in the dining room. Nurse Supervisor A approached the resident and put his/her ungloved hands on the resident's shoulders when asking what was wrong. The resident said he/she could not breathe and did not feel well. Nurse Supervisor A unlocked the resident's wheelchair and propelled the resident in his/her wheelchair down the hall to the resident's room. With ungloved hands and no gown on, Nurse Supervisor A placed in his/her hands on the resident and used a stethoscope on the resident to listen to his/her breathing. During an interview on 9/25/24 at 9:55 A.M., LPN P said the Contact Precautions sign on the resident's door is probably old. There are no residents on the hall who are on disease precautions of any kind. During an interview on 9/26/24 at 9:02 A.M., Certified Medication Technician (CMT) D said the Contact Precautions signs are old and he/she does now know why they are still there. He/She does not know what EBP means. He/She does not know anything about wearing extra PPE for certain residents. During an interview on 9/26/24 at 10:53 A.M., Nurse Supervisor A said the resident has a venous wound and EBP should be used when providing care requiring contact with the resident. 3. Review of the Resident #157's electronic medical record (EMR), showed: -admitted : 9/17/24; -No active diagnoses available for review. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has a urinary catheter; -Interventions: EBP per facility protocol. Review of the facility's EBP list, undated, showed the resident on EBP due to urinary catheter. Review of the resident's order summary, dated 9/23/24, showed an order, dated 9/17/23, EBP refers to an infection control intervention to reduce transmission of MDRO that require gown and glove usage during high contact care activities. Observation on 9/23/24 at 10:58 A.M., showed outside the resident's room an EBP sign was not posted. Occupational Therapy Assistant (OTA) R assisted the resident with gloved hands from the recliner to his/her wheelchair with a gait belt. The resident's urinary catheter was attached on his/her walker. OTA R removed the resident's urinary catheter from the walker and then positioned the resident's urinary catheter under the wheelchair. OTA R then propelled the resident out into the hallway. OTA R did not have a PPE gown on during resident care. During an interview on 9/26/24 at 8:45 A.M., LPN T said the resident requires EBP because he/she has a urinary catheter. EBP is wearing gloves and an isolation gown anytime when a staff member touches the resident. 4. Review of Resident #155's face sheet, showed; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An admitted [DATE]; -Diagnoses included cellulitis (an infection of the skin and tissue below the skin) of the abdominal wall, fistula (an abnormal passageway that connect an organ to the skin), chronic obstructive pulmonary disease, (COPD, a lung disease that constricts the lungs airway), stroke and weakness. Review of the resident's care plan, in use at the time of survey, showed: -Need: The resident has abdominal incision with a wound vac (a device that manages wounds) in place; -Interventions: EBP per facility protocol. Review of the facility's EBP list, undated, showed the resident on EBP due to wounds. Review of the resident's POS, dated 9/23/24, showed an order, dated 9/20/24, EBP refers to an infection control intervention to reduce transmission of MDRO that require gown and glove usage during high contact care activities. Observation and interview on 9/23/24 at 12:35 P.M., showed the resident in his/her room, sitting in his/her recliner with a wound vac attached to his/her abdomen. The resident's family member said the wound vac was applied this morning and that over the weekend a wet to dry dressing was applied to the resident's abdomen until the wound vac could be applied by the wound care nurse. The resident and the resident's family member did not see any staff with an isolation gown on during care. An EBP precaution sign was not posted outside the resident's room. Observation and interview on 9/24/24 at 9:02 A.M., showed an EBP sign posted outside of the resident's room, however no PPE supplies were outside the resident's room. The resident was in his/her room with OTA S. The resident complained of pain to his/her abdomen and that his/her colostomy (a surgically created opening that is through the abdomen that allows stool to be evacuated) pouch needed to be emptied. OTA S propelled the resident to the bathroom and explained to the resident that he/she was going to show the resident how to empty the stool contents of the resident's colostomy. OTA S wore gloved hands and exposed the resident's abdomen. A wound vac was in place near the resident's colostomy stoma (opening). OTA S emptied the resident's colostomy pouch while he/she instructed the resident on the care of the colostomy. OTA S was not wearing an isolation gown during resident care. Observation on 9/26/24 at 9:02 A.M., showed an EBP sign posted outside the resident's room, however no PPE supplies were outside the resident's room. OTA S entered the resident's room and explained to the resident it was time to go to therapy. OTA S applied a gait belt to the resident with ungloved hands and assisted the resident from the resident's recliner to the resident's wheelchair and then propelled the resident out of his/her room. OTA S did not have an isolation gown on during resident care. During an interview on 9/26/24 at 8:45 A.M., LPN T said the resident requires EBP because he/she has a wound vac. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 9/26/24 at 8:51 A.M., CNA C said he/she does not know what EBP means. He/She is not aware of any additional precautions that need to be taken or extra PPE required for some residents. During an interview on 9/26/24 at 9:00 A.M., CNA U said EBP are to be used by staff for residents who have wounds and catheters. Staff should wear gloves and an isolation gown. During an interview on 9/26/24 at 9:17 A.M., CNA G said he/she does not know what EBP means. If someone is on precautions, the nurse should let him/her know. During an interview on 9/26/24 at 9:23 A.M., CNA Q said EBP means to wear gowns and gloves while providing care for some residents. He/She has seen EBP implementation at other facilities, but not at this facility. During an interview on 9/26/24 at 10:53 A.M., Nurse Supervisor A said EBP is used for residents with catheters and wounds. This requires staff to put on gowns and gloves before entering the resident's room to provide direct care. He/She has not seen EBP happening in the facility. Residents on EBP should have signs outside of their doors to show they are on EBP, and PPE should be outside of the door as well. The Infection Preventionist (IP) is responsible for making sure signs and PPE are placed outside of resident rooms. 6. During an interview on 9/26/24 at 11:52 A.M., the IP said he began his role with the facility in July 2024. EBP are used to protect from open systems only, to protect the resident from infection. If a resident has a wound with an open channel, there is risk to get further infection and the resident is placed on EBP. This would include a resident who requires dressing changes. If a resident has a wound vacuum, it would be considered a closed system and EBP would not be used, and standard precautions of gloves only would be used. Residents are placed on EBP upon admission or when they develop a new wound or qualifying condition that gets reported to him during the facility's daily meetings. Residents on EBP should have the appropriate signs outside of their rooms, as well as caddies containing PPE. The Contact Precautions signs outside of rooms who do not require this, but who are actually on EBP, are old and should be removed. If a sign is posted showing any type of precautions, he expected staff to follow the guidelines posted and wear the appropriate PPE as indicated. He expected the facility to implement EBP practices in line with the facility's policies and expectations of the CDC and CMS. During an interview on 9/27/24 at 11:50 A.M., the IP said all staff members, including therapy, are to follow EBP when providing high contact care activities. 7. During an interview on 9/26/24 at 2:17 P.M. with the Director of Nurses (DON) and Administrator, they said a change in staffing resulted in a lack of education regarding EBP. EBP should be implemented for residents with catheters or wounds requiring dressings. For residents on EBP, staff should wear gloves and gowns when changing the resident's sheets and during any care requiring direct contact. EBP should be followed by all departments, including therapy. The IP is responsible for ensuring the correct signage is posted outside of the resident's room, and ensuring PPE is available within staff's range of use. The correct signage will communicate to staff what type of PPE is required for the resident. (continued on next page)

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	265842	A. Building B. Wing	09/26/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Observation on 9/25/24 at 8:02 A.M., showed LPN D and CNA J assisted Resident #1 with a skin assessment. The resident had a Foley catheter that became unhooked from the resident's bedframe and fell on to the floor while the resident was turned side to side. LPN D and CNA J repositioned the resident and left the room. The resident's Foley catheter remained on the floor. Observation on 9/25/24 at 8:08 A.M., showed CNA J entered the resident's room to perform care. At 8:18 A. M., CNA J exited the resident's room. The resident's Foley catheter bag lay on the ground next to the resident's bed. Observations on 9/25/24 at 8:26 A.M., 9/25/24 at 8:39 A.M., 9/25/24 at 8:42 A.M., 9/25/24 at 9:01 A.M., 9/25/24 at 9:29 A.M., and 9/25/24 at 10:00 A.M., showed the resident's Foley catheter bag on the ground next to the resident's bed. During an interview on 9/26/24 at 9:50 A.M., CNA G said if a resident's catheter bag is found on the ground, to pick the catheter bag up and place it back on the resident's bed. During an interview on 9/26/24 at 11:19 A.M., the DON said if a staff member walked into a resident's room and found their catheter bag on the ground, she expected the staff member to clean the bag and place it back on the resident's bed. 9. Observations on 9/25/24, showed: -At 8:08 A.M., CNA J reached into a glove box located outside of the room of Resident #1, and dropped a pair of gloves on the ground. He/She picked the gloves back up and placed the gloves back into the glove box. He/She when back into the resident's room to perform care to the resident; -Continuous observation from 8:08 A.M. to 10:23 A.M., showed the contaminated gloves remained in the glove box; -At 10:23 A.M., CNA G removed the pair of contaminated gloves from the glove box located outside the resident's room, put the gloves on, and entered the resident's room. He/She touched the resident's Foley catheter bag to pick it off the ground and placed it on the resident's bed frame. During an interview on 9/26/24 at 9:17 A.M., CNA G said if staff drop PPE on the floor, they should discard it. It would not be appropriate to drop PPE, such as gloves, on the floor, and then use it while providing care due to contamination issues. During an interview on 9/26/24 at 9:23 A.M., CNA Q said if staff drop gloves on the floor, they should pick them up and throw them away. It would not be appropriate to use the dropped gloves because they have been exposed to germs. During an interview on 9/26/24 at 12:03 P.M., the IP said he expected staff to dispose of gloves if staff members drop them on the ground. During an interview on 9/26/24 at 2:17 P.M., the DON and Administrator said if PPE, such as gloves, becomes contaminated, it is expected that staff dispose of the PPE, not use it on a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Observations of the A2 unit, on 9/23/24 at 11:11 A.M., 9/24/24 at 12:51 P.M., 9/25/24 at 10:24 A.M., and 9/26/24 at 11:25 A.M., showed: -A total of six hand sanitizer dispensers on the three sections of rooms on the unit; -Two sanitizer dispensers were empty on the top section for rooms 215 through 223; -Two sanitizer dispensers were empty on the middle section for rooms 217 through 218; -Two functioning dispensers on the back section for rooms 219 through 222. During an interview on 9/26/24 at 8:51 A.M., CNA C said the hand sanitizer dispensers on A2 have been empty for months. He/She is not sure who fills them. Some residents have signs on their doors instructing staff to sanitize their hands before entering, but the dispensers are empty. During an interview on 9/26/24 at 9:12 A.M., CNA B said the hand sanitizer dispensers on A2 have been out for months. He/She needs to sanitize his/her hands in between each resident's room. During an interview on 9/26/24 at 9:02 A.M., CMT D said the hand sanitizer dispensers have been empty for months. He/She needs to sanitizer his/her hands in between residents during medication administration. He/She uses the sinks to wash his/her hands instead, but it would be helpful to have the sanitizer available. Housekeeping fills the dispensers. During an interview on 9/26/24 at 8:52 A.M., Housekeeping Associate O said he/she did not know who filled the hand sanitizer dispensers. During an interview on 9/26/24 at 10:53 A.M., Nurse Supervisor A said the hand sanitizer dispensers on A2 have been empty for months. Nursing staff need the sanitizer for use in between residents. During an interview on 9/26/24 at 2:17 P.M., the DON and Administrator said the hand sanitizer dispensers on the A2 unit should be functioning and filled for staff use. Maintenance is responsible for ensuring the dispensers are functional. 42795 46888

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 40290 Based on observation, interview and record review, the facility failed to ensure the room for one resident was adequately equipped with a call light at the resident's bedside (Resident #32). The sample was 16. The census was 62. Review of Resident #32's medical record, showed diagnoses included stroke, contracture (fixed tightening of muscle, tendons, ligaments, or skin, preventing normal movement) to left elbow, dementia, and cognitive communication deficit. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/26/24, showed: -Severe cognitive impairment; -Usually understood-difficulty communicating some words or finishing thoughts but is able to if prompted or given time; -Upper extremity impairment on one side. Review of the resident's care plan, in use at the time of survey, showed: -Need: Resident has a communication problem; -Interventions/tasks included ensure/provide a safe environment, call light in reach. Observation on 9/23/24 at 11:09 A.M., showed no call light connected to the port in the wall next to the resident's bed. During an interview on 9/23/24 at 11:24 A.M., the resident used one-word answers and nodded/shook his/her head to respond to simple questions regarding his/her current status. He/She was unable to provide in-depth information regarding his/her status and care needs. Observations on 9/24/24 at 7:22 A.M. and 7:53 A.M., showed the resident on his/her left side in bed. No call light was connected to the port in the wall next to the resident's bed. Observation on 9/24/24 at 1:06 P.M., showed the resident on his/her right side in bed. No call light was connected to the port in the wall next to the resident's bed. Observation on 9/25/24 at 7:30 A.M., showed the resident on his/her back in bed. No call light was connected to the port in the wall next to the resident's bed. Certified Nurse Aide (CNA) C was in the resident's room, about to get the resident up for the day. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 9:42 A.M., CNA C said the resident understands commands, instructions, and can respond verbally with yes/no to questions every now and then. He/She cannot use his/her left hand, but can use his/her right hand and is very good with it. The resident is the only resident on the unit without a call light and CNA C was not sure why. During an interview on 9/25/24 at 2:32 P.M., CNA B said the resident cannot use one of his/her hands, but can use the other one. He/She does not have a call light in his/her room. He/She cannot holler out if he/she needs something and should have a call light. All residents should have call lights next to their beds. During an interview on 9/25/24 at 10:34 A.M., Nurse Supervisor A said the resident has dementia and can talk at times. His/Her left hand is contracted, but he/she has use of his/her right hand and could use a call light. All residents should have a call light next to their bed. Nurse Supervisor A was not aware the resident did not have a call light. During an interview on 9/26/24 at 2:17 P.M., the Director of Nurses (DON) and Administrator said the resident is not verbal but would understand how to use a call light. His/Her left hand is contracted, but he/she does have use of his/her right hand. The DON and Administrator expected all residents to have call lights within reach next to their beds. All staff are responsible for ensuring there are call lights within reach of resident beds. If staff observe a call light is missing from a resident's room, they should notify the nurse and maintenance should be notified. Some staff are not good with entering repair requests into the reporting system used by maintenance, so they can call the front desk and notify the receptionist of the issue, and the receptionist can enter the request into the reporting system for staff.