| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365882 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Springmeade Healthcenter | 4375 South County Road 25 A<br>Tipp City, OH 45371 |

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on medical record review and staff interviews, revealed the facility failed to notified Resident Representative when change in health status occurred requiring medications and laboratory testing. This affected one (#76) of two residents reviewed for notification of change in condition. The facility census was 87.<br><br>Findings include:<br><br>Review of medical record for Resident #76 revealed admitted [DATE], with diagnoses including dementia without behaviors,altered mental status, falls, hypertension, cerebral infarction without residual deficits, anxiety disorder, benign prostatic hyperplasia with urinary tract symptoms, and insomnia,<br><br>Review of the admission Minimum Data Set (MDS) assessment for Resident #76 dated 12/20/24 revealed an impaired cognition. Resident #76 requires moderate assist to dependent on staff for eating, toileting, bed mobility and transfers. Resident #76 was coded as incontinent of bowel and bladder.<br><br>Review of the plan of care for Resident #76 revealed resident is incontinent of bladder related to benign prostatic hyperplasia with urinary tract symptoms, dementia, gait abnormality, and muscle weakness. Interventions include medication administration as ordered, encourage resident to utilize call light system to report the need to use bathroom, check resident daily during rounds and as required, provide incontinence care as needed, monitor for signs and symptoms of urinary tract infections and report abnormalities to physician.<br><br>Review of the physician orders for the month of March 2025 for Resident #76 revealed an order dated 03/16/24 for cefuroxime axetil oral tablet 500 milligram (mg) by mouth two times a for urinary track infection until 03/23/25; an order dated 03/18/25, for Macrobid oral capsule 100 mg give one capsule by mouth two times a day for escherichia coli for seven days, urinary tract infection (UTI)-Stat Oral Liquid (Cranberry-Vitamin C-Inulin) give 30 ml by mouth two times a day for UTI dated 03/17/25; Tylenol tablet 325 mg give two tablets by mouth every four hours as needed for fever dated 03/15/24; ondansetron oral tablet give 4 mg by mouth every 6 hours as needed for nausea and vomiting dated 03/15/25; test for COVID one time only for symptoms dated 03/14/25; and test for flu one time only for flu like symptoms dated 03/14/25.<br><br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of nurses' progress note dated 03/14/25 at 9:25 P.M., for Resident #76 revealed previous assigned nurse reported that resident wasn't acting like his normal self today and had an emesis this AM. STAT (immediately or as soon as possible) laboratory test were ordered. Laboratory staff obtained samples at approximately . 6:45 P.M. to draw blood work. No results at this time. No episodes of emesis noted on this shift. Resident states He feels ok when asked several times. Current vital signs were Temperature 98.0 Fahrenheit (F), pulse (P) 82, respirations (R)16, blood pressure (B/P) was 161/90. Resident was resting comfortably in bed at this time. Respirations are even and unlabored. Reported to oncoming nurse about pending STAT blood work.<br><br>Review of nurses' progress note dated 03/15/25 at 3:02 P.M., for Resident #76 revealed an order for Ondansetron Tablet Disintegrating 4 milligram (mg) give 1 tablet by mouth every six hours as needed for nausea and vomiting and Acetaminophen tablet 325 mg, give 2 tablet by mouth every four hours as needed for fever not exceed 3000 mg in twenty four hours.<br><br>Review of nurses' progress note dated 03/15/25 at 3:05 P.M., for Resident #76 revealed laboratory results received and nurse practitioner notified. Nurse practitioner gave new orders for STAT chest radiograph (x-ray), and glycated hemoglobin on Monday.<br><br>Review of the progress notes dated 03/15/25 at 3:07 P.M., for Resident #76 revealed B/P 175/75, P 73, R 18, oxygen saturation rated (SPO) = 92% Temp 101.6 F. Resident continues to complaint of nausea, dry heaving noted. Tylenol & Zofran administered. Lung sounds diminished but clear. Respirations shallow with use of accessory muscles noted. Resident denies shortness of breath, will continue to monitor.<br><br>Review of the nurses' progress notes dated 3/15/25 at 5:26 P.M., for Resident #76 revealed recheck temperature after Tylenol, was 99.4 F, B/P 130/67 and pulse was 65. Resident continues to deny pain. Resident consumed approximately 10% of evening meal. Resident #76 encouraged to eat but refused. Resident #76 was encouraged to drink fluids and will continue to monitor.<br><br>Review of the nurse's progress note dated 3/15/25 at 5:41 P.M., for Resident #76 revealed the facility received chest x-ray (CXR) results that were negative for pleural effusion, pneumothorax. The Certified Nurse Practitioner was notified of results. Spoke with son and gave update on resident condition.<br><br>Interview on 03/27/25 at 9:25 A.M., with Unit Manager Licensed Practical Nurse (LPN) #3 verified Resident #76 was experience a change in heath status, requiring notification of the Nurse Practitioner (NP). NP ordered a urinalysis, rapid testing for COVID-19 and influenza. LPN #3 confirmed the progress notes for Resident #76 was silent for family notification of the change in condition, laboratory testing or the addition of medications for the treatment of nausea and vomiting.<br><br>Interview on 03/27/25 at 9:40 A.M., with LPN #104 assigned to Resident #76 on 03/15/25 P.M., verified that she did not notify the family of the new orders.<br><br>Request for change of condition policy during the survey process and was not provided for review. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076<br><br>Based on record review, resident interview, staff interviews, and policy review, the facility failed to investigate injury of unknown origin. This affected one (#238) of one resident reviewed for abuse. The facility census was 86.<br><br>Findings include:<br><br>Review of medical record for Resident #238 revealed admitted [DATE]. The resident was admitted with diagnoses including Parkinson's disease, traumatic subdural hemorrhage, and bipolar disorder with psychotic features. The admission Minimum Data Set (MDS) was in process at the time of the survey.<br><br>Review of the 03/20/23 admission skin assessment revealed no areas had been documented on the skin screening.<br><br>Review of the progress notes dated 03/23/25 at 11:57 P.M., revealed a second assessment was completed from admission and Resident #238 was documented to have scattered bruising to bilateral upper extremities. Family and physician were all notified and aware.<br><br>Review of the 03/23/25 skin assessment documented scattered red bruising to bilateral upper extremities.<br><br>In an interview on 03/24/25 at 10:54 A.M., with Resident #238 revealed he felt staff were rough with him during the use of a mechanical lift. He confirmed he had not reported this to the staff at the facility.<br><br>Interview on 03/24/24 at 1:34 P.M., with the Director of Nursing (DON) revealed she had not been informed by Resident #238 or by nursing of a concern staff had been rough with Resident #238 during mechanical lift transfers. She stated she would follow up with the concern.<br><br>Review of the Self-Reported Incident (SRI) number (#) 258587 revealed an investigation was opened regarding the alleged incident on 03/24/25 after the surveyor questioned the facility.<br><br>Interview on 03/31/25 at 2:20 P.M., with the DON and Unit Manager (UM) #61 revealed the DON was unaware of the 03/23/25 progress note regarding the scattered bruising of Resident #238. She verified the admission skin assessment revealed no documentation of bruising. Unit Manager (UM) #61 also present during the interview acknowledged she had observed the bruising during a routine second skin assessment. She stated she followed up with the admitting nurse who informed her the bruising had been present at admission, but he had failed to document them. UM #61 confirmed there was no documentation regarding her investigation. The DON verified she had been unaware of the progress note and second skin assessment of scattered bruising until this interview and acknowledged the lack of investigation was a concern.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property-Ohio Only revised October 2022 revealed it was facility policy to investigate all alleged violations including injuries of unknown source |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure the plan of care reflected the resident preferences for physician participation in urinary catheter care. This affected one (#45) of three resident reviewed for catheter care. The facility census was 87.<br><br>Findings include:<br><br>Medical record review for Resident #45 revealed an admission on 09/02/21, with diagnoses including paraplegia, neurogenic bowel, acute and chronic systolic congestive heart failure, chronic kidney disease, and neuromuscular dysfunction of bladder.<br><br>Review of the comprehensive Minimum Data Assessment (MDS) assessment dated [DATE] for Resident #45 revealed intact cognitive impairment. Resident #45 required set up or clean up assistance for eating, dependent for toileting, supervision for bed mobility and transfers required moderate assistance. Resident #45 was coded as having a urinary catheter and colostomy.<br><br>Review of the plan of care for Resident #45 revealed resident is at risk for complications from usage of urinary catheter (suprapubic) related to neurogenic bladder dated 06/20/23 and revised on 01/21/25. Interventions include removal of catheter is contraindicated 20 french (FR) 10 milliliter (ml), resident will not develop any complications related to catheter usage, resident will be free from signs and symptoms of urinary tract infections (UTI), access and record any changes in bladder status, catheter change per facility policy/physician order, change drainage bag per policy, enhanced barrier precautions, monitor for signs and symptoms of UTI and report abnormalities to physician.<br><br>Review of the active physician orders for Resident #45 revealed an order dated 02/28/25 and discontinued on 03/06/25 for suprapubic catheter 22 FR 30 ml balloon to continuous drainage, change once each month on night shift on the 28 th related to neurogenic dysfunction of bladder.<br><br>Interview on 03/24/25 at 1:41 P.M., with Resident #45 stated the facility had the catheter orders all messed up. Resident #45 stated he went to the hospital in November and after that episode they urologist changes his catheter in his office.<br><br>Observation on 03/31/25 4:00 P.M., of Resident #28's catheter care was completed without concerns.<br><br>Review of the physician office progress notes from visit dated 12/09/25 for Resident #45 revealed resident had a follow up appointment post hospitalization for treatment of UTI with a discharge date of [DATE]. Physician changed the cystostomy tube and resident confirmed he would like to continue with in office exchanges of the suprapubic catheter. Review of the physician visit note revealed a urinary Foley style in size 20 French with 10 ml balloon was placed.<br><br>Review of the physician office visit dated 01/23/25 for Resident #45 revealed physician changed the cystostomy tube.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Treatment Administration Record (TAR) for Resident #45 for the month of January 2025 revealed an order dated 08/28/24 for suprapubic catheter 22 FR 30 ml balloon to continuous drainage, change once each month on night shift on the 28 th. Further review of the TAR revealed the order was discontinued on 01/24/25.<br><br>Review of the physician office visit dated 02/20/25 for Resident #45 revealed physician changed the cystostomy tube with a Foley style urinary catheter in size 20 FR with 10 ml balloon was placed.<br><br>Review of the TAR for Resident #45 for the month of February 2025 revealed an order dated 02/28/28 for suprapubic catheter 22 french 30 ml balloon to continuous drainage, change once each month on night shift on the 28 th. Further review of the TAR revealed the task was unsigned without documentation indicating the task was refused by resident.<br><br>Review of the TAR for Resident #45 for the month of March 2025 revealed an order dated 02/28/28 and discontinued on 03/06/25 for suprapubic catheter 22 french 30 ml balloon to continuous drainage, change once each month on night shift on the 28 th.<br><br>Review of the progress notes for Resident #45 dated 03/19/25 at 10:30 P.M., revealed resident requesting appointment for urologist to be canceled as catheter was changed on that date.<br><br>Interview on 03/30/24 at 3:39 P.M., with MDS Registered Nurse (RN) #87 stated the plan of care was updated with the annual assessment in January 2025. RN #87 verified the medical record for was reviewed and did not contain any information related to the resident's preference of having the suprapubic catheter changed in the physician office. RN #87 verified the current plan of care did not address the resident preference and should have.<br><br>Review of the policy titled Comprehensive Care Planning Procedure, dated 11/13/2017, revealed an interdisciplinary team is responsible for developing, implementing and evaluating the person centered plan of care. Person centered care is defined as a focus on the resident as the focus of control and support the resident in making their own choices. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076<br><br>Based on observations, medical record review, family interview, resident interview and staff interview, the facility failed to ensure residents received assistance with their Activities of Daily Living (ADL's). This affected one (#24) of five residents reviewed for ADL assistance. The faciltiy census was 87.