STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Center	239 Pleasant Street Concord, NH 03301

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 40522 Based on observation, interview, and record review, it was determined that the facility failed to determine clinical appropriateness of self-administration of medication for 1 of 1 resident reviewed for choices (Resident Identifier #48). Findings include: Observation on 7/23/24 at approximately 11:00 a.m. with Resident #48 revealed that Resident #48 had two inhalers at his/her bedside table, which were an Albuterol Sulfate Aerosol Solution 108 (90 Base) microgram/actuation (MCG/ACT) inhaler and a Combivent Respimat (Ipratropium-Albuterol) Inhalation Aerosol Solution 20-100 MCG/ACT inhaler. Interview on 7/23/24 at approximately 11:00 a.m. with Resident #48 confirmed the above observation. Further interview with Resident #48 revealed that he/she self-administers the inhalers unsupervised by staff. Review on 7/24/24 of Resident #48's active physician orders revealed an order for unsupervised self-administration of the Combivent inhaler, dated 2/9/24, and an order for administration by clinician for the Albuterol Sulfate inhaler, dated 1/13/24. Interview on 7/24/24 at approximately 1:23 p.m. with Staff K (Registered Nurse) confirmed the above observation. Staff K revealed that they were unaware that Resident #48 self-administered his/her inhalers. Review on 7/24/24 of Resident #48's medical record revealed that there was no assessment to self-administer the inhalers. Review on 7/24/24 of Resident #48's care plans revealed that there was no care plan for the self-administration of inhalers. Interview on 7/25/24 at approximately 9:30 a.m. with Staff F (Director of Nursing) confirmed above findings. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 7/25/24 of the facility's policy titled, Self-Administration of Medications, revision date of January 2018, revealed .If the resident desires to self-administer medication, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation of time), physical, and visual ability to carry out this responsibility during the care planning process .For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self- administer medication by means of a skill assessment conducted on a [quarterly] basis or when there is a significant change in condition .The result of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan .

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47129 Based on interview and record review, it was determined that the facility failed to ensure that the resident and/or resident representative was informed of the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 2 out of 3 residents reviewed for beneficiary notices (Resident Identifiers are #49 and #139). Findings include: Resident #49 Review on 7/25/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #49 was discharged from Medicare Services on 7/5/24 and remained in the facility. The facility was unable to provide a SNF ABN form for Resident #49. Resident #139 Review on 7/25/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #139 was discharged from Medicare Services on 5/25/24 and remained in the facility. The facility was unable to provide a SNF ABN form for Resident #139. Interview on 7/25/24 at 8:10 a.m. with Staff C (Business Officer) confirmed the above findings. Staff C stated that they had not completed the SNF ABN for Resident #49 and Resident #139.

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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. 48515 Based on interview and record review, it was determined that the facility failed to ensure that alleged violations of abuse or neglect were reported immediately or no later than 2 hours after the allegation was made to the State Survey Agency (SSA) for 2 of 2 residents reviewed for abuse in a final sample of 31 residents (Resident Identifiers are #22 and #49). Findings include: Resident #49 Interview on 7/23/2024 at approximately 11:14 a.m. with Resident #49 revealed that Resident #49 felt scared, bullied and harassed by Staff N (Registered Nurse). Resident #49 stated that he/she told Staff D (Assistant Director of Nursing) about the issue and that Staff D told him/her that Staff N would no longer provide care for Resident #49. Resident #49 said that they talked to Staff D last week sometime. Interview on 7/23/2024 at approximately 12:20 p.m.with Staff D revealed that they had spoken to Resident #49 regarding feeling scared around Staff N. Staff D informed Resident #49 that Staff N would not provide care to him/her. Staff D could not remember the specific date Resident #49 spoke with him/her but it was sometime in the last week. Interview with Staff P (Administrator) on 7/25/2024 at approximately 9:05 a.m. revealed that Staff P was not aware of the above incident until 7/23/2024 and had not reported it to the state. Review on 7/25/2024 of facility policy titled Abuse, Neglect, and Exploitation dated 7/2021, revealed: .A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . 49819 Resident #22 Review on 7/24/24 of facility grievances revealed a grievance dated 7/5/24 and 7/8/24 from Resident #22 regarding Staff O (Licensed Nursing Assistant (LNA)) refusing to put Resident #22 on the bed pan, not cleaning his/her urine collection device after emptying it, and just walking away when asked to get something for meals. Interview on 7/25/24 9:30 a.m. with Staff P (Administrator) confirmed the above allegation of neglect was not reported to the SSA and revealed that Staff O was no longer an employee at the facility.