STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295050	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Reno	445 W. Holcomb Lane Reno, NV 89511

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure the bed controls for 1 of 24 sampled residents (Resident #94) was in working order and the resident was physically able to work the control, resulting in emotional distress and increased pain for the resident. Findings include: Resident #94 Resident #94 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other specified complication, difficulty in walking not elsewhere classified, diaphragmatic hernia without obstruction or gangrene, rectal prolapse, and age related debility. A History and Physical record for Resident #94, dated 06/30/2024, documented the resident had a surgical history of laminotomy and hernia repair. A physician's order dated 07/19/2024, documented Acetaminophen tablet 325 milligrams (mg), give two tablets by mouth every four hours as needed for a pain level of 1-3 on numeric pain scale of 0-10. A physician's order dated 07/19/2024, documented Oxycodone Hydrochloride (HCL), give one tablet by mouth every six hours as needed for a pain level of 4-10 on a numeric pain scale of 0-10. A physician's order dated 07/29/2024, documented Tramadol HCL 50 mg tablets, give one tablet by mouth every six hours as needed for a pain level of 4-6 on a numeric pain scale of 0-10. A facility document titled Maintenance Repair Request, undated, documented repair request for Resident #94's room and bed, room [ROOM NUMBER]-2, related to the bed control on 07/01 and 07/08/2024 prior to Resident #94's admitted to the facility. The Maintenance Repair Request form further documented repair request for the bed control on 07/13, 07/15, 07/22, and 07/24/2024. The Maintenance log documented the bed control was reprogrammed on 07/13/2024, and documented on order in the section of the form titled what was done on 07/22 and 07/24/2024. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/2024 at 3:38 PM, Resident #94 verbalized the bed controls to the resident's bed, used to raise the head and foot of the bed up and down, did not work and as a result the resident was experiencing back pain. Staff came in to assist the resident every now and then, but not often enough. The resident explained staff assisted by resetting the bed control, but the control would stop working again and the resident was not able to reset or fix the bed control. Resident #94 verbalized the resident had asked to have the bed replaced with a different bed and the bed was not replaced. Due to not being able to move the head of the bed up and down to assist with repositioning, the resident had increased back pain. A student nurse responded to Resident #94's call light and reset the bed control. On 07/29/2024 at 3:45 PM, Resident #94 attempted to demonstrate use of the bed control to reposition the head of the bed, but the control did not work. A member of the maintenance team entered Resident #94's room with a new bed control and verbalized the new bed control would not work for the bed Resident #94 was in and the maintenance worker went to look for another control. On 07/31/2024 at 11:07 AM, Resident #94 was sitting up in bed and verbalized the bed control still did not work. The resident was not aware of any further attempts by the facility to replace the remote and verbalized no one had offered to switch the bed out for a different bed. The resident reported having back pain and described the pain as being a 10 out of 10 on a numerical pain scale of 0-10. The resident explained the resident had two back surgeries in the past and had metal appliances in place. Resident #94 verbalized the resident felt staff had become angry with the resident for calling too frequently to request help with the bed control. The resident became tearful and explained the resident would love to be able to work the controls without assistance and verbalized not understanding why the facility could not simply provide a different bed. Resident #94 explained the pain the resident experienced made it difficult to eat and to sleep. Resident #94 expressed not being able to independently adjust the bed made the resident feel angry and depressed. The resident verbalized the resident did not have a lot of money and was upset they had to paid $200.00 a day to lie here in pain. On 07/31/2024 at 11:21 AM, Resident #94 began to cry and verbalized the resident felt upset and was crying due to pain related to not being able to raise or lower the head of the resident's bed as needed. Resident #94 verbalized feeling sad the resident's roommate wanted to move rooms because the resident screamed out in pain at times. Resident #94 explained the resident's roommate would use the roommate's call light to call for help at times, and explained the resident felt staff responded more quickly when the roommate called for help. The resident verbalized no one had returned with a new control for the bed and the resident had talked with several nurses and maintenance workers without results. Resident #94 expressed the resident did not want to lie the head of the bed back down because the resident was afraid they would not be able to sit up again. On 08/01/2024 at 12:36 PM, the DON verbalized a solution to Resident #94's bed control not working would have been to switch the bed out for another bed. The DON explained the concern with Resident #94's bed control not working was resident comfort and pain. The DON confirmed Resident #94's bed should have been replaced with another bed when the resident was not able to work the controls and complained of pain, and explained nursing staff should have been reassessed to ensure the bed control was working. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/2024 at 12:47 PM, The Director of Nursing (DON) entereed Resident #94's room and confirmed Resident #94's bed control had not been replaced or repaired. Resident #94 explained to the DON the resident's bed control did not work correctly and verbalized the resident had asked to have the bed changed out on the very first day and nothing happened. A facility policy titled Servicing Medical Equipment, reviewed on 01/11/2024, documented Maintenance should be contacted for issues concerning resident related medical devices. The procedure included removing the device from the resident care area so it would not be inadvertently used on a resident. A facility policy titled Resident Rights, reviewed on 09/25/2023, documented the facility treated each resident with respect and dignity and cared for each resident in a manner and environment which promoted the maintenance or enhancement of the resident's quality of life. Residents had the right to receive the services and/or items included in the plan of care. Residents had the right to a safe, clean, comfortable homelike environment, including but not limited to receiving treatment and support for daily living safely. Residents had the right to reside and received services in the facility with reasonable accomodation of resident prefereneces except when to do so would endanger the health or safety of the resident or other residents. The facility protected and promoted the rights of the residents.