STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cedars at Broadwell	800 Stoeger Drive Grand Island, NE 68803

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-006.18B3 Based on observations and interview the facility staff failed to ensure 3 of 27 rooms were maintained in good repair and failed to maintain wallpaper and walls in good repair in 2 of 3 halls in good repair. The facility census was 37. Findings are: The following was observed during a facility environmental tour on 05/14/2025 from 2:00 PM till 2:44 PM with the Facility Administrator (FA). -room [ROOM NUMBER] square hole in ceiling exposing under layment, warped rippling paint on the wall near the hole in the ceiling and above the window in the room, yellow brown staining around the hole in the ceiling, gray black fuzzy material along the wall to ceiling trim in this area, ceiling material cracked and protruding down. Gray black fuzzy material on the inside white portion of the curtain hanging in the room over the window. Outside of room above the window a large hole in the roof soffit. -room [ROOM NUMBER] paint on wall is pealing and warped, yellow brown staining to ceiling, trim loose and some missing. Wheelchairs in disrepair, mattresses, and boxes both opened and closed filled room [ROOM NUMBER]. -Hallway ceiling connecting B Wing to C Wing outside of room [ROOM NUMBER] yellow brown stains with edging coming loose and loose pealing wallpaper exposing the white flakey dry wall beneath. -Resident #1 resides in room [ROOM NUMBER] which is the room adjacent to room [ROOM NUMBER]. Resident #15 resides in room [ROOM NUMBER] which is across the hall from room [ROOM NUMBER] and on the opposite side of the hallway connecting B Wing to C Wing. Resident #6 residents in room [ROOM NUMBER] which is adjacent to room [ROOM NUMBER]. In an interview on 05/14/2024 at 2:35 PM with the Facility Administrator (FA), the FA stated that the facility had experienced a water leak due to holes in the roof and water damage from this leak was present in room [ROOM NUMBER], room [ROOM NUMBER], and the hallway connecting B Wing to C Wing. FA was unsure of when the damage had occurred and stated the roof had been repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In and interview on 05/14/2024 at 3:20 PM with the facility Regional Director of Operations (RDO), the RDO confirmed repair of the roof. RDO stated that the water damage had occurred in November of 2023.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 12-006.09C(2) Licensure Reference Number 175NAC 12-006.09C(5) Licensure Reference Number 175NAC 12-006.09C2 Based on observation, record review, and interview the facility failed to ensure the comprehensive care plan (a written plan detailing how staff are to meet the resident's needs) included interventions to meet resident needs related to urinary elimination for 1 resident (Resident 39 and failed to include a discharge plan for 1 resident (Resident 1) of 12 total sampled residents. The facility census was 37. Findings are: A. Record review of the facility policy titled Comprehensive Care Plans dated 8/1/23 revealed that it is the facility policy to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment (a required resident assessment tool used for care planning that details how to provide quality care for a resident). The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment (Minimum Data Set-the mandatory comprehensive assessment tool used for care planning). The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Record review of the Admission Record dated 5/14/24 for Resident 39 revealed that Resident 39 admitted into the facility on [DATE]. Diagnoses included neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), quadriplegia (paralysis that affects all a person's limbs and body from the neck down), and pneumonia. Record review of the Order Summary Report (a list of all physician orders for a resident) for Resident 39 dated 5/14/24 revealed that Resident 39 had a Foley catheter (an indwelling urinary catheter-a tube placed in the body to drain and collect urine from the bladder) with order to change the catheter and urinary collection bag as needed. The order date for the Foley catheter was 4/18/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/09/24 at 9:39 AM in the room of Resident 39 revealed that Resident 39 sat in the recliner with the footrest up. A urinary collection bag (a bag designed to collect urine drained from the bladder through a urinary catheter) hung from the trash can with the bottom resting on the floor. The urinary catheter tubing was secured to the left leg of Resident 39. The urinary collection bag contained moderate dark yellow urine. Observation on 5/14/24 at 1:22 PM in the room of Resident 39 revealed the resident seated in the recliner with the feet down. The urinary collection bag hung from the trash can with the bottom of the collection bag resting on the floor. The urinary catheter tubing contained moderate dark yellow urine. The urinary catheter tubing was secured to the left thigh of Resident 39. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 39 dated 4/22/24 revealed that Resident 39 had an indwelling catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine to a urinary collection bag). Record review of the Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for Resident 39 dated 5/8/24 revealed that it did not contain documentation of the indwelling urinary catheter and did not contain any interventions for staff to care for the indwelling urinary catheter. Interview on 5/14/24 at 8:32 AM with Nurse Aide-D (NA-D) revealed that NA-D looks at the resident care plan to know what care is needed by the resident. Interview on 5/14/24 at 2:34 PM with the Regional Nurse Consultant (RNC) confirmed that Resident 39 has an indwelling urinary catheter. The RNC confirmed that the resident indwelling urinary catheter should be included and interventions addressed on the resident care plan. 49382 B. Review of a facility policy titled 'Discharge Planning Process dated 08/01/2023 revealed: -#2 the facility will determine the residents' expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle and as needed. -#3 If discharge to the community is determined not to be feasible, the facility will document in the clinical record who made the determination and why. -#4 In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care. Discuss with the resident and document the implications and or risks of being discharged to a location that is not equipped to meet their needs and attempt to ascertain why the resident is choosing that location. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. Document refusals of other options that could meet the resident's needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-#7 The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. -#11 the evaluation of the resident's discharge needs, and discharge plan will be completely documented on a timely basis in the clinical record. A review of an Admission Record dated 6/7/2023 indicated the facility admitted Resident #1 on 09/22/2021 with diagnoses of Personality Disorder, which is a mental health condition that involves long term patterns of thoughts and behaviors that are different from what is considered normal, Bipolar Disorder which is a mental health disorder that causes unusual shifts in a person's mood, energy, activity and concentration levels, and Major Depressive Disorder, which is a mental health disorder characterized by persistently depressed mood that causes a significant impairment to daily life. The Quarterly MDS (MDS), which is a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, with an Assessment Reference Date (ARD) of 04/13/2024 revealed Resident #1 had a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact and was understood and always understood others. The resident was documented as being independent with bed mobility transfers eating and toileting. The documentation