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48515 Based on record review and interview, it was determined that the facility failed to notify residents of the bed hold policy before transfers for 3 of 3 residents reviewed for hospitalization s in a final sample of 31 residents (Resident Identifiers are #5, #77 and #146). Findings include: Resident #77 Review on 7/25/2024 of Resident #77's medical record revealed they had been discharged to the hospital on 7/17/2024. Further review of Resident #77's medical record revealed no evidence that the bed hold policy was provided to Resident #77 at time of transfer to the hospital. Resident #146 Review on 7/25/2024 of Resident #149's medical record revealed they had been discharged to the hospital on 6/18/2024. Further review of Resident #149's medical record revealed no evidence that the bed hold policy was provided to Resident #149 at time of transfer. Interview on 7/25/2024 with Staff B (Director of Social Services) at approximately 1:00 p.m. confirmed that bed hold policy was not being provided at time of transfer to the hospital. 47129 Resident #5 Review on 7/25/24 of Resident #5's medical record revealed Resident #5 had been discharged to the hospital on 4/14/24. Further review of Resident #5's medical record revealed no evidence that the bed hold policy was provided to Resident #5 upon transfer to the hospital. Interview on 7/24/24 at 12:08 p.m. with Staff C (Business Office) confirmed that there was no bed hold policy provided to Resident #5 at the time of transfer on 4/14/24. Staff C stated that they did not provide the bed hold policy to residents who are transferred to the hospital. Review on 7/25/2024 of the facility's policy titled, Bed Hold Notice Upon Transfer, dated 7/2021, revealed: .1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and /or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a residents to return to the next available bed .

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40522 Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive person-centered care plan for 1 of 2 residents reviewed for smoking, and 1 of 5 residents reviewed for unnecessary medications in a final sample size of 31 residents (Resident Identifiers are #5 and #48). Findings include: Resident #48 Interview on 7/23/24 at approximately 12:00 p.m. with Resident #48 revealed that he/she smoked supervised by staff. Review on 7/24/24 of Resident #48's smoking/vaping screening assessment dated [DATE] revealed that Resident #48 required supervised smoking. Review on 7/24/25 of Resident #48's care plans revealed that there was no care plan for supervised smoking. Interview on 7/25/24 at approximately 9:30 a.m. with Staff F (Director of Nursing) confirmed the above findings. Review on 7/25/24 of the facility's policy titled, Resident Smoking, revision date of 1/2024, revealed: . Residents who smoke will be further assessed, using the Smoking Evaluation, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all .All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan . 47129 Resident #5 Review on 7/25/24 of Resident #5's current physician's orders revealed that Resident #5 had an order for Eliquis (Anticoagulant) Oral Tablet 2.5 milligram (mg), Give 1 tablet by mouth two times a day related to nonrheumatic aortic (valve) stenosis, with a start date of 4/18/24. Review on 7/25/24 of Resident #5's care plan revealed that there was no care plan for monitoring anticoagulant side effects. Interview on 7/25/24 at 11:30 a.m. with Staff D (Assistant Director of Nursing (ADON)) confirmed the above findings. 49819 (continued on next page)

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Review on 7/25/24 of the facility's policy, Comprehensive Care Plans, revised on 1/2024, revealed: .3. The care planning will describe at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47129 Based on interview and record review, it was determined that the facility failed to follow physician orders for 1 out of 2 residents reviewed for skin conditions (Resident Identifier #80). Findings include: Resident #80 Standards: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009. Page 336- Physicians' Orders, .The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary . Interview on 7/23/24 at 1:15 p.m. with Resident #80 revealed that he/she had wounds on his/her abdomen and groin. Resident #80 stated that they were supposed to be cleaned daily but no one had cleaned them since last week. Review on 7/25/24 of Resident #80's current physician's orders revealed that Resident #80 had an order for Abdomen/groin wounds: Cleanse with wound cleaner, apply skin prep to peri wound, apply Medi honey to wound bed and cover with silicone bordered foam dressing. Use sacral foam dressing for groin wounds, everyday shift and as needed for replacement dressing, with a start date of 5/31/24. Review on 7/25/24 of Resident #80's Treatment Administration Record (TAR) revealed that from 6/1/24 to 6/30/24, Resident #80's wounds were not cleaned 13 out of 30 days and from 7/1/24 to 7/23/24, Resident #80's wounds were not cleaned 17 out of 23 days. Interview on 7/25/24 at 2:41 p.m. with Staff W (Nurse Practitioner) confirmed the above findings. Staff W stated that his/her expectation would be that they were cleaned daily, and nursing staff should be following Resident #80's treatment orders for wound care. Interview on 7/25/24 at 3:05 p.m. with Staff T (Wound Care Nurse) revealed that Resident #80's wounds should be cleaned daily according to the physician's orders. Review on 7/24/24 of the facility's policy, Wound Treatment Management, revised on 1/2024 revealed: .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes .

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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. 50163 Based on interview and record review, it was determined that the facility failed to ensure that a resident received effective pain management for 1 out of 2 residents reviewed for pain in a final sample of 31 residents (Resident Identifier#19). Findings include: Interview on 7/23/24 at approximately 2:30 p.m. with Resident #19 revealed that in the beginning of July 2024, he/she had been awake and in pain all night after the facility ran out of their pain medications. Review on 7/23/24 of Resident #19's progress notes revealed a note, dated 7/7/24 at 8:43 p.m., by Staff L (Registered Nurse (RN)) that stated Resident #19 ran out of Hydrocodone-Acetaminophen 7.5-300 milligrams (MG) on 7/7/24 of the morning dose and no one on the floor was able to assist in getting an emergency dose of the medication out of the E-Kit [Emergency Kit]. Review on 7/24/24 of Resident #19's July Medication Administration Record (MAR) revealed: Hydrocodone-Acetaminophen 7.5-300 mg was scheduled for 8 a.m., 2 p.m., and 8 p.m. daily. Further review revealed the following missed doses of the medication: 7/7/24 at 2 p.m.; 7/7/24 at 8 p.m.; 7/8/24 at 8 a.m.; and 7/8/24 at 2 p.m. Review on 7/24/24 of Resident #19's progress notes revealed a note dated 7/8/24 at 1:23 p.m. by Staff W (Nurse Practitioner) that stated Resident #19 informed him/her of the previous night's pain being significant due to the missed doses of pain medication.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28881 Based on record review, interview, and policy review, it was determined that the facility failed to establish a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation; and failed to determine that drug records were in order and that an account of all controlled drugs were maintained for 2 of 3 narcotic books reviewed and for 1 of 5 residents reviewed for unnecessary medications (Resident Identifier #101). Findings include: Review on 7/25/24 of the facility policy titled, Controlled Substance Administration & Accountability, revised 1/2024, revealed: .Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure .Inventory Verification .b. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. 4th Floor South Side Medication Cart Review on 7/23/24 at approximately 8:30 a.m. of the Controlled Substances Book - Shift Count revealed missing staff signatures for the following dates: 4/9/24 (day nurse coming on duty), 4/27/24 (day nurse going off duty), 5/29/24 (night nurse coming on duty), 6/14/24 (night nurse coming on duty), 6/15/24 (night nurse going off duty), 6/17/24 (night nurse going off duty), 7/23/24 (night nurse going off duty). Interview on 7/23/24 at approximately 8:30 a.m. with Staff H (Licensed Practical Nurse (LPN)) confirmed the above findings. 3rd Floor South Side Medication Cart Review on 7/25/24 at approximately 12:00 p.m. of the Controlled Substances Book - Shift Count revealed missing staff signatures for the following dates: 4/18/24 (day nurse coming on duty), 4/18/24 (day nurse going off duty), 6/4/24 (night nurse coming on duty), and 7/10/24 (night nurse coming on duty). Interview on 7/25/24 at approximately 12:15 p.m. with Staff D (Registered Nurse) confirmed the above findings. 40522 Resident #101 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review on 7/25/24 of the facility's policy titled, Controlled Substance Administration and Accountability, revision date of 1/2024, revealed ; .All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways .All controlled substance obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided .Transferring of Medications: .the count is verified by a co-signature on the Controlled Drug Record [Narcotic book] of both the transferring and receiving nurse .Discrepancy resolution a. any discrepancy in the count of controlled substances or disposition of the narcotic keys is resolved by the end of the shift during which it is discovered .Resolution can be achieved by review of the dispensing and administration records and consulting with all staff with access . Review on 7/25/24 of Resident #101's active physician orders revealed an order for methadone 10 milligram/milliliter (mg/ml), Give 22 mls by mouth daily for chronic pain with a start date of 6/28/24. Review on 7/25/24 of Resident #101 Methadone Concentrate 10 mg/ml narcotic count in the narcotic book, page 71, revealed the following narcotic counts: 7/24/24 at 6:21 a.m. the total amount of Methadone available was 58 mls; 7/24/24 at 10:13 p.m. the facility received a new 30 ml bottle of Methadone 10mg/ml from pharmacy with a total amount of 88 mls