STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Elko Rehabilitation LLC	2850 Ruby Vista Drive Elko, NV 89801

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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** 43311 Based on observation, interview, record review and document review the facility failed to ensure a resident's call light was not draped over an oxygen concentrator and out of reach of the resident for 1 of 18 sampled residents (Resident #53). Findings include: Resident #53 Resident #53 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with agitation, muscle weakness, generalized, and anxiety disorder. Resident #53's Care Plan initiated on 04/18/2024, and revised on 07/15/2024, documented the resident was at risk for falls related to generalized muscle weakness, history of falls, incontinence, and dementia. Interventions included to encourage the resident to call for assistance before getting out of bed or transferring and was an extensive one person assist with stand pivot transfers. On 07/15/2024 at 1:25 PM, Resident #53 was in bed trying to straighten the bed blankets over the resident's legs with the call light draped over the running oxygen concentrator. The resident was not able to reach the call light. On 07/15/2024 at 1:30 PM, a Certified Nursing Assistant (CNA) entered the room and could not initially find the resident's call light device. The CNA found the call light device draped over the oxygen concentrator and attached the call light device to the resident's blanket. The CNA confirmed the resident could not reach the call light while it was draped over the oxygen concentrator and would have to yell for help. The CNA explained Resident #53 knew how to use the call light device. On 07/17/2024 at 3:29 PM, a Licensed Practical Nurse (LPN) explained Resident #53 was able to use the call light device when needed. The LPN explained the resident would be unable to reach the call light if it were draped over the oxygen concentrator. The facility policy titled Responding to Resident Needs, revised 10/2010, documented the primary means for a resident to communicate their need for staff assistance was via the call light. When the resident was in bed or confined to a chair be sure the call light was within easy reach of the resident.

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

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

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50210 Based on observation and interview, the facility failed to ensure the most recent survey results were made available in the facility's secured memory care unit to be readily accessible to residents and visitors. This restricted access had the potential to affect 27 residents. Findings include: On 07/17/2024 at 9:19 AM, there was no evidence the survey results were available for visitors and residents within the facility's secured memory care unit to read. On 07/17/2024 at 9:19 AM, a Registered Nurse (RN) in the memory care unit verbalized being unsure if or where the survey results were available. On 07/18/2024 at 8:50 AM, the Administrator verbalized visitors could use the entrance to the secured memory care unit. The Administrator confirmed the survey results were not posted in the secured memory care unit and residents in the secured memory care unit did not have access to the survey results.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review, and document review, the facility failed to ensure a resident's fall with major injury, resulting in a fracture and incurred at the facility, was reported to the State Agency (Resident #132). The deficient practice could allow a fall with major injury to not be investigated for potential abuse or neglect and not be reported to the State Agency (SA). Findings include: Resident #132 Resident #132 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nondisplaced oblique fracture of shaft of left femur, subsequent encounter for closed fracture with routine healing, muscle weakness (generalized), stiffness of unspecified joint, not elsewhere classified, and repeated falls. The facility Resident Matrix (identified care areas), printed on 07/15/2024, documented Resident #132 had a fall with major injury. A Nursing Progress Note dated 07/03/2024, documented a Certified Nursing Assistant (CNA) heard a loud noise from Resident #132's room. The CNA entered the resident's room and discovered the resident on the floor and the resident's bed was in the highest position. A nurse was retrieved to complete an assessment of the resident. The resident had obtained a skin tear and was complaining of left hip and leg pain. The left leg appeared to be rotated out. As a result, the resident was transferred to the emergency room . A Nursing Progress Note dated 07/03/2024, documented the resident had a distal femur fracture and was being flown to a larger hospital for treatment. Hospital Records dated 07/03/2024, documented the resident was admitted to the hospital secondary to a ground level fall. The resident had broken their femur and required further admission to the hospital with evaluation and management. The resident had a history of being a poor historian and mild cognitive impairment. Hospital Records dated 07/09/2024, documented the resident was admitted to the surgical floor for a femur fracture. The resident was to be discharged on [DATE], requiring appointments for surgical orthopedic aftercare. A Nursing Progress Note dated 07/11/2024, documented a fall review was completed as a result of the resident falling in their room on 07/03/2024. The resident was found on the floor in the room with the bed in an elevated position. A nursing assessment was completed to include the resident's left leg and hip appearing to be rotated outward. The resident was transferred to the hospital for evaluation and then flown to another hospital for an evaluation and surgery on the left hip. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/2024 at 2:16 PM, the Administrator explained Resident #132 had a remote to be able to control the height of the bed and it was assumed the resident had positioned the bed in the highest position on their own. The resident had fallen out of the bed, in the middle of the night, while the bed was in the highest position. As a result, the resident had to be transferred to the hospital for a fractured femur and had to have surgery to repair the fracture. The Administrator explained Resident #132's fall with major injury was not reported to the State Agency because there was no indication abuse or neglect had occurred on behalf of the facility. The Administrator verbalized abuse investigations were reported to the State Agency and the Administrator had conducted a facility investigation as a result of the fall. The facility policy titled Abuse Prohibition and Reporting (Elder Justice Act), last revised 07/13/2023, documented if a resident had an event resulting in serious bodily injury, a report would be made to the State Agency, the Ombudsman's office and law enforcement. The report would be made the State Agency no later than two hours after the incident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43311 Based on observation, interview, and document review, the facility failed to ensure 1) a comprehensive care plan was updated to reflect the assessed wound staging for a Stage III pressure ulcer (Resident #69) and 2) a comprehensive care plan for a resident with a history of falls was updated when new interventions were implemented (Resident #31) for 2 of 18 sampled residents. Findings include: Pressure Ulcer Resident #69 Resident #69 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, apraxia, dysarthria and anarthria, and pressure ulcer of sacral region, Stage III. An Orders Administration Note dated 06/24/2024, documented the wound care nurse performed wound care to the resident's coccyx wound. A Nursing Progress Note dated 06/24/2024, documented the coccyx dressing was clean, dry, and intact (CDI). A physician order dated 06/24/2024, documented cleanse coccyx with wound cleaner, pat dry, apply anacept and collagen to wound bed and cover with foam dressing. Monitor for signs/symptoms of infections, notify provider with any concerns. Every day shift every Monday, Wednesday, and Saturday. A Wound Weekly Observation Tool dated 07/08/2024, documented the resident had a Stage III coccyx wound that had a moderate amount of serosanguinous drainage and required wound care treatment. The definition of a Stage III wound was documented as full thickness tissue loss and included undermining and tunneling. The document indicated under the Observation/Data section the wound originated on the coccyx and was present on 06/23/2024. A physician order dated 07/10/2024, documented Treatment: Cleanse coccyx area with wound cleaner, pat dry, apply hydrogel to wound bed and cover with foam dressing. Every day shift every Monday, Wednesday, Saturday related to pressure ulcer of sacral region, Stage III. Resident #69's Skin Care Plan initiated on 05/06/2024, and revised on 05/15/2024, lacked documented evidence the would was identified as a Stage III pressure ulcer. The Care Plan lacked an update or revision for the coccyx wound assessed as a Stage III wound. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/2024 at 4:18 PM, the Minimum Data Set (MDS) Coordinator explained the coccyx wound had started as blisters and had been initially staged as a II by the Wound Care Nurse on 06/23/2024. The MDS Coordinator confirmed a wound staging, restaging, and resolution should be updated to the Care Plan. The MDS Coordinator confirmed Resident #69's wound care staging was performed by the Wound Care Nurse as a Stage III on 07/08/2024, and was not updated on the Care Plan to accurately reflect the current wound stage assessment and care. On 07/17/2024 at 4:46 PM, the Director of Nursing (DON) confirmed Resident #69's wound was assessed as a Stage III by the Wound Care Nurse on 07/08/2024. The DON confirmed the wound care order and care plan did not match and was not accurate to the resident's current wound assessment or treatment. 50210 Resident #31 Resident #31 was admitted to the facility on [DATE], with diagnoses including unspecified dementia severe with anxiety, hypertension, unspecified severe protein-calorie malnutrition, and muscle weakness. On 07/16/2024 at 9:21 AM, Resident #31's bed was in low position, and a floor mat was on the left side of the bed. On 07/16/2024 at 3:36 PM, Resident #31's bed was in low position, and a floor mat was on the left side of the bed. On 07/17/2024 at 9:12 AM, Resident #31's bed was in low position, and a floor mat was on the left side of the bed. Resident #31's progress notes related to falls documented the following: -On 04/19/2024 at 11:45 PM, Resident #31 was found sitting on the floor mat in front of their bed playing with dolls. -On 04/23/2024 at 3:45 PM, Resident #31 was found on floor mat next to the bed. The bed was in low position. -On 04/26/2024 at 8:10 AM, the Fall Committee met to review the recent fall. The Care Plan was reviewed, the bed was in low position and floor mats were used to help reduce risk of fall-related injuries. -On 05/05/2024 at 3:23 PM, Resident #31 was found on the floor mat next to the bed. The bed was in low position. -On 05/12/2024 at 5:38 PM, Resident #31 was found on the floor mat next to the bed. The bed was in low position. -On 06/10/2024 at 2:30 PM, Resident #31 was found on the floor, floor mat in place, and the bed was in low position. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06/29/2024 at 3:52 PM, Resident #31 was found lying on the floor mat on the left side of the bed, and the bed was in low position. On 07/17/2024 at 9:33 AM, a Certified Nursing Assistant (CNA) verbalized Resident #31 often fell when the resident was put to bed but did not want to go to bed and attempted to get up without assistance. Since the last fall, the facility implemented the following interventions: -asking the resident if they were ready to go to bed. -laying down floor mats. -putting the bed in the lowest position. -ensuring the resident was in the center of the bed. -putting dolls on the bed so the resident did not need to reach for them. -putting pillows at the resident's back. -rounding on the resident more often. On 07/17/2024 at 9:54 AM, a Registered Nurse (RN) verbalized Resident #31 tended to fall out of bed when napping around 2:00 PM to 4:00 PM. The resident would get up without asking for assistance. The RN explained the facility implemented interventions to prevent injury when the resident did fall. These included floor mats, lower bed, waking the resident earlier, and rounding more often. Resident #31's Care Plan with a focus initiated 04/25/2024, and last revised on 07/02/2024, documented Resident #31 was at risk for falling and fall-related injuries relative to hypertension, diabetes, generalized muscle weakness, and medications. The Care Plan did not include interventions related to floor mats or the bed in a low position. On 07/17/2024 at 3:31 PM, the DON verbalized the DON was not familiar with the facility's fall protocol. After discussing with the MDS Coordinator, the DON confirmed if a resident used floor mats and the bed was in low position, both should be documented as interventions on the care plan. The facility policy titled Care Plan Policy, revised 06/01/2022, documented the facility would develop and implement a Comprehensive Person-Centered Care Plan appropriate for each resident and would include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the resident's comprehensive assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on observation, clinical record review, interview, and document review, the facility failed to ensure the catheter drainage bag for a resident with a Foley catheter was placed below the level of the resident's bladder to prevent the potential for urine in the tubing and draining bag from flowing back into the bladder for 1 of 18 sampled residents (Resident #58). Findings include: Resident #58 Resident #58 was admitted to the facility on [DATE], with a diagnosis of neuromuscular dysfunction of bladder, unspecified. A physician's order dated 09/13/2023, documented, 16 French, 10 cubic centimeters, Foley catheter as needed related to neuromuscular dysfunction of bladder, unspecified. On 07/17/2024 at 2:36 PM, Resident #58 was sitting in a wheelchair in the resident's room facing the door. An opened walker was in front of the resident. The resident's catheter drainage bag was hanging from the top rung of the walker in front of the resident. The catheter drainage bag was suspended higher than the resident's bladder while the resident had been sitting in the wheelchair. On 07/17/2024 at 3:14 PM, the Director of Nursing (DON) entered Resident #58's room. Resident #58 was still seated in the wheelchair. The DON confirmed the catheter drainage bag had been placed on the top rung of the walker while the resident had been out of the room and should have been placed below the resident's wheelchair, once the resident had returned to the room, to ensure proper drainage of the catheter. The DON verbalized a catheter drainage bag hung above the level of the bladder could have resulted in a backup of urine and a possible urinary tract infection (UTI) to the resident. The DON verbalized having been unsure if Resident #58 had a previous UTI since admitting to the facility. A physician's order dated 02/09/2024, documented uric acid, culture and sensitivity laboratory tests related to neuromuscular dysfunction of bladder, unspecified. An Antimicrobial Susceptibility and Organism Identification Report, dated 02/11/2024, documented the culture and sensitivity laboratory result for Resident #58 was positive for Klebsiella aerogenes. The facility policy titled, Catheter Care, Urinary, revised 09/2014, documented a urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and draining bag from flowing back into the urinary bladder.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review, the facility failed to ensure a resident with an ostomy received care consistent with professional standards of practice when a Certified Nursing Assistant (CNA) changed the resident's colostomy wafer for 1 of 18 sampled residents (Resident #21). Findings include: Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and colostomy status. On 07/15/2024 at 1:28 PM, Resident #21 verbalized the resident was recently moved from the 300 hall to the 400 hall. Resident #21 verbalized Resident #21 preferred being in the 300 hall because the CNAs knew how to provide care for the resident's colostomy. Resident #21 explained a CNA performed the changing of the ostomy bag and the wafer (the portion which sticks to the resident's skin). A physician order dated 07/16/2024, with a start date of 07/17/2024, documented change colostomy every shower day or as needed (PRN). Resident #21's Care Plan included a focus of colostomy: potential for complications related to new colostomy following necrotizing enterocolitis and colectomy surgery. Resident picks at the stoma paste and pulls it out from under the seal causing leakage. The date initiated was 06/20/2024 and date revised was 07/16/2024. Interventions initiated from 06/20/2024 through 06/26/2024, and assigned to a licensed nurse, included: -Administer treatments for skin impairment per physician order. Notify Medical Doctor (MD) if skin impairment does not respond to current treatment regimen or resident experiences an adverse reaction. -Encourage resident not to play with colostomy or pick/pull at stoma paste to decrease risk of leakage. -Monitor characteristics of stool (frequency, color, amount, consistency). -Monitor for signs and symptoms (s/s) of abnormalities (skin redness/excoriation, swelling, drainage, abdominal distention, bowel sounds). -Notify MD as needed. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/2024 at 3:39 PM, a CNA explained CNAs were allowed to empty ostomy bags and change ostomy wafers. When asked what training the CNA had received related to care of residents with ostomies, the CNA verbalized the CNA had provided care for ostomies in the past but the CNA did not respond to questions regarding previous trainings the CNA had obtained. The CNA explained the CNA would remove the ostomy bag and the wafer attached to the resident's skin when providing ostomy care. The CNA recalled the CNA had provided ostomy care to two residents in the facility. Review of the CNA's Competency-Nurse Aide checklist, signed and dated by the CNA on 02/21/2024, lacked documented evidence the CNA was trained or evaluated for competency to perform changes of a resident's ostomy wafer. On 07/18/2024 at 8:24 AM, a Registered Nurse (RN) explained nurses and CNAs were allowed to change ostomy bags however only nurses were allowed to change an ostomy wafer as changing of an ostomy wafer was outside a CNA's scope of practice. On 07/18/2024 at 9:15 AM, during an interview with the DON, and in the presence of the Assistant Director of Nursing (ADON) and the Regional Nurse Consultant, the DON explained the DON's expectation of staff when changing an ostomy wafer was to assess the resident's skin integrity as feces sitting on the skin could cause skin breakdown. It was important to ensure a good seal from the wafer to the stoma to avoid leaking. The DON explained nurses were allowed to change ostomy wafers but the DON was not aware of this skill being within the CNA's scope of practice. The DON denied CNAs in the facility had received training or had a competency/skills assessment completed for changing of ostomy wafers. The DON reviewed the Competency-Nurse Aide checklist and confirmed changing of an ostomy wafer was not included in the list of nurse aide skills. The DON explained the facility used Lippincott Manual of Nursing as the standard of practice. The Lippincott Manual of Nursing Practice indicated standards of care guidelines for care of the patient with an ostomy included assessment of peristomal skin with each pouching system change. The DON confirmed it was not within a CNA's scope of practice to perform an assessment. The facility policy titled Nursing Home Job Description Certified Nurse's Aide, revised 11/2017, documented the nurse aide's job function was to provide direct resident care as trained and specified in the job training. Nurse aides were to participate in skills performance reviews as directed by the facility. The facility standard of practice titled Lippincott Manual of Nursing Practice: 11th edition, documented standards of care guidelines - care of the patient with an ostomy included assessment of peristomal skin with each pouching system change, documentation of findings, and treatment of any abnormalities (skin breakdown because of leakage, allergy, or infection) as indicated.

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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** 30748 Based on observation, interview, clinical record review, and document review the facility failed to ensure oxygen was administered as ordered for 1 of 19 sampled residents (Resident #25). Findings include: Resident #25 Resident #25 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia and pneumonia, unspecified organism. On 07/15/2024 at 2:10 PM, Resident #25 was resting in bed with an oxygen concentrator running next to the bed. The oxygen concentrator was set at one liter per minute (lpm). A physician's order dated 06/16/2024, documented oxygen at four lpm, via nasal cannula/mask continuous. Resident #25's Care Plan, initiated on 06/18/2024, documented the resident had altered respiratory status/difficulty breathing related to acute/chronic respiratory failure with hypoxia, cough, and active pneumonia infection. Interventions included to administer oxygen as ordered. On 07/16/2024 at 3:24 PM, the resident was lying in bed with the nasal cannula affixed on the face. The oxygen concentrator was turned off and not administering oxygen to the resident. On 07/16/2024 at 3:26 PM, a Licensed Practical Nurse (LPN) entered the resident's room and confirmed the oxygen concentrator was off and not administering oxygen to the resident. The LPN turned on the oxygen concentrator and confirmed the oxygen concentrator was administering one lpm of oxygen to the resident. The LPN then left the resident's room. The LPN checked the resident's clinical record and verbalized the resident was to be administered oxygen at four lpm continuous per the resident's physician order. The LPN was unable to find a physician's order for the administration of oxygen at one lpm. On 07/16/2024 at 3:31 PM, a Registered Nurse (RN) explained the resident was on oxygen at four liters per minute continuously. The resident's oxygen had been attempted to taper down, however results were unsuccessful because his Saturation Levels were a hit and a miss. A discussion had not been had with the resident's physician and was supposed to be discussed with the physician prior to tapering the resident's oxygen for the resident's safety. The RN confirmed the physician order for four lpm continuous administration of oxygen was not being followed and could not locate a physician order to titrate the resident's oxygen up or down. The RN explained if the resident was not being administered oxygen per the physician order or the oxygen concentrator was not actively administering oxygen to the resident, the resident could experience shortness of breath, falls, and confusion in addition to the resident's diagnosis of dementia. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 3:44 PM, the Director of Nursing (DON) explained all physician orders for oxygen were to be followed. If the resident's physician order documented four lpm continuous, then the resident needed to be administered the oxygen at four lpm continuous. The DON verbalized the concentrator needed to be administering oxygen to the resident at all times and if the concentrator was turned off then something could happen to the resident's health and safety. The facility policy titled Physician Orders, dated 08/2014, documented no nurse should take a verbal order from another nurse and carry it through unless the order was from a Physician Designee. The facility policy titled Oxygen Therapy & Safety, last revised 04/09/2020, documented a Doctor would provide a physician order dictating when to use, how often to use, the liter flow and whether to use a cannula or mask. Staff would be responsible to ensure safety of the resident during the use of oxygen therapy. The facility policy titled Pharmaceutical Procedures, last revised 01/31/2024, documented all physician order's pertaining to resident medications were to be followed as written by the physician.