<br><br>Findings include:<br><br>Review of medical record for Resident #24 revealed admitted [DATE]. The resident was admitted with diagnoses including liver cell carcinoma, congestive heart failure, and depression.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 04 indicating significantly impaired cognition. She was independent with eating and required moderate assistance for bed mobility, transfers and toileting hygiene.<br><br>Review of care plan for an actual/potential for oral/dental health problems related to full upper dentures and no lower teeth or dentures with interventions which included assisting with oral cares and encourage denture use.<br><br>Interview on 03/24/25 at 9:36 A.M., with Resident #24's daughter revealed she had a concern staff were not assisting her mother with her dentures. She stated she would come to the facility after breakfast and she would not have them in.<br><br>Observation on 03/25/25 at 2:13 P.M., revealed Resident #24 did not have her upper dentures in.<br><br>Interview and observation on 03/26/25 at 9:00 A.M., revealed Resident #24 did not have her dentures in and she stated she would like them in.<br><br>Interview on 03/26/25 at 12:28 P.M., with Certified Nursing Assistant (CNA) #15 revealed she was unsure if Resident #24 had dentures. She stated she usually got in report if a resident had dentures or the resident would tell her when she was getting them up, She acknowledged if a resident was confused they may not tell her. Upon entering Resident #24's room, a lunch tray was noted on the bedside table. CNA #15 asked if she had dentures and Resident #24 stated she did not know where they were. CNA #15 went into the bathroom where a denture cup was located to the left of the sink. CNA #15 brought the denture back into the room and asked Resident #24 if she was going to eat her meal. Resident #24 stated she could only eat the sherbert. CNA #15 stated maybe she could eat after she put her teeth in. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291<br><br>Based on review of the activity calendar, medical record review, staff interview, resident interview, and policy review, the facility failed to ensure there was an activity program that met the needs of the residents. This affected two (#29 and #70) of three residents reviewed for activities. The census was 87.<br><br>Finding included:<br><br>Medical record review for Resident #70 revealed an admitted [DATE]. Her medical diagnoses included hypertension, dementia, and manic depression.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #70 revealed she was cognitively intact. Her functional status was setup or cleanup assistance for eating, partial/moderate assistance for transfers and toileting, and she was supervision/touching for bed mobility. This assessment included it was very important to do activities with groups of people.<br><br>Review of the activity care plan dated 02/08/25 for Resident #70 revealed the resident was involved in independent activities as evidenced by enjoys word puzzles, listens to radio, reads independently, talking on the telephone, and watches television. The interventions included staff will provide resident with crafting supplies as requested. Staff will provide resident with puzzle books as requested. Staff will provide resident with reading material as requested<br><br>Review of the activities calendar from 03/01/25 through 03/31/25 revealed the last facility led activity was scheduled for 2:00 P.M. for the whole month. For the month of March there was scheduled games at 6:30 P. M. on 03/02/25, 03/09/25, 03/16/25, 03/23/25, and 03/30/25.<br><br>Interview on 03/25/25 at 8:42 A.M., with Resident #70, revealed there wasn't a lot of activities to participate in. She reported at 4:00 P.M. the activities were done and there wasn't anything else.<br><br>Interview on 03/31/25 at 8:28 A.M., with the Administrator, revealed the evening activity which was one day a week was resident led and there wasn't any participation kept on that.<br><br>2. Medical record review for Resident #29 revealed an admitted [DATE]. Medical diagnoses included coronary artery disease, hypertension, peripheral vascular disease, and renal insufficiency.<br><br>Review of the care plan for Resident #29 dated 07/10/24 revealed resident was involved in independent activities as evidenced by enjoys word puzzles, reads independently, watches television, and diamond paintings. Interventions were staff will provide resident with puzzle books as requested will provide resident with reading materials as requested.<br><br>Review of the quarterly MDS assessment dated [DATE] for Resident #29 revealed she was cognitively intact. Her functional status was independent for eating, partial/moderate assistance for toileting, supervision/touching assistance for bed mobility, and transfers. Her assessment revealed it was very important to do things with groups of people.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 03/31/25 at 8:28 A.M., with the Administrator revealed the evening which is one day a week was resident led and there wasn't any participation kept on that.<br><br>Interview on 03/31/25 at 8:47 A.M., with Resident #29 revealed she didn't think the activities were long enough and they were over with at 3:00 P.M. and there wasn't anything to do. She stated the facility only has one night they have them till 6:00 P.M., but that was driven by the residents and they have four people who play cards and she wasn't invited to play. She reported she had been a resident in other facilities and they have activities until at least 6:00 P.M. everyday.<br><br>Interview on 03/31/25 at 8:52 A.M., with Activities Coordinator (AC) revealed she works until 4:00 P.M., everyday. She reported there is a late night activity,ran by residents, but there are 6-8 residents who participate in that and it isn't opened up to the other residents only if they ask to play in the game.<br><br>Interview on 03/31/25 at 9:00 A.M., with the Activity Leader (AL) #122, revealed she didn't work any nights in the facility and the activity they had on Sundays in March were all resident driven and not all of the residents were invited to this. She reported recently she was appointed this position and the previous AC left the position and she realized there wasn't enough activities being conducted in the facility to meet the needs of the residents and that was going to change in April.<br><br>Review of the policy titled Activity Recreation Program, dated 07/20/11, revealed it is the policy of the facility that each community offers an activity/recreation program designed to respond to interests, abilities, potential, and needs of individuals living in the community. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on observation, record review, resident and staff interviews, and policy reviews, the facility failed to timely assess, timely obtain treatments, clarify physician orders and complete physician orders. This affected three (#55, #75 and #76) of three residents reviewed for skin impairment. The facility census was 87.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #75 revealed an admission on 09/13/24, with diagnoses including dislocation of right hip, adjustment disorder with mixed anxiety and depressed mood, dementia without behaviors, hypertension, Alzheimer's disease, macular degeneration, and arthropathy.<br><br>Review of the Braden scale for Resident #75 dated 01/06/25 revealed resident was at low risk for skin breakdown.<br><br>Review of the quarterly MDS dated [DATE] revealed an intact cognition. Resident #75 required assistance for eating, moderate assistance for toileting, transfers and bed mobility. Resident #75 was coded as incontinent with bowel and bladder. Residents #75 were not coded with any pressure ulcer or applications of ointments of dressings.<br><br>Review of the care plan dated 09/14/24, revised on 02/06/25, revealed Resident #75 is at risk for skin breakdown and pressure ulcers, incontinence, weakness, history of right hip dislocation, dementia, and arthritis. Interventions included administer/monitor effectiveness of/response to preventive treatment(s) as ordered, apply protective barrier cream as ordered, assess and record changes in skin status. Report pertinent changes to physician, assist resident with turning and repositioning daily during rounds and as required/prn, provide incontinence care after each incontinent episode and weekly skin assessments by nurse.<br><br>Review of the weekly skin observation tool dated 03/26/25 at 9:21 A.M., for Resident #75 revealed two skin tears on left antecubital. This was the only skin impairments noted.<br><br>Observation on 03/26/25 at 12:35 P.M., of incontinence care for Resident #75 provided by Certified Nurse Aide (CNA) #75 and #78 revealed an open reddened area on coccyx.<br><br>Review of the progress notes dated 03/26/2025 at 12:50 P.M., documented nurse notified of an area to residents inside left buttocks while being changed by CNA's. Small red open area 1.0 cm x 1.0 cm noted. Head to toe assessment and skin check completed and skin check completed. Resident states no pain or discomfort from area. Vital signs were documented as temperature 98.2 degrees Fahrenheit, respirations 18, pulse 67, blood pressure 130/68 and oxygen saturation of 95 percent on room air. The physician was notified of new area and order given for dry dressing changes daily and for the resident was to be seen by wound care team. The resident and family was notified.<br><br>Review of the new skin observation tool dated 03/26/25 at 12:50 P.M., for Resident #75 revealed a red open area to left buttock measuring 1.0 cm x 1.0 cm with not applicable noted for depth.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility incident report for Resident #75 dated 03/26/25 at 12:50 P.M., revealed nurse was notified of an area to resident's inside left buttocks while being changed by CNA's, small red open area measuring 1.0 cm x 1.0 cm noted. Head to toe assessment and skin check completed. Residents denied pain or discomfort to the area. Physician was notified of new area and order given for dry dressing with daily changes. Resident #75 to be seen by wound care team, family and residents were notified.<br><br>Review of the physicians orders for Resident #75 revealed an order dated 03/28/25 for sacrum left side, treatment: cleanse with normal saline, pat dry, apply Medihoney to wound bed, cover with border gauze every day shift for wound care and as needed.<br><br>Review of the wound care Nurse/ Doctor skin observation form dated 03/28/25, for Resident #75 revealed sacrum area measured 2.4 cm x 1.5 cm x 0.1 cm and classified as moisture associated skin damage (MASD). Sacrum area was documented to have moderate amount of serosanguinous drainage.<br><br>Review of the plan of care for Resident #75 dated 03/28/25 revealed resident has an actual impairment to skin integrity of the left buttock related to moisture associated skin damage. Interventions included good nutrition and hydration in order to promote healthier skin, identify potential causative factors and eliminate/resolve where possible, monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physicians, encourage/assist with frequent turning and repositioning during day and night for pressure relief, treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations and weekly skin screen.<br><br>Review of the treatment administration record (TAR) for the month of March 2025 for Resident #75 dated 03/28/25 revealed a treatment for sacrum left side, cleanse with normal saline, pat dry, apply Medihoney to wound bed and cover with border gauze as needed for wound care and a treatment for sacrum left side, cleanse with normal saline, pat dry, apply Medihoney to wound bed and cover with border gauze every day shift for wound care. Further review of the TAR revealed the treatment was signed as completed by the facility staff on 03/29/25.<br><br>Interview on 04/01/25 at 11:40 P.M., with Director of Nursing (DON) verified the electronic health record did not contain an order initiated for the treatment of the wound discovered on 03/26/25. Further verified the order was initiated on 03/28/25 and the first documentation of a dressing application was noted on 03/29/25. DON verified the wound to the sacrum had increased in size and had drainage when measured on 03/28/25 by the Unit Manager.<br><br>2. Review of medical record for Resident #76 revealed an admission on 12/23/24, with diagnoses including dementia without behaviors, altered mental status, falls, hypertension, basal cell carcinoma, and anxiety disorder.<br><br>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], for Resident #76 revealed impaired cognition. Resident #76 requires moderate assistance to total dependence on staff for eating, toileting, bed mobility and transfers. Resident #76 was coded as receiving non-surgical dressing applications during the assessment period.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the plan of care dated 12/24/24 for Resident #76 revealed resident was at risk for skin breakdown, pressure ulcers related to decreased mobility, altered mental status, and basal cell carcinoma of skin. Interventions include administer, monitor, and response to treatment and weekly skin assessment by nurse.<br><br>Review of the physician orders for Resident #76 revealed an order dated 12/26/24, for a scab that is scratched open to forehead; treatment: cleanse with saline pat dry and apply medihoney and bordered gauze daily every day shift and discontinued on 03/26/28. An order dated 12/28/24, for Mupirocin External ointment 2% apply to scratched open scab to top of head topically every day shift, cleanse with saline pat dry apply mupirocin ointment and bordered gauze.<br><br>Observation on 03/26/25 at 12:10 P.M., with Licensed Practical Nurse (LPN) #79 of wound care to head revealed Resident #79 was taken to his room after his shower and explained what treatment was going to be completed. Resident #79 completed hand hygiene prior to donning gloves. LPN #79 cleansed the two areas on forehead with normal saline and gauze pads. LPN #79 applied Mupirocin 2% to both right and left wounds on forehead and covered with bordered dressings. Dressings were labeled with date and initials of LPN #79.<br><br>Review of the Treatment Administration Record for Resident #76 revealed LPN #79 signed as completed on 03/26/25, treatments for the application of Mupirocin 2% ointment to open areas on forehead and Medihoney ointment to open areas of Resident #76 forehead.<br><br>Interview on 03/26/25 at 4:19 P.M., with LPN #79 verified she did not apply the Medihoney as ordered for Resident #76's open areas on his forehead. LPN #79 stated she has not used that for a long time. LPN #79 stated the Medihoney should have been discontinued once the antibiotic (Mupirocin) was received. LPN #79 stated the wounds were thought to be the result of a fall prior to admission but later determined that they were cancer lesions.<br><br>Interview on 03/31/25 at 8:00 A.M., with Director of Nursing (DON) verified treatment orders for Resident #76 were unclear as to which ointments should have been applied to each wound. DON verified treatment orders were changed to reflect application of one ointment to both wounds on Resident #76 forehead and that LPN #79 signed for both treatments as completed on 03/26/25.<br><br>Review of the policy titled Medication Administration Policy dated 11/21/17 and revised on 07/09/21, stated medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice.<br><br>44076<br><br>3. Review of medical record for Resident #55 revealed admitted [DATE]. The resident was admitted with diagnoses malignant neoplasm of the left upper lobe, rheumatoid arthritis, severe protein calorie malnutrition, and atrial fibrillation.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Resident #55 required set up for eating, maximum assistance for toileting hygiene, bed mobility and transfers.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a care plan for risk of skin breakdown revealed interventions which included monitoring complaints of pain and provide interventions as needed and perform weekly skin checks.<br><br>Interview and observation on 03/24/25 at 11:12 A.M., revealed Resident #55 was observed to have an undated mepilex (bordered dressing) on his left forearm. Resident #55 stated he recently awoke during the night, and he was bleeding. He believed his watch may have cut him and his watch was moved to his other arm. Resident #55 removed the mepilex and revealed approximate dime-sized irregularly shaped scabbed area.<br><br>Review of the progress notes, skin assessments and physician orders did not reveal any reference to the skin impairment area.<br><br>Observation on 03/26/25 at 12:01 P.M., of Resident #55 revealed an undated Mepilex on his left forearm. Interview at the time of the observation revealed Resident #55 was unsure when the new Mepilex was placed.<br><br>Interview and observation on 03/26/25 at 1:46 P.M., with Registered Nurse (RN) #30 revealed Resident #55's skin assessment RN #30 verified an undated Mepilex to the left forearm. Removal of the Mepilex revealed a skin injury which was measured at 1.8 centimeters (cm) by (x) 1 cm x .1 cm. She stated she had not been informed of a skin tear during report.<br><br>Interview on 03/26/25 at 2:54 P.M., with Unit Manager #61 revealed it was her expectation to be informed of new skin concerns. She verified she was unaware of a new skin area for Resident #55 and no subsequent skin assessment, risk management document, progress note or change in condition form to notify physician and request treatment had been documented.<br><br>Review of the policy, Skin Care Management, revised 11/17/22 documented all areas identified should be measured and recorded in Point Click Care (PCC). |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on observation, resident interview, staff interviews, medical record review, physician wound documentation review, hospital documentation review, National Pressure Injury Advisory Panel (NPIAP) guidleine review, and policy review, the facility failed to transcribe and implement treatment orders timely for the treatment of pressure ulcers for two (#68 and #80) residents. Actual harm occurred to one resident (#68) when wound care orders were not timely implemented on admission, and the resident received no treatment or intervention from the facility for pressure areas that were present on admission. Resident #68 was admitted with a Stage 2 pressure ulcer to the sacrum/coccyx area on 01/31/25 and received no treatment until 02/04/25, after the wound increased to an unstageable wound. Furthermore, the facility failed to assess and timely implement wound care for two (#11 and #12) additional residents that placed the residents at risk for the potential for more than minimal harm. This affected four (#11, #12, #68 and #80) of five residents reviewed for pressure ulcers. The facility census was 87.<br><br>Findings include:<br><br>1. Review of medical record for Resident #68 revealed an admitted on 01/01/25, with diagnoses including sepsis, malignant neoplasm of bone, malignant neoplasm of urethra, antineoplastic chemotherapy induced pancytopenia, disorders of bone density and structure, irritable bowel syndrome, iron deficiency anemia, malignant neoplasm of cervix, and secondary malignant neoplasm of intra-abdominal lymph nodes. Resident #68 had a hospitalization on [DATE] and returned to the facility on [DATE].<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], for Resident #68 revealed intact cognition. Resident #68 required staff supervision assistance with eating. Resident #68 required maximum assistance for toileting, bed mobility and transfers. Resident #68 was incontinent of bowel and bladder. Resident #68 was determined to be at risk for pressure ulcers. Resident #68 was coded with one unstageable deep tissue injury present on admission.<br><br>Review of the plan of care for Resident #68 revealed resident has actual pressure ulcer related to decreased mobility and weakness on the sacrum. Initially documented as a deep tissue injury present on admission. Interventions include administer/monitor effectiveness of/response to treatment(s) as ordered, assess/record changes in skin status and report changes to physician, enhanced barrier precautions, pressure reducing mattress, measure and document condition of skin weekly, monitor effectiveness of pressure relieving devices, incontinence care after each incontinent episode.<br><br>Review of the hospital documentation wound care dated 01/28/25 for Resident #68 revealed resident had a Stage 2 pressure ulcer to the coccyx gluteal cleft area, red, open and 0.5-centimeter (cm) round.<br><br>Review of the hospital discharge documentation on 01/31/25 for Resident #68 revealed under the assessment and recommendation section revealed Stage 2 pressure ulcer on the coccyx.<br><br>Review of the facility admit/readmit screener form dated 01/31/25 (completed on 02/03/25) for Resident #68 revealed an area to the sacrum identified as moisture associated skin damage (MASD) with a length of 1.5 centimeters (cm). A width or depth was not documented for sacrum.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the weekly skin screener dated 01/31/25 (completed on 01/31/25) at 6:23 P.M. for Resident #68 revealed open area on sacrum with a description of open area 1.5 cm. No width or depth was documented for sacrum.<br><br>Review of the Treatment Administration Record (TAR) for the month of January 2025 for Resident #68 lacked documented evidence of any orders related to sacrum wound treatments.<br><br>Review of the TAR for the month of February 2025 revealed Resident #68 received the first treatment to the sacral wound on 02/04/25.<br><br>Review of the wound nurse practitioner (NP) progress note, dated 02/03/25, for Resident #68 revealed patient was sent to hospital on 01/27/25 for altered mental status and readmitted on [DATE] with a new unstageable wound to the sacral area. The wound measurements were 6.0 cm x 2.0 cm x 0.1 cm.<br><br>Review of the nurse's progress notes dated 02/03/25 at 10:40 P.M., Skin/Wound Note revealed second skin assessment done from resident's readmission and resident noted to have unstageable pressure ulcer to left sacrum. New treatment orders received. Wound nurse practitioner at bedside and classified wound as unstageable to left sacrum measuring 6.0 cm x 2.0cm x 0.1 cm. There is small amount of serosanguineous drainage noted. New treatment orders received for triamcinolone compound cream. Resident family and physician all notified and aware.<br><br>Review of the TAR for the month of February 2025 for Resident #68 revealed an order dated 02/04/25, for triamcinolone acetonide external cream apply to left sacrum topically every shift for pressure (unstageable). Pharmacy to mix equal parts of Silvadene, zinc oxide 20 percent, triamcinolone 0.5 percent: Cleanse wound with soap and water and apply cream to area every shift.<br><br>Review of the weekly skin screener dated 02/07/25 at 2:31 P.M. (completed on 02/09/25 at 2:33 P.M.) revealed skin assessment documentation for site: sacrum with a description documented treatment in place. A width or depth was not documented for sacrum.<br><br>Review of the wound nurse practitioner (NP) progress note dated 02/10/25 for Resident #68 revealed unstageable to sacral area. Wound measures 4.5 cm x 2.0 cm x 0.1 cm. Subcutaneous is exposed, small amount of serosanguineous drainage noted. Wound bed has small pink granulation within the wound bed and a large amount of necrotic tissue within the wound bed including adherent slough. Peri-wound was macerated.<br><br>During an interview on 03/25/25 at 9:00 A.M., Resident #68 stated the wound physician was in to treat the wound a couple of times now. CNA's apply cream when they provide incontinent care. Facility staff tell her it is getting better, but it is painful at times.<br><br>Observation on 03/27/25 at 1:46 P.M. with Wound Physician #302 of sacral wound dressing change and assessment for Resident #68 revealed the old dressing to have serosanguineous drainage on it when removed by physician. Sacral wound is measured at 2.7 cm x 3.0 cm x 0.1 cm. Wound bed noted with small pink bumpy appearance and scattered yellow adherent slough. Wound Physician applied numbing agent to area and debrided wound bed. Wound cleaned and dressing applied.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 03/31/25 at 12:55 P.M. with Director of Nursing (DON) verified that a wound treatment was not initiated when Resident #68 returned to the facility on [DATE], and further verified the length and depth of wound was not documented on the readmission documentation. DON verified the wound was documented as unstageable on 02/03/25 and a wound treatment was documented on the TAR on 02/04/25 for the first time.<br><br>2. Review of the medical record for Resident #11 revealed an admitted on 10/06/22, with diagnoses including but not limited to bipolar disorder, vascular dementia with agitation, Type II diabetes, iron deficiency anemia, and peripheral vascular disease.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #11 dated 01/14/25 revealed the resident had moderate cognitive impairment. Resident #11 required assistance for eating, maximum assistance for bed mobility and was coded as dependent for toileting and transfers. Resident #11 was incontinent of bowel and bladder. Resident #11 was at risk for pressures ulcers and was not coded with any current wounds.<br><br>Review of the Braden assessment completed on 02/04/25 for Resident #11 revealed the resident was at high risk for skin breakdown.<br><br>Review of the plan of care for Resident #11 revealed the resident was at risk for skin breakdown and pressure ulcers related to diabetes ulcers, peripheral vascular disease, incontinence, impaired mobility and hypertension. Interventions and goals included protective barrier cream, assessing and recording changes in skin status, reporting pertinent changes to physicians, incontinence care after each incontinent episode, pressure reduction cushion to wheelchair and mattress on bed, and weekly skin assessments by nurse.<br><br>Review of the active physician orders for Resident #11 revealed the following orders: enhanced barrier precautions to be used during high contact resident care activities dated 11/01/24, Santyl ointment apply to sacrum topically every day shift for wound care, cleanse wound with normal saline, pat dry, apply Santyl to wound bed and apply border gauze, dated 03/31/25.<br><br>Review of the discontinued physician orders for Resident #11 revealed the following discontinued orders:<br><br>Open area to lower intergluteal cleft, cleanse with normal saline, pat dry, apply zinc oxide ointment after each incontinent episode, dated 03/25/25.<br><br>Open area to lower intergluteal cleft, cleanse with normal saline, pat dry, apply zinc oxide ointment after each incontinent episode, and apply Santyl and island dressing every day, dated 03/26/25.<br><br>Santyl ointment apply to left gluteal cleft topically as needed for wound care, dated 03/28/25.<br><br>Santyl ointment apply to left gluteal cleft topically every day shift for wound care, cleanse wound with normal saline, pat dry, apply Santyl to wound bed and apply border gauze, dated 03/28/25.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the Treatment Administration Record for Resident #11 revealed a treatment ordered 03/25/25 for open area to lower intergluteal cleft, cleanse with normal saline, pat dry, apply zinc oxide ointment after each incontinent episode was documented as completed on 03/25/25, 03/26/25, 03/27/25 and 03/28/25.<br><br>Review of the weekly skin assessment dated [DATE] at 12:17 A.M., for Resident #11 revealed lower intergluteal cleft - new order to cleanse with normal saline, pat dry, apply zinc oxide ointment after each incontinent episode. No measurements or wound stage were included in the assessment; the wound was simply described as opened.<br><br>Review of the nurse's progress note dated 03/25/25 at 12:20 A.M., for Resident #11 revealed new order for open area to lower intergluteal cleft, cleanse with normal saline, pat dry, apply zinc oxide ointment after each incontinent episode physician and nurse practitioner were notified of the opened area.<br><br>Review of the wound care nurse skin observation dated 03/26/25 at 4:42 P.M., for Resident #11 revealed stage three pressure ulcer on sacrum measuring 0.5 centimeters (cm) x 3.5 cm x 0.1 cm. Treatment for area is to cleanse area with normal saline, pat dry, apply Santyl to wound bed and cover with border gauze. Family and physician aware.<br><br>Review of the nurse's progress note dated 03/26/25 at 4:45 P.M. and noted as a late entry, revealed new wound discovered on routine weekly skin assessment. Area measured, physician notified, new treatment order received to cleanse area, pat dry, apply Santyl to wound bed, cover with border gauze daily and as needed (PRN), Resident #11 was referred to wound physician, placed on wound rounds. Family notified.<br><br>Interview on 03/31/25 at 1:23 P.M., with Licensed Practical Nurse (LPN) Unit Manager #3 stated she observed the wound on 03/26/25 during weekly skin assessments and noted the initial location of the wound was not clear. LPN #3 verified that measurements of the wound were obtained on 03/26/25 and not at the time of discovery. LPN #3 states she notified the physician and described the appearance of the wound and was given the order for the Santyl. LPN #3 stated the wound was stage three when she observed the area on 03/26/25 and she added the resident to the wound physician's list for treatment. LPN #3 stated the wound was discovered during the weekly skin assessments. LPN #3 verified she made the change in the orders and discontinued the zinc oxide and ordered the Santyl.<br><br>Interview on 03/31/25 at 2:00 P.M., with Director of Nursing (DON) verified the wound was not measured on discovery and should have been. The DON verified the wound was assessed on 03/26/25 as a stage three pressure ulcer. The DON verified the wound should not have been identified at that stage and should have been identified sooner.<br><br>44076<br><br>3. Review of medical record for Resident #80 revealed an admitted [DATE]. The resident was admitted with diagnoses including cerebral infarction, dementia with behavioral disturbances, and diabetes mellitus.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe impaired cognition. He required assistance for eating, moderate assistance for toileting, bed mobility and transfers.<br><br>Review of the hospital physician orders dated 02/14/25, from the discharge summary, for Resident #80 documented a right heel pressure injury. The last measurements were on 02/13/25, with a measurement of 1. 5 centimeters (cm) by (x) 3.0 cm x Unable To Determine (UTD) depth due to necrotic tissue. A second wound was documented as a coccyx pressure wound. The last measurements were on 02/13/25 of 0.8 cm x 0.3 cm x 0.01 cm. Orders were Medihoney (antibacterial) and foam border every other day.<br><br>Review of the 02/14/25, admission skin assessment revealed two areas were identified. The coccyx was specified as redness with no other description or measurement and the right heel was documented as scab with no other description or measurement.<br><br>Review of the admission physician assessment dated [DATE] revealed all available records were reviewed and the skin assessment documented negative for rash, ulcers, itching, dryness, skin/nail changes, dry skin or lesions.<br><br>Review of the 02/14/25, admission Braden scale revealed a score of 16 indicating Resident #80 was at low risk for pressure ulcers.<br><br>Review of the care plan review revealed the resident had the potential for skin breakdown with interventions which included floating heels in bed, applying skin prep to heels and monitor for effectiveness of treatment and notify Medical Doctor or Nurse Practitioner if wound worsens or does not respond.<br><br>Review of the progress notes did not reveal any documentation the physician had been updated on weekly wound assessments.<br><br>Review of the admission physician orders, dated 02/14/25, revealed the facility did not transcribe the wound care orders from the hospital discharge paperwork which were: to cleanse the right heel and coccyx with wound cleanser and apply Medihoney to the wound every other day and cover with foam border.<br><br>Review of the February 2025 Treatment Administration Record (TAR) revealed no documented treatments to the heel or the coccyx, until 02/18/25. There was no evidence of the hospital orders being completed.<br><br>Review of the 02/17/25, skin assessment revealed a right heel diabetic ulcer measuring 5.0 cm x 5.0 cm and a stage three pressure sacral pressure ulcer measuring 2.5 cm x 1 cm x 0.3 cm.<br><br>Review of the 02/17/25 progress note documented a stage three (full thickness) pressure ulcer to sacrum with serosanguinous drainage noted with a large amount of granulation tissue and a small amount of slough noted. Diabetic ulcer to right heel dark brow/black in color. Physicians and family were notified, and new treatment orders were received, but not documented as implemented until 02/18/25.<br><br>(continued on next page) |

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| | 365882 | A. Building<br>B. Wing | 04/03/2025 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the physician orders revealed an order to paint right heel with betadine every shift with a start date of 02/18/25 and an order to cleanse sacral wound with saline, pat dry, apply Medihoney gel and cover with bordered gauze every shift with a start date of 02/18/25. Review of the February 2025 TAR revealed the treatment was initiated and completed as ordered.<br><br>Review of the 02/24/25 skin assessment revealed the right heel diabetic ulcer measured 5.0 cm x 5.0 cm x unable to determine and the sacral wound measured 2.5 cm x 1.0 cm x 0.3 cm.<br><br>Review of the 03/03/25 skin assessment revealed the right heel diabetic ulcer measured 5.0 cm x 3.0 cm x unable to determine and the sacral wound measured 1.0 cm x 1.0 cm x 0.3 cm.<br><br>Review of the 03/06/25 skin assessment revealed the right heel diabetic ulcer measured 5.0 cm x 3.0 cm x unable to determine and the sacral wound measured 1.0 cm x 1.0 cm x 0.2 cm.<br><br>Review of the wound physician notes dated 03/13/25 revealed stage two pressure wound to the sacrum measuring 0.4 cm x 0.2 cm x .01 cm. Treatment plan was for Medihoney once daily for 30 days. A second wound was documented as an unstageable pressure wound the right heel which measured 4.0 cm x 3.0 cm x UTD. The treatment plan was for Santyl (debriding ointment) once a day for 30 days. This was the first assessment completed by the wound physician and review of the March 2025 TAR revealed the orders from this assessment were not implemented by the facility until 03/22/25.<br><br>Review of the wound physician notes dated 03/20/25 revealed the right heel pressure ulcer measured 5.2 cm x 2.0 cm x UTD and was documented as improved evidenced by decreased surface area and the sacral pressure wound measured 0.3 cm x 0.3 cm x 0.1 cm. and was documented as exacerbated due to generalized decline of patient.<br><br>Review of the physician orders revealed an order for right heel to cleanse with saline, pat dry apply Santyl and bordered gauze with a start date of 03/22/25.<br><br>Interview on 03/31/25 at 2:20 P.M., with the Director of Nursing and Unit Manager Licensed Practical Nurse (LPN) #61 verified the admission treatment orders had not been implemented on admission 02/14/25 and skin treatments had not been initiated until 02/18/25 after two skin assessments with documented areas of concern. Discussion was had regarding the varied right heel ulcer documentation. LPN #61 acknowledged the hospital, and wound physician diagnosed the right heel as a pressure area, while the facility diagnosed it as a diabetic ulcer. LPN #61 explained the diagnosis was made by Physician #2. The DON verified the 03/13/25 right heel treatment order had not been started until 03/22/25. She also verified Resident #80 had not been seen by a wound physician until 03/13/25. LPN #61 explained that the new wound physician did not start at the facility until 03/06/25 and a face sheet was not provided to the physician for a visit, so the resident was not seen until the wound physician visited the following week (03/13/25).<br><br>34291<br><br>4. Review of the medical record for Resident #12 revealed an admitted [DATE]. Medical diagnoses included atrial fibrillation, coronary artery disease, heart failure, and hypertension.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the admission MDS dated [DATE] revealed Resident #12 was moderately cognitively impaired. His functional status was set up or cleanup for eating, substantial/maximal assistance for toileting, bed mobility, and transfers.<br><br>Review of the care plan dated 02/25/25 revealed the resident has actual impairment related to skin integrity to the sacrum is a Stage III present on admission, left heel unstageable present on admission and the right heel present on admission. Interventions of educate the family, eliminate causative factors, promote good nutrition, encourage position change and repositioning during the night and monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to physicians were initiated on 03/06/25 and implement heel boots and pressure relieving reducing mattress while in bed were initiated on 03/20/25.<br><br>Review of the admission skin assessment dated [DATE] revealed he had wounds to his left heel that was unstageable, right heel that was soft and pink, and to the vertebrae mid upper back was reddened. There were no measurements included with the heel or vertebral wounds upon admission.<br><br>Further review of the assessment of these wounds on 02/27/25 revealed they were all staged as unstageable. The vertebrae wound was documented, and the right buttock wound was documented as unstageable. Review of the skin assessment dated [DATE] revealed the following: right buttock measured 2. 0 cm by 7.0 cm by 0.3 cm and wound was documented as unstageable; right heel measured 6.0 cm by 7.0 cm by 0.1 cm and wound was documented as unstageable and the left heel measured was 8.0 cm by 5.0 cm by 0.1 cm, with no wound classification being documented.<br><br>Interview with the LPN #61 on 04/01/25 at 2:00 P.M., confirmed these wounds were not measured upon admission and should have been. She stated the wound that was documented on admission as being on the vertebrae was not on the vertebrae, but on the right buttock. LPN #61 verified there was no skin alteration on the vertebrae.<br><br>Review of the policy titled Skin Care Management Procedure, dated 07/01/02 and revised on 12/09/22, states upon admission or readmission a full skin assessment should be conducted within two to six hours of arrival and documented in the electronic medical record to ensure proper documentation of existing skin condition. Weekly skin assessment will be completed and documented in the electronic health record to identify new areas of concern.<br><br>Review of the National Pressure Injury Advisory Panel (NPIAP) at https://www.npuap. org/resources/educational-and-clinical-resources, revealed a pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).<br><br>Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. 1 Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on record review, observation, staff interview, and review of the policy, the facility failed to conduct a thorough investigation to determine and identify potential hazards and resident-specific interventions to reduce and/or eliminate falls. Additionally, the facility failed to implement required equipment in place to prevent accidents. This affected three (#8, #76, #237) of three residents reviewed for falls or accidents. The census was 87.<br><br>Findings include:<br><br>1. Medical record review for Resident #76 revealed an admission on 12/23/24 with diagnoses including dementia without behaviors, altered mental status, falls, hypertension, cerebral infarction without residual deficits and anxiety disorder.<br><br>Review of the Admission Minimum Data Set (MDS) assessment for Resident #76 dated 12/30/24 revealed an impaired cognition. Resident #76 requires moderate assistance to total dependency on staff for eating, toileting, bed mobility and transfers. Resident #76 was coded as having falls prior to admission and falls since admission.<br><br>Review of the plan of care for Resident #76 dated 12/24/24 revealed resident was at risk for falls, injuries related to recent fall, dementia, altered mental status, gait abnormality and muscle weakness. Interventions include assess for and record any additional fall risk factors, monitor need for and provide therapy consultation as ordered, monitor resident for signs and symptoms of adverse effects from medications and inform physician, offer to lay down if appears tired, provide resident with appropriate non-skid footwear at all times when up, and report incidences of falls to physician and family/responsible party.<br><br>Review of the physician order for Resident #76 revealed no orders related to fall interventions.<br><br>Review of the facility fall assessment for Resident #76 completed on 12/23/24 revealed the resident was at high risk for falls.<br><br>Review of the progress notes for Resident #76 dated 01/28/25 at 9:04 P.M., revealed during shift change report with the aides and nurses, a loud noise was heard and this nurse observed resident on floor in common area by the recliner and wheelchair next to the dining room. Resident stated he did not hit his head but fall was not witnessed. Resident #76 was not able to tell this nurse what happened. Vital signs were blood pressure (B/P) 182/84, Pulse (P) 87, temperature (T) 97.3 respirations (R) 16 oxygen saturation (O2) 97%, Full range of motion (ROM) in all eel chair (W/C) and neurochecks initiated. Resident representative and doctor notified. Intervention to do frequent checks when resident is awake.<br><br>Review of the seventy-two hour every shift assessment follow-up documentation dated 01/28/25 at 6:14 P.M. , for Resident #76 revealed resident was alert, orientation was all absent, cognition was confused. Resident #76 denied pain, and intervention for frequent checks when resident was up in chair.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the seventy-two hour every shift assessment follow up documentation dated 01/29/25 at 8:18 A.M. , for Resident #76 revealed resident was alert, oriented to person, cognition was confused, ROM was within normal limits in all joints. Resident #76 denied pain, and intervention for section was silent.<br><br>Review of the progress notes for Resident #76 dated 01/29/25 at 9:59 A.M., revealed Interdisciplinary Team (IDT) met to discuss fall that occurred on 01/28/25, resident noted to have fallen self-ambulating. Intervention was to keep his walker within reach.<br><br>Review of the progress note for Resident #76 dated 02/03/25 at 6:14 P.M., revealed nurse was getting medication out of the med cart and looked up resident had got out of the W/C and tried to stand up. Resident did fall backwards but did not hit head. Resident stated he were just trying to get out to go home. Resident range of motion (ROM) equal in all extremities, vital signs were B/P 146/69, P 74, R 16, T 98.2 , oxygen saturation was 95 percent on room air. No complaints of pain or discomfort. Will continue to monitor through shift. Physician and nurse practitioner notified.<br><br>Review of the seventy-two hour every shift assessment follow up documentation dated 02/03/25 at 6:50 P.M. , for Resident #76 revealed resident was alert, oriented to person, cognition was confused, ROM was within normal limits in all joints. Resident #76 denied pain, and intervention was frequent visual checks.<br><br>Review of the progress note dated 02/04/25 at 3:21 P.M., for Resident #76 revealed IDT meet to discuss fall that occurred on 02/03/25. Resident #76 was noted to stand up from wheelchair (w/c), resident fell backwards. Intervention is to offer resident assistance to bed following dinner.<br><br>Review of the seventy-two hour every shift assessment follow up documentation dated 02/04/25 at 8:42 P.M. , for Resident #76 revealed resident was alert, oriented to person, cognition was confused, ROM was within normal limits in all joints. Resident #76 denied pain, and intervention was frequent visual checks.<br><br>Review of the facility fall investigation for Resident #76 dated 01/28/25 at 6:14 P.M., revealed the investigation did not include a comprehensive evaluation of the fall data to assist in specific hazards that may have been present at the time of the fall. The document revealed predisposing environmental factors as none, predisposing physiological factors as confusion, and predisposing situation factors as ambulating without assist. Intervention at the time of the fall was frequent checks when awake. No documentation of the determination of root cause analysis of the fall.<br><br>Review of the facility fall investigation for Resident #76 dated 02/03/25 at 6:40 P.M. revealed the investigation did not include a comprehensive evaluation of the fall to assist in specific hazards that may have been present at the time of the fall. The document revealed predisposing environmental factors as none, predisposing physiological factors as confusion, and predisposing situation factors as ambulating without assist. Intervention at the time of the fall was to monitor through shift. No documentation of the determination of root cause analysis of the fall.<br><br>Observation on 03/27/25 at 4:19 P.M., of Resident #76 sitting in the common area in his wheelchair and walker was in front of the wheelchair.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 03/27/25 at 3:19 P.M., with the Director of Nursing (DON) stated the facility will meet as a team and discuss the fall. They have a form that is completed (Fall Tracker) that contains review date, date area skin identified, resident name, unit, shift, initial documentation complete in nursing notes, family notified in progress notes, physician notified in progress notes, interventions initiated at the time of the fall, specify interventions, injury, if major injury unavoidable, form complete, and if major injury fall check list completed. DON verified conversation regarding the environment, what the resident reported, what staff observed, and interventions were all discussed in the meeting and the unit managers would document in the progress note under IDT note for intervention. DON verified the facility did not collect witness statements from staff at the time of the falls or have documentation of the root cause analysis.<br><br>Review of the policy titled Fall Management, dated July 2002, and revised on 12/03/2019, revealed under number four that documentation in the progress notes in the progress notes should include a complete account of the events surrounding the fall including notification of the family and the physician.<br><br>34291<br><br>2. Medical record review for Resident #237 revealed an admitted [DATE]. Medical diagnoses included atrial fibrillation, heart failure, renal failure, and cerebrovascular attack (CVA).<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Functional status was setup or clean-up assistance or eating, substantial/maximal assistance for toileting, supervision or touching assistance for bed mobility, and partial/moderate assistance for transfers.<br><br>Observation on 03/24/25 at 1:59 P.M., revealed Resident #237 was heard yelling around the corner from the surveyor and then was seen sitting in a wheelchair with the foot pedals off of it.<br><br>Interview on 03/24/25 at 2:05 P.M.,with the Certified Nurse Assistant (CNA) #54 revealed she had been working in the facility for a week and was pushing the resident across the hall to get weighed and the resident got her left foot caught under the wheelchair which was the left knee that had a big bruise on it. The aide admitted she didn't place the foot pedals or rests on the wheelchair because she was going across the hall.<br><br>Review of the medical record dated 03/24/25 at 2:39 P.M., revealed CNA #54 was pushing resident in wheelchair to get a weight, resident was holding her feet up and her left foot went down on the floor. Resident let out a scream, This nurse ran out to resident and resident stated that her left knee hurt, and her left knee was already the knee that was hurt from her fall that landed her in the hospital before admitting to the facility. Physician was notified and stated to add the resident to the list to be seen on this day. After the incident resident stated that her knee does not currently hurt and she thinks that it just scared her more than anything. Foot pedals put onto wheelchair and education given to resident and staff on importance of using foot pedals. Family also notified and aware.<br><br>3. Medical record review for Resident #8 revealed an admitted [DATE]. Medical diagnoses included fractures, respiratory failure, and hypertension.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the protected fall investigations for the following falls for 11/24/24, 12/22/24, and 03/22/25 for Resident #8 revealed they were blank pieces of paper with yes and no answers put on the pieces of paper that couldn't be followed to be determined what was going on with the falls.<br><br>Review of progress dated 11/24/24 upon admission revealed the Resident #8 had come into the facility after having a fall at home. She had multiple fractures on right side which included right scapula, right pinky, right wrist and right first and second ribs.<br><br>Review of care plan dated 11/25/24 for Resident #8 revealed resident was at risk for falls related to recent fall with multiple right-sided fractures. Interventions were on 11/25/24 were assess and record any additional fall risk factors, keep call light within reach and remind the resident to use the call light, monitor for side and symptoms of medications, provide resident with the proper footwear, educate on safety measures to reduce falls, what to do if fall occurs and how to fall to reduce injury, report incidences of falls to physician and family, and monitor for need of therapy evaluation. On 11/26/24 provide resident with a reacher. On 12/23/24, educate resident on using the call light and wait for help before getting up unassisted.<br><br>Review of fall dated 11/25/24 at 12:17 P.M., revealed the resident was found lying on her left side on the floor in front of her recliner. Resident had large amount of blood coming from the left side of head. Resident was alert and answering questions appropriately. Vitals obtained and emergency services notified of need for transfer to emergency room (ER). She returned at 10:50 P.M. with five stitches to her forehead and bruising on her forehead and left eyebrow.<br><br>Review of a post-fall note dated 11/26/24 at 4:27 P.M. revealed the resident was found on her left side on the floor in front of her recliner. She was bleeding from her head and was alert and answering questions. Immediate intervention was to send to the emergency room (ER) for evaluation and treatment due to her hitting her head. The new fall intervention was to provide a Reacher for her due to the resident fell while trying to bend over to pick up a pen off the floor.<br><br>Review of the fall investigation for this fall revealed dated 11/26/24 same as above, resident assessed and an open wound was found she went to the ER, level of pain was 6/10 call light wasn't used, she was incontinent, weakness/fainted, admitted within seventy-two hours.<br><br>Review of the progress notes dated 12/22/24 revealed Resident #8 was on the floor next to the bed bleeding. The resident stated she was trying to turn off the nebulizer and was going to get back into the bed and slipped and fell . Full assessment was completed. Resident complained of pain in her left upper extremity, left hip and head. She was sent to the ER due to pain and head trauma. Review of the hospital record dated 12/22/24 revealed negative results for all testing.<br><br>Review of the fall investigation dated 12/22/24 revealed Resident #8 was oriented times three. There was a laceration to the top of her scalp, call light not used, drowsy, gait imbalance, impaired memory, weakness, fainted, ambulating without assistance, improper footwear, and recent room change.<br><br>Review of Interdisciplinary Team (IDT) note dated 12/23/24 revealed she was educated on using the call light and waiting on the response.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of quarterly MDS dated [DATE] revealed Resident #8 was cognitively intact. She was setup or clean up for eating, dependent for toileting, partial/moderate for bed mobility, and substantial/maximal for transfers.<br><br>Review of the progress notes dated 03/22/25 revealed there wasn't a note for the fall on 03/22/25 by the nurse.<br><br>Review of the fall investigation dated 03/22/25 revealed she was found on the floor by visitors walking by the room. The resident stated she was trying to get to the window. Range of motion (ROM) could not be performed due to the pain and medication was given for the pain. Hospice was in house and came by to assess and ordered X-rays of the lumbar. She had an injury to the sacrum, and top of scalp and left iliac crest. She oriented to person and place.<br><br>Review of the X-rays for Resident #8 dated 03/22/25 revealed diffuse degenerative lumbar spondylosis with multilevel age-indeterminate vertebral body compression fractures. If there has been an new onset of pain or recent trauma, recommend MRI for more optimal evaluation of acuity of fractures.<br><br>Review of the IDT progress notes dated 03/24/25 revealed Resident #8 had a fall on 03/22/25 when resident was observed on the floor next to the bed. Resident did complain of pain in her wrist, ribs and buttocks. There were orders for X-rays for the lumbar. The results were received and no new orders. The new intervention was to keep the bed low.<br><br>Interview with the Administrator and Unit Manager LPN #61 on 03/31/25 at 10:31 A.M., revealed they had meetings for falls and discussed RCA, but didn't have it documented. They stated the information was protected by Quality Assurance and Performance Improvement (QAPI) for falls and they didn't have a RCA for the falls.<br><br>Interview with the Regional Director of Nursing (RDON) #300 on 03/31/25 at 1:11 P.M., revealed root cause analysis (RCA) was discussed in their IDT meeting and it was determined in this meeting in person and they tried to convey it in the IDT note. She revealed the facility doesn't document every step of the way to the RCA. The facility doesn't determine when the staff last saw the resident, doesn't do witness statements, they don't say what interventions were in place before the fall, and doesn't see when the resident were toileted last.<br><br>Review of the policy titled Fall Management, dated July 2002 and revised on 12/03/2019, revealed under number four that documentation in the progress notes in the progress notes should include a complete account of the events surrounding the fall including notification of the family and the physician. |

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| Springmeade Healthcenter | 4375 South County Road 25 A<br>Tipp City, OH 45371 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>39702<br><br>Based on medical record review, staff interview, and policy review, the facility failed to timely initiate treatments to treat urinary tract infections. This affected one (#76) of three residents reviewed for antibiotic administration. The facility census is 87.<br><br>Findings include:<br><br>Medical record review for Resident #76 revealed an admission on 12/22/24 with diagnoses including dementia without behaviors, altered mental status, falls, hypertension, cerebral infarction without residual deficits, and benign prostatic hyperplasia with urinary tract symptoms.<br><br>Review of the Admission Minimum Data Set (MDS) assessment for Resident #76 revealed an impaired cognition. Resident #76 requires moderate assist to dependent on staff for eating, toileting, bed mobility and transfers. Resident #76 was coded as incontinent of bowel and bladder.<br><br>Review of the plan of care for Resident #76 revealed resident is incontinent of bladder related to benign prostatic hyperplasia with urinary tract symptoms, dementia, gait abnormality, and muscle weakness. Interventions include medication administration as ordered, encourage resident to utilize call light system to report the need to use bathroom, check resident daily during rounds and as required, provide incontinence care as needed, monitor for signs and symptoms of urinary tract infections and report abnormalities to physician.<br><br>Review of nurses' progress note dated 03/14/25 at 9:25 P.M. for Resident #76 revealed previous assigned nurse reported that resident wasn't acting like his normal self today and had an emesis this am. STAT (immediately or as soon as possible) laboratory test were ordered. Laboratory staff obtained samples at approximately 6:45 P.M. to draw blood work. No results at this time. No episodes of emesis noted on this shift. Resident states He feels ok when asked several times. Current vital signs were Temperature 98.0 Fahrenheit (F), Pulse , 82 Respirations 16, blood pressure was 161/90. Resident was resting comfortably in bed at this time. Respirations are even and unlabored. Reported to oncoming nurse about pending STAT blood work.<br><br>Review of nurses' progress note dated 03/15/25 at 3:02 P.M., for Resident #76 revealed an order for Ondansetron Tablet Disintegrating 4 milligram (mg) give 1 tablet by mouth every six hours as needed for nausea and vomiting, Acetaminophen tablet 325 mg, give 2 tablet by mouth every four hours as needed for fever not exceed 3000 mg in twenty four hours.<br><br>Review of nurses' progress note dated 03/15/25 at 3:05 P.M., for Resident #76 revealed laboratory results received and nurse practitioner notified. Nurse practitioner gave new orders for STAT chest radiograph (x-ray), glycated hemogoblin on Monday.<br><br>Review of the progress notes dated 03/15/25 at 3:07 P.M., for Resident #76 revealed B/P 175/75, P<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 73, R 18, oxygen saturation rated (SPO) = 92% Temp 101.6. Resident continues to complaint of nausea, dry heaving noted. Tylenol & Zofran administered. Lung sounds diminished but clear. Respirations shallow with use of accessory muscles noted. Resident denies shortness of breath, will continue to monitor.<br><br>Review of the nurses' progress notes dated 03/15/25 at 5:26 P.M., for Resident #76 revealed recheck temperature after Tylenol was 99.4 F, B/P 130/67 and pulse was 65. Resident continues to deny pain. Resident consumed approximately 10% of evening meal. Resident #76 encouraged to eat but refused. Resident #76 was encouraged to drink fluids and will continue to monitor.<br><br>Review of the nurse's progress note dated 3/15/25 at 5:41 P.M., for Resident #76 revealed facility received chest x-ray results that were negative for pleural effusion, pneumothorax. NP was notified of results. Spoke with son and gave update on resident condition.<br><br>Review of the physician orders for the month of March 2025 for Resident #76 revealed an order dated 03/16/24 for cefuroxime axetil oral tablet 500 milligram (mg) by mouth two times a for urinary track infection until 03/23/25, an order dated 03/18/25 for Macrobid oral capsule 100 mg give one capsule by mouth two times a day for escherichia coli for seven days, urinary tract infection(UTI)-Stat Oral Liquid (Cranberry-Vitamin C-Inulin) give 30 ml by mouth two times a day for UTI dated 03/17/25, Tylenol tablet 325 mg give two tablets by mouth every four hours as needed for fever dated 03/15/24, ondansetron oral tablet give 4 mg by mouth every 6 hours as needed for nausea and vomiting dated 03/15/25, test for covid one time only for symptoms dated 03/14/25 and test for flu one time only for flu like symptoms dated 03/14/25.<br><br>Review of nurses's progress note dated 03/16/25 at 9:21 A.M., revealed resident resting in bed with eyes closed, easily around, alert to name only. Resident #76 denies shortness of breath or pain at this time. Vital signs obtained and hypertensive noted. Resident #76 noted with fever. Resident continues to dry heave & complain of nausea. PRN Zofran & Tylenol given with morning medications with positive effect. Dark yellow urine obtained for urinalysis and collection tube labeled appropriately & placed in locked refrigerator on hall. Oncoming nurse notified. Resident did not consume any breakfast this am. Writer was able to assist resident with drinking 60 milliliters (ml) of apple juice. Fluids encouraged. Resident wanted to stay in bed due to not feeling well.<br><br>Review of nurses's progress note dated 03/16/25 at 11:00 A.M., indicating a change in condition reported on this Evaluation abnormal vital signs, altered mental status fever with elevated blood pressure, nausea and vomiting, seems different than usual talks/communicates less tired,weak, confused, or drowsy. B/P 178/88, P 88, R 18.0, T 100.7, oxygen saturation rate 93.0 % on room air, Blood Glucose (BS) 250.0, resident evaluation for this change in condition were: mental status evaluation: altered level of consciousness was increased confusion, weakness, nausea and/or vomiting, decreased appetite/fluid intake, and fever of 101.7, no oral intake and general malaise.<br><br>Review of nurse's progress noted dated 03/16/25 at 11:46 A.M., revealed family in to see resident this am. Nurse educated family on residents signs and symptoms, intake/output, medications and test results. Per request of family, resident is being sent to hospital for evaluation.<br><br>Review of the progress note dated 03/16/25 at 8:30 P.M., for Resident #76 revealed resident returned from hospital transferred per son to facility. Physician was notified.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the hospital discharge records for Resident #76 dated 03/16/25 revealed an order to initiate cefuroxime oral tablet 500 mg by mouth two times a day for urinary tract infection.<br><br>Review of the medication administration record for Resident #76 for March 2025 revealed cefuroxime axetil oral tablet 500 mg by mouth two times a day was not initiated on 03/16/25 when the order was received. Further reviewed confirmed administration of cefuroxime was initiated on 03/18/25 at 8:00 A.M.<br><br>Interview on 03/31/25 at 9:25 A.M., with Registered Nurse (RN) #30 verified cefuroxime axetil oral tablet 500 mg was available in the on sight emergency medication dispensary.<br><br>Interview on 03/31/25 at 2:37 P.M., with the Director of Nursing and Unit Manager Licensed Practical Nurse (LPN) #61 verified that they have the ability to change orders for when medication administration was to be started but the system will automatically move to the next schedule dose time if it is not changed. DON verified cefuroxime axetil oral tablet 500 mg by mouth two times a day was not initiated on 03/16/25 and should have been.<br><br>Review of the policy titled Medication Administration Policy dated 07/09/21, states medication will be administrated to resident as prescribed and by persons lawfully authorized to administer mediation in a manner consistent with good infection control. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076<br><br>Based on record review, staff interviews, family interview, policy review, Centers for Disease (CDC) guidance review, and hospital documentation review, the facility failed to ensure the prescribed duration of antibiotics had been provided for Clostridioides Difficile (C-Diff). This affected one (#24) of seven reviewed. The facility census was 86.<br><br>Findings include:<br><br>Review of medical record for Resident #24 revealed admitted [DATE]. The resident was admitted with diagnoses including liver cell carcinoma, congestive heart failure, and depression.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had significantly impaired cognition. She was independent with eating and required moderate assistance for bed mobility, transfers, and toileting hygiene.<br><br>Review of the 01/30/25 progress note documented positive C-Diff results. The physician was contacted, and new orders were received for Vancomycin (antibiotic) four times a day for seven days.<br><br>Review of the physician orders revealed an order for Vancomycin 50 milligrams (mg) per (/) milliliter (ml). Give five ml four times a day (8:00 A.M., 12:00 P.M., 4:00 P.M. and 8:00 P.M.) with a start date of 01/31/25 at 12:00 P.M.<br><br>Review of the January Medication Administration Record (MAR) revealed a 9 was documented on 01/31/25 at 12:00 P.M., 4:00 P.M. and 8:00 P.M. indicating to see Nursing Notes.<br><br>Review of the progress nursing note dated 01/31/25 at 12:03 P.M. revealed Vancomycin was unavailable from the pharmacy.<br><br>Review of the progress nursing note dated 01/31/25 at 3:50 P.M. documented the facility was waiting on pharmacy for Vancomycin.<br><br>Review of the progress nursing note dated 01/31/25 at 11:08 P.M. revealed Vancomycin was unavailable. The pharmacy was contacted and would send the medication stat.<br><br>Review of the progress nursing note dated 02/01/25 at 1:55 A.M. revealed Vancomycin was unavailable. The pharmacy was contacted and would send the medication stat.<br><br>Review of the February MAR revealed Vancomycin was given four times daily on 02/01/25 through 02/06/25 and at 8:00 A.M. on 02/07/25.<br><br>Review of the progress nursing note dated 02/10/25 at 2:12 P.M. revealed resident had increased lethargy and confusion, and daughter demanded she be sent to the hospital for further evaluation. The daughter had been informed testing could be done at the facility, but she wanted Resident #24 sent anyway.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 03/24/25 at 9:49 A.M., with Resident #24's daughter revealed Resident #24 had been treated for C-diff at the facility. The daughter had been called by another resident's family member because she had been concerned about Resident #24's increased confusion. Resident #24's daughter stated she called the facility and told them to send her to the hospital.<br><br>Interview on 03/31/25 at 2:20 P.M., with the Director of Nursing verified Resident #24 did not receive a full seven days of Vancomycin. The DON recognized the order was not updated to indicate the actual start date of the medication on 02/01/25 resulting in three missed doses. She also acknowledged Resident #24 had a decline which resulted in her hospitalization .<br><br>Review of the hospital discharge date d 02/14/25 revealed Resident #24 presented to the hospital after a recent diagnosis of C-Diff and presented with altered mental status. Review of the hospital documentation revealed a diagnosis of sepsis secondary to C-Diff and Pancolitis (inflammation spread throughout the colon) demonstrated on Computerized Tomography (CT) imaging, C-Diff antigen positive.<br><br>Review of CDC guidance, https://www.cdc.gov/c-diff/about/index.html revealed treatment for C-Diff infection usually takes a specific antibiotic such as Vancomycin for at least 10 days. Complications although rare included serious intestinal condition, such as a toxic megacolon, sepsis, and death.<br><br>Review of the policy, Medication Administration revised 07/09/21 revealed medications would be given as prescribed. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702<br><br>Based on medical record review, observation, and staff interviews, the facility failed to ensure medication was safely and appropriately stored. This affected three (#11, #68, #75) of three residents reviewed for medication storage. The facility census was 87.<br><br>Findings include<br><br>1. Medical record review for Resident #11 revealed an admission on 10/06/22, with diagnoses including bipolar disorder, vascular dementia with agitation, type two diabetes, iron deficiency anemia, and peripheral vascular disease.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #11 dated 01/14/25 revealed resident had moderate cognitive impairment. Resident #11 required assistance for eating, maximum assistance for bed mobility and was coded as dependent for toileting and transfers. Resident #11 was incontinent of bowel and bladder. Resident #11 was at risk for pressures ulcers and was not coded with any current wounds.<br><br>Review of the plan of care for Resident #11 revealed resident was at risk for skin breakdown and pressure ulcers related to diabetes ulcers, peripheral vascular disease, incontinence impaired mobility and hypertension. Interventions included goals and interventions of protective barrier cream, assess and record changes in skin status, report pertinent changes to physician, incontinence care after each incontinent episode, pressure reduction cushion to wheelchair and mattress on bed and weekly skin assessments by nurse.<br><br>Review of the active and discontinued physician orders for Resident #11 was silent for any orders for antifungal powder.<br><br>Observation on 03/24/25 at 9:19 at A.M., of Resident #11 bedside table revealed an open unlabeled three ounce bottle of antifungal powder with miconazole nitrate two percent. Further observation of label on antifungal powder revealed a warning label stating if swallowed get medical help or contact the poison control center.<br><br>Interview 03/24/25 at 10:19 A.M., with Registered Nurse (RN) #30 verified that the powder should not be in the room for the certified nurse assistant (CNA) to apply. Further verified Resident #11 does not have an order to used the antifungal powder.<br><br>Interview on 04/01/25 at 11:52 P.M., with Administrator verified anti fungal powder should not be left in the room and currently is stored in a manner that gives access to staff without the knowledge of how to use it.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Medical record review for Resident #68 revealed an admission on 01/01/25 with diagnoses that includes but not limited to sepsis, malignant neoplasm of bone, malignant neoplasm of urethra, antineoplastic chemotherapy induced pancytopenia, is, disorders of bone density and structure, irritable bowel syndrome, iron deficiency anemia, malignant neoplasm of cervix, and secondary malignant neoplasm of intra-abdominal lymph nodes.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] for Resident #68 revealed intact cognition. Resident #68 required staff supervision assistance with eating. Resident #68 required maximum assistance for toileting, bed mobility and transfers. Resident #68 was incontinent of bowel and bladder. Resident #68 was determined to be at risk for pressure ulcers. Resident #68 was coded with one unstageable deep tissue injury present on admission.<br><br>Review of the plan of care for Resident #68 revealed resident has actual pressure ulcer related to decreased mobility and weakness on the sacrum. Initially documented as a deep tissue injury present on admission. Interventions include administer/monitor effectiveness of/response to treatment(s) as ordered, assess/record changes in skin status and report changes to physician, enhanced barrier precautions, pressure reducing mattress, measure and document condition of skin condition weekly, monitor effectiveness of pressure relieving devices, incontinence care after each incontinent episode.<br><br>Review of the physician orders for the month of March 2025 for Resident #68 revealed an order dated 02/04/25 for triamcinolone acetonide external cream apply to left sacrum topically every shift for pressure (unstageable). Pharmacy to mix equal parts of Silvadene, zinc oxide 20 percent triamcinolone 0.5 percent: Cleanse wound with soap and water and apply cream to area every shift.<br><br>Interview on 03/25/25 at 9:00 A. M., with Resident #68 stated wound physician in to treat wound a couple of times now. CNA's apply cream when they provide incontinent care. Facility staff tell her it is getting better but it is painful at times.<br><br>Observation on 03/27/25 at 1:46 P.M., with Wound Physician #302, Unit Manager Licensed Practical Nurse (LPN) #3 and #61 revealed three containers with white screw type lids in Resident #68's room labeled with Resident #68's name. Directions included triamcinolone acetonide external cream apply to left sacrum topically every shift.<br><br>Interview on 03/27/25 at 1:46 P.M., with Unit Managers LPN #3 and #61 confirmed the presence of the three white containers with screw type lids in Resident #68's room. LPN #3 removed the containers from the room. Both LPN #3 and #62 verified the medication should not be in the resident room and unsupervised by licensed personal.<br><br>3. Review of the medical record for Resident #75 revealed an admission on 09/13/24 with diagnoses including dislocation of right hip, adjustment disorder with mixed anxiety and depressed mood, dementia without behaviors, hypertension, Alzheimer's disease, macular degeneration, and arthropathy.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed an intact cognition. Resident #75 required set up assistance for eating, moderate assistance for toileting, transfers and bed mobility. Resident # 75 was coded as incontinent with bowel and bladder. Resident #75 did not have any skin concerns and was not coded during assessment period of receiving applications of ointments or dressings.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the plan of care dated 09/14/24 and revised on 02/06/25 revealed Resident #75 was at risk for skin breakdown and pressure ulcers, incontinence, weakness, history of right hip dislocation, dementia, arthritis. Interventions included administer/monitor effectiveness of/response to preventive treatment(s) as ordered, apply protective barrier cream as ordered, assess and record changes in skin status and report pertinent changes to physician, assist resident with turning and repositioning daily during rounds and as required or needed, complete skin risk assessment quarterly.<br><br>Observation on 03/24/25 at 10:19 A.M., bedside table revealed an open unlabeled three ounce bottle of antifungal powder with miconazole nitrate two percent. Further observation of label on antifungal powder revealed a warning label stating if swallowed get medical help or contact the poison control center.<br><br>Interview 03/24/25 at 10:19 A.M., with Registered Nurse (RN) #30 verified that the powder should not be in the room for the CNA to apply. Further verified Resident #11 does not have an order to used the antifungal powder. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>34291<br><br>Based on observation, resident interviews, family interview, staff interview, and policy review the facility failed to ensure meals were served to residents at a safe temperature and palatable. This affected four (#12, #45, #55 and #70) of five residents reviewed for food. This had the potential to affect all the residents . The facility identified there were not any residents who could not eat anything by mouth. The census was 87.<br><br>Findings included:<br><br>Interview on 03/24/25 at 11:21 A.M., with Resident #55 revealed his meals were often served cold. His daughter added this was also a concern of hers because he already has a poor appetite.<br><br>Interview on 03/24/25 at 1:41 P.M., with Resident #45 revealed when he ate in his room the food was cold. Breakfast and dinners were the worst. He reported the trays on the 300 hall was delivered last and the food was cold and stated the facility wasn't using plate warmers for quite sometime now.<br><br>Observation of the dining carts on 03/25/25 at 7:24 A.M., revealed the last cart of the facility was delivered to the 300 hall. At 7:44 A.M., the last tray was sampled and the temperature of the eggs were 92.5 degrees, the oatmeal was 119, the bacon and the toast was not tested , and the cranberry juice was 56 degrees. The food was sampled by the surveyor and the eggs, bacon, and toast were cold and the taste was not palatable.<br><br>Interview on 03/25/25 at 7:47 A.M., with Assistant Dietary Manager (ADM) #43 confirmed the meal was cold and it was because the dietary staff used insulated warmer plates instead of the metal plates. She reported there were only two halls that the staff could use the metal plates for and the rest of the facility would receive the insulated plates. She reported the previous company would not pay for new metal plates, so they continued to use the insulated ones for the entire facility.<br><br>Interview on 03/25/25 at 8:42 A.M., with Resident #70 revealed the food was served cold in the mornings.<br><br>Interview on 03/25/25 at 11:13 A.M., with Resident #12 revealed he liked his food to be served hot to him and reported his food was cold when it was delivered to him for meals.<br><br>Review of the policy titled Food Temperatures - Hot and Cold Policy & Procedure dared 05/01/13 revealed the purpose was to assure that hot and cold foods are held to a temperature that will ensure food safety and food palatability.<br><br>PROCEDURE:<br><br>A. HOT FOODS<br><br>1. Foods requiring cooking - refer to chart to determine proper internal cooking temperature and<br><br>time for cooking<br><br>(continued on next page) |

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|---|---|---|---|
| | 365882 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Springmeade Healthcenter | 4375 South County Road 25 A<br>Tipp City, OH 45371 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2. Microwave cooking<br><br>a. Foods must be stirred frequently or midway to compensate for uneven heating of food<br><br>b. Covered while cooking to retain surface moisture<br><br>c. Refer to chart to determine proper internal cooking temperature and time for cooking<br><br>d. Allowed to stand for 2 minutes after cooking to allow for temperature equilibrium<br><br>3. Holding hot food - unless preparing, cooking or cooling, hot food must be kept at a temperature of 135 degrees or higher. Check temperature before serving.<br><br>4. Reheating foods that have been cooked and then refrigerated shall be reheated to a temperature of 165 degrees and remain at that temperature for at least 15 seconds before being served. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34291<br><br>Based on observation, staff interview and policy review, the facility failed to ensure the kitchen was a clean environment and food was served in a safe manner. This affected all of the residents. The facility identified all the residents received meals from the kitchen. The census was 87.<br><br>Findings included:<br><br>Observation of the kitchen on 03/24/25 at 8:35 A.M., revealed there were five panels of lights in the ceiling in the dishwasher area, and three sets of five lights in the ceiling that ran from one side of the kitchen area to the other side that had a grey flaky substance either inside of the light panel or on the outside of the light panel. There was a vent on the far end of the dishwasher area that had a thick black substance on the outside of it. Further review revealed there were four windows in the kitchen that had a splashes of a white substance on all of them and the screens had a thick layer of grey particles on them. During the observation one of the windows were open and the wind was blowing into the kitchen.<br><br>Interview on 03/24/25 at 8:50 A.M., with the Culinary Manager (#32) confirmed the above mentioned items in the kitchen needed#5<br><br>Observation of tray line on 03/26/25 at 11:27 A.M., revealed Assistant Dietary Manager (ADM) #43 was serving the food. She washed her hands and applied gloves and starting plating the food, but the Vegetable Lasagna became hard to cut so she took her left gloved hand and put it on the Lasagna to get it out of the pan. She proceeded to reach with right gloved hand to place a piece of garlic bread onto the plate. She turned around with her gloved hands and went through the meal tickets and came back to the serving line and continued to serve with the same gloves touching the Lasagna with her left gloved hand and then picking up a bread stick with the right gloved hand. She used her right gloved hand to reach up to the top of the steam table and straightened the meals tickets out and then went back to plating the food with using her left hand to touch the Lasagna and her right gloved hand to pick up the garlic bread stick. She proceeded to the prep table behind her and pulled off some aluminum foil to cover the bread sticks and continued to plate the food in the same manner until the surveyor asked her if she should change her gloves in between dirty surfaces to the food with her gloves on.<br><br>Interview on 03/26/25 at 11:37 A.M. with the ADM #43 confirmed she was using her gloved hands from dirty surfaces to the food and should have changed the gloves or just used the utensils to pick up the food.<br><br>Review of the policy titled Handwashing Policy and Procedure, dated 05/01/13, revealed the policy was to control the development and spread of infection and disease and to ensure that proper hand washing techniques are followed. Wash hand during work as often as is necessary to keep them clean and to prevent cross-contamination when changing tasks and when handling exposed food to be cleaned. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076<br><br>Based on staff interviews, observations, record review, review of infection tracking, policy review, Centers for Disease (CDC) guidelines review, review of testing documentation, review of water testing results and water testing staff interviews, the facility failed to wear proper Personal Protective Equipment (PPE) when providing resident care for residents in Enhanced Barrier Precautions (EBP), failed to ensure complete hand hygiene during a dressing change, failed to timely monitor infection tracking and monitoring was accurately and timely maintained, the facility failed to provide updated policies to address Legionella, and provide scheduled monitoring procedures of at risk water systems and provide a system approach to a positive Legionella testing. This had to affect all residents in the faciltiy. The faciltiy census was 87.<br><br>Finding include:<br><br>1. Review of medical record for Resident #78 revealed admitted [DATE]. The resident was admitted with diagnoses including displaced fracture of left lower leg, type two diabetes mellitus, chronic kidney disease stage four and Rheumatoid Arthritis. The resident remained at the facility.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. She required set up for eating, moderate assistance for bed mobility, and maximum assistance for transfers and toileting hygiene.<br><br>Record review of the physician orders for Resident #78 revealed an order for Enhanced Barrier Precautions (EBP) with a start date of 02/27/25.<br><br>Observation on 03/26/25 at 9:29 A.M., with Registered Nurse (RN) #30 of Resident #78's dressing change revealed RN #30 applied gloves prior to the dressing change. No other Personal Protective Equipment was donned. An interview in the hall right outside the door directly following dressing change revealed RN #30 stated she had been unaware Resident #78 required EBP. She stated there was no sign on the door to the room to indicate her. We then entered the bathroom where an EBP sign was taped to the back of the bathroom door indicating gowns and gloves were required for direct care. RN #30 stated there was no PPE present. Upon observation, blue material enclosed in a clear plastic bags were observed on the shelves in the bathroom. RN #30 was asked if the blue items were gowns, and she proceeded to remove a blue plastic gown from the bag. RN #30 stated she had never seen one of those in the room before.<br><br>2. Review of medical record for Resident #240 revealed admitted [DATE]. The resident was admitted with diagnoses including congestive heart failure, diabetes mellitus type two, and chronic obstructive pulmonary disease. The resident was discharged home on 03/25/25.<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. He required set up assistance for eating, bed mobility, moderate assistance with transfers maximum assistance with toileting hygiene. He was documented with one stage three pressure ulcer present upon admission.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation of skin assessment on 03/25/25 at 10:13 A.M., for Resident #240 by Licensed Practical Nurse (LPN) #70, accompanied by Unit Manager (UM) #61, found Resident #240 in the bathroom after having a bowel movement. LPN #70 donned gloves and used a soapy washcloth to thoroughly cleanse stool from Resident #240. She placed the washcloth in a clear plastic bag and using the same gloved hand, she grabbed a paper ruler. Without removing her gloves, she measured the open area to Resident #240's sacral area. Directly following the observation, LPN #70 verified she did not change gloves after providing perineal (peri) care and used the soiled gloves to touch a paper ruler. She then used her gloves hands and paper ruler to measure an open wound.<br><br>3. Interview on 03/31/25 at 10:10 A.M., with Infection Preventionist Registered Nurse (IPRN) #52 revealed infections are tracked throughout the month. She stated Point Click Care (PCC) would alert her when a resident had started on an antibiotic. She would then determine the infection type and whether it met McGreers (infection surveillance) and the antibiotic prescribed. The type of infection was mapped by color coding the infection. She would place a correlating colored dot on the room map of the facility, she explained this allowed her to visual see if there was a pattern. IPRN #52 explained if a cluster of infections were noted on a certain hall, an investigation would be initiated and an intervention and or education would be provided if possible.<br><br>Review of the infection tracking and mapping was completed from July 2024 to present day was completed. Review of the mapping for October and November 2024 revealed a cluster of Urinary Tract Infections (UTI's) on the 300 hall. IPRN #52 explained the cluster was recognized and she and the Director of Nursing (DON) provided staff education on hand washing and peri care.<br><br>Review of the February infection documentation revealed there had been nine residents with Urinary Tract Infections (UTI's). The tracing revealed they were scattered throughout the facility. A review of the March infections revealed there were 20 residents diagnosed with UTI's. Further review revealed no tracings for infections had been completed for March.<br><br>Interview, at the time of review, with IPRN #52 verified no tracing had been completed for March, despite the fact the UTI's had doubled. IPRN #52 acknowledged without tracing, she was unable to determine if there was a pattern and no education of staff had yet been provided as an intervention.<br><br>4. Interview on 03/31/25 at 3:23 P.M., with Maintenance Manager (MM) #34 revealed third party company comes to the facility to perform Legionella water testing. He stated the lines in empty rooms are flushed but he was unable to provide any documentation. He verified he had not completed any hot water temperatures in rooms or of the hot water heater and added the facility staff had not been performing interventions or inspections for Legionella, leaving the testing to the third-party company.<br><br>Interview on 03/31/25 at 4:34 P.M., with the Administrator revealed the facility did not have an updated Legionella Policy reflecting the new ownership. She stated the facility had still been operating under the old policy. She was unable to provide facility staff documentation for Legionella prevention including any water temperature, line flushing or inspections.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the last water testing by Company #1 revealed there were ten water areas tested for Legionella. Two of the ten areas were documented above the detection limit of one Colony Forming Unit (CFU) per (/) milliliter (ml). The Rehabilitation sink hot water faucet tested at 13 CFU/ml and the 100 hall Nurse station cold water faucet tested at 10 CFU/ml. Further review of the testing results for those two results revealed Legionella was detected in accordance with International Organization for Standardization (ISO) 11731 however further attempts to stereotype were inconclusive and the morphologies were included in the total Legionella reported.<br><br>A phone interview on 04/02/25 at 2:30 P.M., with the Administrator revealed she had not been aware of positive Legionella testing at the facility. She denied any resident had tested positive with Legionella.<br><br>A three-way phone interview on 04/02/25 with Company #1 Technician #300 and the Administrator was completed at 4:18 P.M. Technician #300 verified the local health department had not been contacted after two areas had tested positive during facility testing on 12/16/24. He revealed the standard for positive results was to flush the water lines and retest. Technician #300 acknowledged the flushing of the lines and retesting had not taken place until the day of the interview. Technician #300 explained the results of the 04/02/25 testing would take 14 days stated no additional interventions were put into place and the local health department had not been notified at the time of the interview.<br><br>Review of the facility policy, Water Safety/Legionella Plan revised May 2022 revealed all at risk water system would have scheduled have recommended monitoring procedures that include items such as checking temperature, cleaning and disinfecting. Some at risk items included hot and cold-water storage tanks, water heaters, faucet flow restrictors and ice machines. There would be a system approach to any positive result from testing.<br><br>Review of CDC guidelines, at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html revealed glove removal should be done after work on a soiled body site.<br><br>Review of the policy titled , Isolation Precautions Process, revised August 2022 documented EBP would be utilized for residents with wounds. EBP included wearing gloves and gowns during high contact resident care including wound care.<br><br>39702<br><br>5. Review of the medical record for Resident #75 revealed an admission on 09/13/24 with diagnoses including but not limited to dislocation of right hip, adjustment disorder with mixed anxiety and depressed mood, dementia without behaviors, hypertension, Alzheimer's disease, macular degeneration, and arthropathy.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition. Resident #75 required set up assistance for eating, moderate assistance for toileting, transfers and bed mobility. Resident #75 was coded as incontinent with bowel and bladder.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the plan of care for Resident #75 dated 03/28/25 revealed actual impairment to skin integrity of the left buttock related to moisture associated skin damage. Interventions include identify potential causative factors and eliminate/resolve where possible, monitor location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration physician, encourage/assist with frequent turning and repositioning, treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations and weekly skin screen.<br><br>Observation on 03/24/25 at 2:28 P.M., of Resident #75 sitting in her wheelchair with kerlix style dressing on her left upper arm dated 03/24/25. Observation of EBP information sheet from the United States Department of Health and Human Services Center for Disease Control and Prevention attached to bathroom door in Resident #75's room. EBP had a stop sign on both upper corners, large type advising everyone must: clean their hands, including before entering the room and when leaving the room. Sign had small photo of alcohol-based hand rub in a white box beside the information. Additionally, the sign advised providers and staff must also: wear gloves and a gown for the following high contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care of use including central line, urinary catheter, feeding tube, tracheostomy and wound care for any skin opening requiring a dressing.<br><br>Interview on 03/24/25 at 2:28 P.M., with Resident #75 stated she fell and injured her arm. Resident #75 stated it was a few days ago but denied any pain.<br><br>Interview on 03/24/25 at 2:37 P.M., with LPN #11 assigned to Resident #75's room stated she was not sure which resident had enhanced barrier precautions in place and would have to check the medical record as the sign on the bathroom door in Resident #75's room had a photocopy of the EBP guidelines.<br><br>Interview on 03/24/25 at 2:38 P.M., with House Keeping Manager (HKM) #96 verified the sign on the door did not indicate which resident in the room was in the EBP. HKM #96 verified she hangs the signs on the door when advised by management. HKM #96 states she is not sure how it should be marked to identify which resident is on EBP.<br><br>Observation and Interview on 03/26/25 at 11:45 A.M., with HKM #96 stated she is replacing all paper EBP from rooms. HKM #96 states that she is replacing all the signs in the facility with laminated ones and then marking the bed that has the EBP in place at the top of the sheet. HKM #96 verified gowns and gloves are placed in the bathroom for staff to use.<br><br>Review of the wound care nurse/ physician skin observation form dated 03/28/25 revealed left elbow skin tear measuring 7.5 centimeters (cm) x 5cm x 0.1 cm and sacrum 2.4 cm x 1.5 cm x 0.1 cm classified as moisture associated skin damage (MASD). Sacrum documented with moderate amount of serosanguinous drainage and left elbow documented with large amount of yellow drainage.<br><br>Review of the physicians orders for Resident #75 revealed an order Wound Location: Sacrum left side Treatment: Cleanse with normal saline, pat dry, apply Medihoney to wound bed, cover with border gauze every day shift and as needed for wound care dated 03/28/25 and cephalexin tablet 500 milligrams (mg) one tablet three times a day for wound dated 03/28/25.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 04/01/25 at 11:37 A.M., of incontinent care for Resident #75 with Certified Nurse Assistant (CNA) #305 and Licensed Practical Nurse (LPN) #11. CNA #305 and LPN #11 entered Resident #75's room. CNA #11 went to the bedside of the resident and explained the procedure and assisted resident to position on her right side. LPN #11 completed hand hygiene and donned gloves, provided barrier onto overbed table and laid dressing supplies on the barrier. LPN #11 removed old wound dressing folded it into her glove, removed glove and discarded it. Border dressing was observed with small amount of drainage. LPN #11 completed hand hygiene with soap and water and applied gloves. LPN #11 proceeded to cleanse wound with normal saline and gauze 4x4's. LPN #11 removed gloves and completed hand hygiene with soap and water. LPN #11 used cotton tip swab to remove medihoney from medication cup and apply to wound. LPN #11 then covered the coccyx wound with border dressing, initialed and dated dressing.<br><br>Interview on 04/01/25 at 12:00 P.M., with LPN #11 confirmed the resident did not have a sign on the bathroom door indicating Resident #75 had Enhanced Barrier Precautions. LPN #11 verified wound care was completed for Resident #75 without donning personal protective equipment (PPE) and should have if she is in EBP.<br><br>Interview on 04/01/25 at 12:00 P.M. with CNA #305, stated she was assigned to Resident #75 and provided incontinent care. CNA #305 stated she assisted resident with activities of daily living since arrival for her shift and did not utilize PPE. CNA #305 verified the facility did not have a sign on the door alerting staff of EBP.<br><br>Review of the policy titled Infection Prevention and Control Program, dated 11/05/21, stated it is the facility's practice to prevent, recognize and control to the extent possible the onset and the spread of infection. Additionally, the policy states the development, implementation and maintenance of an effective infection prevention and control program to include implementation of practices consistent with accepted standards that will help reduce the spread of infections and prevent cross contamination. |