stated the resident only wished to be asked about discharge on comprehensive assessments. The comprehensive annual assessment dated [DATE] revealed the resident denied wanting to talk to someone about the possibility of leaving the facility and return to live and receive services in the community. Review of Resident #1's Care Plan, which is a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident, with the print date of 05/08/2024 revealed a focus of the resident requires 24-Hour care and assistance with activities of daily living, meals, activities, ect. Long Term Care is planned per resident and friend. With a revision date of 02/01/2024. A focus of resident has limitation in ability to perform activities of daily living with a revision date of 09/18/2023. Interventions of bed mobility independent, dressing independent, transfers independent, toilet use independent, and eating independent. All with revision dated of 08/23/2023. In an interview completed on 05/08/24 at 10:21 AM Resident #1 stated that their wish is to discharge from facility. Resident stated had contacted an Assisted Living facility and they were going to come and evaluate the resident but the facility contacted the Assisted Living and told them things about the resident so the Assisted Living would not accept the resident. A review of Resident #1's Progress Notes revealed on 08/10/2023 a care plan meeting was held with the Ombudsman in attendance. The documentation revealed that Resident #1 wants to live independently. In an interview on 05/14/2024 at 2:20 PM with the facility Director of Nursing (DON), the DON confirmed no documentation in Resident #1's medical record or care plan reflecting the residents expressed discharge goal, barriers to the goal, or interventions by the facility to assist resident in meeting their discharge goal. In an interview on 05/14/2023 at 2:30 PM with the facility Regional Nurse Consultant (RNC), the RNC confirmed that the residents wish to discharge from the facility expressed in the care plan meeting held on 08/10/2023 was not addressed further by the facility after the meeting was held.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 12-006.09C1c Based on record review and interview the facility failed to ensure care plan meetings were completed to allow residents/resident representatives to participate in development and revision of the resident's plan of care (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for 5 of 12 sampled residents (Residents 11, 18, 14, 1, and 25). The facility census was 37. Findings are: A. Record review of the facility policy titled Care Planning-Resident Participation dated 8/1/24 revealed the facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. The facility will honor the resident's choice in individuals to be included in the care planning process. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care. The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. Record review of the Admission Record for Resident 11 dated 5/14/24 revealed that Resident 11 admitted into the facility on [DATE]. Diagnoses included stroke, hemiplegia (paralysis) of the left side, and dementia. Resident 11 has a child listed as their personal representative. Record review of the care plan invite for Resident 11 dated 7/18/23 revealed that a care plan meeting was scheduled for 8/17/23. The invite was marked that the resident/resident representative wished to attend the care plan meeting. Record review of the progress notes for Resident 11 from 8/1/23 through 5/14/24 revealed no documentation of any care plan meetings occurring during the timeframe (a period of over 9 months with no care plan meeting). Record review of the electronic health record for Resident 11 revealed no documentation of any care plan meetings for Resident 11 between 8/1/23 and 5/14/24. Interview on 5/14/24 at 1:05 PM with the Facility Administrator (FA) confirmed that the expectation is for resident care plan meetings to occur quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/14/24 at 1:30 PM with the Facility Administrator (FA) confirmed that the facility had no documentation of any resident care plan meetings conducted from 8/1/23 through 5/14/24. B. Record review of the Admission Record for Resident 18 dated 5/14/24 revealed that Resident 18 admitted into the facility on [DATE]. Diagnoses included major depression, monoplegia (paralysis) of right lower limb, and sleep apnea. Record review of the undated care plan invite for Resident 18 revealed that a care plan meeting was scheduled for 9/7/23. Record review of the progress notes for Resident 18 from 8/1/23 through 5/14/24 revealed no documentation of any care plan meetings occurring during the timeframe (a period of over 9 months with no care plan meeting). Record review of the electronic health record for Resident 18 revealed no documentation of any care plan meetings for Resident 18 between 8/1/23 and 5/14/24. Interview on 5/14/24 at 12:22 PM with Resident 18 revealed that the resident had not been invited to a care plan meeting in over 6 months and Residnet 18 could not remember when a care plan meeting had last occurred. Interview on 5/14/24 at 1:30 PM with the Facility Administrator (FA) confirmed that the facility had no documentation of any resident care plan meetings conducted from 8/1/23 through 5/14/24. C. Record review of the Admission Record for Resident 14 dated 5/14/24 revealed that Resident 14 admitted into the facility on [DATE]. Diagnoses included muscle weakness, altered mental status, and metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). Record review of the progress notes for Resident 14 from 12/31/23 through 5/14/24 revealed no documentation of any care plan meetings occurring during the timeframe (a period of over 4 1/2 months with no care plan meeting). Record review of the electronic health record for Resident 14 revealed no documentation of any care plan meetings for Resident 14 between 12/31/23 and 5/14/24. Interview on 5/8/24 at 11:34 AM with the spouse of Resident 14 revealed that the facility had not provided any care plan meetings for Resident 14 since the resident admitted into the facility. Interview on 5/14/24 at 1:30 PM with the Facility Administrator (FA) confirmed that the facility had no documentation of any resident care plan meetings conducted from 12/31/23 through 5/14/24. 49382 D. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an Admission Record dated 6/7/23 indicated the facility admitted Resident #1 on 09/22/2021 with diagnoses of Personality Disorder, which is a mental health condition that involves long term patterns of thoughts and behaviors that are different from what is considered normal, Bipolar Disorder which is a mental health disorder that causes unusual shifts in a person's mood, energy, activity and concentration levels, and Major Depressive Disorder, which is a mental health disorder characterized by persistently depressed mood that causes a significant impairment to daily life. In an interview on 05/08/2024 at 10:50 AM with Resident #1, Resident #1 stated the last care plan meeting that the resident was invited to or notified of was months ago when the Ombudsman attended. In a record review of Resident #1 Progress Notes revealed on 08/10/2023 a care plan meeting was held that the Resident #1 chose not to attend. From 08/11/2023 through 05/14/2024 there was no further documentation of a care plan meeting being held for Resident #1. In a record review of the electronic health record for Resident #1 revealed no documentation of any care plan meetings for Resident #1 between 08/11/2023 and 05/14/2024 which is greater than 9 months with no care plan meeting. Interview on 05/14/2024 at 1:30 PM with the Facility Administrator (FA) confirmed that the facility had no documentation of any resident care plan meetings conducted from 08/01/2023 through 05/14/2024. E. Review of an Admission Record dated 5/14/24 revealed the facility admitted Resident #25 on 11/22/2022 with diagnoses of depressive disorder, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily activities, and anxiety disorder, a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities. In an interview on 05/08/2024 at 9:10 with Resident #25, Resident #25 stated they used to receive a piece of paper letting them know when their care plan meeting was held but had not received one in a long time. Could not remember when had last been invited or attended a care plan meeting. Record review of the care plan invite for Resident #25 dated 08/29/2023 revealed that a care plan meeting was scheduled for 09/21/2023. The invite was left blank not indicating residents wishes to attend or not attend the meeting. In a record review of Resident #25 Progress Notes revealed no progress notes reflecting a care plan meeting was held from 09/21/2023 through 05/14/2024. In a record review of the electronic health record for Resident #25 revealed no documentation of any care plan meetings for Resident #25 from 09/21/2023 through 05/14/2024, which is greater than 8 months with no care plan meeting. Interview on 05/14/2024 at 1:30 PM with the Facility Administrator (FA) confirmed that the facility had no documentation of any resident care plan meetings conducted from 09/21/2023 through 05/14/2024.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49382 Licensure Reference Number 175NAC 12-006.09D3(5) Based on record review, and interview the facility failed to ensure routine bowel movements for 1, (Resident #19) of 4 sampled residents. The facility census was 37. Findings are: Review of a facility document labeled Constipation Prevention dated 08/01/2023 revealed an as needed laxative, which is a medication administered to promote bowel movements, will be offered during the third day without a bowel movement. A suppository will be offered the morning of the fourth day without a bowel movement. If a resident does not have a bowel movement after an as needed laxative and a suppository is provided, and assessment of the abdomen, bowel sounds, pain and appetite will be completed. The primary physician will be notified. A review of an Admission Record dated 5/14/24 indicated the facility admitted Resident #19 on 04/20/2024 with diagnoses of Schizophrenia which is severe mental health disorder that can result in hallucinations, delusions, and extremely disorder thinking and behavior that interfere with daily life, compression fracture of the vertebra which is a break in the small bones in the back, chronic kidney disease which is when the kidneys are damaged and cannot filter blood as well as they should, and type two diabetes which is when the body cannot regulate the amount of sugar that is in the blood stream. The Admission MDS (MDS), which is a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, with an Assessment Reference Date (ARD) of 04/24/2024 revealed that Resident #19 had a Brief Interview for Mental Status (BIMS) score of 3, which indicates the resident is cognitively severely impaired, and was usually understood and usually understood others. Staff provided supervision or touching assistance with bed mobility toilet use, and transfers, the resident was independent with eating. The resident was occasionally incontinent of bladder and always continent of bowel and constipation was not present. Review of Resident #19 Care Plan, which is a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident revealed no focus, goal, or intervention related to resident's bowel status. Review of a facility supplied document labeled Task Bowel Movements dated 05/09/2024 revealed Resident #19 did not have a documented bowel movement from 04/20/2024 to 04/24/2024 and 04/29/2024 to 05/05/2024. Review of Resident #19 Medication Administration Record (MAR) revealed no as needed administration of laxative 04/20/2024 to 04/24/2024 and 04/29/2024 to 05/05/2024. Review of Resident #19 Physician Orders revealed no orders for an as needed laxative. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 10:50 AM with Registered Nurse C (RN-C), RN-C reported the Director of Nursing (DON) or Infection Prevention (IP) nurse would give the list of individuals needing to have a bowel movement to the medication aides passing medications to provide and intervention to those residents. In an interview on 05/13/2024 with Medication Aide K (MA-K), MA-K Reported they would get the list from the DON or the IP nurse about residents who had not had a bowel movement. MA-K reported they would follow the hand written directions on the paper on what to do for that resident whether to give them something as needed for a bowel movement or just ask the resident if had a bowel movement and chart their response. In an interview on 05/13/2024 at 1:50 PM the IP nurse it was confirmed that Resident #19 did not have a bowel movement, intervention, and or documentation of assessment of abdomen addressing constipation from 04/20/2024 to 04/24/2024 and 04/29/2024 to 05/05/2024. In an interview on 05/13/2024 at 2:00 PM the DON confirmed that Resident #19 did not have any orders for as needed laxative to relieve constipation. DON confirmed Resident #19 did not have a bowel movement, intervention, and or documentation of assessment of abdomen addressing constipation from 04/20/2024 to 04/24/2024 and 04/29/2024 to 05/05/2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC 12-006.09D Based on record review and interviews; the facility staff failed to manage complaints of pain for 1 (Resident 192) of 2 sampled residents. The facility staff identified a census of 37. Findings are: Record review of the Admission Record dated 5/14/24 for Resident 192 revealed that Resident 192 admitted into the facility on [DATE] with a diagnosis of the following: -Closed left subtrochanteric femur fracture (break in thigh bone) -Pelvic fracture (to the hip bones, sacrum, or coccyx) -Diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired) -Obesity (abnormal or excessive fat accumulation that presents a risk to health) -Hyperlipidemia (abnormally high concentration of fats in the blood) -Hypertension (pressure in the blood vessels are too high) -COPD (condition involving constriction of the airways in breathing) -Chief Complaint: PAIN Record review of Resident 192's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 05/07/2024 revealed the facility assessed Resident 192's Brief Interview of Mental Status (BIMS) as a 12. According to the MDS Manual a score of 08 to 12 suggests the Resident is moderately impaired. Further review of Resident 192's MDS dated [DATE] revealed the following information about Resident 192: -independent for toilet/oral hygiene -set up assistance needed for dressing upper and lower body -partial assistance for bathing -pain assessment interview revealed frequent pain was experienced, affected sleep frequently, occasionally interfered with therapy activities and interfered with day-to-day activities frequently. -on a scale of 0-10, Resident 192's pain was identified as a 6. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of information titled Learning About the 0 to10 Pain Scale found at www.KaiserPermanente.org revealed the following information: -0 = No pain. -1 = Pain is very mild, barely noticeable. Most of the time you don't think about it. -2 = Minor pain. It's annoying. You may have sharp pain now and then. -3 = Noticeable pain. It may distract you, but you can get used to it. -4 = Moderate pain. If you are involved in an activity, you're able to ignore the pain for a while, but it is still distracting. -5 = Moderately strong pain. You can't ignore it for more than a few minutes, however, with effort you can still work or do some social activities. -6 = Moderately stronger pain. You avoid some of your normal daily activities and you have trouble concentrating. -7 = Strong pain. It keeps you from doing normal activities. -8 = Very strong pain. It's hard to do anything at all. -9 = Pain that is very hard to bear. You can't carry on a conversation. -10 = Worst pain possible. Record review of Resident 192's baseline care plan (BCP) (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) dated 05/04/2024 and revised on 05/08/2024 revealed Resident 192 was on a pain management regimen and takes analgesics routinely. The goal set to manage pain listed on the BCP stated the resident will be free of adverse effects from analgesics and with pain below the Resident's acceptable level. Interventions identified on Resident 192's BCP reveled the following: -administer medications as ordered. Monitor for side effects and effectiveness. -attempt non-pharmacological pain interventions when not contraindicated: massage, repositioning, peaceful environment, aroma therapy, music etc . -report any adverse effects to the practitioner/physician. -report to the physician if the pain management regimen is not effective. Record review of Resident 192's admission assessment-pain evaluation completed on 05/04/2024 at 4:45 AM revealed the following information: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-complaints of pain were identified, -on a scale of 0-10, Resident 192's pain was identified as a 10 -non-verbal indicators of pain revealed positive for grimacing, restlessness, crying/distress, and tense posture On 05/08/2024 at 11:04 AM an interview was conducted with Resident 192. During the interview Resident 192 revealed that they were admitted for a fractured femur, and revealed there was no pain medication available until the following day. Resident stated they reported to the nurse they were in excruciating pain and became tearful when speaking about the pain. During an interview on 05/09/2024 at 11:30 AM RN-C (Registered Nurse-C) stated when a resident is admitted , the nurse will fax the list of medications to the pharmacy before 4:45 PM for a same-day delivery. During the interview, RN-C stated if the medications do not arrive, they would contact the physician and a backup pharmacy is used. On 05/09/2024 at 11:41 AM Staffing Manager (SM) revealed that there is an emergency drug box at the facility with medications available if necessary, including narcotics medications. A record review of the undated emergency drug box list of contents revealed a list of pain management medications. A record review of Resident 192's medication administration record (MAR) for the month of May revealed the following orders for pain management: - Acetaminophen Oral Tablet 325 milligram (mg) (Acetaminophen) Give 2 tabs orally every 4 hours as needed for PAIN. Further review of Resident 192's MAR for May 2024 revealed the following: -No doses were documented as administered on 05/03/2024 -First doseof Acetaminiophen was provided on 05/04/2024 at 1:37 AM with a pain level rating 9. - Oxycodone Tablet 5 mg Give 1 tablet orally every 6 hours as needed for PAIN -No doses were documented as administered on 05/03/2024 -First dose of oxycodone was provided on 05/04/2024 at 7:26 AM with a pain level rating 8. - Document Non-Pharmacological Pain Management Intervention: 1= Deep Relaxation, 2= Heat to the site, 3= Cold/Ice to the site, 4= Massage, 5=Meditation, 6=Music, 7=Going to bed, 8=Quiet Place, 9=Repositioning, 10= Aromatherapy, 11= Guided imagery 12= Other/See progress Note, as needed for Pain Document Non-Pharmacological Pain Management Intervention -No Non-Pharmacological Pain Management Interventions were documented as administered for the month of May. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a policy dated 08/01/2023 with a revision on 11/28/2023 titled Pain Management revealed: The facility must ensure that pain management is provided to resident who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The policy explanation and compliance guidelines state the facility will utilize a systemic approach for recognition, assessment, treatment and monitoring of pain. Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior, or mental status, new pain or an exacerbation of pain). c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: a. Facial expressions (e.g. grimacing, frowning, fright, or clenching of jaw) b. Behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical activities. c. Negative vocalizations (e.g. groaning, crying, whimpering, or screaming) 3. Pain management and treatment: a. Factors influencing the choice of treatments include: i. The resident current medications ii. Available treatment options A record review of the admission agreement dated 05/03/2024 revealed that pharmacy services are available throughout the facility. If the resident chooses another pharmacy, it must be a pharmacy that will provide services in accordance with 24-hour service and delivery. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/09/2024 at 2:45 PM with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) revealed the facility's expectation to receive medications. The DON stated the admission nurse is to fax the medication list to the pharmacy prior to 4:30 PM. The DON stated that if the admission is later than expected, the facility will ensure the resident comes with necessary medications until the pharmacy can fulfill the request. If in the event medications are not brought with the resident, the emergency medication kit is available for medication administration when medications are needed. The DON confirmed that medications to control pain should be provided to those who are prescribed and in need.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 49382 Licensure Reference Number 175NAC 12-006.10D Based on observation, record review, and interview the facility failed to ensure 4 (Residents #19, #11, #193, and #21) of 13 residents were free of significant medication errors for. The facility census was 37. Findings are: A. Review of a facility policy titled, Insulin, which is a medication administered by injection to help regulate blood sugar levels, Pen, dated 08/01/2024 revealed item #6, Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. Item #11 section H titled Prime the insulin pen: dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Section I set the insulin dose. Review of a document labeled Instructions for Use dated 07/2023 revealed, step #6 to prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up tap the cartridge holder gently to collect air bubbles at the top, continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. In an observation of medication administration on 05/13/2024 at 11:40 AM with Registered Nurse (RN-C) revealed RN-C obtained Resident #21 insulin pen from the drawer in the medication cart. RN-C cleansed the tip of the pen with an alcohol wipe and attached the needle to the top of the insulin pen. RN-C reported RN-C would be administering Resident #21 22 units of insulin. RN-C reported the resident was to receive 20 units per physician orders and would add 2 units for priming the insulin pen. RN-C knocked on Resident #21 door and entered the room. With gloved hands RN-C grasped a portion of Resident #21's lower right abdomen and placed the needled tip of the insulin pen to the exposed skin. RN-C pressed down on the plunger portion of the insulin pen and counted to 5. RN-C then pulled back the insulin pen from the resident's abdomen and returned to the medication cart. In an interview with RN-C on 05/13/2024 at 11:55 AM, RN-C reported adding 2 units of insulin to the perscribed dose was how they were trained/instructed to prime an insulin pen. RN-C report they did not recall the date of last competency by the facility where these instructions for priming an insulin pen were provided. In an interview with the Director of Nursing (DON), on 05/13/2024 at 4:00 PM the DON confirmed that RN-C did not prime the insulin pen correctly. The DON confirmed the last competency was completed with RN-C on 11-01-2022 on blood glucose monitoring not insulin administration. B. Review of a facility policy titled, Insulin Pen, dated 08/01/2024 revealed: -Insulin pens must be clearly labeled with the