STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375117	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hills Living Center	1100 West Georgia Jones, OK 73049

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm 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. 35389 Based on observation, record review, and interview, the facility failed to ensure the physician was notified when a resident experienced a change in their skin condition that required medical intervention for one (#12) of four sampled residents reviewed for non pressure skin conditions. The administrator identified 114 residents resided in the facility. The DON identified 10 residents with non pressure wounds resided in the facility. Findings: An undated Physician Notification for Resident Change in Condition policy, read in parts, Document in the medical record the date, time and name of each physician notified, actions taken and/or resident's response to treatment .Physician notification may be indicated in the following situations .new or worsening wounds. Resident #12 had diagnoses which included vasculitis, bipolar disorder, and schizoaffective disorder. A Wound Progress Note, dated 01/09/25, documented the resident had a wound to their right lower leg, left lower leg, left gluteal fold and right thigh. The note did not document the resident had any wounds to their feet. The note was signed by the wound NP. A Physician Order, dated 01/13/25, read in part, Start - Wound care [one] dose for wound care ONE TIME AND PRN SOILING PRIOR TO WOUND CARE CONSULTATION: Cleanse with NS. Apply silver alginate to areas with purulent drainage. Cover non-purulent area with vaseline gauze. Wrap with rolled gauze. REFER TO WOUND CARE AT FACILITY FOR THURSDAY 01/16/25. A Physician Order, dated 01/14/25, documented to cleanse wounds to bilateral foot with normal saline, pat dry, apply silver alginate to areas with purulent drainage, cover non-purulent area with Vaseline gauze, wrap with rolled gauze, daily and as needed. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 10:28 a.m., LPN #2 entered Resident #12's room to provide wound care. LPN #2 was observed telling Resident #12 I can't touch your feet until wound care looks at it Thursday. Resident #12 was observed with dressings to their bilateral feet. There was no date observed on the dressings. LPN #2 stated it was their fault, and that they had completed the dressing change on 01/13/25 with the hospice nurse. LPN #2 stated they could not touch the resident's feet until wound care evaluated them. LPN #2 stated hospice did not want them to be messed with until they were evaluated. On 01/14/25 at 10:38 a.m., Resident #12 was observed with dressings to their bilateral feet. There was a red brown soilage observed on the underside of the resident's left foot. On 01/14/25 at 10:54 a.m., LPN #2 stated it was their understanding the hospice shower aide took Resident #12's sock off and the skin came off the left foot. LPN #2 stated both feet were just kind of raw and really flaky. They stated staff had been putting Aquaphor on the resident's legs for months. LPN #2 stated the issue with the resident's feet occurred Friday 01/10/25. They stated they received an order to treat the feet yesterday (01/13/25) to put silver alginate and xeroform on it. LPN #2 stated the order came from hospice, and LPN #2 helped the hospice nurse with dressing the resident's feet yesterday. LPN #2 stated hospice did not want Resident #12's feet messed with until the wound doctor could evaluate them. LPN #2 stated the undated dressings had been on the resident's feet since yesterday. LPN #2 was asked about the soilage on the resident's left foot dressing. LPN #2 stated they could change it and let hospice know they had to change it. LPN #2 stated hospice had cultured the wounds yesterday. LPN #2 stated when the hospice aide had removed Resident #12's sock, they stated the resident's skin stuck to the sock. LPN #2 stated it was just the top layer of the resident's foot like a flesh wound. LPN #2 stated they cleaned the area with normal saline and yesterday when they were looking at it, there was some on the bottom as well. LPN #2 stated on Friday they had cleaned the area and covered it with a four by four. LPN #2 was asked if the doctor was notified and was an order received for the wound care they provided to this area on Friday. LPN #2 stated they texted the resident's hospice, but I don't know if they came out because it happened at 2:45 3:00 o'clock. On 01/14/25 at 12:33 p.m., Resident #12 was observed in the main dining area seated in their wheelchair. There was bright red soilage observed on the resident's left foot that continued over the lateral side. On 01/14/25 at 12:36 p.m., LPN #2 stated they would see if the resident would