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	295078	A. Building B. Wing	07/18/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, clinical record review, interview, and document review the facility failed to ensure Dialysis Communication forms were completed and maintained for 1 of 18 sampled residents (Resident #24) and a resident with a hemodialysis catheter did not share a room with a resident who had a wound infected with a multi-drug resistant organism (MDRO) for 1 of 18 sampled residents (Resident #26). Findings include: Resident #24 Resident #24 was admitted to the facility on [DATE], with diagnoses including end stage renal disease, diabetes mellitus type II, and dependence on renal dialysis. Resident #24's physician order dated 04/23/2024, documented dialysis at 11:00 AM every day shift Tuesday, Thursday, and Saturday. Resident #24's Care Plan initiated on 04/24/2024, documented the resident had dialysis at 11:00 AM on Tuesday, Thursday, and Saturday. Interventions included monitor arteriovenous (AV) fistula to left upper arm for bruit and thrill as ordered and monitor for shortness of breath and edema; listen to lung sounds as needed. The following Dialysis Communication Forms were incomplete in Resident #24's clinical record: -05/14/2024 and 06/18/2024: Post-Dialysis Information was undated, unsigned, and lacked a physical assessment for shunt/location status, bruit/Thrill present, bleeding, and general condition of resident. The vital signs were listed, however they were not dated or signed off by a licensed nurse. -07/06/2024: Post-Dialysis Information was undated, unsigned, and lacked a physical assessment for shunt/location status, bruit/thrill present, bleeding, and general condition of resident. The vital signs were listed, however they were not dated. A Licensed Practical Nurse (LPN) signed the form but did not date the signature. On 07/17/2024 at 3:07 PM, an LPN explained the Dialysis Communication Form were to be completed by the facility nurse prior to the resident leaving the facility and upon return to the facility. The Dialysis company was responsible to complete the Dialysis Center Information portion of the form. On 07/18/24 at 8:27 AM, the Director of Nursing (DON) explained the facility nurses were responsible to fill out the Dialysis Communication Form prior to the resident going to dialysis and and then fill out the bottom portion (or Post-Assessment portion) of the form upon the resident's return to the facility. The DON verbalized the expectation of nursing was to assess and document on the form completely or the resident could experience a gap in care. The DON confirmed the missing Post-Assessment portions for the Dialysis Communication Forms on 05/14/2024, 06/18/2024, and 07/06/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Hemodialysis Access Care, revised 09/2010, documented the facility licensed nurse was responsible to complete the pre and post sections of the Dialysis Communication Form. 49557 Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage five and type two diabetes mellitus with diabetic chronic kidney disease. On 07/15/2024 at 1:12 PM, room [ROOM NUMBER] had a Centers for Disease Control (CDC) sign on the door indicating contact precautions were in place. The sign stated everyone must perform hand hygiene before entering and when leaving the room, providers/staff must put on gloves and a gown before entering the room. A Personal Protective Equipment (PPE) cart was located outside the door, in the hallway. The placard on the wall outside the room indicated the room belonged to Resident #26 and Resident #40. Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, and pressure ulcer of right buttock, unstageable. On 07/16/2024 at 8:31 AM, Resident #26 explained the contact precaution sign on the resident's door was intended for Resident #40 due to wounds on Resident #40's legs. Resident #26 denied staff regularly wore a gown or gloves while providing care to Resident #26. Resident #26's Care Plan including a focus of skin: resident with port to right upper chest which was being used. Resident was receiving care via the Enhanced Barrier Precaution (EBP) program. The date initiated was 04/18/2024, with a revision date of 07/05/2024. On 07/16/2024 at 9:48 AM, a Certified Nursing Assistant (CNA) explained the CDC contact precaution sign on the door of room [ROOM NUMBER] was in place because Resident #40 had a wound on the resident's hip. On 07/16/2024 at 1:30 PM, a Licensed Practical Nurse (LPN) explained Resident #40 was on contact precautions due to a wound cultured and positive for Methicillin-Resistant Staphylococcus Aureus (MRSA). An Antimicrobial Susceptibility and Organism Identification Report with a collection date of 06/19/2024, and a reported date of 06/22/2024, documented a culture from Resident #40's right gluteal was positive for MRSA. A progress note dated 06/23/2024, documented Resident #40's dressing on the resident's right glute was saturated and coming off. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 06/27/2024, documented Resident #40's dressing on the resident's right gluteal was saturated and coming off. A progress note dated 07/01/2024, documented Resident #40 was on MRSA precautions. A progress note dated 07/01/2024, documented Resident #40's wound culture came back positive for MRSA. A progress note dated 07/04/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/05/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/11/2024, documented Resident #40's dressing on the resident's right glute was coming off. On 07/16/2024 at 3:15 PM, the Infection Preventionist (IP) confirmed Resident #40 was on contact precautions for MRSA in the resident's wound. The IP explained the IP and/or the physician were able to make decisions on when to place residents on TBP or EBP. The facility used and followed CDC signage when placing a resident on TBP or EBP. EBP was used to protect residents from possible transmission of infection and protected staff so the infection was not carried on clothing. On 07/16/2024 at 3:35 PM, the IP provided a copy of the facility's Transmission-Based Precautions (TBP) policy. The IP confirmed the policy stated residents on contact precautions were to be placed in a private room. The IP confirmed Resident #40 was not in a private room. The IP explained the reason for placing a resident on contact precautions in a private room was to reduce the risk of spread of the resident's infection. The IP confirmed Resident #40's roommate, Resident #26, had a dialysis port in the resident's right upper chest. The IP confirmed placing Resident #26 in a shared room with Resident #40 put Resident #26 at an increased risk of contracting a multi-drug resistant organism (MDRO). On 07/16/2024 at 5:07 PM, during an interview with the DON and in the presence of the IP, the DON confirmed the DON provided oversight of the IP. The DON confirmed MRSA was an MDRO. The DON confirmed the facility's policy stated to place a resident on contact precautions in a private room or with a resident with the same infection with the same microorganism. The DON verbalized the DON knew MRSA could be detrimental to immunocompromised residents. On 07/16/2024 at 7:01 PM, a Health Program Specialist employed by the State, explained it was recommended by the State to the facility to have placed Resident #40 in a single occupancy room or in a room with another resident with a known history of MRSA, if a room was available. The facility had two halls vacant for the exception of three occupied rooms. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Categories of Transmission-Based Precautions, revised 01/2024, documented it was the policy of the facility to follow nationally recognized standards and guidelines for transmission-based (isolation) precautions. Contact precautions were implemented for residents known to be infected or colonized with organisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact precautions included but were not limited to skin or wound infections or colonization with MDROs. Residents were to be placed in a private room or placed with a resident with the same infection with the same microorganism. The facility policy titled Infection Control, revised 01/31/2024, documented the purpose of isolation techniques was to protect the resident and personnel from infection and to halt the spread of infectious agents. The CDC document titled Management of Multidrug-Resistant Organisms in Healthcare Settings (2006), updated October 2022, documented recommendations for MDRO prevention in long-term care facilities included using contact precautions in addition to standard precautions for those residents whose infected secretions or drainage could not be contained. Contact precautions were intended to prevent transmission of infectious agents which were transmitted by direct or indirect contact with the resident or the resident's environment. Recommendations for resident placement included placing residents with MDROs in single-resident rooms or cohorting residents with the same MDRO when a single room was not available. A single resident room was preferred for residents who require contact precautions. The CDC document titled Frequently Asked Questions about Enhanced Barrier Precautions in Nursing Homes, dated 06/28/2024, documented EBP was recommended for residents with indwelling medical devices as indwelling medical devices placed residents at higher risk of carrying or acquiring an MDRO. Indwelling medical devices were described as a direct pathway for pathogens to enter the body and cause infections. Examples of indwelling medical devices included hemodialysis catheters. Cross reference with tag F880

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **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 1) the Director of Nursing (DON) had the knowledge necessary to correctly implement contact precautions for a resident with known infection with a Multi-Drug Resistant Organism (MDRO), and 2) the DON had the knowledge and skills necessary to access resident records and navigate the Electronic Medical Record (EMR) after the facility underwent a change of ownership with a new EMR program. This lack of knowledge had the potential to effect the entire census of 79. Findings include: On 07/15/2024 at 1:12 PM, room [ROOM NUMBER] had a Centers for Disease Control (CDC) sign on the door indicating contact precautions were in place. The sign stated everyone must perform hand hygiene before entering and when leaving the room, providers/staff must put on gloves and a gown before entering the room. A Personal Protective Equipment (PPE) cart was located outside the door, in the hallway. The placard on the wall outside the room indicated the room belonged to Resident #26 and Resident #40. Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage five and type two diabetes mellitus with diabetic chronic kidney disease. Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, and pressure ulcer of right buttock, unstageable. On 07/16/2024 at 8:31 AM, Resident #26 explained the contact precaution sign on the resident's door was intended for Resident #40 due to wounds on Resident #40's legs. Resident #26 denied staff regularly wore a gown or gloves while providing care to Resident #26. A progress note dated 06/23/2024, documented Resident #40's dressing on the resident's right glute was saturated and coming off. A progress note dated 06/27/2024, documented Resident #40's dressing on the resident's right gluteal was saturated and coming off. A progress note dated 07/01/2024, documented Resident #40 was on MRSA precautions. A progress note dated 07/01/2024, documented Resident #40's wound culture came back positive for MRSA. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 07/04/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/05/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/11/2024, documented Resident #40's dressing on the resident's right glute was coming off. A Census List, printed by the facility on 07/18/2024, indicated Resident #26 was moved into room [ROOM NUMBER] on 10/15/2023. A Census List, printed by the facility on 07/18/2024, indicated Resident #40 was moved into room [ROOM NUMBER] on 05/22/2024. On 07/16/2024 at 5:07 PM, during an interview with the DON and in the presence of the IP, the DON explained the intent of Transmission-Based Precautions (TBP) was to prevent the spread of infections. The facility followed CDC and physician recommendations when deciding to place residents on TBP. The DON verbalized it was the DON's understanding if staff entered the resident's room with contact precautions in place and did not come into contact with the resident, staff would not be required to don PPE. The DON confirmed Methicillin-Resistant Staphylococcus Aureus (MRSA) was an MDRO. The DON verbalized the DON knew MRSA could be detrimental to immunocompromised residents. The DON verbalized it was questionable whether a resident on contact precautions should be in a shared room. The DON confirmed the facility's policy stated to place a resident on contact precautions in a private room or with a resident with the same infection with the same microorganism. The DON confirmed Resident #40 had dressings described as saturated prior to 07/15/2024. A Job Description: Director of Nursing Services, signed and dated by the DON on 06/21/2024, documented the primary purpose of the DON position was to ensure the highest quality of resident care was maintained at all times. The DON was responsible for managing all clinical systems of the facility and participating as the lead committee member for those systems including but not limited to the infection prevention and control program. The DON was responsible to ensure all staff followed best standards of practice. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Categories of Transmission-Based Precautions, revised 01/2024, documented it was the policy of the facility to follow nationally recognized standards and guidelines for transmission-based (isolation) precautions. TBP would be implemented, in addition to standard precautions, and were based upon the means of transmission in order to prevent or control infections. Contact precautions were implemented for residents known to be infected or colonized with organisms which could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact precautions included but were not limited to skin or wound infections or colonization with MDROs. Residents were to be placed in a private room or placed with a resident with the same infection with the same microorganism. Gloves were to be worn upon entering the room if contact with the resident or potentially contaminated surfaces was possible. Staff were to wear a gown when entering the room if it was anticipated staff would have substantial contact with the resident, the resident's environment, or items in the resident's room. Gowns were required if the resident had wound drainage not contained by a dressing. The facility policy did not follow CDC guidance regarding gown and glove usage when entering resident rooms with contact precautions in place. The CDC document titled Management of Multidrug-Resistant Organisms in Healthcare Settings (2006), updated 10/2022, documented recommendations for MDRO prevention in long-term care facilities included using contact precautions in addition to standard precautions for those residents whose infected secretions or drainage could not be contained. Contact precautions were intended to prevent transmission of infectious agents which were transmitted by direct or indirect contact with the resident or the resident's environment. Recommendations for resident placement included placing residents with MDROs in single-resident rooms or cohorting residents with the same MDRO when a single room was not available. A single resident room was preferred for residents who require contact precautions. Healthcare personnel caring for residents on contact precautions should wear a gown and gloves for all interactions which may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning a gown and gloves upon room entry and discarding before exiting the resident room was done to contain pathogens. The CDC document titled Transmission-Based Precautions, dated 04/03/2024, documented TBP was a second tier of basic infection control and was to be used in addition to standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions were needed to prevent infection transmission. Contact precautions were to be used for residents with known or suspected infections which represented an increased risk for contact transmission. In long-term care settings, room placement decisions were made while balancing risks to other residents. PPE was to be used appropriately including gloves and a gown. A gown and gloves were to be worn for all interactions which may involve contact with the resident or the resident's environment. Donning PPE upon room entry and properly discarding before exiting the room was done to contain pathogens. Cross reference with tag F880 50210 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/2024 at 3:31 PM, during an interview with the DON and in the presence of the Regional Nurse Consultant, the DON verbalized the DON was not familiar with the facility's fall protocol to include the reference to interdisciplinary team minutes and did not know where to look to find them. The DON left the interview to ask the Assistant DON. Upon return, the DON verbalized being unsure how to access a resident's MAR. Once the MAR was accessed, the DON was not sure how to interpret a checkmark on a resident's MAR for side effect monitoring. The DON confirmed being unable to see whether side effects were exhibited for the resident per the MAR but did not know where to look for documentation of the side effects. The DON left to ask the Assistant DON. Upon return, the DON explained the DON's EMR training was informal and minimal. The facility's DON job description signed by the DON on 06/21/2024, documented the DON was accountable for directing all clinical services of the facility and overseeing nursing staff training upon hire and ongoing in-service education programs.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 50210 Based on observation and interview, the facility failed to ensure nursing hours were posted in the facility's secured memory care unit to be readily accessible to visitors and residents. This restricted access to nursing hours had the potential to affect 27 residents. Findings include: On 07/17/2024 at 9:19 AM, the secured memory care unit lacked nursing hours posted. On 07/17/2024 at 9:19 AM, a Registered Nurse (RN) in the memory care unit verbalized nursing hours were not posted in the facility's secured memory care unit. On 07/18/2024 at 8:50 AM, the Administrator verbalized visitors could use the entrance to the secured memory care unit. On 07/18/2024 at 10:07 AM, the Administrator verbalized the nursing hours were not posted in the facility's secured memory care unit and confirmed the residents in the secured memory care unit did not have access to the nursing hours posted outside the memory care unit.

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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. 49557 Based on observation, interview, and document review the facility failed to ensure expired medications were not kept in a medication cart for 1 of 2 medication carts reviewed for medication storage. Findings include: On 07/17/2024 at 12:36 PM, during a review of a medication cart in the 600 hall and in the presence of a Registered Nurse (RN), the following items were found: -A bottle containing Fish Oil 1200 milligrams (mg) (360 mg Omega-3) capsules. The expiration date on the bottle was January 2024. -A bubble pack containing 25 tablets of Tramadol 50 mg. The expiration date on the bubble pack was 05/14/2024. On 07/17/2024 at 12:41 PM, the RN explained facility staff did a monthly check of the medication cart for expired medications. The RN explained the importance of removing expired medications from a medication cart was residents could get sick if an expired medication was administered. On 07/17/2024 at 2:22 PM, the Director of Nursing (DON) explained failure to remove expired medications from a medication cart could result in a medication error and expired medications, if administered to a resident, may not have the same effect as prescribed. The facility policy titled Pharmaceutical Procedures, revised 01/31/2024, documented all expired medications were to be returned to the pharmacy for proper disposition and crediting considerations. The only exception was for controlled drugs, which would be disposed of on the premises by two licensed staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35601 Based on observation, interview and document review the facility failed to ensure hand washing was performed between the passing of resident beverages, touching residents and in between assisting two residents with eating. Findings include: On 07/15/2024 at 4:55 PM, in preparation for dinner in the 600 hall dining room, a Certified Nursing Assistant (CNA) completed the following sequential tasks without performing hand hygiene between tasks: -The CNA assisted a resident to a dining room seat, patted the seat, and touched the resident's oxygen tubing to reposition the tubing. -Retrieved three glasses and filled with ice and water then served to residents. -Pushed a resident in a wheel chair to a table. -Touched a resident's shoulder. -Entered the satellite pantry, retrieved a coffee pot and mug, poured the cup of coffee, served it to the resident and put the coffee pot back in the satellite pantry. -Retrieved six glasses and filled them with ice and then water. Served water glasses to residents, embraced a resident with a full hug. -Poured two more glasses of water, served, retrieved towels and began placing on residents as bibs. -Put left arm around a resident while talking to the resident. -Placed a right hand on a resident's chest while talking to the resident. -Put a towel bib on a resident. -Retrieved residents from the television area and pushed one resident in a wheel chair to a dining table. -Embraced a resident with a full hug. -Retrieved mugs and placed two mugs in front of two residents, entered the satellite pantry, retrieved a coffee pot and poured for two residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Reentered the satellite pantry, retrieved a pitcher of a milky beverage and poured for two residents. -Reentered the satellite pantry, retrieved juice from fridge and placed pitchers of juice on the counter. -Readjusted a resident's towel bib, repositioned the resident's glasses on their face and placed CNA's right hand on the left knee of the resident. -Touched a resident's right arm and back with the CNA's left hand. On 07/15/2024 at 5:16 PM, the CNA washed their hands. On 07/15/2024 at 5:16 PM, the CNA recalled using hand sanitizer before assisting residents to the dining room, serving residents, and assisting residents with set-up. The CNA confirmed the CNA did not perform hand hygiene to include hand sanitizer between touching each resident. The CNA verbalized the CNA did not have to wash hands when touching residents, such as giving hugs. The CNA verbalized the CNA's preference was to wash hands when handling the cups. On 07/15/2024 at 5:24 PM, the CNA explained the CNA double checked and confirmed the CNA can use only hand sanitizer when serving cups up to a handful of times to include filling ice and water cups and touching residents. 49557 On 07/15/2024 at 5:49 PM, while seating between two residents in the 400 hall dining room, a CNA2 completed the following sequential tasks without performing hand hygiene between tasks: -Provided feeding assistance to a resident. -Assisted a second resident with cleaning up a small amount of food the resident dropped on the table and on the resident's clothing, then provided feeding assistance to the same resident. -Provided feeding assistance to the first resident. -Provided feeding assistance to the second resident. On 07/15/2024 at 5:58 PM, the CNA2 confirmed the CNA2 did not perform hand hygiene between assisting each resident with eating. The CNA2 explained hand hygiene was required to be performed prior to providing feeding assistance for residents and in between each resident. On 07/18/2024 at 9:06 AM, the Director of Nursing (DON) explained hand hygiene was required to be performed by staff prior to any initiation of resident care. The DON confirmed hand hygiene was required to be performed prior to and after meals or contact with each resident. The facility policy titled Infection Control, revised 01/31/2024, documented hand washing was the foundation of controlling infectious disease. Staff were to perform hand washing when between residents. (continued on next page)

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	295078	A. Building B. Wing	07/18/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Handwashing Procedure, adopted 08/2019, documented when to wash hands: every time you enter the satellite pantry, after touching clothes, face, body or hair, after handling soiled equipment, and after engaging in any activity which would contaminate hands. Hand antiseptic may be used after washing hands and was not to be used as a substitute for handwashing.