resident mane, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If the label is missing, the pen will not be used a new pen must be ordered. -Stored unopened insulin pens in a refrigerator. Review of a document labeled Lantus learn how to inject insulin dated 2003 revealed tostore unused Lantus in the refrigerator. Review of a document labeled Levemir prescribing information dated 12/2022 revealed to store unused Levemir in the refrigerator. In an observation completed on 05/13/2024 from 11:55 AM to 12:42 PM the following was observed: -Resident #19 had two opened insulin pens manufacturer labeled Levemir FlexPen. Both pens had facility labels also present. One label had the Open Date of 05/02/2024 written on it. The other pen did not have an open date written on it and was being stored in the medication cart and not under refrigeration. The instructions for administration on the facility label were missing the first portion or each line making the instructions illegible on both pens. -Resident #19 also had a pen with the manufacturer label Insulin Lispro Injection KwikPen. The instructions for administration on the facility label were missing the first portion or each line making the instructions illegible. The pen was being stored in the medication cart and not under refrigeration. -Resident #11 had one opened insulin pen in the medication cart with the manufacture label Tresiba FlexTouch. On the manufacture label was visible smeared black writing illegible. The pen did not have a facility label present. The pen was not labeled with the resident's name, prescribing physician's name, medication name, prescribed dose, strength, and quantity of the medication, expiration date, and appropriate instructions and precautions. The pen was being stored in the medication cart and not under refrigeration. -Resident #11 had one opened insulin pen in the medication cart with the manufacture label Insulin Aspart FlexPen. On the manufacture label was visible smeared black writing illegible. The pen had a facility label present. The label did not have the prescribing physician's name, medication name, prescribed dose, strength, and quantity of the medication, expiration date, and appropriate instructions and precautions. The residents first name only was handwritten in black on the label. The pen was being stored in the medication cart and not under refrigeration. -Resident # 193 hand one insulin pen with the manufacture label Insulin Aspart FlexPen with the open date handwritten as 05/12/2024. The instructions for administration on the facility label were missing the first portion or each line making the instructions illegible. The pen was being stored in the medication cart and not under refrigeration. -Resident #21 had two insulin pens with the manufactured label Lantus SoloStar. One had the open date of 05/07/2024 handwritten on the facility label. The other pen did not have an open date on the label. The instructions for administration on the facility label were missing the first portion or each line making the instructions illegible on both pens. Both pens were being stored in the medication cart and not under refrigeration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #21 had two insulin pens with the manufactured label Insulin Lispro Injection KwikPen. One had the open date of 05/12/2024 handwritten on the facility label. The other pen did not have an open date on the label. The instructions for administration on the facility label were missing the first portion or each line making the instructions illegible on both pens. Both pens were being stored in the medication cart and not under refrigeration. In an interview with the Director of Nursing (DON), on 05/13/2024 at 4:00 PM the DON confirmed that all of the pens were not labeled and stored per facility and manufacturer recommendations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 12-006.17B Licensure Reference Number 175NAC 12-006.17C Licensure Reference Number 175NAC 12-006.17D Licensure Reference Number 175NAC 12-006.04A2a Based on observation, interview, and record review the facility failed to ensure that staff followed requirements for wearing and discarding of Personal Protective Equipment (PPE) (specialized equipment worn by an employee for protection against infectious disease) in resident rooms for residents with Covid-19 infection and for residents requiring Enhanced Barrier Precautions (use of PPE to reduce transmission of multi-drug resistant germs that employs targeted gown and glove use during contact with a resident) to prevent the potential for Covid-19 and cross contamination. This had the potential to affect all facility residents; The facility failed to ensure a pre-employment health history screening was completed and reviewed to prevent the potential for transmissible disease for 5 of 5 sampled facility staff which had the potential to affect all facility residents. The facility failed to ensure that staff performed hand sanitization (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) between resident rooms during laundry delivery to prevent the potential for cross-contamination. This affected 6 residents (Residents 5, 8, 10, 39, 35, and 30); The facility failed to ensure that staff performed hand sanitization during urinary catheter care (urinary catheter is a tube placed in the body to drain and collect urine from the bladder) and failed to maintain catheter care equipment to prevent the potential for cross contamination for 1 resident (Resident 39). The facility census was 37. Findings are: A. Record review of the facility policy titled Covid-19 Prevention, Response, and Reporting dated 4/1/24 revealed that the facility will ensure that appropriate interventions are implemented to prevent the spread of Covid-19 and promptly respond to any suspected or confirmed Covid-19 infections. The facility will establish a process to identify and manage individuals with suspected or confirmed Covid-19 infection to include ensuring that everyone is aware of the recommended infection prevention control practices (IPC) by posting visual alerts (signs, posters) at the entrance and in strategic places to include instructions about current IPC recommendations. The section IPC practices when caring for residents with suspected or confirmed Covid-19 infection revealed that health care workers who enter the room of a resident with suspected or confirmed Covid-19 should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher (N95 face mask), gown, gloves, and eye protections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled Transmission-Based (Isolation) Precautions (additional infection control measures including wearing face masks and goggles/face shields to prevent the spread of infections) dated 4/1/24 revealed that it is the facility policy to take appropriate precautions to prevent transmission of pathogens (disease causing germs), based on the pathogens' modes of transmission. The facility will have PPE readily available near the entrance of the resident's room and will put on appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. Observation on 5/8/24 at 8:41 AM outside the room door of Resident 93 revealed signage signifying the room is a Red Zone (designation of a resident room as an isolation zone when a resident in the room is suspected or confirmed to have Covid-19). The sign titled Red Zone revealed the required PPE for room entry to consist of gown, N95 mask, face shield, and gloves. Door closed at all times. Record review of the facility Covid-19 Evaluation for Resident 93 dated 5/1/24 revealed that Resident 93 tested positive for Covid-19. Observation on 5/8/24 at 12:34 PM outside of the room of Resident 93 (a resident positive for Covid-19) revealed that Nurse Aide-D (NA-D) wore a surgical face mask. NA-D placed an N95 face mask over the surgical mask and carried a meal tray into the room of Resident 93. (NA-D did not put on the gown, gloves, and face shield required for entry into the room of Resident 93). NA-D exited the room with the plate cover and set it on the top shelf of the 3-shelf cart. NA-D performed hand sanitization using alcohol-based hand sanitizer and removed and discarded the N95 mask. NA-D pushed the 3-shelf cart down the hall stopping at the room of Resident 7. NA-D carried a room tray into the room and placed it on the over bed table for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 5/09/24 at 10:59 AM at the facility C-D nurse's station revealed that Nurse Aide-D (NA-D) and Nurse Aide-E (NA-E) approached the room door of Resident 93. NA-D stated to NA-E are you ready to do this?. A sign outside the room door of Resident 93 revealed Red Zone. NA-D did not perform hand sanitization. NA-D put on gloves, then an N95 face mask, and then a gown. NA-E did not perform hand sanitization. NA-D did not put on a face shield for eye protection. NA-E put on a gown, then an N95 face mask, and then gloves. NA-E did not put on a face shield for eye protection. NA-E knocked on the door and NA-E and NA-D entered the room. NA-D spoke to Resident 93 and the resident mumbled and stated yes. NA-D told Resident 93 they will change the resident's brief. NA-D removed the brief and discarded it. NA-D removed the gloves. NA-D did not perform hand sanitization or put on new gloves. NA-D placed a new brief under the resident. NA-D and NA-E continued to speak to the resident. NA-D would lean towards the face of Resident 93 when speaking to the resident. NA-D's face was within 12 inches of the face of Resident 93. Resident 93 would answer yes. Resident 93 moaned with repositioning side to side to properly place the new brief. NA-E told Resident 93 pants would be put on. NA-E slipped the resident feet through the pant legs. NA-D and NA-E sat Resident 93 up on the edge of bed. The faces of NA-D and NA-E were within 2 feet of Resident 93's face while assisting the resident. NA-D and NA-E placed a new T-shirt and button up shirt on Resident 93. NA-D and NA-E asked Resident 93 if the resident would like to go to the recliner. Resident 93 responded yes. NA-E applied a gait belt (a belt device placed around a resident's abdominal area used to aid in the safe movement of a resident with mobility problems) to Resident 93. NA-E and NA-E stood resident at the side of the bed and pulled up the resident's pants. NA-D told Resident 93 they would walk to the recliner. Resident 93 was unable to take a step so NA-D and NA-E sat Resident 93 back on the edge of the bed. NA-E placed a wheelchair near Resident 93. NA-D and NA-E stood and pivoted Resident 93 into the wheelchair. NA-D leaned in towards Resident 93's face and asked Resident 93 if the resident wanted to stay in the wheelchair or go to the recliner. Resident 93 stated recliner. NA-E transferred Resident 93 in the wheelchair to the front of the recliner. NA-E and NA-D instructed Resident 93 to stand as they assisted Resident 93 to stand using the gait belt. Resident 93 pivoted into the recliner with maximum assist of NA-D and NA-E. NA-D combed the resident's hair. NA-D picked up the breakfast meal tray from the over bed table. NA-D exited the resident room with the breakfast meal tray and NA-E exited the room carrying the trash bag. Interview on 5/9/24 at 1:53 PM with Nurse Aide-D (NA-D) revealed that NA-D had received training on transmission-based precautions and wearing PPE. NA-D confirmed that staff are to wear all PPE into the Covid-19 positive resident room. NA-D revealed the PPE includes gloves, gown, and N95 face mask. NA-D was asked by this surveyor if staff are required to wear a face shield for eye protection in the room of a Covid-19 positive resident. NA-D revealed they have face shields available, but they are not required to be worn. Interview on 5/9/24 at 1:58 PM with Nurse Aide-E (NA-E) revealed that NA-E has worked in the facility about a month and that NA-E received training from the facility on transmission-based precautions and PPE. NA-E revealed that PPE use was reviewed again after Covid-19 positive residents were found in the building. NA-E revealed PPE required to be worn in a Covid-19 positive resident room for entry is gown, gloves, mask, and face shield. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/9/24 at 3:08 PM with the facility Infection Preventionist (IP) confirmed that the facility currently has 2 residents positive for Covid-19. The IP confirmed that the rooms of those 2 residents are a red zone for isolation. The IP revealed that the IP posted signage outside the rooms of the 2 isolation residents to alert staff of the required PPE to be worn for room entry. The IP confirmed that staff were told PPE is not optional and that they have to put it on especially for Covid-19 isolation rooms. The IP confirmed the expectation for PPE worn in isolation rooms is for a gown, N95 face mask, face shield, and gloves. B. Record review of the facility policy titled Enhanced Barrier Precautions dated 2024 revealed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (disease causing germs that are not killed by antibiotics). An order for enhanced barrier precautions will be obtained for residents with indwelling medical devices including urinary catheters (a tube placed in the body to drain and collect urine from the bladder). The facility will make gowns and gloves available immediately near or outside of the resident's room. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. High contact resident care activities include transferring the resident. Enhanced barrier precautions should be followed outside the resident's room when performing transfers. Record review of the Admission Record for Resident 21 dated 5/14/24 revealed that Resident 21 admitted into the facility on [DATE]. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 21 dated 3/2/24 revealed that Resident 21 has an indwelling urinary catheter. Observation on 5/8/24 at 3:25 PM outside the room of Resident 21 revealed that signage was posted documenting Stop. Enhanced Barrier Precautions. The sign titled Enhanced Barrier Precautions revealed the directions that staff are required to gloves and a gown for high contact resident care including resident hygiene and transfers. Observation on 5/8/24 at 3:25 PM revealed that Nurse Aide-H (NA-H) pushed the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) into the room of Resident 21 (a resident on Enhanced Barrier Precautions). NA-H wore only a surgical face mask. The face mask was positioned under the chin of NA-H and did not cover the mouth or nose of NA-H. NA-H did not wear a gown as required. Observation on 5/8/24 at 3:38 PM revealed that NA-H exited the room of Resident 21 with the mechanical body lift. Observation on 5/9/24 at 2:40 PM outside the room of Resident 21 revealed that NA-H and NA-L entered the room of Resident 21. NA-H and NA-L each wore only a surgical face mask. NA-L exited the room [ROOM NUMBER] minutes later. NA-L went down the hall and got a mechanical total body lift and brought it to the room of Resident 21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 5/9/24 at 2:42 PM revealed that NA-L performed hand sanitization and put on a gown and gloves. NA-H exited the room of Resident 21 and put on a gown and then gloves. NA-L pushed the mechanical total body lift into the room. NA-H got a wheelchair and pushed it to the doorway of Resident 21's room. NA-L backed the mechanical total body lift out of the room so that NA-H could take the wheelchair into the room. NA-H pushed the wheelchair into the room of Resident 21. NA-L then returned the mechanical total body lift into the room of Resident 21 and closed the room door. Observation on 5/9/24 at 2:54 PM outside the room of Resident 21 revealed that NA-H exited the room of Resident 21 holding a used light blue gown against their uniform. NA-H carried the soiled gown past rooms 16, 17, 18, 19, 20, 21, 22, 23, and 24. NA-H discarded the soiled gown into the trash container located in the hallway near room [ROOM NUMBER]. NA-H had not discarded the gown before exiting the room of Resident 21 as required. Interview on 5/9/24 at 2:55 PM with NA-H revealed that NA-H had been trained on use of PPE and how to keep staff and residents safe from Covid and other diseases. NA-H revealed that the training included demonstrating proper putting on and taking off of PPE. Interview on 5/14/24 at 10:35 AM with the facility Infection Preventionist (IP) confirmed that Resident 21 is on Enhanced Barrier Precautions due to Resident 21 having an indwelling urinary catheter. The IP confirmed that staff are required to wear a gown and gloves if they are going to touch the resident including during transfers, bathing, and other hygiene. The IP confirmed that there should be a trash can in the room of Resident 21 for discarding the gown and gloves before exiting the room. The IP confirmed that a soiled gown should be discarded in the resident's room and not carried down the hall past other resident rooms. C. Record review of the undated document titled Staff Medical File List revealed the first document on the list was the Health Questionnaire. Interview on 5/13/24 at 1:30 PM with the facility Human Resources (HR) revealed that the Staff Medical File List is a checklist for required items needed for the employee health file. Record review of the undated facility employee list revealed that Nurse Aide-E (NA-E) had a start date of 11/9/23. Record review of the employee health file for Nurse Aide-E (NA-E) revealed that it contained a Staff Medical File List. The Health Questionnaire in the file revealed that it was signed by NA-E on 11/9/23. The section titled Test Information (performed by nurse) contained blank lines for recording blood pressure, temperature, pulse, respiration, and lung sounds. The section had not been completed. The signature line and date for the Director of Nursing (DON) review was blank. There was no documentation that the Health Questionnaire was reviewed for potential transmissible disease. Record review of the undated facility employee list revealed that Nurse Aide-D (NA-D) had a start date of 11/1/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the employee health file for Nurse Aide-D (NA-D) revealed that it contained a Staff Medical File List. The Health Questionnaire in the file revealed that it was not dated, and the employee signature and date was blank. The section titled Test Information (performed by nurse). contained blank lines for recording blood pressure, temperature, pulse, respiration, and lung sounds. The section had not been completed. The signature line and date for the Director of Nursing review was blank. Record review of the undated facility employee list revealed that Nurse Aide-H (NA-H) had a start date of 4/8/24. Record review of the employee health file for Nurse Aide-H (NA-H) revealed that it contained a Staff Medical File List. The Health Questionnaire in the file revealed that it was signed by NA-H and dated 4/8/23. The section titled Test Information (performed by nurse) contained blank lines for recording blood pressure, temperature, pulse, respiration, and lung sounds. The section had not been completed. The signature line and date for the Director of Nursing review was blank. Record review of the undated facility employee list revealed that Medication Aide-I (MA-I) had a start date of 1/22/24. Record review of the employee health file for Medication Aide-I (MA-I) revealed that it contained a Staff Medical File List. The Health Questionnaire in the file revealed that was signed by MA-I on 1/22/24. The section titled Test Information (performed by nurse) contained blank lines for recording blood pressure, temperature, pulse, respiration, and lung sounds. The section had not been completed. The signature line and date for the Director of Nursing review was blank. Record review of the undated facility employee list revealed that Nurse Aide-J (NA-J) had a start date of 2/26/24. Record review of the employee health file for Nurse Aide-J (NA-J) revealed that it contained a Staff Medical File List. The Health Questionnaire in the file revealed that was signed by NA-J on 2/26/24. The section titled Test Information (performed by nurse) contained blank lines for recording blood pressure, temperature, pulse, respiration, and lung sounds. The section had not been completed. The signature line and date for the Director of Nursing review was blank. Interview on 5/13/24 at 12:47 PM with the Facility Administrator (FA) confirmed that the facility performs pre-employment health history screens using the Health Questionnaire. The FA confirmed that the pre-employment health history screens are to be reviewed by the Director of Nursing to identify any transmissible disease to protect residents from staff with any transmissible disease. D. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility Infection Prevention and Control Program dated 4/1/24 revealed that the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. All staff are responsible for following all policies and procedures related to the program. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. All staff shall receive training regarding the facility's infection prevention and control program, including policies and procedures related to their job function. All staff shall demonstrate competence in relevant infection control practices. Record review of the facility policy titled Handwashing/Hand Hygiene dated August 2019 revealed that the facility considers hand hygiene (hand sanitization- hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Perform hand hygiene after handling used dressings, contaminated equipment or other items, and after contact with objects in the immediate vicinity of the resident. Observation on 5/8/24 at 12:44 PM revealed that Laundry Aide-A (LA-A) pushed a 2-shelf cart outside the room of Resident 21. LA-A moved the cover on the top of the cart with the bare hands and picked up clothing on hangers. LA-A carried the clothing into the room of Resident 21 and hung the clothes in the closet. LA-A removed empty used hangers from the closet and exited the room. LA-A placed the empty hangers on top of the clothing on the cart. LA-A did not perform hand sanitization. LA-A pushed the cart to the room of Residents 5 and 8 (roommates). LA-A moved the cover over the clothing on the top of the cart and removed clothing on hangers. LA-A carried the clothing into the room and placed them in the closet for Resident 5. LA-A removed used empty hangers from the closet and exited the room. LA-A placed the used hangers on the top of the cart. LA-A did not perform hand sanitization. LA-A removed a hanger with clothing off the top of the cart and carried it to the room for Resident 8. LA-A handed the hanger of clothing to the unidentified nurse aide inside the room door. LA-A did not perform hand sanitization. LA-A pushed the cart to the room of Resident 10. LA-A moved the cover on the top of the clothing and removed clothing on hangers from the top of the cart and carried the clothing into the room of Resident 10. LA-A hung the clothing in the closet in the room and removed used empty hangers. LA-A exited the room with the used hangers and placed them under the cover and on top of the clothes on the cart. LA-A did not perform hand sanitization. LA-A pushed the cart to the room of Resident 39. LA-A moved the cover from the clothing and rummaged through the clothing with the bare hands. LA-A removed 3 hangers with clothing and carried them into the room of Resident 39. LA-A hung the clothing in the closet for Resident 39 and exited the room. LA-A did not perform hand sanitization. LA-A pushed the cart to the room of Resident 35. LA-A moved the cover from the clothes and removed clothing on hangers from the top of the cart. LA-A carried the clothing into the room of Resident 35. LA-A hung the clothing in the closet of Resident 35. LA-A removed used empty hangers from the closet and exited the room. LA-A sat the used hangers on the clothing on the top of the cart and pulled the cover over them. LA-A did not perform hand sanitization. LA-A pushed the cart to the room of Resident 30. LA-A moved the cover and removed clothing on hangers from the top of the cart. LA-A carried the clothing into the room of Resident 30 and hung them in the closet. LA-A removed used empty hangers from the closet and exited the resident's room. LA-A placed the used hangers on the top of the cart. LA-A did not perform hand sanitization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/14/24 at 8:41 AM with the facility Housekeeping Supervisor (HS) confirmed that staff should put used hangers on the bottom shelf of the cart when removed from the resident room. HS confirmed that staff are expected to perform hand sanitization between resident rooms during laundry delivery. E. Record review of the facility policy titled Emptying a Urinary Catheter Collection Bag dated August 2022 revealed the general guidelines to use a clean and separate measuring container for each resident. These can be rinsed between uses for a single resident. Do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (If accidental contamination occurs, wipe the drain spout with an alcohol sponge or swab). Attach the collection bag to the bedframe- never to side rails. Keep the collection bag and tubing off the floor at all times to prevent contamination and damage. The section titled Steps in the Procedure revealed wash and dry your hands thoroughly. Put on disposable gloves. Place a paper towel on the floor beneath the drainage bag. Position the measuring container under the collection bag. Remove the drain tube from its holder. Unclamp the valve and let the urine flow into the measuring container. After the drainage bag has emptied clamp the valve. Wipe the drain with an alcohol sponge or swab. Replace the drain spout back into its holder. Measure and record the urinary output if indicated. Pour urine down the commode (toilet) and flush the commode. Rinse the measuring container and return to its designated storage area. Record review of the Admission Record dated 5/14/24 for Resident 39 revealed that Resident 39 admitted into the facility on [DATE]. Diagnoses included neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), quadriplegia (paralysis that affects all a person's limbs and body from the neck down), and pneumonia. Record review of the Order Summary Report (a list of all physician orders for a resident) for Resident 39 dated 5/14/24 revealed that Resident 39 had a Foley catheter (an indwelling urinary catheter) with order to change the catheter and urinary collection bag as needed. The order date for the Foley catheter was 4/18/24. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 39 dated 4/22/24 revealed that Resident 39 had an indwelling catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine to a urinary collection bag). Observation on 5/8/24 at 9:26 AM in the room of Resident 39 revealed that Resident 39 sat in the recliner with the footrest up. A urinary collection bag (a bag designed to collect urine drained from the bladder through a urinary catheter) (urinary catheter is a tube placed in the body to drain and collect urine from the bladder) hung from the trash can with the bottom resting on the floor. Observation on 5/09/24 at 9:39 AM in the room of Resident 39 revealed that Resident 39 sat in the recliner with the footrest up. A urinary collection bag hung from the trash can with the bottom resting on the floor. The urinary catheter tubing was secured to the left leg of Resident 39. The urinary collection bag contained moderate dark yellow urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled Handwashing/Hand Hygiene dated August 2019 revealed that the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The use of gloves does not replace handwashing/hand hygiene. The section titled Procedure revealed the steps for washing hands. Wet hands first with water, then apply product (soap). Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Perform hand hygiene before applying non-sterile gloves. Observation on 5/13/24 at 12:50 PM revealed that Nurse Aide-F (NA-F) entered the room of Resident 39. NA-F went to the bathroom sink and turned the water on. NA-F applied soap to the dry right hand and wet the left hand. NA-F scrubbed the hands with soap for 8 seconds and then rinsed the hands underneath running water for 8 seconds. (NA-F did not wet the hands before applying soap and did not scrub the hands for at least 20 seconds before rinsing the hands). NA-F dried the hands and applied gloves. Resident 93 was seated in the recliner in the room with the urinary catheter urine collection bag inside a blue privacy cover hanging from the side of the trash can next to the recliner. The bottom of the urinary catheter collection bag rested on the floor. NA-F placed a paper towel on the floor near the urinary catheter bag and sat a graduate cylinder (a plastic measuring container) on the paper towel. NA-F removed the urine collection bag from the privacy cover. The urine collection bag contained approximately 200 cubic centimeters (CC) of moderate dark straw-colored urine. NA-F removed the drain tube from the holder on the urine collection bag and wiped the drain tube with an alcohol prep pad. NA-F opened the drain tube and drained the urine from the urine collection bag into the graduate cylinder. NA-F closed the drain and wiped the drain tube with a new alcohol prep pad. The drain tube dropped onto the floor. NA-F obtained a new alcohol prep pad and wiped the drain tube and placed the drain tube back into the holder on the urine collection bag. NA-F placed the privacy cover on the urine collection bag and hung the bag from the side of the trash can. The bottom of the catheter bag rested on the floor. (NA-F did not ensure the catheter bag did not rest on the floor). NA-F carried the graduate cylinder containing the urine into the resident's bathroom. NA-F poured the urine into the toilet and flushed the toilet. NA-F obtained a paper towel and briefly wiped the inside of the graduate cylinder. NA-F left the paper towel in the graduate cylinder and turned the cylinder upside down. NA-F placed the upside-down graduate cylinder on the paper towel on the toilet tank lid. (NA-F did not rinse the graduate cylinder as required). Interview on 5/14/24 at 10:35 AM with the facility Infection Preventionist (IP) confirmed that the handwashing procedure is to be followed by staff. The IP confirmed that the steps for handwashing include wetting the hands before applying soap and to scrub with soap for 20 seconds before rinsing the hands. The IP revealed that graduate cylinders for emptying urine from catheter urine collection bags are switched out weekly on Sunday. The IP confirmed that staff are expected to rinse the graduate cylinder with water after use and set it upside down on paper towel to dry and not allow contamination into them. Observation on 5/14/24 at 1:22 PM in the room of Resident 39 revealed that NA-F exited room. Resident 39 was seated in the recliner with the feet down. The urinary collection bag hung from the trash can with the bottom of the collection bag resting on the floor. The urinary catheter tubing contained moderate dark yellow urine and approximately 6 inches of the tubing hung inside the graduate cylinder on the floor next to the urinary collection bag. The graduate cylinder sat on the floor. There was no paper towel or other barrier underneath the graduate cylinder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 5/14/24 at 1:22 PM with Nurse Aide-F (NA-F) revealed that NA-F hangs the catheter urine bag from the rim of the trash can. NA-F confirmed that the catheter urine collection bag should not touch the floor. NA-F confirmed that after emptying urine from the graduate cylinder it is to be rinsed out and a paper towel placed inside of it. NA-F revealed that the cylinder is then stored upside down.