allow a dressing change to their feet after lunch. They stated there were activities from two to four the resident would not want to miss. 01/14/25 at 2:29 p.m., Resident #12 was observed in the main dining area with a red tinged dressing present to their left foot. Resident #12 did not permit the dressing change to their feet prior to the surveyors leaving on 01/14/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 10:14 a.m., LPN #2 stated they were a new nurse and might have the policy wrong. They stated to their understanding they were supposed to contact the hospice nurse to get orders from them. LPN #2 stated with wounds they usually told the hospice nurse and they usually told ADON #1. They stated on Friday they were running out of the facility and it was their fault. They stated normally on wounds they would tell ADON #1 and they would contact the wound care doctor. LPN #2 stated on Friday, they dropped the ball. LPN #2 stated the wound was superficial and there was nothing on the bottom. On 01/15/25 at 12:27 p.m., the DON stated they would have to get the facility policy for what do do if staff identified a change in the resident's skin. On 01/15/25 at 1:14 p.m., the DON chose for the surveyor to ask policy questions in the presence of the regional clinical director, the administrator, the regional nurse. On 01/15/25 at 1:16 p.m., the regional clinical director stated if a resident had a brand new wound, the staff wound notify the provider. They stated if the resident was an established wound care provider patient, they would call and notify them. On 01/15/25 at 1:18 p.m., the regional clinical director stated if the resident was a hospice resident and there was a change in the resident's skin, they would notify the hospice provider or nurse. On 01/16/25 at 8:11 a.m., the wound NP stated they came every Thursday and saw Resident #12. They stated the resident was paralyzed and stiff with a lot of autoimmune issues like vasculitis on their lower legs. On 01/16/25 at 8:20 a.m., the wound NP stated they spoke with ADON #1 on Tuesday (01/14/25) who reported the resident had broke out with one between the toes. The wound NP stated they believed hospice had given them orders and they took a culture due to purulent drainage.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49701 Based on observation and interview, the facility failed to provide a safe, clean, and comfortable shower room in three of the four shower rooms observed. ADON #1 identified the facility had seven shower rooms. Findings: An undated facility Safe Environment policy, read in part, facility will maintain a safe, comfortable, and homelike environment. The policy also read, the facility will be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. On 01/21/25 at 10:03 a.m., housekeeper #1 stated they cleaned hall 500 shower room every day, but the rust stains leaking from the rusted safety bars would not come off no matter how much it they were scrubbed. They stated the brown paint on the floor was peeling up all over the place and the shower room acted as a storage room as well. They stated this shower room was about to be remodeled, but they were not sure when. On 01/21/25 at 10:05 a.m., the floor had a sticky residue that caused shoes to stick to the floor while walking in the shower room. The entire right side of the shower room was being used as storage. There were two mechanical lifts, a wheel chair, a walker, a mattress, a sling for the lift, multiple storage totes, closed boxes, 3-three drawer plastic containers, a bedside table with a closed box blocking access to the sink, and two large trash cans on wheels blocking access to the toilet. There was also a shower bench with one of the seat planks unattached. On 01/21/25 at 10:13 a.m., CNA #2 stated they believed all residents got a shower on their shower days in that shower room. They stated, We try to keep their feet dry when they get out to keep it from sticking. for the most part it works, they are going to be redoing it. They also stated, There is stuff in their but typically we don't use it for storage. The toilet and sink work and when we need to use them, we just move the trash bins out of the way. They stated they were unaware that one of the shower chairs was currently broken. On 01/21/25 at 10:21 a.m., hall 100 shower room was observed to have a full dirty laundry basket on the floor, the paint had started peeling on the floor, and one of the shower chairs by the cabinets did not have one of the wheels on it. The wheel was inside the shower stall. On 01/21/25 at 10:23 a.m., CNA #3 stated the laundry basket should have been taken to the dirty linen next door. They stated the floor had looked that way since at least April of 2024 when they started. They stated they do not use the broken shower chair. On 01/21/25 at 12:42 p.m., the administrator stated that hall 500 was going to be remodeled first as soon as survey was done and then hall 100 was next. The administrator stated they were aware the shower room had been used for storage. They called maintenance to have it cleaned back out, stating they were unaware that stuff was back in there. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/25 at 5:27 p.m., the maintenance director opened the door to the shower room for 600. They stated the power was off because the exhaust fan needed to be fixed. The temperature felt very cold. The shower room on hall 600 was located across from the exit door and the outside temperature was in the 30's at the time.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46653 On 01/17/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Resident #18 was free from abuse by not implementing company policy and procedures. This resulted in Resident #18 experiencing psychosocial harm. A nursing note, dated 12/25/24 at 9:39 a.m., read in part, [Resident #18] was observed walking down 400 hallway. [Resident #54] got mad and started ranting saying that,I will stub them because they didn't like that particular resident. The note also read, [Resident #54] pulled out a rail road track nail with the gestures of attacking [Resident #18]. The note also read, This Nurse yelled for help along side the Nurse aide who was close and witnessed they rushed to intercept and prevent any possible attack to the [Resident #18] who was asked to go back in their room. [Resident #54] did not succeed and the DON with another Nurse managed to retrieve the track nail from [Resident #54]. On 01/14/25 at 2:32 p.m., the DON was asked about reporting abuse according to company policy and procedures for the 12/25/24 note. They stated they did not believe it was resident abuse because Resident #54 was on hall 400 and Resident #18 was sent another hall. On 01/15/25 at 9:32 a.m., the DON was asked about company policy and procedures for reporting of the 12/25/24 note. They stated, It's an behavioral incident. No documentation was reported at the time of the incident. According to policy it should have been reported. On 01/16/25 at 10:23 a.m., CNA #1 was asked about the 12/25/24 note. They stated, [Resident #54] was the instigator. I feel like [they] overheard that [they] was flirting. [Resident #54] started walking towards [them] and said I'm going to beat [Resident #18] ass. Then [they] was moved to hall one. On 01/16/25 at 11:41 a.m., Resident #18 was asked about the 12/25/24 incident. They stated, I remember everything and everyday. [Resident #54] yelled at me and was trying to get me to fuss and fight. I tried to avoid [Resident #54] but, I felt nervous and unsafe. On 1/17/25 at 4:20 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 1/17/25 at 4:34 p.m., the administrator and DON were notified of the immediate jeopardy situation and was provided the IJ template. On 1/21/25 at 8:12 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal documented, Plan of removal for abuse, neglect and exploitation. 1. On 12/27/24 resident #54 had a Risk Management Agreement put into place due to resident consuming alcohol outside of facility and returning to facility becoming agitated and verbally aggressive. The resident has had no further behaviors since 12/25/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Psych Consult (Millennium) notified of residents past aggressive and verbal behaviors when under the influence. PA conducted a Tele Med evaluation 1/17/25 and noted no behaviors since 12/25/24 and resident has not exhibited any threatening or aggressive behaviors at this time. 3. On 1/15/25 residents' primary care physician documented that resident is not a threat to [them] or others and has not been in the past month. How will the facility ensure that other residents, outside of hall 400, are safe? 4. Resident has been placed on Q15 minute behavior monitoring and if any aggressive behaviors are noted resident will be placed on 1:1 monitoring until aggressive behaviors subside. What are the details of in-servicing nursing staff? Is this licensed nurses, nurse aides, all staff, etc? 5. In-service conducted with nursing staff (to include nurses, med aides, and CNA', as well as other departments.) over Abuse and Neglect and management of aggressive residents was completed on 12/28/24 and again on 1/17/25. All other nursing staff not present will be in-serviced before working their next shift. Agency has been notified of the in-service required and materials have been provided. They will in-service any contract staff that work at Oak Hills before their next shift scheduled. 6. The Administrator, DON, and ADON's have been in-serviced over recognizing mental and verbal abuse and the Incident Reporting and Investigation Policy. 7. Resident #18 has been moved to a different hall to create distance between [them] and resident #54 per [their] request when interviewed. 8. Safe Surveys have been conducted on hall 400 and throughout the building randomly. No other residents have any complaints or concerns. 9. Resident 54 care plan updated accordingly. On 01/21/25 at 11:33 a.m., after interviews with the facility staff, review of resident safe surveys, and in-services on abuse, the immediacy was lifted. The deficient practice remained at a potential for more than minimal harm. Based on record review and interview, the facility failed to ensure a resident was protected from resident to resident abuse for one (#18) of three sampled residents reviewed for abuse. The administrator identified 114 residents in the facility. Findings: An undated Abuse and Neglect policy, read in part, w. Following the initial verbal investigation, the Administrator will take written statements from all employees, residents, any witness if any, and will determine action to be taken. The policy also read, The Abuse/Neglect of this facility will be implemented to ensure all residents entrusted in our care will be free from mental, verbal, or physical abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An undated document titled, Things Residents Don't Need or Should Avoid, read in part, 11. Residents are encouraged not to consume ALCOHOLIC BEVERAGES or use of any DRUGS NOT ORDERED BY THE PHYSICIAN. The facility may obtain a physician's order for alcohol use as physician deems appropriate either routine or for special activities. If any outside drug or alcohol use is suspected, nurse should monitor resident's condition and notify physician as indicated. The Unusual Occurrence policy, revised 12/2007, read in part, 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within (48) hours of reporting the event or as required by federal and state regulations. 1. Resident #18 had a diagnoses which included unspecified schizophrenia. A quarterly assessment, dated 11/22/24, documented the resident's cognition was moderately impaired. On 01/16/25 at 11:41 a.m., Resident #18 was about the 12/25/24 incident. They stated, I remember everything and everyday. [Resident #54] yelled at me and was trying to get me to fuss and fight. I tried to avoid [Resident #54], but I felt nervous and unsafe. A annual assessment, dated 11/24/24, documented the resident's cognition intact. An Admission Packet, signed by Resident #54 on 11/17/22, read in part, [DRUG FREE AND HEALTH CARE CENTER POLICY] It is the policy of this facility to provide a safe environment that promotes the welfare of its residents, associates and visitors. Substances and alcohol abuse threatens the quality of patient care and the safety of our residents and associates. This facility therefore, will maintain a drug and alcohol free Health Care Center policy. A physician's order, dated 04/10/24, read in part, May consume alcoholic beverages unless otherwise contraindicated .Status Discontinued . End Date 04/26/24 .Revision Date. A nursing note, dated 04/03/24, read in part, This nurse heard screaming and yelling, I ran to the front and saw resident [Resident #54] yelling in residents' face and attempted to hit them, staff intervened and separated both residents. [Resident #54] smelled of alcohol. Residents were separated by staff, res continued to be combative, yelling and attempting to attack other residents. Resident escorted to room, police notified. Police arrived and calm resident down for a few minutes, resident then ran back into TV and continued to make threatening remarks towards and other residents. A behavior note, dated 07/04/24, read in part, while I was in [Resident #54] room tending to [their]roommate [Resident #54] became irate yelling about the staff not taking care of [them] and catering to [their] roommate. I attempted to talk to resident to alleviate [their] concerns when I smelled alcohol on [their] breath. Resident continued to fuss and cuss with a raised voice and followed me into the hallway calling me bitches and yelling fuck you and accusing the 3-11 staff for killing all the residents that have passed. I tried to reason with resident but they became worse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing note, dated 08/02/24, read in part, [Resident #54] was drunk and belligerent. angrily kicking and punching doors, walls and other objects in the hall. Running into other residents' rooms and threatening them. Waking up residents and taking them to their room, cussing and threatening staff. A behavior note, dated 08/13/24, read in part, [Resident #54] drunk and is screaming and cussing and trying to pick a fight with the other residents. A nursing note, dated 11/02/24, read in part, [Resident #54] signed self out on 7-3 shift, returned to facility around 3p.m. being loud yelling at staff members calling them names, several staff members smelt alcohol on residents breath. A annual assessment, dated 11/24/24, documented the resident's cognition intact. A Care Plan, dated 12/02/24, read in part, [Resident #54] is at risk for behavior problems. [Resident #54] has hx (history) of consuming mouthwash containing alcohol as well as signing self out the facility to obtain alcohol becoming intoxicated. The care plan also read, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. A behavior note, dated 12/03/24, read in part [Resident #54] is drunk starting trouble with another resident and staff, threatening to beat them up, kicking and banging on their door, yelling threats and accusations up and down the hall. A nursing note, dated 12/25/24 at 9:39 a.m., read in part, [Resident #18] was observed walking down 400 hallway. [Resident #54] got mad and started ranting saying that,I will stub them because they didn't like that particular resident. The note also read, [Resident #54] pulled out a rail road track nail with the gestures of attacking [Resident #18]. The note also read, This Nurse yelled for help along side the Nurse aide who was close and witnessed they rushed to intercept and prevent any possible attack to the [Resident #18] who was asked to go back in their room. [Resident #54] did not succeed and the DON with another Nurse managed to retrieve the track nail from [Resident #54]. There were no new interventions implemented after the incident on 12/25/24. On 01/15/25 at 9:32 a.m., the DON was asked about the company policy and procedure for the 12/25/24 note. They stated, It's an behavioral incident. No documentation was reported at the time of the incident. According to policy it should have been reported. On 01/15/25 at 9:37 a.m., the director of clinical care was asked about behaviors in the 12/03/24 behavior note. They stated, It is an pattern of behavior. On 01/15/25 at 9:38 a.m., the DON was asked about the company policy and procedures for the 12/03/24 behavior note. They stated, I was unaware of the situation and its been reported that [Resident #54] drinks mouthwash to get drunk. On 01/15/25 at 9:58 a.m., the director of clinical care was asked about the company policy and procedures for the 11/02/24 nursing note, they stated, They should have put it in the Spectrum binder, so they can notify the PA. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/15/25 at 10:04 a.m., the DON was asked about the company policy and procedures for the 08/02/24 note. They stated, No incident report was done for 08/02/24. On 01/15/25 at 10:05 a.m., the DON was asked about the company policy and procedures for resident protection. They stated, We usually put it in a care plan. On 01/15/25 at 10:17 a.m., the director of clinical care was about the company policy and procedures concerning the 08/02/24 note. They stated, The way it's stated in the nursing notes, yes. It's vague. It should have been reported as alleged abuse. On 01/15/25 at 10:18 a.m., the DON stated, The 08/02/24 incident, I take it as two different situations. On 01/15/25 at 10:19 a.m., the DON was asked about the company policy on incident reporting for the 08/02/24 behavior note. They stated an incident report should have been done. On 01/15/25 at 10:22 a.m., the director of clinical care was asked about incident reporting procedures according to policy for the 08/02/24 note. They stated, An incident report should have been done. On 01/15/25 at 1:31 p.m., a revised care plan for Resident #54 was received on 01/15/25 at 1:31 p.m. by the regional nurse. The undated care plan, read in part, [Resident #54] is at risk for behavior problems. [Resident #54] has a hx (history) of consuming mouthwash containing alcohol as well as signing self out of facility to obtain alcohol becoming intoxicated. Has a history of pan handling for money. [Resident #54] can become verbally and physically aggressive to staff and peers. [Resident #54] is known to kick walls and other things when angry or intoxicated. [Resident] typically goes back to the resident he was angry with and will apologize to them for his behavior. On 01/16/25 at 10:23 a.m., CNA #1 was asked about the 12/25/24 note. They stated, [Resident #54] was the instigator. I feel like [they] overheard that [they] was flirting. [Resident #54] started walking towards [them] and said I'm going to beat [Resident #18] ass. Then [they] was moved to hall one. On 01/16/25 at 11:41 a.m., Resident #18 was asked about the 12/25/24 incident. They stated, I remember everything and everyday. [Resident #54] yelled at me and was trying to get me to fuss and fight. I tried to avoid [Resident #54], but I felt nervous and unsafe. On 01/17/25 at 9:39 a.m, the DON was asked about the 08/02/24 note. They stated the note read, [Resident #54] is drunk and belligerent and No labs or breathalyzers were used to confirm this statement. On 01/17/25 at 9:41 a.m., the DON was asked about policy and procedures for residents who consume alcohol concerning the 08/02/24 note. They stated, We don't have a policy for breathalyzers. I cannot confirm this happened! That's someone's opinion. On 01/17/25 at 9:54 a.m., LPN #5 was asked about reporting abuse according to company policy, They stated, Ensure the resident is safe and report it immediately to my superior that day and document. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/17/25 at 9:55 a.m., LPN #5 was asked about alcohol consumption of residents according to policy. They stated, Alcohol, its not allowed, its not encouraged, we would have to doctors orders to see what kind of meds they are taking. On 01/17/25 at 9:56 a.m., LPN #5 was asked about identified concerns related to alcohol consumption with residents. They stated they would report the use of alcohol to nursing leadership. On 01/17/25 at 9:57 a.m., the DON was about Resident #54's signed admission packet and alcohol consumption. They stated, If they sign out and go drink the facility can't control it. [Resident #54] was notorious for drinking mouthwash. On 01/17/25 at 9:57 a.m., the regional nurse was asked about Resident #54's alcohol consumption according to company policy and procedures. They stated, Things residents don't need or should avoid policy, number 11. We are going to put update the careplan. We are not a treatment center. On 01/17/25 at 9:58 a.m., the administrator was asked about the company policy and procedures for incident reporting. They stated, Have we addressed it promptly? Probably not. On 01/17/25 at 11:15 a.m., the director of clinical care was asked about incident reporting according to company policy. They stated, According to Abuse/Neglect Policy and Unusual Occurrence policy it (facility reported incident) should have been submitted within two hours. On 01/17/25 at 11:16 a.m. the clinical director of client care was asked about identifying unsafe residents in the 12/03/24 behavior note. They stated, No. On 01/17/25 at 11:17 a.m., the DON was asked to identify unsafe residents in the 12/03/24 behavior note. They stated, No. On 01/17/25 at 11:18 a.m., the DON was asked if an investigation was done according to company policy and procedures for the 12/03/24 behavior note. They stated, No. On 01/17/25 at 11:26 a.m., the director of client care was asked about identifying abuse according to company and procedure and identifying psychological harm. They stated,During the event of some these incidents they were not safe.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46653 Based on record and interview, the facility failed to thoroughly investigate an allegation of abuse for two (#18 and #54) of three sampled residents reviewed for abuse and neglect. The administrator reported the census was 114. Findings: An undated Abuse and Neglect policy, read in part, w. Following the initial verbal investigation, the Administrator will take written statements from all employees, residents, any witness if any, and will determine action to be taken. The Unusual Occurrence policy, revised 12/2007, read in part, 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within (48) hours of reporting the event or as required by federal and state regulations. 1. Resident #18 had diagnoses which included unspecified schizophrenia. A nursing note, dated 11/29/24, read in part, another resident on hall 400 reported that [Resident #18] had offered [them] 7$ and a coke for a hand job. Another resident on 300 hall reported that [Resident #18] asked for a blowjob. [Resident #18] admitted to doing these things and was asked to stay away from other resident. There was no documentation an investigation was completed for the incident. On 01/16/25 at 3:10 p.m., the DON reported no incident report was done. On 01/16/25 at 3:11 p.m. the regional nurse stated, No incident report was done. 2. Resident #54 had diagnoses which included bipolar and major depressive disorder. A behavior note, dated 08/02/24 at 10:43 p.m., read in part, [Resident #54] drunk and belligerent, angrily kicking and punching doors, walls and other objects in the hall. Running into other residents' rooms and threatening them. A nursing note for Resident #54, dated 12/03/24 at 5:32 p.m., read in part, is drunk starting trouble with [Resident #18] and staff, threatening to beat him up, kicking and banging on his door, yelling threats and accusations up and down the hall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident #54, dated 12/25/24 at 