available; 7/25/24 at 5:38 a.m. 22 mls of Methadone was taken for medication administration with total amount remaining as 66 mls; 7/25/24 (no time documented and signed by one licensed nurse), stated corrected with no documentation of reason for the correction of narcotic count and a total amount left available of 40 mls. Interview on 7/25/24 at approximately 11:18 a.m. with Staff X (Licensed Practical Nurse) confirmed the above findings and that the 40 mls was a discrepancy in the narcotic count. Interview on 7/25/24 at approximately 2:05 p.m. with Staff U (Registered Nurse) confirmed that the nurses failed to document the transfer of medication appropriately and miscalculated the remaining amount of methadone available which resulted in the discrepancy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50163 Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were labeled and stored in accordance with currently accepted professional principles for 2 of 3 medication carts observed and for 1 of 1 residents reviewed for self administration of mediations (Resident Identifiers are #18, #73, and #48). Findings include: Observation on 7/23/24 at approximately 8:40 a.m. of the [NAME] medication cart, on the third floor, revealed Resident #73's two Insulin Aspart Flex pens that had an expiration date of 7/20 and 7/21. Further observation revealed that Resident #18's Humulin Regular U-500 insulin pen was open and used, with no open expiration date on the label. Interview on 7/23/24 at approximately 8:50 a.m. with Staff S (Registered Nurse) confirmed the above findings. Review on 7/25/24 of Insulin Aspart manufacturer's instructions revealed: .Dispose after 28 days, even if there is insulin left in the pen. Review on 7/25/24 of Humulin R U-500 manufacturer's instruction revealed: .When stored at room temperature, Humulin R U-500 KwikPen can only be used for a total of 28 days . 28881 Observation on 7/23/24 from 12:30 p.m. to 12:45 p.m. of the North Medication Cart on 4th floor revealed it was unlocked in the hallway with no staff within sight. There were 2 residents wheeling themselves in the hallway. Interview on 7/23/24 at 12:45 p.m. with Staff I (Registered Nurse) confirmed the cart was unlocked and unattended for approximately 15 minutes. Review of facility policy titled, Storage of Medication, dated May 2018, revealed: .Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access . 40522 Resident #48 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review on 7/25/24 of the facility's policy titled, ID3: Bedside Storage Medication, revision date of January 2018, revealed: .A written order for the bedside storage of medication is present in the resident's medical record .Bedside Storage of medications is indicated on the residents medication administration record (MAR) and the care plan for appropriate medications .For residents who self-administer medication .the following conditions are met for bedside storage to occur: 1) The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlock storage is deemed inappropriate. Facility management should have a copy of the key in addition to the resident .The resident is instructed in the proper use of bedside medications, including, what the medication is for, how it is to be used, how often it may be used, proper cleaning of inhalers where applicable, proper storage of the medication .The resident should be able to repeat the instruction or demonstrate appropriate use of the medications. The completion of this instruction is documented in the resident's medical record. Periodic review of these instructions with the resident is undertaken by the nursing staff as deemed necessary . Observation on 7/23/24 at approximately 11:00 a.m. with Resident #48 revealed that Resident #48 had two inhalers at his/her bedside table, which was an Albuterol Sulfate Aerosol Solution 108 (90 Base) microgram/actuation (MCG/ACT) inhaler and a Combivent Respimat (Ipratropium-Albuterol) Inhalation Aerosol Solution 20-100 MCG/ACT inhaler. Further observation revealed that the two above mentioned inhalers were not in a lock box or locked storage compartment. Interview on 7/23/24 at approximately 11:00 a.m. with Resident #48 confirmed the above observation. Interview with Resident #48 revealed that Resident #48 kept his/her inhalers at their bedside and had no lock box or lock storage compartment in his/her room. Review on 7/24/24 of Resident #48's active physician orders revealed an order for unsupervised self-administration of the Combivent inhaler, as mentioned above, dated 2/9/24, and an order for administration by clinician of the Albuterol Sulfate inhaler, as mentioned above, dated 1/13/24. Further review