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on interview, record review, and document review the facility failed to provide the required documentation for discharge when a resident was emergently transferred to an acute care hospital for 1 of 24 sampled residents (Resident #76). Findings include: Resident #76 Resident #76 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified, acute pulmonary edema, and unspecified asthma, uncomplicated. A Minimum Data Set 3.0 (MDS) discharge assessment dated [DATE], Section A, documented Resident #76 had an unplanned discharge to a short term acute care hospital with return anticipated. A Resident Census Report for Resident #76 documented the resident was admitted to an acute care hospital on 05/26/2024, and returned to the facility on [DATE]. A Nurse Progress Note dated 05/26/2024, documented Resident #76 was yelling out, and when the nurse entered the resident's room the resident was found lying in bed. Resident #76 verbalized the resident had fallen on the floor but was able to get back in bed without assistance. Resident #76 required extensive assistance to transfer from one surface to another and it was highly unlikely the resident would have been able to self-transfer back to bed. Resident #76's oxygen saturation level was at 67 percent (%) and the resident was having a hard time breathing. The resident was placed on a non-rebreather mask with oxygen running at 10 liters per minute (LPM) and the resident's oxygen saturation level had improved to 88%. Paramedics arrived and Resident #76 was transferred to an acute care hospital emergency room (ER). On 08/01/2024 at 11:31 AM, a Registered Nurse explained when a resident was transferred to an acute care hospital an e-Interact form was completed and entered into the resident's clinical record. On 08/01/2024 at 12:32 PM, the Director of Nursing (DON) confirmed Resident #76's clinical record lacked documented evidence an e-Interact form or other method of communication was provided to the acute care hospital regarding the resident's care needs. The DON confirmed the e-Interact form was to be completed each time a resident was transferred to the ER and sent with the resident. The e-Interact form was a tool used to transfer resident care information between facilities. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Transfers and Discharges, revised 06/28/2024, documented the facility ensured the necessary information was conveyed to the receiving provider for residents being transferred or discharged to another health care setting in accordance with federal guidance. All necessary information to meet the resident's needs, was communicated using a standardized communication method, such as the eInteract transfer form (a form used to communicate resident history, infection status, allergies, current concerns or issues, and other pertinent care areas) and included resident status, reason for transfer, recent vital signs, diagnoses and allergies, medications, special risk, treatments and devices, most recent labs, diagnostic test, and immunizations. The facility ensured the transfer/discharge of a resident under any circumstances was documented in the resident's medical record and the appropriate information was communicated to the receiving health care institute or provider.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on record review, interview, and document review the facility failed to submit for evaluation of the Pre-Admission Screening and Annual Resident Review (PASRR or PASARR) level II to the state designated authority for 1 of 24 sampled residents (Resident #76) when the resident had a new diagosis of schizophrenia. The failure had the potential to deprive the resident of the care and services necessary to meet their mental health needs. Finding include: Resident #76 Resident #76 was admitted to the facility on [DATE], and readmitted on [DATE], and 05/29/2024, with a diagnosis of acute and chronic respiratory failure with hypoxia, bipolar disorder, current episode depressed, mild or moderate severity, unspecified. A diagnosis of schizophrenia, unspecified, was added when the resident was readmitted to the facility on [DATE], and was documented as present upon readmission. A PASRR Level I Identification Determination for Resident #76 was dated 02/11/2021. A Minimum Data Set 3.0 (MDS) admission assessment dated [DATE], was marked 'NO' for a diagnosis of schizophrenia. The MDS assessment question, was the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or related condition was marked 'NO'. A Medical Diagnosis Report for Resident #76 documented a diagnosis of schizophrenia, unspecified was first active upon readmission to the facility on [DATE]. An MDS assessment dated [DATE], was marked 'NO' for a diagnosis of schizophrenia. An MDS five day assessment, dated 04/16/2024, documented a diagnosis of schizophrenia. On 08/01/2024 at 12:03 PM, the Director of Nursing (DON) verbalized during the admission process the Medical Records team entered a resident's diagnoses based on the diagnoses included in the History and Physical (H&P) provided by the sending facility. On 08/01/2024 at 12:18 PM, the DON explained the Business Office was in charge of completing and updating PASRR determination submissions. On 08/01/2024 at 12:20 PM, the Business Office Manager (BOM) explained PASRRs were reviewed upon each admission after the resident's diagnoses were entered into the resident's clinical record. A PASRR level II screening request was submitted for any mental health diagnosis identified including schizophrenia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/2024 at 12:27 PM, the BOM confirmed when Resident #76 was readmitted on [DATE] with a new diagnosis of schizophrenia, a PASRR level II submission was not completed and should have been completed when the new diagnosis was identified. A facility policy titled Pre-admission Screening and Resident Review (PASARR), reviewed on 09/25/2023, documented the facility referred all residents with newly evident or possible serious mental disorder, intellectual disabilities, or related conditions for a Level II review upon a significant change in status assessment. Any resident with newly evident or possibly serious mental health disorders was referred, by the facility, to the appropriate state designated mental health or intellectual disability authority for review.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review and document review, the facility failed to 1) complete bowel and bladder assessments upon admission for determination of candidacy to a bowel and/or bladder retraining program for 12 of 24 sampled residents (Resident #26, #32, #39, #40, #68, #86, #94, #105, #117, #185, #440, and #442) and 2) offer a bowel and bladder retraining program for residents assessed to be candidates for retraining for 10 of 24 sampled residents (Resident #2, #12, #13, #51, #52, #55, #60, #76, #235, and #443). This deficient practice had the potential to affect residents' ability to maintain their highest continent status. Findings include: Lack of Complete Bowel and Bladder Assessments Resident #26 Resident #26 was admitted to the facility on [DATE], with a principal diagnosis of other specified local infections of the skin and subcutaneous tissue. Resident #26's Minimum Data Set 3.0 (MDS) assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #26's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #32 Resident #32 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of nondisplaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing. Resident #32's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was not rated for bladder continence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #32's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. On 08/01/2024 at 11:13 AM, the Director of Nursing (DON) confirmed Resident #32's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #39 Resident #39 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Resident #39's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was frequently incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #39's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #40 Resident #40 was admitted to the facility on [DATE], with a principal diagnosis of displaced trimalleolar fracture of the right lower leg, subsequent encounter for closed fracture with routine healing. Resident #40's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was occasionally incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #40's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #68 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #68 was admitted to the facility on [DATE], with a principal diagnosis of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing. Resident #68's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #68's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #86 Resident #86 was admitted to the facility on [DATE], with a principal diagnosis of other low back pain. Resident #86's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was not rated for bladder continence. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #86's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #94 Resident #94 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of acute posthemorrhagic anemia. Resident #94's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #94's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #105 Resident #105 was admitted to the facility on [DATE], with a principal diagnosis of acute respiratory failure with hypoxia. Resident #105's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #105's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. On 08/01/2024 at 11:13 AM, the DON confirmed Resident #105's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #117 Resident #117 was admitted to the facility on [DATE], with a principal diagnosis of displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing. Resident #117's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was frequently incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #117's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #185 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #185 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of spinal stenosis, lumbar region without neurogenic claudication. Resident #185's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was occasionally incontinent of bladder. -The resident was occasionally incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #185's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #440 Resident #440 was admitted to the facility on [DATE], with a principal diagnosis of other fractures of lower end of left radius subsequent encounter for closed fracture with routine healing. Resident #440's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was occasionally incontinent of bladder. -The resident was occasionally incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #440's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. Resident #442 Resident #442 was admitted to the facility on [DATE], with a principal diagnosis of other specified chronic obstructive pulmonary disease. A progress note for Resident #442 dated 07/30/2024, documented the resident was incontinent of bowel. Resident #442's clinical record lacked documented evidence of a bowel and bladder evaluation completed on admission. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/01/2024 at 2:00 PM, the DON confirmed Resident #26, #39, #40, #68, #86, #94, #117, #185, #440 and 442's clinical records lacked documented evidence of a bowel and bladder evaluation completed on admission. Lack of Bowel and Bladder Retraining Program Offered On 07/31/2024 at 10:01 AM, the Assistant DON verbalized the facility did not have a comprehensive list of residents who were incontinent of the bowel or bladder. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of encounter for removal of internal fixation device. Resident #2's evaluation for bowel and bladder training dated 08/19/2023, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #2's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was not rated for bladder continence. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. On 08/01/2024 at 1:01 PM, the DON confirmed the facility did not implement a toileting program for retraining in 08/19/2023, when Resident #2 was a candidate. Resident #12 Resident #12 was admitted to the facility on [DATE], with a principal diagnosis of displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing. Resident #12's evaluation for bowel and bladder training dated 07/06/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #12's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 Resident #13 was admitted to the facility on [DATE], with a principal diagnosis of paroxysmal atrial fibrillation. Resident #13's evaluation for bowel and bladder training dated 07/07/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #13's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was frequently incontinent of bladder. -The resident was frequently incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #51 Resident #51 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of metabolic encephalopathy. Resident #51's evaluation for bowel and bladder training dated 01/22/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #51's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was frequently incontinent of bladder. -The resident was frequently incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. On 08/01/2024 at 1:01 PM, Resident #51 explained when the resident was admitted to the facility, Resident #51 was continent, knew when the resident had urges, and was strong enough to go to the restroom, but the facility required the resident to wear incontinence briefs. The resident expressed the resident was not asked if the resident had urges, nor was offered alternatives to a brief. Resident #51 explained the resident requested to use a bed pan and was denied. The resident verbalized the resident was still continent, but declined in strength and was no longer strong enough to go to the restroom. Resident #51 verbalized wearing the incontinence briefs felt demeaning and was gross. The resident explained the resident had no other choice. On 07/31/2024 at 1:42 PM, a Certified Nursing Assistant (CNA) verbalized Resident #51 was incontinent and wore incontinence briefs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/31/2024 at 2:25 PM, a Registered Nurse (RN1) verbalized Resident #51 was incontinent because the resident did not get out of bed. On 07/31/2024 at 2:44 PM, an RN2 verbalized Resident #51 was incontinent of both bowel and bladder and wore incontinence briefs but was not on a bowel and bladder retraining program. On 08/01/2024 at 1:01 PM, the DON confirmed the facility did not implement a toileting program for retraining when Resident #51 was a candidate on 01/22/2024. Resident #52 Resident #52 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of infection and inflammatory reaction due to internal left knee prosthesis, subsequent encounter. Resident #52's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #52's evaluation for bowel and bladder training dated 07/24/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #55 Resident #55 was admitted to the facility on [DATE], with a principal diagnosis of embolism and thrombosis of arteries of the lower extremities. Resident #55's evaluation for bowel and bladder training dated 05/18/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #55's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #60 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of generalized anxiety disorder. Resident #60's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was frequently incontinent of bladder. -The resident was always incontinent of bowel. -A toileting program was not being used to manage the resident's bowel incontinence. Resident #60's evaluation for bowel and bladder training dated 05/06/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. Resident #76 Resident #76 was admitted to the facility on [DATE], and readmitted on [DATE], with a principal diagnosis of acute and chronic respiratory failure with hypoxia. Resident #76's evaluation for bowel and bladder training dated 06/10/2024, documented the resident was a good candidate for toileting and timed or scheduled voiding. Resident #76's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following: -A trial of a toileting program had not been attempted. -The resident was always continent of bladder. -The resident was always continent of bowel. On 08/01/2024 at 11:25 AM, the DON explained when Resident #76 was continent and evaluated as a good candidate for individual training, the bowel and bladder training program should have been implemented and staff were expected to work with the resident on bowel and bladder retraining. Resident #235 Resident #235 was admitted to the facility on [DATE], with a principal diagnosis of displaced fracture of base of neck of left femur, subsequent encounter for closed fracture with routine healing. Resident #235's evaluation for bowel and bladder training dated 07/27/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. A progress note for Resident #235 dated 07/29/2024, documented the resident was incontinent of both bowel and bladder. Resident #443 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #443 was admitted to the facility on [DATE], with a principal diagnosis of encounter for surgical aftercare following surgery on the digestive system. Resident #443's evaluation for bowel and bladder training dated 07/25/2024, documented the resident was a candidate for toileting and timed or scheduled voiding. On 08/01/2024 at 10:57 AM, the DON confirmed the evaluation for bowel and bladder training was considered the comprehensive, interdisciplinary review and assessment of the resident's continence status conducted on admission and quarterly per the facility policy. The evaluation for bowel and bladder training to determine whether a resident was a candidate for the bowel and bladder program was expected to be completed by the admitting nurse within 24 hours of admission to the facility. The DON explained it was the responsibility of the DON to ensure evaluations were completed. The DON verbalized an effective bowel and bladder training program would include evaluations, voiding diaries, discussions with residents, and regular toileting, which were not being done, with the goal of maintaining or reaching a resident's highest possible function. The DON explained the bowel and bladder training program was important to preserve good quality of life and to prevent incontinence related health concerns including urinary tract infections and skin breakdown. The DON verbalized the facility did not have a bowel and bladder program since the DON started working at the facility approximately one year prior. On 08/01/2024 at 2:00 PM, the DON explained evaluations for bowel and bladder training were completed for residents marked incontinent on the admission assessment, so not all residents would have an evaluation for bowel and bladder training. The DON confirmed this did not follow the facility policy. The DON did not know why Resident #76 had an evaluation for bowel and bladder training and a determination Resident #76 was a good candidate. The facility policy titled Urinary Incontinence Management, reviewed 08/23/2023, documented each resident incontinent of urine was to be identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible. The facility was to ensure a resident who was continent of bladder and bowel on admission received services and assistance to maintain continence. The facility policy titled Incontinence Management, Urinary, Long-Term Care, revised 12/11/2023, documented the facility would conduct a comprehensive, interdisciplinary review and assessment of the resident's continence status on admission, quarterly, and with significant change of urinary function including factors that predisposed the resident to the development of urinary incontinence. The facility should begin incontinence management by implementing an appropriate bladder retraining program.

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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** 49557 Based on observation, interview, clinical record review and document review the facility failed to ensure Oxygen was administered as ordered for 1 of 24 sampled residents (Resident #442). Findings include: Resident #442 Resident #442 was admitted to the facility on [DATE], with diagnoses including other specified chronic obstructive pulmonary disease (COPD) and dependence on supplemental Oxygen. On 07/29/2024 at 3:55 PM, Resident #442 was lying in bed and was receiving Oxygen at six Liters Per Minute (LPM) via Nasal Cannula (NC). On 07/31/2024 at 9:46 AM, Resident #442 was lying in bed and was receiving Oxygen at five LPM via NC. A physician's order dated 07/26/2024, documented Oxygen at four LPM, continuously per NC, every shift for COPD. On 07/31/2024 at 9:50 AM, a Registered Nurse (RN) explained Resident #442 had an order for Oxygen to be administered at four LPM via NC for the resident's COPD. The RN entered Resident #442's room and confirmed the resident was receiving Oxygen at five LPM. The RN confirmed the liter flow did not match the physician's order. On 08/01/2024 at 1:02 PM, the Director of Nursing (DON) explained the DON's expectation of nursing staff when administering Oxygen to a resident was to first make sure there was a physician's order. The DON confirmed Resident #442 had a physician's order for Oxygen to be administered at four LPM. The DON confirmed administering Oxygen at five LPM was not following the physician's order. The DON explained if Resident #442 was requiring an increased amount of Oxygen, the DON's expectation was nursing staff would have assessed the resident and obtained a new physician order. The facility policy titled Oxygen Administration (Safety, Storage, and Maintenance), revised 02/27/2024, documented the facility must ensure a resident needing respiratory care was provided such care consistent with professional standards. An Oxygen order was to be written for the specific liter flow required by the resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 40377 Based on interview, document review, and personnel record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had a performance evaluation completed annually for 1 of 3 CNAs employed greater than one year sampled for personnel record review (Employee #13). Findings include: On 07/31/2024 at 10:30 AM, the Staff Development Coordinator (SDC) participated in an interview to confirm the accuracy of the Personnel Records Checklist completed by the facility for 20 employees. Employee #13 Employee #13 was hired as a CNA with a start date of 10/11/2022. Employee #13's personnel file documented a performance evaluation dated 03/08/2024. On 07/31/2024 at 10:44 AM, the SDC confirmed Employee #13 did not have a performance evaluation completed on or before the employee's anniversary date of 10/2023 and confirmed Employee #13's only performance review was completed on 03/08/2024. On 07/31/2024 at 1:21 PM, the Director of Nursing (DON) verbalized all CNAs were required to have a performance review annually. The DON verbalized it was a corporate directive to review all CNAs in April annually. The facility policy titled Performance Evaluations, reviewed 12/08/2023, documented annual performance reviews were given to all associates.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure Controlled Drug Records (CDR) were correctly completed for 2 of 3 inspected medication carts to reflect an accurate reconciliation of controlled medications for 8 of 24 sampled residents (Resident #96, #5, #89, #93, #77, #102, #94, and #109). Findings include: Station One Front Hall Medication Cart Resident #96 Resident #96 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and dysarthria following cerebral infarction. A physician's order dated 05/30/2024, documented tramadol 50 milligram (mg), give one tablet by mouth every six hours as needed for a pain level of 4-10 (on a numeric pain scale of 0-10). On 08/01/2024 at 8:41 AM, the Station One Front Hall medication cart included a CDR for Resident #96. The last entry on the CDR, dated 07/31/2024 at 7:05 PM, documented eight 50 mg tablets of tramadol were available. Resident #96 had seven 50 mg tablets of tramadol remaining. A Registered Nurse (RN) 1, confirmed the count documented in the CDR was eight and should have documented seven tablets remaining. On 08/01/2024 at 8:42 AM, the Staff Development Coordinator RN (SDC RN), confirmed the amount of medication remaining and the amount of medication documented as remaining on the CDR did not match. The SCD RN explained in order to ensure and accurate count of controlled substances, nurses were expected to document the amount of each medication remaining at the time the medication was removed from the medication cart and prior to administration. Accurate accounting and documentation of controlled substances helped to ensure an accurate account of medications being administered and staff accountability related to diversion of medications. Station Two Medication Cart Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other epilepsy, intractable, with status epilepticus, and other muscle spasm. A physician's order dated 06/07/2023, documented clonazepam 0.5 mg tablets, give one tablet by mouth two times per day for anticonvulsant as evidenced by (AEB) seizures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 03/08/2023, documented lacosamide 200 mg tablets, give one tablet by mouth two times per day for seizures. Resident #89 Resident #89 was admitted to the facility on [DATE], with diagnoses including low back pain, and pain in throat. A physician's order dated 03/06/2024, documented tramadol hydrochloride (HCL) 50 mg tablets, give one tablet by mouth every six hours as needed for a pain level of 4-10 (on a numerical scale of 0-10). Resident #93 Resident #93 was admitted to the facility on [DATE], with diagnoses including other sequelae of cerebral infarction, headache unspecified, and personal history of other diseases of the nervous system and sense organs. A physician's order dated 07/09/2024 documented Lyrica (pregabalin) 75 mg capsules, give one capsule by mouth two times per day for neuropathy pain. A physician's order dated 07/24/2024, documented tramadol HCL 50 mg tablets, give one tablet by mouth every six hours for a pain level of 4-10 (on a numerical scale of 0-10). Resident #77 Resident #77 was admitted to the facility on [DATE], with diagnoses including cellulitis of right lower limb, cellulitis of left lower limb, unspecified open wound, right lower leg, subsequent encounter, and a history of falling. A physician's order dated 02/22/2024, documented hydrocodone-acetaminophen 5-325 mg tablets, give one tablet by mouth every six hours as needed for a pain level of 7-10 (on a numerical scale of 0-10). Resident #102 Resident #102 was admitted to the facility on [DATE], with dysarthria following cerebral infarction, cellulitis of the left lower limb, and other chronic pain. A physician's order dated 05/20/2024, documented oxycodone HCL 5 mg tablets, give one tablet by mouth every four hours as needed for a pain level of 4-10 (on a numerical scale of 0-10). Resident #94 Resident #94 was admitted to the facility on [DATE], with diagnoses including rectal prolapse, and age related debility, and infectious gastroenteritis and colitis, unspecified. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 07/19/2024, documented oxycodone HCL 5 mg tablets, give one tablet by mouth every eight hours as needed for a pain level of 4-10 (on a numerical pain scale of 0-10). Resident #109 Resident #109 was admitted to the facility on [DATE], with diagnoses including osteomyelitis of vertebra, thoracic region, osteomyelitis of vertebra, lumbosacral region, and dorsalgia, unspecified. A physician's order dated 07/05/2024, documented oxycodone HCL 5 mg tablets, give one tablet by mouth every six hours as needed for a pain level of 7-10 (on a numerical pain scale of 0-10). On 08/01/2024 at 9:40 AM, the Station Two Medication Cart included CDR's for Resident #5, #89, #93, #77, #102, #94, and #109 with medications documented as follows: Resident #5 -A CDR for clonazepam 0.5 mg tablets documented one remaining tablet. There were zero tablets of the medication available. -A CDR for lacosamide 200 mg tablets documented seven remaining tablets. There were six tablets of the medication available. Resident #89 -A CDR for tramadol 50 mg tablets documented one remaining tablet. There were zero tablets of the medication available. Resident #93 -A CDR for Lyrica 75 mg capsules documented 13 remaining capsules. There were 12 capsules available. -A CDR for tramadol 50 mg tablets documented two remaining tablets. There was one tablet available. Resident #77 -A CDR for hydrocodone-acetaminophen 5-325 mg tablets documented eight tablets were remaining. There were seven tablets available. Resident #102 -A CDR for oxycodone HCL 5 mg tablets documented one remaining tablet. There were zero tablets remaining. Resident #94 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A CDR for oxycodone HCL 5 mg tablets documented 11 remaining tablets. There were 10 tablets remaining. Resident #109 -A CDR for oxycodone HCL 5 mg tablets documented four remaining tablets. There were three tablets remaining. On 08/01/2024 at 9:40 AM, RN2 verbalized the RN had passed medications earlier in the morning and did not document controlled substance administered by the nurse on each resident's CDR located in the Narcotics Logbook (NARC log) and confirmed the count to reconcile each medication would not be accurate as a result. The nurse confirmed the nurse was responsible for documenting each controlled substance administered on the residents' corresponding CDR located in the NARC log at the time of administration. On 08/01/2024 at 10:04 AM, the SDC RN confirmed the CDRs for Residents #5, #89, #93, #77, #102, #94, and #109, did not match the actual amount of each medication available and the controlled substances could not be accurately reconciled as a result. The SDC RN verbalized a correct count of controlled substances completed at the time of administration was important to aid in the prevention of diversion as well as to ensure residents were not inadvertently given an extra dose of the medication. The facility policy titled Medication Storage and Administration Quick Reference Guide, last revised August 2022, documented the controlled medication count record (CDR) was documented at the time the dose was removed and prior to administration of the medication to reflect the declining count.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) loose and unlabeled medications were removed from 2 of 3 inspected medication carts, and 3) medications were not left unattended and unsecured in a resident room for 1 of 24 sampled residents Resident (#40). Findings include: Medication Storage Carts On [DATE] at 9:56 AM, during an inspection of the Station Two Medication Cart, a small, white, round pill was found on the bottom of the cart's controlled substance drawer. An RN assigned to the medication cart was not able to identify the medication and/or who the medication belonged to. On [DATE] at 10:04 AM, the Staff Development Coordinator Registered Nurse (SDC RN) confirmed the medication found loose in the bottom of the Station Two Medication Cart's controlled substance drawer, should have been removed from the cart and confirmed the expectation was all medications in the medication cart would be labeled and in the appropriate containers. Station Two Back Hall Medication Cart On [DATE] at 10:12 AM, during an inspection of the Station Two Back Hall Medication Cart, the following medications were located inside the medication cart and were not labeled: -One 90 microgram (mcg) albuterol sulfate - hydrofluoroalkane (HFA), in a gray dispenser, the inhaler was not labeled. -One 90 mcg albuterol sulfate inhaler in a white dispenser, the inhaler was not labeled. -One foil packet containing 23 ampules of ipratropium bromide/albuterol sulfate inhalation solution 0.5 milligrams (mg)-3.0 mg per 3 milliliter (ml) ampule. The packet was found in a manufacturer's box for albuterol sulfate inhalation solution 0.083 percent (%) per 3 mls. -One brown baggie containing 10 ampules of albuterol inhalation solution, 3 ml ampules. On [DATE] at 10:14 AM, the (SDC RN) confirmed the two inhalers, the packet of ipratropium/albuterol solution ampules, and the baggie of albuterol ampules were not labeled and should have been labeled prior to placing the medications into the medication cart. The SDC RN verbalized it was important to label all medications prior to placing them in the medication cart to ensure residents received the correct medications and to ensure the medications were not administered after they had expired. The SDC RN confirmed due to not being labeled, it could not be determined who the medications belonged to. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:27 AM, the SDC RN verbalized the concern with unlabeled medications included not knowing who the medication belonged to, which could lead to a resident getting the wrong medication or the medication being administered to the wrong resident. A facility policy titled Medication Storage and Security in the Facility, documented te provider pharmacy dispensed medications in containers that met legal requirements, including requirements of good namufacturing practices. Medicatons were kept and stored in these containers. 30748 Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including end stage renal disease, hypotension of hemodialysis, and dependence on renal dialysis. On [DATE] at 12:05 PM, next to Resident #40's bed, on the side table, was a white, unknown pill, in a paper administration cup. The resident explained the pill had not been in the room that long. Two Certified Nursing Assistants (CNA) entered the room at the same time and did not address the unsecured pill sitting on the resident's side table. On [DATE] at 12:09 PM, an RN entered the resident's room and confirmed there was an unsecured pill sitting on the resident's side table. Resident #40 verbalized the RN was familiar with the resident and that was why the pill was left unsecured in the resident's room. The RN explained licensed nurses were to watch residents swallow medications and were not to walk away until medications were administered properly to residents. It was unacceptable to leave medications in a resident's room, left unattended, and unsecured. The RN verbalized the RN was responsible for ensuring safe medication administration processes, to include observing the resident take the medication and not walk away, leaving the medication unsecured. A physician's order dated [DATE], documented Sevelamer Carbonate 800 mg tablet. Give one tablet by mouth before meals for End Stage Renal Disease (ESRD) with meals and snacks. Resident #40's clinical record lacked a physician's order for self-administration for the Sevelamer Carbonate tablets. On [DATE] at 2:14 PM, the Director of Nursing (DON) explained the expectation was for nurses to watch residents swallow medications before walking away from a resident. Unless a medication was care planned, a physician's order to self-administer a medication or a resident had a preference to take medications on their own, then medications were to be secured at all times. The DON verbalized it was not appropriate to leave a medication with the resident, leave a medication accessible to other residents and walk away from the resident with the medication left at the bedside. The DON verbalized a medication left unattended and unsecured, could be administered by a resident wandering the facility and cause harm to a resident. The DON confirmed there was no physician order for Resident #40 to self-administer medications. (continued on next page)

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	295050	A. Building B. Wing	08/01/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Storage and Administration Quick Reference Guide, last revised [DATE], documented staff were to remain with the resident until medications were swallowed and to never leave medications at bedside.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 35601 Based on observation, interview, and document review, the facility failed to ensure the outside receptacle area was kept free of trash, leaves, seepage from the receptacle container, leakage of an air conditioning hose causing a build-up of a thickened substance, and flies. Findings include: On 07/29/2024 at 8:38 AM, the outside gated facility receptacle area had an accumulation of leaf debris and gloves for medical care. The receptacle container had seepage causing a built-up dried puddle of liquid waste, accumulated over time and deposited on the cement. Another puddle (wet liquid) had accumulated within the gated area, in the corner. A vent and hose were present however, the source of the liquid could not be identified. The Certified Dietary Manager (CDM) was present and verbalized the receptacle area needed a spray down. The CDM was unable to identify the source of the liquid puddle. On 08/01/2024 at 1:50 PM, the outside gated receptacle area remained with an accumulation of leaf debris and gloves for medical care. The receptacle container had seepage causing a built-up dried puddle of liquid waste to remain on the cement. Another puddle (wet liquid) had continued to accumulate within the gated area, in the corner; However, a thickened substance had appeared in the liquid, in the form of tiny bumps or bubbles. The area was now odorous indicative of the smell of garbage on a hot summer day with multiple flies present. On 08/01/2024 at 1:53 PM, the CDM confirmed the condition of the receptacle area remained the same as the observation on 07/29/2024, with the addition of the thickened liquid puddle. The CDM did not know what was causing the liquid to thicken or the source of the puddle. On 08/01/2024 at 2:07 PM, a Maintenance Assistant explained the source of the thickened liquid deposited on the cement, in the receptacle area outside, was from the air conditioner leaking. The Maintenance Assistant suggested the thickening bubble like substance could be from the water mixing with oil underneath the leaking trash compactor. The facility policy titled, Disposal of Garbage and Refuse, last reviewed 04/30/2024, documented all areas where garbage/refuse was located was to be kept clean, free of debris and free of foul odors and waste fat. The garbage storage area was maintained in a sanitary condition. Garbage and refuse containers were to be maintained in a good condition (no leaks).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, document review, and interview, the facility failed to complete Treatment Administration Records (TAR) for the administration of a skin protective ointment for 1 of 24 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of paraplegia. A physician's order dated 05/15/2024, documented skin protective ointment to perianal area at each brief change. Confirm every shift. Resident #2's TAR dated 05/20/2024, and 06/26/2024, lacked documented evidence the skin protective ointment had been administered per the physician's order. On 08/01/2024 at 1:29 PM, the Director of Nursing (DON) confirmed Resident #2's TAR dated 05/20/2024, and 06/26/2024, lacked documented evidence the skin protective ointment had been administered per the physician's order. The DON verbalized it was the DON's expectation nursing staff were to document in the resident's clinical record immediately upon administration of a medication or treatment. The facility policy titled, Documentation, Long-Term Care, undated, documented administration of medications and treatments were to be documented as soon as possible in the resident's electronic health record to ensure accuracy and reflect ongoing care.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43310 Based on interview and document review the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify the facility lacked a process to ensure bowel and bladder assessments were completed upon admission for determination of candidacy to a bowel and/or bladder retraining program and to offer a bowel and bladder retraining program for residents assessed to be candidates for a bowel and bladder retraining program resulting in the potential to affect residents' ability to maintain their highest continent status. Findings include: On 08/01/2024 at 11:33 AM, the Director of Nursing (DON) verbalized incontinence impacted a resident's quality of life and explained it was important for residents to be able to achieve or maintain the resident's highest level of continence. Incontinent residents were at risk of developing urinary tract infections, and skin breakdown. On 08/01/2024 at 11:34 AM, the DON verbalized the DON was not sure when the facility last had a Bowel and Bladder program and explained the DON had worked at the facility for approximately one year and there had not been a program in place during this time. On 08/01/2024 at 2:15 PM, the Regional [NAME] President confirmed the QAPI committee had not identified the facility's lack of a Bowel and Bladder program. The Regional [NAME] President explained during the COVID-19 pandemic, the Restorative Nurse Aide (RNA) program was discontinued and had not been reintroduced. The Regional [NAME] President verbalized the facility could have identified the lack of a Bowel and Bladder program by conducting audits, such as reviewing resident admission assessments. A facility policy titled Quality Assurance and Performance Improvement (QAPI) Plan, dated 01/15/2024, documented the facility believed in a resident-centered approach to care in which the total health needs of the resident were met. The QAPI program utilized an ongoing, data driven, pro-active approach to advance the quality of life and quality of care for all residents at the facility. The scope of the QAPI program encompassed all segments of care and services provided by the facility which impacted clinical care, quality of life, resident choice, and care transitions with participation from all departments. Cross reference with F690

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for a resident with a chronic wound for 1 of 94 unsampled residents (Resident #26). Findings include: Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter and unspecified open wound, right thigh, subsequent encounter. On 07/29/2024 at 10:08 AM, Resident #26 verbalized the resident had wounds. The resident recalled having the wounds for at least seven months and verbalized facility staff were providing wound care. Resident #26's room lacked EBP signage and a Personal Protective Equipment (PPE) cart. A physician's order dated 07/06/2024, documented wound care: clean right medial thigh wound with Normal Saline (NS), pat dry, apply Xeroform, cover with clean dry dressing (CDD) every Monday, Wednesday, Friday and as needed (PRN). A physician's order dated 07/06/2024, documented wound care: clean abdominal wound with NS, pat dry, apply Xeroform, cover with CDD every Monday, Wednesday, and Friday. A Wound Observation Tool dated 07/26/2024, documented Resident #26 had a wound on the resident's right medial thigh. The wound was described as chronic and non-healing. A Wound Observation Tool dated 07/26/2024, documented Resident #26 had a wound on the resident's abdomen. The wound was described as chronic and non-healing. On 08/01/2024 at 8:39 AM, the Licensed Practical Nurse (LPN) assigned to Resident #26 confirmed the resident had wounds and was receiving wound care on Mondays, Wednesdays, Fridays and PRN. The LPN confirmed residents with wounds typically had EBP in place. The LPN verbalized the LPN was not sure why Resident #26 did not have EBP in place and would contact the Director of Nursing (DON). On 08/01/2024 at 8:54 AM, the DON confirmed Resident #26 should have had EBP in place as soon as the resident had orders for wound care. On 08/01/2024 at 9:36 AM, the Infection Preventionist (IP) explained EBP was used for any resident with extensive wound care or an open wound. The IP confirmed Resident #26 should have had EBP in place. The IP explained EBP was used to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Enhanced Barrier Precautions, reviewed 06/03/2024, documented EBP was an infection control intervention used to reduce transmission of Multi-Drug Resistant Organisms (MDROs). EBP employed gown and glove use during high-contact resident care activities. EBP was to be used for residents with wounds and/or indwelling medical devices.