STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335533	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Gasport L L C	4540 Lincoln Drive Gasport, NY 14067

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 43802 Based on interview and record review conducted during a Complaint investigation (#NY00319528) during the Standard survey completed on 7/19/24, the facility did not ensure that all alleged violations of abuse and neglect were thoroughly investigated for one (Resident #36) of five residents reviewed. Specifically, there was a lack of employee interviews and statements to rule out abuse regarding an injury of bruising below the resident's right eye. The finding is: The facility policy and procedure titled, Facility Incident/Abuse Investigation and Reporting, with a revision date of 6/7/23, documented the facility will conduct an immediate and thorough investigation, upon discovery of an incident including injury of unknown source. An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. The investigation should rule out or confirm abuse, mistreatment, or neglect by review of supporting evidence, including interviews and statements that offer valid information, observations, and record review. The outcome is determined by fact, based on the evidence and not on opinion. The Director of Nursing services interview shall consist of but not limited to the following: an interview with the person(s) reporting the incident, pertinent staff interviews preceding the incident minimally 2 shifts for any unexplained injuries of unknown etiology. Resident #36 had diagnoses that included unspecified dementia without behavioral disturbance, mood and anxiety disorder, peripheral vascular disease (decreased blood flow of extremities), spinal stenosis (a condition where spinal column narrows and compresses the spinal cord). The Minimum Data Set (a resident assessment tool) dated 6/17/23 documented Resident #36 had severe cognitive impairment. The assessment tool documented that Resident #36 had no impairment on the upper or lower extremities and was totally dependent on staff for locomotion on unit and off unit, including extensive assistance for personal hygiene and bathing. The comprehensive care plan dated 6/24/23 documented Resident #36 had a self-performance deficit related to dementia and spinal stenosis while transferring. Resident #36 was care planned for a maximal assist of two, handheld assist stand pivot method. Resident #36 was non-ambulatory and was wheelchair dependent and was to have two care givers for personal hygiene due to behavioral problems. (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 7/26/23 at 7:32 AM by Licensed Practical Nurse Supervisor # 1 documented they were notified Resident #36 had a small, dark purple bruise to the outer aspect of right eye. Resident #36 was combative with care and often swings randomly at times striking themselves or others. Resident #36 showed no signs or symptoms of pain. Review of an incident report dated 7/26/23 at 4:00 AM completed by Licensed Practical Nurse Supervisor #1, documented they were notified that Resident #36 had a small, dark purple bruise to the outer aspect of their right eye. Resident was noted to be combative with care, and often swings randomly at times striking themselves or others. Resident #36 showed no signs or symptoms of pain. Resident #36 was unable to give description of the incident. Resident #36 was oriented to person. Predisposing Physiological factors included agitation, severe cognitive decline, impaired memory, confused, and incontinent. Resident #36 was a two-assist transfer and call bell was within reach, plan of care was followed. A note on the incident report dated 7/28/23 written by the Director of Nursing, documented the investigation was completed. The resident was unable to make a statement as to what happened due to their current mental status. A Certified Nursing Assistant found a deep purple bruise measuring 1 x 1 to the resident's outer right eye. No other delayed injuries were observed, no care plan changes were made. The resident was a 2-person caregiver due to how combative the resident was during care and the bruise was attributed to this combativeness. There were no interviews or statements from staff who worked the previous two shifts included for this investigation. During an interview on 7/19/24 at 1:47 PM with Certified Nursing Assistant #1, they stated during their shift on 7/26/23 they noticed the bruising on Resident #36 right eye when they entered the resident's room to perform care and they informed their supervisor immediately. They stated they were trained to have two assists with this resident due to combative behavior. They stated they would give the resident a towel or sheet to keep their hands busy while the other aide provided care. During an interview on 7/19/24 at 1:59 PM with Licensed Practical Nurse #5, they stated that Resident #36 was to always have two aides while providing care due the resident's behaviors. The aides were trained if Resident #36 became combative to reapproach the resident later. They stated that Resident #36 did try and kick them the other day and tried to swat them a few times. They stated they were trained to reapproach at another time when Resident #36 was combative. During an interview on 7/19/24 at 1:53 PM with the Director of Nursing, they stated that they were able to rule out abuse for the incident that occurred on 7/26/23 because they knew Resident #36 was combative and would grab their own arms, flail their arms in the air, and often hit themselves. They stated this Resident always had two care givers when providing care, one to provide care and one to distract the Resident. They stated that the bruising of the right eye was not an unknown injury and did not go back 48 hours to get witness statements because they believed the injury was of a known source. They stated that based on their investigation they concluded the Resident's regular demeanor and combativeness was the cause. If they believed the injury to be abuse, they would have reported it as abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/24 at 2:36 PM with the Administrator, when asked if they felt that the Director of Nursing did a complete investigation on the incident that occurred on 7/26/23 with Resident #36 right eye injury of unknown source, they stated due to the resident's combativeness it was a reasonable conclusion the injury occurred due to Resident #36 behaviors. The Administrator stated getting witness statements from staff who worked previous shifts could have been done and would be a good step to take in the future, however, it did not change their position about this incident's conclusion. They stated that they felt a reasonable conclusion was founded and that the injury of Resident #36's right eye was due to combativeness and probably self-inflicted. 10NYCRR 415.4(b)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview, observation, and record review conducted during a Complaint investigation (#NY00322578) conducted during a Standard survey, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #38) of two residents reviewed for accidents. Specifically, Resident #38 who was a risk for elopement, eloped from the facility without staff knowledge and was outside of the facility for 20 minutes. The finding is: The policy and procedure titled Risk of Elopement dated 1/26/22 documented that a safe environment is provided for patients/residents who are at risk to wander. The policy and procedure titled Loss of Resident/Missing Resident dated 11/09 documented that all staff will be able to follow an organized plan to enable us to locate a missing resident as quickly as possible. The policy and procedure titled Elopement Security System Alarms/Devices dated 5/08 documented that security alert devices are used to alert staff to resident movement outside a designated area. The policy and procedure documented that alarm devices will be assessed at regular intervals to ensure proper functioning and wander guard devices will be monitored every shift by placing it on the treatment administration record. The policy and procedure titled Exits dated 10/22 documented that all unsupervised exits will be magnetically locked or equipped with an alarm and will be kept free of obstructions for the safety of security of the residents. The policy and procedure documented that at no time will the magnetic locks be disengaged or alarmed door alarms are in the off position and unsupervised at the same time. Resident #38 was admitted to the facility with diagnoses of dementia and depression. Review of the Minimum Data Set (a resident assessment tool) dated 6/8/24 documented that the resident was severely cognitively impaired, usually understood by others, sometimes understands others. The Minimum Data Set documented Resident #38 had wandering behaviors one to three days in the last seven days. Review of an Elopement Risk assessment dated [DATE] documented that Resident #38 was ambulatory (can walk independently); was a new admission and questioned the need to be in the facility; cognitively impaired with poor decision making skills; has a diagnosis of dementia; has a history of wandering; making statements of leaving or looking for someone; displays behaviors that indicated that an elopement may be forthcoming; educate staff to and add to care guide; utilize wander guard system; apply wander detection bracelet; and post resident's photo at the front desk. Review of the comprehensive care plan dated 7/26/23 it documented that Resident #38 was a risk for elopement with interventions to include a wander guard alarm and the resident's photograph at the front desk to identify them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician order dated 7/26/23 documented that Resident #38's wander guard placement was to be checked every shift. Review of an undated document titled Nursing Supervisor Door Check Log documented that all doors should be checked every shift to ensure they were locked by trying to push the door open and, if there were any issues with the door, the door must be manned until maintenance fixed the problem. Review of a Nursing Supervisor Door Check dated 8/14/23 to 8/22/23 documented that doors were checked on the 11 PM to 7 AM shift. Review of the August 2023 Mag Lock and Wander Guard System Daily Audit documented that the magnetic lock doors were in working order and that the delayed egress (exit) signage was posted. Review of the August 2023 treatment administration record documented that Resident #38's wander guard was checked on each shift. Review of a security video dated 8/21/23 revealed that at 3:54 PM, Certified Nurse Assistant #9 left through the Unit C emergency exit door. The ambulance door was noted to have an emergency exit only sign. At 3:58 PM, Resident #38 left through the same door. The Investigation Summary Form dated 8/21/23 documented that Resident #38 was last seen at 3:53 PM by the Unit C emergency exit door and the resident was redirected away from the door. Certified Nurse Assistant #9 exited the Unit C emergency exit door at 3:55 PM. Certified Nurse Assistant #9 did not let the door closer close the door as designed and manually closed the door which caused the door not to latch correctly. Resident #38 pushed open the Unit C emergency exit door at 3:58 PM. At 4:12 PM, a family member reported that a resident may be outside the facility. Resident #38 was found on a neighbor's front lawn at 4:19 PM. It was noted that the Unit C emergency exit door does not have a wander guard alarm. Multiple observations of Unit C emergency door exit from 7/15/24 to 7/19/24 during day shift hours revealed that the door was locked. Additional observations during this time of the Unit C emergency exit door revealed no staff exited the emergency exit door. Multiple observations from 7/15/24 to 7/19/24 of Resident #38 wandering through the facility. Resident #38 did not attempt to leave the facility during these observations. Resident #38 was noted to have a wander guard bracelet on their ankle. During a telephone interview on 7/18/24 at 10:13 AM, Certified Nurse Assistant #9 stated they entered a code on the Unit C emergency exit door and exited the facility to go to their car to retrieve their phone. They stated that they obtained the code from another employee to open the emergency exit door. Certified Nurse Assistant #9 stated they saw other employees use that exit before. They stated that held the door open because they saw a nurse and they thought the nurse might want to use the door as well. They stated that they did not know that Resident #38 was behind them or in the hall. Certified Nurse Assistant #9 did not see the resident exit the building. They stated they thought they closed the emergency exit door correctly. They stated that they were in-serviced on elopement after the incident. Certified Nurse Assistant #9 stated that they no longer work for the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24 at 10:52 AM, the Director of Nursing stated that Certified Nursing Assistant #9 saw them down the end of the hall and held the door open. They stated that made a no motion with their hands to indicate that they weren't leaving the building. The Director of Nursing stated that they were going to talk to Certified Nurse Assistant #9 after they came back into the facility. The Director of Nursing stated that they thought that Certified Nurse Assistant #9 had closed the door all the way, so the lock engaged. The Director of Nursing did not realize that the door was not closed. The Director of Nursing stated that they did not realize that Resident #38 had left the building through the emergency exit door. They stated the resident was brought back, and a full body assessment was done to check for any injuries. The Director of Nursing stated that they expect employees to use the correct entrances and exits when entering or leaving the building. During an interview on 7/19/24 at 10:31 AM with the Administrator stated that they expect staff to use the correct employee entrances and exits. The Administrator stated that Certified Nurse Assistant #9 was an agency employee and no longer worked at the facility. The following corrective actions were implemented by the facility to correct the non-compliance as of 8/28/23 at 11:00 PM: -Resident #38 was assessed for injuries at the time of the elopement and none noted. -Starting on 8/21/23, facility staff and Certified Nursing Assistant #9 were educated on resident elopement; proper use of emergency exit doors; proper exit and entry doors for employees and to ensure doors latch correctly; and not to give door codes to outside vendors including agency staff. -During the Standard survey period from 7/15/24 to 7/19/24, Resident #38 was not observed attempting to elope. -During the Standard survey period from 7/15/24 to 7/19/24, employees were not observed using the Unit C emergency exit door as an exit or entrance. -During the Standard survey period from 7/15/24 to 7/19/24, emergency exit doors were observed to have emergency exit signs with instructions of how to open door in case of emergency. -During the Standard survey period from 7/15/24 to 7/19/24 verified through record review and staff interview, it was determined that the facility re-educated 100% of their employees on emergency exit doors, exits and entrances for employees, not to give door codes to outside vendors and elopement. 10NYCRR 415.12(h)(1)

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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** 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 7/19/24, the facility did not ensure that residents who had an indwelling (foley) catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (Resident #37) of one resident reviewed. Specifically, there was lack of voiding trial (removal of a urinary catheter to see if someone can pass urine normally) when the resident was readmitted to the facility from the hospital with a foley catheter and the lack of a urology (part of health care that focuses on diseases of the urinary system) consult. The finding is: The policy and procedure titled Catheter (urinary) Insertion and Removal dated 9/2/20, documented prior to insertion or upon continued use upon admission, the unit coordinator or designee will discuss and document the involvement of the resident/representative of the risk and benefits of the use of a catheter, removal of the catheter when criteria or indication for use is no longer present, and the right to decline the use of a catheter. Resident #37 had diagnoses including hemiplegia (paralysis on one side of the body), type 2 diabetes, and major depressive disorder. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderately impaired cognition and an indwelling urinary catheter. The comprehensive care plan dated 6/26/24 documented the resident had a urinary catheter related to neurogenic bladder (bladder with diminished sensation). Interventions included catheter care every shift and to follow provider orders for catheter/irrigation. Review of the hospital discharge summary dated 4/26/24 documented the resident was admitted with severe sepsis thought to be secondary to urinary tract infection with chronic foley catheter secondary to neurogenic bladder chronic foley catheter and to follow up with urology. Review of nurse Progress Notes dated 4/29/24 at 9:36 AM revealed the resident was seen by the Medical Director who wanted a voiding trial done to discontinue the foley catheter. On 4/30/24 at 2:21 PM, the resident's foley was removed. On 5/2/24 at 7:55 PM, the resident voided large amount of urine and had no complaints. Review of nurse and physician Progress Notes from 4/30/24-6/9/24 revealed the urinary catheter was not re-inserted and the resident was not seen by a urologist. The Order Summary Report (medical provider orders) documented an active order dated 6/12/24 for a foley catheter 16 French (measurement scale used to describe dimension of medical device tubing) with 10 cubic centimeter bulb, change as needed. Review of nurse and physician Progress Notes dated 6/12/24-7/17/24 revealed there was no documentation that a voiding trial was completed upon readmission from the hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 7/15/24 at 10:47 AM, Resident #37 stated they had a catheter that was put in during their last hospital stay and had asked staff to remove it. The resident stated it had been in for over two weeks and they had a urinary tract infection recently but wasn't sure if they still did. The resident had a urinary collection bag in a privacy bag hooked onto the bed frame that had clear yellow urine in the catheter tubing. During an interview on 7/18/24 at 1:49 PM, Licensed Practical Nurse #7 stated when the resident went to the hospital, they decided they had retention, so they put in the foley catheter, and the Licensed Practical Nurse #7 wasn't sure if they did a voiding trial when the resident returned to the facility in June. During an interview on 7/18/24 at 3:43 PM, the Registered Nurse Resident Care Coordinator #1 stated Resident #37 had a foley catheter for a neurogenic bladder diagnosis that was documented in a hospital discharge summary in April. The Registered Nurse Resident Care Coordinator #1 reviewed the resident's electronic medical record and stated they didn't see any urology consults and that the resident was re-hospitalized in June with stroke like symptoms caused by a urinary tract infection. They stated a voiding trial wasn't done since the readmission in June because of the same issue the resident was hospitalized with. During an interview on 7/19/24 at 10:00 AM, the Infection Preventionist/Director of Nursing stated they didn't know the reason Resident #37's foley catheter wasn't removed since most recent readmission, the Minimum Data Set (MDS) nurse would know because they make sure residents had the correct diagnosis and if the foley wasn't appropriate, they would do a voiding trial. During an interview on 7/19/24 at 10:39 AM, the Minimum Data Set (MDS) Coordinator reviewed Resident #37's electronic medical record and stated the resident got the neuromuscular dysfunction of the bladder diagnosis in April 2024 hospitalization and had a voiding trial when they were readmitted in April. They stated the resident didn't have the catheter when they went back to the hospital in June, and they didn't catch that because the discharge summary said chronic foley and it didn't click to them that the resident didn't have the foley when they were sent to the hospital in June. Because of the diagnosis of neurogenic bladder, they didn't question the foley catheter. The Minimum Data Set Coordinator stated it didn't look like the resident saw a urologist. During a telephone interview on 7/19/24 at 11:20 AM, the Medical Director stated Resident #37 should have had a voiding trial when they were readmitted from the hospital. When asked about the neurogenic bladder diagnosis from April and the subsequent voiding trial in April the Medical Director stated they always did a voiding trial when someone returned with a foley catheter. The Medical Doctor stated if they were not able to discontinue the foley, then they would follow up with a urologist. The Medical Director stated they didn't know why a voiding trial wasn't done when the resident was readmitted in June and that the resident was more at risk for sepsis, that was why they tried to remove the foley catheter as fast as they could. 10 NYCRR 415.12(d)(1)(2)

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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** 43802 Based on observation, record review, and interview conducted during a Standard survey completed on 7/19/24, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases/infections or implement a system of surveillance designed to identify possible communicable diseases/infection before they can spread to other persons in the facility for three (Residents #3,22, and 37) of six residents reviewed. Specifically, the issues involved; staff did not wear a gown during peripherally inserted central catheter (a catheter that is inserted through a vein and advanced until the tip enters the central venous system) care; staff did not wear a gown and gloves during medication administration for a resident on contact and enhanced barrier precautions (infection control interventions including gown and glove use for high contact resident care activities designed to reduce transmission of multidrug-resistant organisms) (Resident #22). Residents who had an indwelling urinary catheter did not have signs posted that indicated enhanced barrier precautions (Resident #3, 37) and staff did not wear a gown while emptying the urine collection bag (Resident #37). In addition, the Infection Preventionist/program did not track close contacts of residents who were diagnosed with scabies (parasitic infestation of the skin caused by tiny mites). The findings are: The policy and procedure titled Infection Prevention and Control-General Statement dated 5/2023 documented the facility would perform surveillance investigation and monitoring to prevent the spread of infection. This includes a system for preventing and controlling infections and communicable disease for all residents and staff. The Centers for Medicare and Medicaid Services Quality Safety and Oversight memoranda QSO-24-08-NH dated 3/20/24, documented enhanced barrier precautions were indicated for residents with indwelling medical devices even if the resident was not known to be infected or colonized with a multidrug-resistant organism. Examples of indwelling medical devices include central lines and urinary catheters. Enhanced barrier precautions were to be used when staff performed wound care for any skin opening that required a dressing. The memo also documented enhanced barrier precautions are employed for high contact resident care activities including the care or use of a urinary catheter. The document titled Policy on Outbreak Investigation and Infection Control Measures revised 6/24 documented an outbreak is one case of infection that is highly communicable, including scabies. Steps to be taken to facilitate the investigate include but are not limited to clarification of nature and extent of problem, planning investigative process, institution of control measures. The document titled Policy on Disease Specific Isolation/Precautions dated 6/11/24 documented Enhanced Barrier Precautions may be recommended for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug-resistant organism. Examples of indwelling medical devices include central lines and urinary catheters. Contact precautions are intended to prevent infections that are spread by direct contact or indirect contact with the resident or their environment and require use of personal protective equipment, including gown and gloves upon entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Resident #22 diagnosis include necrotizing fasciitis (bacterial infection), methicillin resistant staphylococcus aureus (antibiotic resistant bacteria) infection and Alzheimer's disease. The Minimum Data Set (resident assessment tool) dated 6/10/24 documented the resident understood, usually understands, and had severe cognitive impairment. Resident #22 was dependent on staff for transfers, required partial/moderate assist with hygiene, and received intravenous (through the vein) medications. During an observation on 7/15/24 at 10:40 AM, Resident #22's private room had sign (laminated orange) posted outside room indicating enhanced barrier precautions. At 10:44 AM Resident #22 exited the shower room in a shower chair covered with a bath blanket. Nursing staff transporting Resident #22 to their room were wearing a gown and gloves. The comprehensive care plan revised on 7/16/24 documented Resident #22 had an active infection related to infected sacral (area above the tailbone) decubitus (bedsore) and rash positive for scabies 7/16/24. Interventions included enhanced barrier precautions, labs and diagnostic testing per medical doctor order, transmission-based precautions as per policy, and administer antibiotic/medication as ordered. Review of Lab Results Report dated 7/16/24 documented a skin scraping to rule out scabies was collected on 7/16/24 at 9:00 AM and reported on 7/16/24 at 2:45 PM. The results showed sarcoptes scabiei (scabies). Review of Kardex Report (guide used by staff to provide care) dated 7/17/24 documented enhanced barrier precautions and transmission-based precautions as per policy. During an observation on 7/17/24 at 8:43 AM, Resident #22's private room had additional signage posted outside the room that included a white laminated sign with stop signs present instructing all staff and visitors to check with the nurse prior to entering the room. Different precaution levels were listed that included contact, droplet, enhanced droplet, and airborne. The sign indicated what personal protective equipment was needed for each precaution level. Contact precautions were marked and indicated use of gloves and gown. The enhanced barrier precaution sign remained. During an observation from the hallway on 7/17/24 at 1:55 PM, Registered Nurse Resident Care Coordinator #1, was in Resident #22's room wearing only gloves and was observed to disconnect infusion tubing connected to Resident #22's right arm, peripherally inserted central catheter (PICC) and flushed the catheter with a syringe. Registered Nurse Resident Care Coordinator #1 adjusted Resident #22 bed sheets over their arms while they leaned into the side of the bed with their scrubs (clothing) touching the sheets on the bed. During an interview on 7/17/24 at 1:59 PM, Registered Nurse Resident Care Coordinator #1 stated the facility identified residents on precautions by the signs that were posted outside the resident's room and that they received a list from the Director of Nursing or Assistant Director of Nursing of all residents on precautions. They stated the type of personal protective equipment that was required depended on what type of precautions a resident was on and what the staff were doing with the resident on precautions. Registered Nurse Resident Care Coordinator #1 stated they did not know why Resident #22 was on enhanced barrier precautions, but believed it was for wound care. They stated that enhanced barrier precautions were implemented on residents with an active infection. They stated they did not apply a gown prior to entering Resident #22's room as they were not performing wound care. (continued on next page)

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	335533	A. Building B. Wing	07/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 7/17/24 at 2:05 PM, Registered Nurse Resident Care Coordinator #1 observed the signage outside Resident #22's room and stated that Resident #22 was on contact precautions. Then stated I guess I should have been wearing a gown as it states it right there on the sign. They stated it was important to follow precautions to prevent spreading whatever it was the resident had. Additionally, they stated they did not know Resident #22 had scabies and should have been informed. During an observation of medication administration on 7/18/24 at 8:25 AM, Licensed Practical Nurse #3 entered Resident #22's room. There were signs on the outside of the room that indicated the resident was on contact precautions and enhanced barrier precautions. The Licensed Practical Nurse #3 did not put on personal protective equipment including gloves and gown before they entered the room. The Licensed Practical Nurse #3 handed the plastic medication cup to the resident, the resident took the medications and handed the cup back to the Licensed Practical Nurse #3. The Licensed Practical Nurse #3 then touched the overbed table and brought it closer in front of the resident and exited the room without washing their hands. The Licensed Practical Nurse #3 went to their medication cart and performed hand hygiene with hand sanitizer. The Licensed Practical Nurse #3 stated they thought Resident #22 was on precautions because of their wound and was on intravenous antibiotics. Licensed Practical Nurse #3 stated they weren't sure about the two signs outside the resident's doorway and that anyone with a foley catheter or wound were on enhanced barrier precautions. If a resident was on contact precautions you had to wear gloves and a gown when they were dealing with that specific area during hands on care, not when they passed a meal tray or gave medications. During an interview on 7/19/24 at 12:39 PM, Infection Preventionist/Director of Nursing stated they expected nursing staff to wear proper personal protective equipment prior to entering a resident's room as posted on the precaution signs posted outside a resident's room. They stated Registered Nurse #1 should have been wearing a gown and gloves prior to entering Resident #22's room because that was what was required. They stated wearing a gown protects personal clothing from coming in contact acquiring what the resident has. 2. Review of Precaution Status Weekly Report updated 7/15/24, Resident #3 and Resident #37 were not listed as being on precautions, specifically enhanced barrier precautions and had foley catheters. Resident #3 had diagnoses included obstructive and reflux uropathy (obstruction in the urinary tract), benign prostatic hyperplasia with lower urinary tract symptoms and retention of urine. The Minimum Data Set, dated dated dated [DATE] documented Resident #3 usually understood/usually understands, had moderate cognitive impairment and an indwelling catheter. The comprehensive care plan initiated 11/1/2022 documented Resident #3 had a urinary catheter. Interventions included urinary catheter care every shift, change urinary drainage bag as needed, and follow orders for catheter/irrigation. There was no documented evidence the resident was on enhanced barrier precautions. During an observation on 7/15/24 at 11:53 AM, 7/18/24 at 9:38 AM and 7/19/24 at 12:50 PM, Resident #3 was in their room and had a foley catheter bag in a privacy cover. There was no signage posted indicating Resident #3 was on enhanced barrier precautions, and there was no personal protective equipment set up outside the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/17/24 at 1:43 PM, Certified Nurse Aide #7 stated they were aware of which residents were on precautions by the signage posted outside the resident's room, bins with personal protective equipment were also located outside the room, and they also received a report from the nurse. They stated they knew what personal protective equipment to wear by what was posted on the sign. Certified Nurse Aide #7 stated personal protective equipment was required for residents on enhanced barrier precautions, which would include any resident with a wound, infection, or tubes going into their bodies. During an interview on 7/18/24 at 10:01 AM, Licensed Practical Nurse #5, Unit Manager, stated Resident #3 was not on enhanced barrier precautions because their urine was contained within the foley. They stated that nursing staff used standard precautions and if staff felt they would be splashed while draining urine from the urinary collection bag they could wear a gown. Licensed Practical Nurse #5 stated enhanced barrier precautions weren't needed for residents with a foley. Resident #37 had diagnoses including hemiplegia (paralysis on one side of the body), type 2 diabetes, and major depressive disorder. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderately impaired cognition and an indwelling urinary catheter. The comprehensive care plan dated 6/26/24 documented the resident had a urinary catheter related to neurogenic bladder (bladder with diminished sensation). Interventions included catheter care every shift and to follow provider orders for catheter/irrigation. There was no evidence the resident was on enhanced barrier precautions. During observation on 7/16/24 at 2:49 PM and 7/17/24 at 8:24 AM Resident #37 was in their room with a foley catheter bag in a privacy cover. There were no signs for enhanced barrier precautions on the doorway or wall near the door. There was no bin for personal protective equipment near the resident's door. During an observation on 7/18/24 at 1:52 PM, Certified Nurse Aide #5 wore gloves while they emptied Resident #37's urine collection bag. The Certified Nurse Aide #5 did not wear a gown during the observation. During an interview on 7/18/24 at 2:00 PM, Certified Nurse Aide #5 stated they never wore a gown when they emptied a foley catheter because they tried to be careful and not splash the urine anywhere. The Certified Nurse Aide #5 stated they would wear a gown if the resident had something in the urine, like an infection. During an interview on 7/18/24 at 3:43 PM, the Registered Nurse Resident Care Coordinator #1 stated after a resident had completed their antibiotics for a multidrug-resistant organism, then they were placed on enhanced barrier precautions. It was for people who have had infections that never went away but weren't active anymore. They stated they've had education about it and the guidance was confusing. They didn't know residents with foley catheters were supposed to be on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/19/24 at 9:11 AM, the Infection Preventionist/Director of Nursing stated residents who had a multidrug-resistant organism that completed antibiotic treatment but had a wound with secretions would be placed on enhanced barrier precautions when staff performed care. The Infection Preventionist/Director of Nursing stated a resident with a foley catheter would not have to be on enhanced barrier precautions and if staff felt there was a risk for splash when emptying a foley catheter bag they would wear a gown and the gown was optional with any resident who had a catheter or indwelling device. The Infection Preventionist/Director of Nursing stated that there was a risk for splashing of urine while staff emptied a foley collection bag. During an interview on 7/19/24 at 1:10 PM, Corporate Quality Assurance Nurse, stated everybody was on Enhanced Barrier Precautions, then changed to basically anyone not contained, to make it more homelike. Standard precautions are used for residents with foley catheters. They stated they can't say with 100% certainly that staff aren't going to get splashed. 3. The undated facility document titled Scabies Line List documented two residents were confirmed positive for scabies since 7/9/24. Review of the facility document titled Permethrin Cream List (topical treatment for scabies) starting 7/10/24 revealed a list of seven staff members including the Infection Preventionist/Director of Nursing and six Certified Nurse Aides. During a telephone interview on 7/18/24 at 11:15 AM, the Regional Epidemiologist stated during a facility outbreak, the Infection Preventionist/Director of Nursing should have a line list of every staff with potential exposures to the positive scabies cases and which staff accepted the treatment. The lists of contacts should be as inclusive as possible initially in order to treat them all at the same time ideally, that is what helps to not provide an escape system for scabies. During an interview on 7/19/24 at 9:11 AM, the Infection Preventionist/Director of Nursing stated the list they provided was the staff members who opted for scabies treatment, and it did not include all close contacts of the resident who tested positive for scabies on 7/9/24. They stated they had their scheduler working on that contact list. The Infection Preventionist/Director of Nursing stated that guidance from Epi (Epidemiologist) did mention contact tracing, but it had been confusing, and they were just trying to get everything done. They've had help with room cleaning but not much help with the contact tracing aspect. During an interview on 7/19/24 at 2:49 PM, the Infection Preventionist/Director of Nursing stated it was important to do the tracking so if anyone got a rash, they would know where it came from, and they could track back to know where it started and if it was spreading. During a telephone interview on 7/19/24 at 11:24 AM, the Medical Director stated that they had been informed of the outbreak and that the facility should have a list of staff who had contact with the scabies positive residents for tracking purposes. 10 NYCRR 415.19(a)(1)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 43802 Based on interview and record review conducted during the Standard survey completed on 7/19/24, the facility did not ensure an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for one (Resident #65) of one resident reviewed. Specifically, Resident #65 received Augmentin (antibiotic, Amoxicillin-Potassium Clavulanate 875-125 milligram) for osteomyelitis (bone infection) since 7/25/23 and there was no ongoing monitoring by the Antibiotic Stewardship Program including communication, tracking of its use, appropriate indications for continued use, or follow up appointment with the Infectious Disease Physician as recommended. The finding is: Review of the policy and procedure titled Antibiotic Stewardship Program effective 5/2017, documented the primary goal is to optimize the treatment of infections and clinical outcomes while minimizing unintended consequences of antibiotic use. The antibiotic stewardship program includes a system of monitoring antibiotic use. Actions to improve antibiotic prescribing/use include institute an antibiotic time-out which is an antibiotic review process to reassess the ongoing need for and choice of antibiotic while waiting for more information. Tracking: the facility will track adherence to clinical assessment documentation of signs and symptoms, vital signs, and physical examination findings of infection; the facility will track adherence to prescribing documentation (dose, duration, indication.) Resident #65 had diagnoses which included osteomyelitis (bone infection) of vertebra, sacral (sacrum) and sacrococcygeal (sacrum/coccyx (tailbone)) region; pressure ulcer of sacral region (stage 4, full thickness tissue loss with expose bone, tendon, or muscle), and methicillin resistant staphylococcus aureus (bacteria that is resistant to certain antibiotics) infection. The Minimum Data Set (resident assessment tool) dated 7/8/24 documented Resident #65 was cognitively intact and was receiving an antibiotic. The comprehensive care plan initiated 1/2/2023, revised 4/18/2024 revealed there was no documented evidence of antibiotic use for osteomyelitis. Review of hospital consult by infectious disease dated 12/2/2022 documented sacral osteomyelitis. Recommendations included: 12/17/2022 start Augmentin 875 twice a day for months until wound is better; check labs (complete blood count, comprehensive metabolic panel, erythrocyte sedimentation rate, and c-reactive protein) monthly and fax to infectious disease. Additionally, recommended return to clinic in 3 months with future appointment scheduled for 3/2/23 with infectious disease. Review of the Order Summary Report from 1/2/23 to 7/17/24 documented an active physician order for Augmentin 875-125 milligrams with instructions to give 1 tablet by mouth every morning and at bedtime for osteomyelitis with a start date of 7/28/2023. There was no stop date. Review of the monthly infections list, as identified by the Director of Nursing from July 2023 to June 2024 revealed there was no documented evidence the antibiotic/Augmentin use was monitored and tracked for Resident #65. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medication Administration Record from July 2023 through July 2024 documented Resident #65 received Augmentin 875-125 milligrams twice a day for osteomyelitis. Review of Progress Notes transcribed by Medical Provider, Medical Doctor #1, dated 8/21/23 through 7/11/2024 documented no evidence of antibiotic use and no documented rationale for the continued use of the antibiotic. Review of nursing Progress Notes dated 1/2/2024 through 7/17/2024 did not document evidence that Resident #65's was being monitored for antibiotic use. During an observation and interview on 7/17/24 at 11:15 AM, Resident # 65 was lying in bed watching television. Resident #65 stated they saw an infectious disease doctor while at a local hospital for their pressure ulcer on their butt prior to being transferred from a sister facility in January of 2023. Resident #65 stated they don't recall seeing an infectious disease doctor since. During an interview on 7/19/24 at 8:45 AM, Licensed Practical Nurse #5 Unit Manager stated the Infection Preventionist/ Director of Nursing tracks antibiotic use in the facility. Licensed Practical Nurse #5 Unit Manager stated that Resident #65 was started on Augmentin prior to coming to facility for osteomyelitis. They stated Resident #65's sacral pressure ulcer was healing well, and there has been no recent signs/symptoms of infection noted or reported. They stated that to their knowledge there has been no follow up consults related to Resident #65's osteomyelitis in the last year. Additionally, they stated that long term use of antibiotics could cause problems like Clostridioides difficile (C. diff- infection of the colon) and antibiotic resistance. During an interview on 7/19/24 at 8:57 AM, Director of Nursing/Infection Preventionist stated they generate, run an antibiotic report every month and discuss at quality assurance and performance improvement (QAPI) meetings. They stated they track only acute antibiotic use and residents who are admitted to the facility on an antibiotic. They stated they do not track Resident #65 antibiotic use for osteomyelitis as they were receiving it long term. Additionally, they stated they have not reviewed Resident #65 antibiotic use since Medical Doctor #1 reinstated it last year (7/2023). During a telephone interview on 7/19/24 at 10:47 AM, Pharmacy Consultant stated they do not provide, nor have they been asked to provide the facility with a monthly antibiotic report. They stated all antibiotics should be tracked, to monitor for appropriate usage and resistance. Additionally, they stated antibiotics were reviewed at quality assurance and performance improvement (QAPI) meeting. During a telephone interview on 7/19/24 at 11:15 AM, Medical Doctor #1 stated they expected the facility to follow protocol for tracking antibiotic use. They stated they accessed Resident #65's medical record electronically and that Resident #65 was receiving Augmentin for chronic osteomyelitis. Medical Doctor #1 was unable to say whether Resident #65 has had any follow up consults with infectious disease concerning the osteomyelitis. They stated they follow the recommendations from the wound team at the facility. They stated they would only document on the antibiotic if there were ill effects from it. Additionally, they stated they attend quality assurance and performance improvement (QAPI) meetings and antibiotic use was discussed, however they could not recall if Resident #65's use of Augmentin has been discussed. 10NYCRR 415.12(l)(1)