of the Resident #48's active physician orders revealed no orders for the inhalers, as mentioned above, to be kept at bedside. Interview on 7/24/24 at approximately 1:23 p.m. with Staff K (Registered Nurse) confirmed the above observation and that the inhalers were not secured in a locked compartment. Review on 7/24/24 of Resident #48's medical record revealed that there was no instructions provided to Resident #48 of proper bedside storage of Resident #48's prescribed Albuterol Sulfate and Combivent inhalers. Interview on 7/25/24 at approximately 9:30 a.m. with Staff F (Director of Nursing) confirmed above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Center	239 Pleasant Street Concord, NH 03301

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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	Provide and implement an infection prevention and control program. 49819 Based on interview, observation, and record review, it was determined that the facility failed to follow established infection control guidelines for facility water management that has the potential to effect the facility census of 148 residents who resided at the facility; and the facility failed to follow the Center for Disease Control and Prevention (CDC) guidelines for Enhanced Barrier Precautions (EBP) to prevent spread of infections for 1 of 2 residents reviewed for EBP (Resident Identifier #101). Findings include: Review on 7/25/24 of the facility policy titled, Water Management Program with a revision date of 1/2024 revealed: .Policy Explanation and Compliance Guidelines: .1. A water management team .including facility leadership, the Infection Preventionist, maintenance employees .2. The Maintenance Director maintains documentation that describes the facility's water system .4. Data to be used for completing risk assessment may include .a. Water system schematic/description .f. Water temperature logs .5. Based on risk, control points will be identified. Review on 7/25/24 of the facility policy titled, Legionella Surveillance with a revision date of 1/24 revealed: . Policy Explanation and Compliance Guidelines: .2. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies .5. Primary prevention strategies .d. Temperature controls: i. Cold water shall be stored and distributed below 68 degrees Fahrenheit (F). ii. Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F . Interview on 7/25/24 at approximately 10:30 a.m. with Staff U (Infection Preventionist) confirmed that the facility had no plumbing map, schematic, or description available. Staff U did not know if the facility had a system to monitor control measures in place to prevent the introduction and spread of Legionella. Interview on 7/25/24 at approximately 12:00 p.m. with Staff V (Maintenance Director) confirmed the facility did not have control measures in place to prevent the introduction and spread of Legionella or a system to monitor any control measures. 50163 Resident #101 Observation on 7/24/24 at approximately 8:40 a.m of Staff K (Registered Nurse) during medication administration on the second floor revealed Staff K administered Ceftriaxone intravenously (IV) to Resident #101 through his/her peripherally inserted central catheter (PICC). Further observation of Staff K revealed that he/she wore gloves during the medication administration but Staff K was not wearing a gown. Interview on 7/24/24 at approximately 9:45 a.m with Staff K confirmed that Resident #101 had a PICC line and they did not wear a gown when administering medications through the PICC line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	07/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 7/25/24 of facility policy titled, Enhanced Barrier Precautions, revised 4/24, revealed: .Policy Explanation and Compliance Guidelines: .2.b. An order of enhanced barrier precautions will be obtained for resident with any of the following: i. Wounds (.) and/or indwelling medical devices (e.g., central lines, .) even if the resident is not known to be infected or colonized with a Multidrug- Resistant Organism (MDRO) . Review on 7/25/24 of the CDC policy titled, Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug Resistant Organisms (MDRO's), Updated July 2022 revealed: . Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. MDRO's may be indirectly transferred from resident-to-resident during these high-contact activities. Nursing home resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO's. The use of gown and gloves for high-contact resident care activities is indicated, .Enhanced Barrier Precautions, Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: .Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator .