STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295106	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trellis Centennial	8565 W Rome Blvd Las Vegas, NV 89149

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a care plan for anticoagulant use was formulated and a physician order was obtained for monitoring the resident while on anticoagulant (blood thinning) therapy for 1 of 19 sampled residents (Resident 166). This deficient practice had the potential to result in unrecognized bleeding complications, delayed medical intervention, and serious adverse outcomes such as internal bleeding, hospitalization , or death. Findings include: Resident 166 (R166) R166 was admitted on [DATE], with diagnoses including dementia, Parkinson's disease, and abnormalities of gait and mobility. The Minimum Data Set (MDS) dated [DATE], documented R166 had an anticoagulant with indication. The History and Physical dated 04/28/2025, documented the plan was to administer Lovenox for deep vein thrombosis (blood clot). A Physician order dated 04/28/2025, documented Lovenox injection solution prefilled syringe 40 milligrams (mg) 4 milliliters (ml). Inject 40 mg subcutaneously daily at 8:00 AM for deep vein thrombosis. The Medication Administration Record (MAR) from 04/28/2025 to 05/07/2025 documented the Lovenox was administered nine (9) times. R166's medical records lacked documented evidence a care plan for anticoagulant use was formulated, a physician order was obtained, and monitoring for anticoagulant therapy was implemented. On 05/07/2025 at 12:15 PM, a Licensed Practical Nurse (LPN) explained monitoring residents on anticoagulant therapy included a care plan, routine assessments for signs of bleeding such as bruising, bleeding gums, hematuria, and black tarry stools and then notifying the physician of any abnormal findings. The LPN confirmed no physician order was in place to monitor for bleeding until 05/07/2025. The LPN indicated a physician order should have been obtained and R166 should have been monitored. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2025 at 8:07 AM, during the medication pass, a Registered Nurse (RN) administered Lovenox to R166 without assessing for signs of bleeding or adverse reactions. The injection was given in the abdominal area. On 05/08/2025 at 4:20 PM, the Registered Nurse (RN) indicated residents receiving anticoagulant therapy should have been care planned, monitored for signs and symptoms of bleeding and required a physician order. The RN explained without an order, no prompt would have been generated for implementation. The RN indicated documentation should have reflected monitoring for signs of bleeding or coagulation issues, such as confusion or other clinical indicators, in the MAR. On 05/07/2025 at 1:00 PM, the Director of Nursing (DON) indicated residents receiving anticoagulant therapy should have been care planned, monitored for signs of bleeding and any complications should have been reported. The DON explained Lovenox was ordered by the physician a few days after R166's admission and confirmed by the charge nurse on 04/28/2025. The DON acknowledged monitoring was not transcribed and confirmed no documented evidence of bleeding assessments were present. On 05/08/2025 at 12:44 PM, a Physician Assistant (PA) indicated the use of anticoagulants required a physician order which included monitoring for signs and symptoms of bleeding and adverse reactions. The PA indicated these included bruising, petechiae, hematomas, hematuria, melena, bleeding gums, nosebleeds, severe skin discoloration, and any unusual bleeding. The PA indicated the findings should have been documented and promptly reported to the physician. A facility policy titled Anticoagulation-Clinical Protocol, revised November 2018, emphasized the need to monitor for signs of bleeding in residents on anticoagulant therapy. The policy directed staff to assess for adverse reactions and stated if signs such as bruising, hematuria (blood in urine), or hemoptysis (spitting up blood) were present, the nurse must consult the physician before administering the next dose.

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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	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure a physician's order for the use of Oxygen (O2) and corresponding care instructions were obtained for 1 of 19 sampled residents (Resident 166). This deficient practice had the potential to result in improper administration of O2 therapy, increased risk of respiratory complications, and failure to monitor the resident's response to treatment. Findings include: Resident 166 (R166) R166 was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD) with exacerbation, acute respiratory failure, and dementia. On 05/06/2025 at 9:50 AM, R166 was in bed, verbally responsive with garbled words. R166 was on O2 flowing at 1 liter per minute (LPM) via nasal cannula, with no humidifier in place. R166 had mild shortness of breath. The Admission assessment dated [DATE], documented R166's respiratory status included crackling sounds. The Admission Minimum Data Set, dated dated dated [DATE], documented the brief interview mental status score of 14/15, indicating cognitive status was intact. R166 had shortness of breath. R166's medical records lacked documented evidence a physician order was obtained for O2, and care orders were in place. On 05/07/2025 at 9:23 AM, R166 was in bed with eyes closed. O2 was flowing at 1.5 LPM via nasal cannula, with no signs or symptoms of respiratory distress. A Licensed Practical Nurse (LPN) indicated familiarity with R166 and indicated the resident had been continuously dependent on O2 via nasal cannula. The LPN verified and confirmed there was no physician order for the use of O2 and no order specifying when to change the nasal cannula. The LPN indicated an order should have included the flow rate, frequency, and schedule for changing the cannula. The LPN emphasized the importance of a physician's order to ensure O2 was administered appropriately, not too much and not too little. to prevent complications such as O2 toxicity or carbon dioxide retention. On 05/07/2025 at 1:00 PM, the Director of Nursing (DON) confirmed there was no physician order in place for the use of O2 or for cannula changes. The DON indicated O2 saturation was monitored a few days after admission. The DON indicated R166 was diagnosed with COPD and respiratory failure and had refused O2 upon admission, as documented. The DON indicated staff were expected to obtain and transcribe a physician order at the onset of O2 use, including associated care instructions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2025 in the afternoon, the Physician Assistant (PA) indicated the use of supplemental O2 required a physician's order. The PA indicated the order was expected to specify the flow rate, delivery method such as nasal cannula or mask, frequency and duration such as continuous or as needed, and monitoring parameters such as O2 saturation and signs of hypoxemia. The PA indicated the importance of monitoring to prevent complications from excessive O2, which could have led to toxicity or respiratory depression, and from insufficient O2, which could have resulted in hypoxia and organ damage. A facility policy titled Oxygen Administration, revised in 2010, documented a physician's order was required for this procedure. Review the resident's care plan and assemble the equipment and supplies as needed, including the humidifier bottle. A facility policy titled Medication and Treatment Orders, revised July 2016, documented medications should have been administered only upon written order.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51395 Based on interview, record review and document review, the facility failed to ensure pain medication was administered per the physician order and physician order obtained for pain level rated 4-6/10 using the numerical pain scale 0-10 (0= no pain and 10= worst pain) for 1 of 19 sampled residents (Resident 265). The deficient practice had the potential to lead to inadequate pain management, an increased risk of adverse effects, and compromised patient safety. Findings include: Resident 265 (R265) R265 was admitted on [DATE] with diagnoses including cellulitis of right and left lower limb, muscle weakness, and acute and chronic respiratory failure with hypoxia. A physician order dated 04/21/2025 documented: Pain- PRN (as needed) Pain Scale 0-10: 0= No Pain 1-2= Least Pain 3-4= Mild Pain 5-6= Moderate Pain 7-8= Severe Pain 9-10= Very Severe/Horrible/Worst pain. A Physician order dated 04/21/2025 documented Tylenol tablet 325 milligram (MG) give two tablets by mouth every six hours as needed for mild pain rated 1-3/10. A Physician order dated 04/21/25 documented Hydrocodone-Acetaminophen oral tablet 10-325 milligram (MG) give one tablet by mouth every four hours as needed for severe pain rated 7-10/10. The Medication Administration Record (MAR) for May 2025 documented Hydrocodone-Acetaminophen oral tablet 10-325 milligram (MG) administered for pain scale rating of 4/10 on the following dates: -05/01/2025 -05/02/2025 -05/03/2025 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R265's medical record lacked a physician order for pain medication coverage when pain was rated on a scale of 4-6/10. On 05/07/2025 at 02:09 PM, a Registered Nurse (RN), explained the process for administering pain medication was to have the resident rate the level of pain, review the medication order and administer the medication according to the pain level parameter and physician order. The RN explained if there were no orders to administer medications at the pain rating provided by the resident, the staff would notify the physician for clarification. The RN reviewed R265's MAR for May 2025 and confirmed the medication was not administered as per physician orders. On 05/07/2025 at 03:01PM, the Director of Nursing (DON) explained the process would be for staff to assess the resident for the location of pain and severity of pain, record findings and administer the medication as per physician orders. The DON reviewed R265s MAR for May 2025 and confirmed the Hydrocodone-Acetaminophen 10-325 MG tablet was administered for pain rating of 4/10 when orders specified 7-10/10. The DON explained the expectation would be for the staff to provide alternative medication if an order was available or contact the physician for clarification. The DON reviewed the Tylenol order for mild pain of 1-3/10 and confirmed R265 lacked orders for pain rated 4-6/10 and explained the staff should have contacted the physician for new orders or clarification. The Facility policy titled Administering Medications, revised April 2019 documented, Medications are administered in a safe and timely manner, and as prescribed.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50513 Based on observation, interview, record review, and document review, the facility failed to develop a care plan, monitor behaviors, and provide behavioral health services for 1 of 19 sampled residents (Resident 215). Specifically, the facility failed to document the resident's hospital-diagnosed anxiety as an active medical condition, develop a baseline care plan addressing behavioral health interventions for anxiety, and implement timely interventions until after the resident expressed suicidal ideation. This deficient practice resulted in psychosocial harm as evidenced by the resident's reported feelings of suicidal ideations. Findings include: Resident 215 (R215) R215 had been admitted on [DATE] and readmitted on [DATE] with diagnosis including Chronic Obstructive Pulmonary Disease (COPD) and heart failure. A Hospital Discharge Summary dated 04/30/25 documented discharge diagnosis including COPD with acute exacerbation, shortness of breath, pneumonia, hypertension, and anxiety. R215's Physician History and Physical dated 04/30/25 documented past medical history and current assessment both included anxiety. On 05/01/25, therapy evaluations identified behavioral indicators: - Occupational Therapy Evaluation documented anxiety, self-limiting, agitated, and aggressive. - Speech/Language/Cognitive Therapy Evaluation documented anxiety. The Minimum Data Set (MDS) dated [DATE] documented: - Section C: Brief Interview for Mental Status (BIMS) a score of 12, indicating moderate cognitive impairment - Section D: Resident Mood Interview, a total severity score of 10, indicating moderate depression - Section I: Active Diagnosis listed I5700: Anxiety Disorder. The medical record lacked documented evidence of anxiety being coded as an active medical condition until 05/06/2025, when diagnosis code F41.9: Anxiety Disorder, unspecified, was entered. The baseline care plan initiated on 04/30/2025 lacked documented evidence of focus, goals, or interventions related to anxiety. The Progress Notes documented: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	- 04/30/25 - R215 refused weight upon admission, three times. - 05/01/25 - refused therapy evaluation; physician was informed. - 05/02/25 - refused bedside care and became verbally aggressive to staff. Charge Nurse aware. Refusal of bathing/shower. - 05/03/25 - Behavior Symptom charting documented rejection of care. - 05/04/25 - Behavior Symptom charting documented rejection of care, yelling, screaming, and use of abusive language. - 05/06/25 - refused care and bathing/showers. The record lacked documented evidence of activity participation or self-directed/independent activities between 04/30/2025 and 05/08/2025. On 05/06/25 at 9:13 AM, R215 was observed lying in bed, alert and oriented, with a flat affect, downturned gaze, and heavy eyelids. R215 verbalized feeling depressed, hopeless, and had suicidal ideation, stating, Yes, all the time, when asked about thoughts of self-harm. The resident also reported having asked staff for medication to help with anxiety, trouble sleeping, and sadness, but was told the facility would not provide any. On 05/06/25 at 9:28 AM, the survey team immediately notified the Director of Nursing (DON) of R215's reported suicidal ideation. On 05/06/25 at 10:22 AM, a Nurse's Note written by the DON documented R215 verbalized being sad and expressed thinking of hurting themselves, and when asked how, R215 replied, I will go to the garage and run the car. The Physician was notified, a psychiatric consult was ordered for the next day, and Hydroxyzine 25 milligram (mg) was prescribed for anxiety. On 05/07/25 at 3:39 PM, the Nurse Practitioner Notes titled Psychiatric Consultation documented R215 reported severe depression, feelings of helplessness, hopelessness, having low mood, avolition, and feeling frustrated. R215 admitted verbalizing to suicidal ideations due to feeling frustrated because of trouble sleeping and trouble breathing. Prior psychiatric diagnosis included depression and anxiety. On 05/08/25 at 1:39 PM, the DON verbalized the refusal of therapy, showers, meals, or weight checks could be a sign of anxiety. The social worker, nursing, and therapy should address these concerns in the Interdisciplinary Care Team (IDT) meeting. The DON confirmed there was no baseline care plan for anxiety. On 05/08/25 at 2:15 PM, the LPN confirmed the resident was readmitted with behavior issues, frequently refused ADL care, refused bathing and showering, did not participate in activities, and was often aggressive used foul language towards the nursing and therapy staff, but the physician had been notified. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 05/08/25 at 2:35 PM, the CNA in charge of R215 verbalized the resident often refuses care and had been aggressive since the readmission on 04/30/25. The CNA verbalized being scared to go in R215 room due to the aggressive behavior and will often ask another staff member to accompany them. The CNA verbalized the nurse is aware of the aggressive behavior and refusal of care. On 05/08/25 at 3:39 PM, the Physical Therapist Assistant (PTA) verbalized during R215's Physical Therapy (PT) session on 05/02/25, the resident had displayed anxiety because of self-limiting factors such as being very aggressive with the PT staff, requiring a lot of encouragement, getting agitated very quickly, and visibly shaking from anxiety. The PTA verbalized the resident's hospital discharge summary included the medical diagnosis of anxiety. On 05/08/25 at 3:50 PM, the DON reviewed R215's care plan and verbalized the care plan only included focuses for aggression with use of foul language and aggression to staff, refusal of care, and at risk for decreased psychosocial well-being. An intervention listed under the refusal of care initiated on 05/01/25, documented the Interdisciplinary Care Team (IDT) would collaborate to identify underlying causes. An intervention listed under the at risk for psychosocial well-being documented R215 should be assessed for clinical issues which may cause or contribute to the mood pattern. The DON stated R215 was discussed in IDT, but documentation could not be confirmed. On 05/09/25 at 8:32 AM, R215's Physician verbalized the staff was expected to monitor the resident for behaviors and signs of anxiety even though there were no orders to monitor behavior. The Physician verbalized anxiety was a condition that would typically require care planning or monitoring. The facility should monitor the resident and inform the physician if there are 3 or more refusals in a row. On 05/09/25 at 9:35 AM, the Activities Assistant reported the resident never showed any interest in activities and did not participate. On 05/09/25 at 1:26 PM, the DON confirmed there is no documented IDT discussion of R215's behavioral symptoms, root cause, or interventions for anxiety before 05/06/2025. The policy provided by the facility titled Behavioral Assessment, Intervention and Monitoring, dated 2001, documented as part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, substance use disorder, or mental disorder. The IDT team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. The interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. Interventions and approaches will be based on a detailed assessment of physical, psychosocial and behavioral symptoms and their underlying causes, as well as the potential situation and environmental reasons for the behavior. The care plan would have included, at a minimum: - a description of the behavioral symptoms, including frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations. - targeted and individualized interventions for the behavioral and/or psychosocial symptoms (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	- the rationale for the interventions and approaches - specific and measurable goals for targeted behaviors - how staff will monitor for effectiveness of the interventions.

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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** 40131 Based on observation, interview, record review, and document review, the facility failed to ensure: 1) The shared glucometer device was disinfected using Environmental Protection Agency (EPA)-approved disinfectant wipes for 1 of 19 sampled residents (Resident 171). 2) Handwashing with soap and water was performed before and after entering the room of a resident on contact isolation for Clostridium difficile (C. diff) for 1 of 19 sampled residents (Resident 166) and required personal protective equipment (PPE) was donned when entering rooms in contact isolation precautions in 2 of 2 units. This deficient practice had the potential to expose residents to bloodborne pathogens and other infectious agents, increasing the risk of cross-contamination and facility-acquired infections. Findings include: 1) Resident 171 (R171) R171 was admitted on [DATE] and readmitted on [DATE], with diagnoses including diabetes mellitus and chronic kidney disease. On 05/08/2025 at 9:12 AM, during the medication pass, a Registered Nurse (RN) prepared medication, including insulin, and checked R171's blood glucose using the EvenCare G3 glucometer. After use, the glucometer was disinfected with an alcohol pad and returned to the cart. The RN indicated alcohol pads were considered acceptable per the pharmacy's last visit. Micro-Kill disinfectant wipes were available and used to clean the cart's surfaces. The RN explained no other residents on the assignment required a blood glucose check during the morning pass. On 05/08/2025 at 11:40 AM, a Licensed Practical Nurse (LPN) explained the shared glucometer was disinfected after each use with EPA-approved wipes per the manufacturer's instructions. The LPN indicated the device was required to remain visibly wet for 3 to 5 minutes before being returned to the medication cart. The LPN confirmed this procedure was part of the facility's infection control protocol to prevent cross-contamination. On 05/08/2025 at 11:55 PM, the Director of Nursing (DON) indicated alcohol pads were not appropriate for disinfecting shared glucometers and confirmed Licensed Nurses had been educated. The DON indicated Micro-Kill disinfectant wipes were available in each medication cart and nurses were expected to use EPA-approved disinfectant per infection control procedures. The DON verified no residents had active bloodborne pathogen diagnoses. On 05/08/2025 at 2:35 PM, the Infection Preventionist (IP) indicated shared glucometers were to be disinfected before and after each use with EPA-approved disinfectant wipes, maintaining a 3-minute contact time. The IP indicated failure to follow this protocol posed a cross-contamination risk, as the glucometer was shared, and residents were not assigned individual devices. The IP confirmed Licensed Nurses had been educated on proper disinfection procedures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Blood Glucose Monitoring System User's Guide-Cleaning and Disinfecting Procedures for the EvenCare G3 Meter indicated the device must be cleaned and disinfected between each resident's use. Approved products include Medline Micro-Kill Germicidal Bleach Wipes (EPA Registration Number: 37549-1). The manufacturer's instructions specified the glucometer must be wiped thoroughly, ensuring the surface remained visibly wet for the recommended contact time. 2) Resident 166 (R166) R166 was admitted on [DATE] with diagnoses including dementia and hypertension and was a resident in Unit 2. A Physician Order dated 04/27/2025, documented contact precautions for possible Clostridium Difficile (C-diff) secondary to loose stool. On 05/08/2025 at 7:40 AM, contact isolation signage had been posted on the door of R166's room. The contact isolation signage instructed staff and visitors to wear gowns and gloves before entering the room, perform hand hygiene with soap and water before and after contact, use dedicated or disinfected equipment, and consult nursing staff before entry. PPE was available at the entry. A Certified Nursing Assistant (CNA) and Wound Care Treatment Nurse (WCTN) entered Resident 166's room without donning PPE, and handwashing had not been performed. Another CNA entered and exited the room without donning PPE or performing handwashing. The staff members explained did not pay attention to the isolation signage prior to entry. Staff acknowledged handwashing with soap and water should have been performed for a resident on Clostridium difficile precautions and PPE, including gloves and a gown, should have been worn when entering a room, but these actions had not been performed. On 05/08/2025 at 4:34 PM, the WCTN confirmed R166 had been on contact isolation for C. diff due to loose stools. The WCTN indicated having been pulled by a CNA to assist with R166's Oxygen. The WCTN explained entered the room without noticing the contact isolation signage and realized this after exiting the room. The WCTN acknowledged handwashing, and the use of PPE had not been performed. The WCTN indicated handwashing should have been performed both before and after entering the room to prevent cross-contamination for residents on C. diff isolation. On 05/08/2025 at 3:00 PM, the Infection Preventionist (IP) indicated signage, and PPE had been placed at the doorway in accordance with contact precautions. The IP explained all staff and visitors were expected to follow transmission-based precaution (TBP) protocols, including wearing appropriate PPE and performing hand hygiene. The IP indicated for residents on C. difficile isolation, handwashing with soap and water was required as alcohol-based hand sanitizers were not effective against C. difficile spores. The IP indicated staff entering a resident's room on contact precautions for C. difficile were required to perform handwashing to prevent cross-contamination. The IP indicated the facility had provided education on TBP protocols, including handwashing and the proper donning and doffing of PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295106	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trellis Centennial	8565 W Rome Blvd Las Vegas, NV 89149

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Isolation-Transmission-Based Precautions and Enhanced Barrier Precautions, revised September 2022, indicated TBP precautions were initiated when a resident showed signs of a transmissible infection, was admitted with symptoms, or had a lab-confirmed infection with transmission risk. Contact precautions were implemented for residents known or suspected to be infected with organisms spread through direct or indirect contact. When a resident was placed on TBP, appropriate signage was posted at the room entrance to inform personnel and visitors of the required precautions. The signage identified the type of Centers for Disease Control and Prevention (CDC) precautions, personal protective equipment (PPE) instructions, and other relevant protocols. 51395 Resident 267 (R267) R267 was admitted on [DATE] with diagnoses including post laminectomy syndrome, disruption of external operational (surgical) wound, and infection and inflammatory reaction due to internal fixation device of spine. R267 resided on Unit 1. A Physician order dated 04/28/2025 documented Contact Precaution due to neck wound culture positive for methicillin-susceptible staphylococcus aureus every shift. R267 had a sign posted to the left of the door documented the following: -Contact Precautions: put on gloves and gown before room entry and discard gloves and gown before room exit. A plastic three drawer storage bin stocked with personal protective equipment (PPE) including disposable gowns was present outside R267's room. On 05/06/2025 at 10:31 AM, a visitor entered R267's room with no PPE. On 05/06/2025 at 10:35 AM, a Registered Nurse (RN) explained the process for contract precautions was to apply gloves and gown when entering contact precautions rooms and remove gloves and gown when exiting. The RN explained staff and visitors were to abide by precautions, and visitors were educated to use PPE. 05/06/2025 at 10:36 AM, a visitor, who identified themselves as R267's spouse, was seated at R267's bed side in a chair approximately three feet from left side of the bed with no gown or gloves on. R267's spouse explained being unaware R267 was on contact precautions and PPE was required when visiting. On 05/06/2025 at 10:50 AM, the RN provided R267's spouse a gown and gloves and explained the PPE needed to be applied upon entrance of R267's room and removed when leaving the room. The RN explained staff and visitors would need to adhere to contact precautions to prevent the spread of infection. The Care plan dated 04/28/2025 documented the following: (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Isolation Precautions: Resident requires contact precautions due to neck wound culture methicillin-susceptible staphylococcus aureus with interventions of: -ask family members, visitors, & care providers to stay home if they are sick. -educate resident and visitor about isolation precautions. Stress hand hygiene when visiting resident. -education of patients, families, visitors, and care providers about how infections are transmitted and how illness can be prevented -follow universal precautions when working with residents in isolation. -maintain isolation using contact precautions - use of personal protective equipment as recommended for type of infection On 05/08/2025 at 09:12 AM, the Infection Preventionist (IP) explained the isolation process for residents and visitors was to place the appropriate signage for the isolation and explain the reason and the process for use of personal protective equipment (PPE) to the resident and their family members. The staff would then place a bin with PPE supplies outside the resident room for staff and visitors to access upon entrance into the resident room. The IP stated the education for family and visitors included an explanation on the use of gloves, gown, and hand sanitizer. The education would sometimes be documented in the progress note but on occasion it would be missed. R267's medical record lacked documented evidence that education had transpired with R267's spouse and the facility was unable to provide documented evidence of education with family. On 05/08/2025 at 09:17AM, the IP explained the expectation was for visitors and staff to adhere to the isolation precautions to prevent the spread of infections. The IP confirmed not speaking with R267's spouse until 05/07/2025 and the conversations should have been documented. On 05/08/2025 at 02:40 PM, a Licensed Practical Nurse (LPN) entered R267's with no PPE. The LPN confirmed that gloves and gown should have been donned prior to entering the resident room. The LPN explained the need to utilize PPE was to protect the residents and self from the spread of infection. The facility policy titled Isolation- Transmission-Based Precautions & Enhanced Barrier Precautions, revised September 2022, documented Contact Precautions were implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Staff and Visitors wear gloves (clean, non- sterile) when entering room. Staff and Visitors wear a disposable gown upon entering the room and remove before leaving the room.