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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** 50210 Based on interview, document review, and clinical record review, the facility failed to ensure treatment administered, side effect monitoring, pain monitoring, COVID-19 symptom monitoring, and behavior monitoring was documented for 1 of 18 sampled residents (Resident #20). Findings include: Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including unspecified dementia unspecified severity with mood disturbance, Alzheimer's Disease with late onset, anxiety disorder unspecified, and major depressive disorder recurrent unspecified. Treatment A physician's order dated 04/17/2024, documented to apply lotion on shower days every day shift on Wednesdays and Saturdays. Resident #20's June 2024 Treatment Administration Record (TAR) lotion administration had blank spaces on Saturday 06/15/2024. Resident #20's progress notes lacked documented evidence lotion was administered on 06/15/2024. Side Effect Monitoring Resident #20's physician's orders dated 04/17/2024, documented the following: -Monitor antidepressant Amitriptyline common side effects two times a day. indicate letter if observed and document in Electronic Medical Record (EMR) if needed: A. sedation, B. drowsiness, C. dry mouth, D. constipation, E. blurred vision, F. extrapyramidal reaction, G. excess weight gain, H. edema, I. postural hypotension, J. sweating, K. loss of appetite, L. urinary retention, M. nausea and vomiting, N. confusion, O. anxiety, P. other. -Monitor antipsychotic Seroquel common side effects two times a day. Indicate letter if observed and document in EMR if needed: A. sedation, B. drowsiness, C. dry mouth, D. constipation, E. blurred vision, F. extrapyramidal reaction, G. excess weight gain, H. edema, I. postural hypotension, J. sweating, K. loss of appetite, L. urinary retention, M. other. Resident #20's June 2024 TAR documented the following: -Amitriptyline side effect monitoring had blank spaces on 06/06/2024, 06/14/2024, and 06/22/2024. The other dates of the month documented a check for confirmation of side effect monitoring. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seroquel side effect monitoring had blank spaces on 06/06/2024, 06/14/2024, and 06/22/2024. The other dates of the month documented a check for confirmation of side effect monitoring. Resident #20's progress notes lacked documented evidence of antidepressant or antipsychotic side effect monitoring on 06/06/2024, 06/14/2024, and 06/22/2024. Pain Monitoring A physician's order dated 04/17/2024, documented to assess pain every shift using a 0-10 scale or verbal descriptor scale for pain monitoring related to pain in the right hip and other chronic pain. Resident #20's June 2024 TAR had a blank space for pain monitoring on the day shift of 06/15/2024. Resident #20's progress notes lacked documented evidence of pain monitoring on 06/15/2024. COVID-19 Symptom Monitoring A physician's order dated 04/17/2024, documented COVID-19 monitoring to include assessing for fever, cough, sore throat, shortness of breath, headache, chills, vomiting, diarrhea, new loss of taste or smell, muscle pain, and diarrhea. Document N for no symptoms present and Y for symptoms present. Notify the doctor and document symptoms in progress note every shift for COVID-19 screening. Resident #20's June 2024 TAR lacked documented evidence COVID-19 symptoms were monitored during the day shift on 06/15/2024. Resident #20's progress notes lacked documented evidence of COVID-19 symptom monitoring on 06/15/2024. Behavior Monitoring Resident #20's physician's orders dated 04/17/2024, documented the following: - Monitor for target behaviors r/t amitriptyline use. Target Behaviors: 1. yelling out for help, 2. verbal behaviors toward others, 3. physical behaviors toward others, 4) refusal of cares -Monitor for target behaviors related to antipsychotic use two times a day. 1. Refusals of care, 2. verbal behaviors toward others, 3. disruptive behaviors in the dining hall Resident #20's June 2024 TAR documented the following: -Amitriptyline behavior monitoring had blank spaces at 3:00 PM on 06/06/2024, 06/14/2024, and 06/22/2024. The other dates of the month document a check for confirmation of side effect monitoring. -Seroquel behavior monitoring had blank spaces at 3:00 PM on 06/06/2024, 06/14/2024, and 06/22/2024. The other dates of the month document a check for confirmation of side effect monitoring. Resident #20's progress notes lacked documented evidence of antidepressant or antipsychotic behavior monitoring on 06/06/2024, 06/14/2024, and 06/22/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/2024 at 2:07 PM, a Registered Nurse (RN) verbalized a blank space in the TAR would mean the administering nurse did not document in the EMR. If monitoring was not completed, an indication should be documented using the key on the TAR. The RN explained progress notes could be linked with further descriptions if the monitoring had not occurred. The RN confirmed blank spaces on Resident #20's June 2024 TAR for treatment, side effect monitoring, pain monitoring, COVID-19 symptom monitoring, and behavior monitoring on the days and times mentioned above. On 07/17/2024 at 2:33 PM, a Licensed Practical Nurse (LPN) explained a blank space on the TAR could mean the time frame for administration passed. For monitoring, administering nurses had the whole shift to observe and document. The LPN verbalized even if the resident was not available or outside of the facility, the administering nurse should indicate it on the TAR. On 07/17/2024 at 4:06 PM, the Director of Nursing (DON) confirmed blank spaces on the TAR for treatment, side effect monitoring, pain monitoring, COVID-19 symptom monitoring, and behavior monitoring on the days and times mentioned above. The DON explained those blank spaces meant the administering nurses forgot to document on those days and times. The facility policy titled Psychoactive Medication Use, Intervention and Monitoring, revised 12/2016, documented if the resident was treated for altered behavior, the interdisciplinary team would document any improvements or worsening in the individual's behavior, mood, and function. If the resident used psychoactive medications, the psychotropic committee would monitor for side effects and complications related to those medications.

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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** 43311 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) Enhanced Barrier Precautions (EBP) were implemented for 2 of 7 sampled residents (Resident #58 and #69), 2) the facility peformed active infection surveillance for July 2024, 3) a Licensed Practical Nurse (LPN) performed hand hygiene between residents while administering medications and 4) a resident on contact precautions did not share a room with another resident who did not have the same infection with the same microorganism, did not have meals in a shared dining room, and staff understood the Personal Protective Equipment (PPE) requirements when entering a room with contact precuation signage in place for 1 of 18 sampled residents (Resident #40). Findings include: Enhanced Barrier Precautions Resident #58 Resident #58 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus without complications, benign prostatic hyperplasia without lower urinary tract symptoms, and acute on chronic respiratory failure with hypoxia. A physician order dated 04/25/2024, documented 16 French 10 cubic centimeters (cc) Foley catheter as needed related to neuromuscular dysfunction of bladder, unspecified. Resident #69 Resident #69 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, apraxia, dysarthria and anarthria, and pressure ulcer of sacral region, Stage III. A physician order dated 07/10/2024, documented the following for wound treatment: -cleanse coccyx with wound cleaner, pat dry, apply hydrogel to wound bed and cover with foam dressing. Monitor for any signs or symptoms of infection, notify provider with any concerns. Every day shift Monday, Wednesday, Saturday related to pressure ulcer of sacral region, Stage III. Resident #69's Care Plan, last reviewed 06/03/2024, documented the resident's care was to be provided using EBP protocol. On 07/15/2024 at 5:35 PM, during a facility tour, Resident #69 and Resident #58's rooms did not have an EBP sign on the resident's room door or on the wall outside of each door. Both rooms lacked a PPE cart outside the room doors. On 07/16/2024 at 1:54 PM, the IP/ADON explained any resident receiving wound care should have EBP and confirmed Resident #69 received wound care three times weekly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/2024 at 2:42 PM, Resident #69 and #58's rooms did not have EBP signage on the room door or a PPE cart outside the rooms. On 07/16/2024 at 2:47 PM, the IP/ADON explained each resident on EBP should have a sign on the door indicating EBP in use and what PPE to wear. The IP/ADON verbalized all residents with an indwelling catheter would be placed on EBP and confirmed Resident #58 had an indwelling catheter. On 07/16/2024 at 3:15 PM, the IP/ADON communicated the facility used the Centers for Disease Control (CDC) signage for resident precautions. EBP would include residents with a Foley catheter, an ostomy, and a wound requiring a dressing change. The IP/ADON explained the purpose of using the EBP was to protect the resident from possible transmission of infection and to protect staff from carrying the infection on staff clothing. On 07/16/2024 at 5:07 PM, the Director of Nursing (DON) explained infection precautions were based on the provider's recommendations and the CDC recommendations for EBP, PPE, and isolation. The DON communicated the infection control program was intended to prevent the spread of infection and prevent cross-contamination between the staff and residents and the IP was responsible for the program. The DON expected staff to don/doff gowns and gloves during care of resident's on EBP. On 07/18/2024 at 8:39 AM, the IP/ADON confirmed the facility followed the CDC guidance for infection control. The IP/ADON confirmed the facility did not follow CDC standards with the lack of EBP signage and PPE carts at the point of care for Resident #58 and #69. The facility policy titled Infection Control, revised 01/31/2024, documented all residents with known or suspected infectious conditions would be cared for using the most appropriate nursing care for the benefit and safety of the resident concerned, the other residents in the facility, and employee safety. A Centers for Medicare and Medicaid memo titled Quality, Safety, and Oversight (QSO)-24-08-Nursing Homes (NH), dated 03/20/2024, documented EBP recommendations included the use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of the multidrug-resistant organism status, in addition to residents who had an infection or colonization with a CDC-targeted other epidemiologically important [NAME] Drug Restistant Organisms (MDROs). Staff should be aware of which residents require the use of EBP prior to providing high-contact care. It was critical to ensure staff had awareness of the facility's expectations about hand hygiene and gown/glove use and access to appropriate supplies. This was accomplished by the following: Surveillance On 07/16/2024 at 1:58 PM, the Antibiotic Stewardship binder did not include infections, antibiotic use, tracking, room mapping, or trending for July 2024. The IP/ADON could not produce a Monthly Antibiotic/Infection Control Log for July 2024 and confirmed the IP/ADON had not yet performed infection trending or tracking for the month of July because the IP had been on vacation. The IP/ADON explained the IP/ADON kept track of infections in handwritten notebooks throughout the month and confirmed the IP/ADON had not yet started an infection notebook for July 2024 and could not produce the June 2024 notebook. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/2024 at 3:01 PM, the IP/ADON explained the facility used Point Click Care (PCC) as the facility's electronic documentation system. PCC included a screening tool completed by nursing staff when an infection was suspected. The IP/ADON would see the information on the dash board in PCC, discuss the resident in the daily clinical meeting, would document the discussion in the handwritten notebook, and transfer the information to the Monthly Antibiotic/Infection Control Log at the end of each month. An infection map was used to locate each type of infection by resident room and was completed monthly. The IP/ADON confirmed a map for July 2024 had not yet been created and would only include residents who were taking an antibiotic, omitting residents with infections not currently treated with antibiotics, including a wound infection of Methicillin Resistant Staphylococcus Aureus (MRSA). The IP/ADON explained the IP/ADON would not know if an infection was currently contained or spreading throughout the facility as there was not a current infection map for July 2024. On 07/18/2024 at 9:10 AM, the Administrator confirmed the IP/ADON was responsible for oversight and execution of the Infection Control and Prevention Program and the Antibiotic Stewardship program. A job description titled Assistant Director of Nursing, documented the primary responsibilities of the ADON included supervision of the infection control and antibiotic stewardship program. Specific duties included completion of the weekly Infection Control Report, review numbers of infections and isolations to determine areas of concern, monitor completion of weekly measurements and documentation of wounds, and monitor/ensure compliance of standard precautions, the vaccine program, bloodborne pathogens, and CDC guidelines for isolation/treatment of infections. 49557 Hand Hygiene During Medication Pass On 07/17/2024, during the medication pass from 4:11 PM through 4:24 PM, an LPN administered medications to five residents and did not perform hand hygiene prior to preparing medication for each resident, prior to administering medication to each resident, or after administering medication to each resident. On 07/17/2024 at 4:25 PM, the Licensed Practical Nurse (LPN) confirmed the LPN did not perform hand hygiene prior to medication preparation and administration or after medication administration. The LPN explained hand hygiene was required to be performed between each resident. On 07/18/2024 at 9:06 AM, the DON explained hand hygiene was required to be performed by staff prior to any initiation of care with a resident. The DON confirmed hand hygiene was required to be performed during medication pass, prior to and after each resident interaction. The facility policy titled Infection Control, revised 01/31/2024, documented hand washing was the foundation of controlling infectious disease. Personnel were to wash hands when between residents. Contact Precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/15/2024 at 1:12 PM, room [ROOM NUMBER] had a sign on the door indicating contact precautions were in place. The sign stated everyone must perform hand hygiene before entering and when leaving the room, providers/staff must put on gloves and a gown before entering the room. A PPE cart was located outside the door, in the hallway. The placard on the wall outside the room indicated the room belonged to Resident #40 and Resident #26. Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage five and type two diabetes mellitus with diabetic chronic kidney disease. Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, and pressure ulcer of right buttock, unstageable. On 07/16/2024 at 8:31 AM, Resident #26 explained the contact precaution sign on the resident's door was intended for Resident #40 due to wounds on Resident #40's legs. Resident #26 denied staff regularly wore a gown or gloves while providing care to Resident #26. On 07/16/2024 at 9:16 AM, a Certified Nursing Assistant (CNA)1 entered room [ROOM NUMBER]. The CNA1 was not wearing a gown or gloves. On 07/16/2024 at 9:48 AM, a CNA2 explained the sign on the door of room [ROOM NUMBER] was in place because Resident #40 had a wound on the resident's hip. The CNA2 further explained the sign was intended to notify staff to don a gown when providing care to Resident #40 if the care required physical contact with the resident. The CNA2 verbalized a gown was not required when providing care to Resident #26. On 07/16/2024 at 1:30 PM, an LPN explained staff received infection control training quarterly. The LPN confirmed the training covered the topics of EBP and transmission-based precautions (TBP). The LPN explained staff knew a resident was on EBP or TBP by a sign on the resident's door. The LPN verbalized the sign would instruct staff on what PPE was required and when staff was required to wear it. The LPN explained Resident #40 was on contact precautions due to a wound cultured and positive for Methicillin-Resistant Staphylococcus Aureus (MRSA). The sign meant staff were required to don a gown and gloves for hands on care for Resident #40 such as showers, transfers, and changing the resident's clothing. A gown and gloves were not required when staff were only walking in the room. The LPN explained the intent of using a gown and gloves when providing care to Resident #40 was to prevent the transfer of MRSA onto staff clothing which could then be transferred to other residents. An Antimicrobial Susceptibility and Organism Identification Report with a collection date of 06/19/2024, and a reported date of 06/22/2024, documented a culture from Resident #40's right gluteal was positive for MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #40's Care Plan included a focus of MRSA: The resident had MRSA to a stage four pressure injury to right gluteal. The date initiated was 07/01/2024, and was revised on 07/15/2024. Interventions included: -Contact Precautions. Wear gown and masks when changing contaminated linens. Place soiled linens in marked biohazard. Bag linens and close bag tightly before taking to laundry. -Mask/face shield to be worn during procedures with risk of splashes or droplet contamination of bodily fluids. -Observe standard precautions for infection control. -Open wounds should be kept covered, rather than open to air. -Resident areas to be thoroughly cleaned using disinfectants. -Resident care equipment to be appropriately cleaned, disinfected or sterilized according to facility protocol. A progress note dated 06/23/2024, documented Resident #40's dressing on the resident's right glute was saturated and coming off. A progress note dated 06/27/2024, documented Resident #40's dressing on the resident's right gluteal was saturated and coming off. A progress note dated 07/01/2024, documented Resident #40 was on MRSA precautions. A progress note dated 07/01/2024, documented Resident #40's wound culture came back positive for MRSA. A progress note dated 07/04/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/05/2024, documented Resident #40's dressing on the resident's right glute was saturated and falling off. A progress note dated 07/11/2024, documented Resident #40's dressing on the resident's right glute was coming off. Progress notes dated from 06/23/2024 through 07/14/2024, documented Resident #40 was in the shared dining room for meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/2024 at 3:01 PM, the Minimum Data Set (MDS) Coordinator explained the MDS Coordinator updated residents' care plans based on interviews with the residents, meetings held with the interdisciplinary team (IDT), and clinical record review. The MDS Coordinator confirmed Resident #40's care plan included an intervention for contact precautions due to MRSA. The MDS Coordinator explained this intervention was added to Resident #40's care plan by the MDS Coordinator after the MDS Coordinator read a progress note in the resident's clinical record. The progress note indicated a lab result came back showing the resident was positive for MRSA. The MDS Coordinator explained adding the intervention to the care plan would give floor staff access to see the resident was positive for MRSA and the interventions needing to be implemented. The MDS Coordinator then verbalized the IP/ADON would be responsible to place precaution signage on the resident's door and a PPE cart in the hall. On 07/16/2024 at 3:15 PM, the IP/ADON explained the IP/ADON and/or the physician were able to make decisions on when to place residents on TBP or EBP. The IP/ADON used resident symptoms to guide the decision on which precautions were appropriate and if a resident had a wound the facility was culturing it would be more of a contact thing. The IP/ADON verbalized the facility used and followed CDC signage when placing a resident on TBP. The IP/ADON explained contact precautions were used when contact was how a possible contaminant was spread, staff were to wear a gown and gloves when providing care. The IP/ADON explained if a resident was on contact precautions due to a wound, and the wound was covered with a dressing, staff were not required to wear PPE if the care being provided did not include contact with the resident. The IP/ADON explained examples of when EBP was used were when residents had ostomies, catheters, and any wound requiring a dressing change. EBP was used to protect residents from possible transmission of infection and protected staff so the infection was not carried on clothing. With EBP, care such as showering, transfers, and anything with close contact required staff to wear a gown and gloves. The IP/ADON verbalized contact precautions and EBP were similar and it depended on if the infected area was covered or not. The IP/ADON explained the facility had one resident on contact precautions and the resident was allowed to come out of the resident's room and eat meals in the shared dining room because the resident's wound was covered. The IP/ADON confirmed the resident the IP/ADON was referring to was Resident #40. On 07/16/2024 at 3:21 PM, the IP/ADON retrieved a copy of the CDC signage the facility used for EBP and contact precautions and placed them side by side. The IP/ADON confirmed the sign for EBP instructed staff to don a gown and gloves prior to high-contact care activities. The IP/ADON confirmed the contact precautions sign instructed staff to don a gown and gloves prior to room entry and the sign did not specify PPE was only required for direct contact with the resident. The IP/ADON explained Resident #40 was previously on EBP. The resident was later placed on contact precautions after a culture of the resident's wound was positive for MRSA. The IP/ADON believed the wound culture result was received on 06/29/2024. The intent of placing Resident #40 on contact precautions was so staff would know the resident had an infection with the potential to spread. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Elko Rehabilitation LLC	2850 Ruby Vista Drive Elko, NV 89801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/2024 at 3:35 PM, the IP/ADON provided a copy of the facility's TBP policy. The IP/ADON confirmed the policy stated residents on contact precautions were to be placed in a private room. The IP/ADON confirmed Resident #40 was not in a private room. The IP/ADON confirmed Resident #40's roommate, Resident #26, had a dialysis port in the resident's right upper chest. The IP/ADON confirmed placing Resident #26 in a shared room with Resident #40 put Resident #26 at an increased risk of contracting an MDRO. On 07/16/2024 at 5:07 PM, during an interview with the DON and in the presence of the IP/ADON, the DON confirmed the DON provided oversight of the IP/ADON. The DON confirmed MRSA was an MDRO. The DON explained the intent of TBP was to prevent the spread of infections. The facility followed CDC and physician recommendations when deciding to place residents on TBP. The DON verbalized it was the DON's understanding if staff entered a resident's room with contact precautions in place, and did not come into contact with the resident, staff would not be required to don PPE. The DON verbalized the DON knew MRSA could be detrimental to immunocompromised residents. The DON verbalized it was questionable whether a resident on contact precautions should be in a shared room. The DON confirmed the facility's policy stated to place a resident on contact precautions in a private room or with a resident with the same infection with the same microorganism. The DON confirmed Resident #40 had dressings described as saturated prior to 07/15/2024. On 07/17/2024 at 7:07 AM, Resident #26 was observed to have been moved to another room. Resident #40 remained in room [ROOM NUMBER], a CDC contact precautions sign remained on the door, and a PPE cart remained in the hall near the resident's doorway. The facility policy titled Infection Control, revised 01/31/2024, documented residents who were diagnosed as having an infectious disease or condition which did not warrant strict isolation procedures were to be restricted to the residents' rooms if the infection could not be contained. Activities were to be controlled such as going to the dining room and visitors to the room were to be limited. The purpose of isolation techniques was to protect the resident and personnel from infection and to halt the spread of infectious agents. The facility policy titled Categories of Transmission-Based Precautions, revised 01/2024, documented it was the policy of the facility to follow nationally recognized standards and guidelines for transmission-based (isolation) precautions. Transmission-based precautions would be implemented, in addition to standard precautions, and were based upon the means of transmission in order to prevent or control infections. Contact precautions were implemented for residents known to be infected or colonized with organisms which could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact precautions included but were not limited to skin or wound infections or colonization with MDROs. Residents were to be placed in a private room or placed with a resident with the same infection with the same microorganism. Gloves were to be worn upon entering the room if contact with the resident or potentially contaminated surfaces was possible. Staff were to wear a gown when entering the room if it was anticipated staff would have substantial contact with the resident, the resident's environment, or items in the resident's room. Gowns were required if the resident had wound drainage not contained by a dressing. The facility policy did not follow CDC guidance regarding gown and glove usage when entering resident rooms with contact precautions in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDC document titled Management of Multidrug-Resistant Organisms in Healthcare Settings (2006), updated 10/2022, documented recommendations for MDRO prevention in long-term care facilities included using contact precautions in addition to standard precautions for those residents whose infected secretions or drainage could not be contained. Contact precautions were intended to prevent transmission of infectious agents which were transmitted by direct or indirect contact with the resident or the resident's environment. Recommendations for resident placement included placing residents with MDROs in single-resident rooms or cohorting residents with the same MDRO when a single room was not available. A single resident room was preferred for residents who require contact precautions. Healthcare personnel caring for residents on contact precautions should wear a gown and gloves for all interactions which may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning a gown and gloves upon room entry and discarding before exiting the resident room was done to contain pathogens. The CDC document titled Transmission-Based Precautions, dated 04/03/2024, documented contact precautions were to be used for residents with known or suspected infections which represented an increased risk for contact transmission. Transport and movement of residents outside of the resident's room was to be limited to medically-necessary purposes. When transport or movement was necessary, infected or colonized areas of the resident's body were to be covered and staff were to don clean PPE to handle the resident at the transport location. A CDC document titled Implementation of PPE Use in Nursing Homes to Prevent Spread of MDROs, dated 07/12/2022, described EBP as an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP involved gown and glove use during high contact resident care areas for residents known to be colonized or infected with an MDRO, as well as those at increased risk of acquiring MDROs, such as residents with wounds or indwelling medical devices. Effective EBP implementation required staff training on PPE and the availability of PPE and hand hygiene supplies at the point of care. Cross reference with tag F698, F726, F881, and F882

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on document review and interview, the facility failed to ensure tracking and trending of infections and antibiotic use was accurately monitored and completed for July 2024 for 2 of 2 residents on an antibiotic and diagnosed with an infection (Resident #13 and #8). The deficient practice had the potential to affect the facility's entire resident census of 79. Findings include: Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including unspecified fracture of shaft of humerus, left arm, subsequent encounter for fracture with routine healing. A physician order dated 07/01/2024, documented Ciprofloxacin Hydrochloride (HCl) oral tablet 750 milligrams (mg), give 750 mg by mouth two times a day for arm infection related to unspecified fracture of shaft of humerus, left arm, subsequent encounter for fracture with routine healing. Resident #8 Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia and other specified urinary incontinence. A physician order dated 07/13/2024, documented Doxycycline Hyclate oral tablet 100 mg give one tablet by mouth two times a day for elevated white blood cells (WBC) for five days. A physician order dated 07/14/2024, documented Amoxicillin oral capsule 500 mg, give two capsules by mouth two times a day for elevated WBC until 07/17/2024. On 07/16/2024, the Antibiotic Stewardship binder lacked identification of infections, antibiotic use, tracking, room mapping, and trending for July 2024. The facility lacked a Monthly Antibiotic /Infection Control Log for July 2024. On 07/16/2024 at 1:58 PM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) could not produce a Monthly Antibiotic/Infection Control Log for July 2024, and confirmed the IP/ADON had not performed infection trending or tracking for the month of July 2024, for a total of 16 days. The IP/ADON explained the IP/ADON kept track of infections in handwritten notebooks throughout the month and confirmed the IP/ADON had not yet started an infection notebook for July 2024, because the IP/ADON had been on vacation for three days in July. The IP/ADON explained the person covering the IP/ADON did not have access to the Monthly Antibiotic/Infection Control Log and could not create or update the document with active infections and antibiotic use for July 2024, during the IP/ADON's absence. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/16/2024 at 3:01 PM, the IP/ADON explained the facility used Point Click Care (PCC) as the facility's electronic documentation system. PCC included a screening tool completed by nursing staff when an infection was suspected. The IP would see the information on the dash board in PCC, discuss the resident in the daily clinical meeting, and would document this in the handwritten notebook and then transfer the information to the Monthly Antibiotic/Infection Control Log at the end of each month. An infection map was to be used to locate each type of infection by resident room and was to be completed monthly. The IP confirmed a map for July 2024 had not yet been created and would only include residents who were taking an antibiotic, omitting residents with infections, not currently treated with antibiotics. The IP/ADON lacked an understanding of the difference between tracking infections and tracking antibiotics to treat infections. Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, and pressure ulcer of right buttock, unstageable. On 07/16/2024 at 1:30 PM, a Licensed Practical Nurse (LPN) explained Resident #40 was on contact precautions due to a wound cultured and positive for Methicillin-Resistant Staphylococcus Aureus (MRSA). An Antimicrobial Susceptibility and Organism Identification Report with a collection date of 06/19/2024, and a reported date of 06/22/2024, documented a culture from Resident #40's right gluteal was positive for MRSA. On 07/16/2024 at 3:35 PM, the IP/ADON confirmed the lack of tracking infections for July 2024, placed the other residents at an increased risk of contracting a multi-drug resistant organism (MDRO) or other infections. On 07/16/2024 at 5:07 PM, during an interview with the Director of Nursing (DON) and in the presence of the IP/ADON, the DON confirmed the DON provided oversight of the IP/ADON. The DON confirmed MRSA was an MDRO. The DON verbalized the DON knew MRSA could be detrimental to immunocompromised residents. On 07/18/2024 at 9:10 AM, the Administrator confirmed the IP/ADON was responsible for the execution of the Infection Control and Prevention Program and the Antibiotic Stewardship program. The facility policy titled Antibiotic Stewardship, revised 01/31/2024, documented the facility would follow an Antibiotic Stewardship program which included the core elements as outlined by the CDC. The Infection Preventionist was the designated coordinator of the Infection Prevention and Control Program. The facility would track antibiotic use daily and would monitor for all adverse reactions/outcomes related to antibiotic therapy. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A CDC document titled Core Elements of Antibiotic Stewardship for Nursing Homes, dated 03/18/2024, documented the seven core elements of the ASP was as follows: -Leadership Commitment: Demonstrate and support safe and appropriate antibiotic use. -Accountability: Identify nursing, physician, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship. -Drug expertise: establish access to individuals with experience or training in antibiotic stewardship. -Action: Implement at least policy or practice to improve antibiotic use. -Tracking: Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use in the facility. -Reporting: Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff, and other relevant staff. Cross-reference with tag F880 and F882

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on observation, interview, clinical record review, and document review, the facility failed to 1) ensure the Infection Preventionist (IP) had the education and competency to demonstrate the tracking and trending of infections was accurately completed and monitored with the potential to affect the facility's entire resident census of 79, 2) retain education and training when the Infection Preventionist did not demonstrate competency in the implementation of the Antibiotic Stewardship Program (ASP) and infection surveillance (lack of competency in medication differentiation, inaccurate infection control log, lack of infection surveillance), and 3) demonstrate understanding of contact precautions and following of the Center for Disease Control (CDC) guidance related to the implementation of contact precautions for 1 of 18 sampled residents (Resident #40). Findings include: Education/Competency On 07/16/2024 at 1:58 PM, the Antibiotic Stewardship binder did not include infections, antibiotic use, tracking, room mapping, or trending for July 2024. The Infection Preventionist (IP)/Assistant Director of Nursing (ADON) could not produce a Monthly Antibiotic/Infection Control Log for July and confirmed the IP/ADON had not yet performed infection trending or tracking for the month of July 2024, because the IP/ADON had been on vacation for three days in July. The IP/ADON explained the IP/ADON usually kept track of infections in handwritten notebooks throughout the month and confirmed the IP/ADON had not yet started an infection notebook for July 2024. On 07/16/2024 at 3:01 PM, the IP/ADON explained an infection map was to be used to locate each type of infection by resident room and was to be completed monthly to identify trends. The IP/ADON explained the infection tracking and mapping occurred at the end of the month and would not have a current infection or antibiotic resident list. The IP/ADON confirmed a map for July 2024, had not yet been created and would only include residents who were taking an antibiotic, thus omitting residents with infections not currently treated with antibiotics. ASP On 07/16/2024, the Antibiotic Stewardship binder lacked identification of infections, antibiotic use, tracking, room mapping, and trending for July 2024. On 07/16/2024, in the afternoon, the IP/ADON was asked to produce a list of all residents currently on antibiotics. On 07/16/2024 at 2:37 PM, the IP/ADON produced an Order Listing Report dated 07/16/2024 and printed at 2:06 PM, which was generated from the facility's electronic documentation system. The report listed five residents who were supposed to be prescribed antibiotics, however only two of the residents were on an antibiotic, two residents were on an antifungal medication, and one resident was on an anti-viral medication. The IP/ADON confirmed the provided list was accurate and complete to include all residents currently on an antibiotic. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP/ADON lacked the understanding of the difference between an antibiotic medication, an antifungal medication, and an antiviral medication. On 07/16/2024 at 3:01 PM, the IP/ADON verbalized the IP/ADON had not been tracking infections not associated with an antibiotic prescription and did not include those infections on the facility mapping to trend infection spread. The IP/ADON explained the IP/ADON would not know if an infection was currently contained or spreading throughout the facility as there was not a current infection map for July 2024. The IP/ADON explained the daily stand up meeting members would discuss any new infections or suspected infections but did not document the data or map the rooms to ascertain infection spread throughout the facility. The IP/ADON confirmed the lack of surveillance of infections and antibiotics for July 2024. On 07/18/2024 at 9:10 AM, the Administrator confirmed the IP was responsible for the execution of the Infection Control and Prevention Program and the Antibiotic Stewardship program. The Administrator confirmed the lack of an IP job description and explained the role was considered a nursing role of the ADON. A job description titled Assistant Director of Nursing, documented the primary responsibilities of the ADON included supervision of the infection control and antibiotic stewardship program. Specific duties included completion of the weekly Infection Control Report, reviewed numbers of infections and isolations to determine areas of concern, monitor completion of weekly measurements and documentation of wounds, and monitor/ensure compliance of standard precautions, the vaccine program, bloodborne pathogens, and CDC guidelines for isolation/treatment of infections. The facility policy titled Antibiotic Stewardship, revised 01/31/2024, documented the facility would follow an Antibiotic Stewardship program which included the core elements as outlined by the CDC. The Infection Preventionist was the designated coordinator of the Infection Prevention and Control Program. The facility would track antibiotic use daily and would monitor for all adverse reactions/outcomes related to antibiotic therapy. A CDC document titled Core Elements of Antibiotic Stewardship for Nursing Homes, dated 03/18/2024, documented the seven core elements of the ASP was as follows: -Leadership Commitment: Demonstrate and support safe and appropriate antibiotic use. -Accountability: Identify nursing, physician, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship. -Drug expertise: establish access to individuals with experience or training in antibiotic stewardship. -Action: Implement at least policy or practice to improve antibiotic use. -Tracking: Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use in the facility. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Reporting: Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff, and other relevant staff. Cross-reference with tag F880, F881, and F883 49557 Contact Precautions On 07/15/2024 at 1:12 PM, room [ROOM NUMBER] had a CDC sign on the door indicating contact precautions were in place. The sign stated everyone must perform hand hygiene before entering and when leaving the room, providers/staff must put on gloves and a gown before entering the room. A Personal Protective Equipment (PPE) cart was located outside the door, in the hallway. The placard on the wall outside the room indicated the room belonged to Resident #40 and Resident #26. Resident #40 Resident #40 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, and pressure ulcer of right buttock, unstageable. Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic kidney disease, stage five and type two diabetes mellitus with diabetic chronic kidney disease. On 07/16/2024 at 8:31 AM, Resident #26 explained the contact precaution sign on the resident's door was intended for Resident #40 due to wounds on Resident #40's legs. Resident #26 denied staff regularly wore a gown or gloves while providing care to Resident #26. On 07/16/2024 at 3:15 PM, the IP/ADON explained the IP/ADON and/or the physician were able to make decisions on when to place residents on TBP or EBP. The IP used resident symptoms to guide the decision on which precautions were appropriate and if a resident had a wound the facility was culturing it would be more of a contact thing. The IP/ADON verbalized the facility used and followed CDC signage when placing a resident on TBP. The IP/ADON explained if a resident was on contact precautions due to a wound, and the wound was covered with a dressing, staff were not required to wear PPE if the care being provided did not include contact with the resident. The IP/ADON verbalized contact precautions and EBP were similar and it depended on if the infected area was covered or not. On 07/16/2024 at 3:21 PM, the IP/ADON retrieved a copy of the CDC signage the facility used for EBP and contact precautions and placed them side by side. The IP/ADON confirmed the sign for EBP instructed staff to don a gown and gloves prior to high-contact care activities. The IP/ADON confirmed the contact precautions sign instructed staff to don a gown and gloves prior to room entering the room and sign did not specify PPE was only required for direct contact with the resident. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP/ADON explained Resident #40 was previously on EBP and was later placed on contact precautions when a culture of the resident's wound was positive for MRSA. The IP/ADON believed the culture result was received on 06/29/2024, and the intent of placing Resident #40 on contact precautions was so staff would know the resident had an infection with the potential to spread. On 07/16/2024 at 3:35 PM, the IP/ADON provided a copy of the facility's TBP policy. The IP/ADON confirmed the policy stated residents on contact precautions were to be placed in a private room. The IP/ADON confirmed Resident #40 was not in a private room. A Job Description: Assistant Director of Nursing, signed and dated by the IP/ADON on 06/26/2023, documented the IP/ADON was responsible to monitor and ensure compliance with CDC guidelines for isolation/treatment of infections. The facility policy titled Categories of Transmission-Based Precautions, revised 01/2024, documented it was the policy of the facility to follow nationally recognized standards and guidelines for transmission-based (isolation) precautions. Transmission-based precautions would be implemented, in addition to standard precautions, and were based upon the means of transmission in order to prevent or control infections. Contact precautions were implemented for residents known to be infected or colonized with organisms which could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact precautions included but were not limited to skin or wound infections or colonization with MDROs. Residents were to be placed in a private room or placed with a resident with the same infection with the same microorganism. The CDC document titled Management of Multidrug-Resistant Organisms in Healthcare Settings (2006), updated 10/2022, documented recommendations for MDRO prevention in long-term care facilities included using contact precautions in addition to standard precautions for those residents whose infected secretions or drainage could not be contained. Recommendations for resident placement included placing residents with MDROs in single-resident rooms or cohorting residents with the same MDRO when a single room was not available. A single resident room was preferred for residents who require contact precautions. Healthcare personnel caring for residents on contact precautions should wear a gown and gloves for all interactions which may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning a gown and gloves upon room entry and discarding before exiting the resident room was done to contain pathogens. The CDC document titled Transmission-Based Precautions, dated 04/03/2024, documented contact precautions were to be used for residents with known or suspected infections which represented an increased risk for contact transmission. The CDC document titled Frequently Asked Questions about Enhanced Barrier Precautions in Nursing Homes, dated 06/28/2024, documented EBP differed from contact precautions as contact precautions required the use of a gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on clinical record review, interview, and document review the facility failed to ensure a resident was screened for eligibility to receive the influenza and pneumococcal vaccinations for 1 of 5 residents sampled for vaccinations (Resident #26). Findings include: Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnoses including chronic kidney disease, Stage IV, type II diabetes mellitus with diabetic chronic kidney disease, dependence on renal dialysis, and acute and chronic respiratory failure with hypoxia. A facility document titled Influenza Vaccine Immunization Assessment/Consent, signed 05/02/2023, documented the following: -Risk Assessment: blank -Assessment for contraindications to pneumococcal vaccine: blank -Consent for immunization: signed by resident and documented the influenza vaccine was administered on 05/02/2023. A facility document titled Pneumococcal Vaccine Immunization Assessment/Consent, signed 05/02/2023, documented the following: -Assessment of pneumococcal immunization status: blank -Assessment for Contraindications: blank -Consent for immunization: signed by resident on 05/02/2023. Resident #26's clinical record lacked documented evidence the resident was screened for eligibility to receive the influenza and pneumococcal vaccines. On 07/18/2024 at 8:45 AM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) communicated the expectation was for all residents to be screened for eligibility of the pneumococcal and influenza vaccines to ensure it was safe to administer the vaccinations to the residents. The IP/ADON confirmed Resident #26 had signed the consent and received the vaccinations but was not screened for eligibility of the influenza and pneumococcal vaccines prior to administration. On 07/18/2024 at 9:10 AM, the Administrator confirmed the IP was responsible for the execution of the Infection Control and Prevention Program and the Antibiotic Stewardship program. The Administrator confirmed the lack of an IP job description and explained the role was considered a nursing role of the ADON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor of Elko Rehabilitation LLC	2850 Ruby Vista Drive Elko, NV 89801

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Influenza Vaccination, revised on 01/31/2024, documented a resident's immunization status was assessed annually and were screened for contraindication prior to administering the vaccine. The facility policy titled Pneumococcal Vaccination, revised on 01/31/2024, documented all residents aged [AGE] years or more and all residents determined to be at high risk would be offered the pneumococcal vaccine as recommended by the CDC. The resident would be screened for contraindications prior to administering the pneumococcal vaccine.