9:39 a.m., read in part,[Resident #18] was observed walking down 400 hallway. [Resident #54] got mad and started ranting saying that, 'I will stub them' because they didn't like that particular resident. The note also read, [Resident #54] pulled out a rail road track nail with the gestures of attacking [Resident #18]. The note also read, This Nurse yelled for help along side the Nurse aide who was close and witnessed they rushed to intercept and prevent any possible attack to the [Resident #18] who was asked to go back in their room. [Resident #54] did not succeed and the DON with another Nurse managed to retrieve the track nail from [Resident #54]. There was no documentation investigations were completed for the incidents. On 01/15/25 at 9:58 a.m., the DON stated, No incident report was done. On 01/17/25 at 11:10 a.m., the regional director of client care was about company policy and procedures for investigating incidents. They reported there was no state reportable submitted according to policy and they had no records of investigation according to company policy and procedures. On 01/17/25 at 11:16 a.m. the regional director reported the 12/03/24 incident should have been reported within two hours and according to policy. On 01/17/25 at 11:19 a.m., the regional director reported the unusual occurrences number three in the company policy should have been followed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure assessments were completed timely for two (#67 and #98) of 28 sampled residents reviewed for resident assessments. The administrator identified 114 residents resided in the facility. Findings: 1. An Annual Resident Assessment, dated 8/23/24, was the last assessment completed for Resident #67. A billing census documented billing had been stopped on 9/26/24. There was no discharge assessment. 2. An Admission Resident Assessment, dated 8/12/24, was the last assessment completed for Resident #98. A billing census documented billing had been stopped on 8/26/24. There was no discharge assessment. On 01/21/25 at 11:51 a.m., MDS #1 stated Resident #67 was a death in facility on 9/06/24. They stated it had not been completed, but should have been completed within 14 days of the discharge. MDS #1 stated Resident #98 discharged on [DATE], but the discharge had not been completed. They stated there was no reason why it was not completed within the 14 day requirement. On 01/21/25 at 6:15 p.m., ADON #1 brought in LPN #5 to respond to questions about the MDS assessments because they were not familiar with MDS. LPN #5 stated that both discharges had not been completed within the required time frame, but they should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 35389 Based on observation, record review, and interview, the facility failed to ensure a resident care plan was revised for one (#57) of one sampled resident observed self-administering a medication. The administrator identifed no residents with orders to self-administer medications resided in the facility. Findings: A Care Plans policy, revised 12/2016, read in parts, Assessments of residents are ongoing and care plans are revised as information about residents and the residents' conditions change .The interdisciplinary team must review and update the care plan. Resident #57 had diagnoses which included chronic obstructive pulmonary disease with acute exacerbation and acute and chronic respiratory failure with hypoxia. Resident #57's care plan documented focus: the resident had a physician's order for unsupervised self-administration of the following medications: Albuterol sulfate, date initiated 06/13/22, revision date 06/13/22. It documented goal: Resident #57 would take medications safely as prescribed through the review date, date initiated 06/13/22, revision on 12/13/24. The interventions listed for this care plan goal were dated 06/13/22. The most recent Medication Self Administration Safety Screen form for Resident #57 was dated 06/13/22. A Physician Order, dated 09/10/24, documented ipratropium-albuterol inhalation solution (bronchodilator) 0.5-2.5 3MG/3ML one application inhale orally every six hours as needed for shortness of breath. There was no recent medication self-administration safety screen for Resident #57 to self-administer medications in the resident's clinical record. There was no physician's order to self-administer medications in the resident's clinical record. On 01/14/25 at 8:32 a.m., Resident #57 was observed seated on the side of their bed with a nebulizer mask on and the machine running. The resident stated they did breathing treatments once every six hours. They stated staff gave it to them and they did not keep the medication in their room. On 01/14/25 at 8:33 a.m., Resident #57 stated they turned the nebulizer machine off themselves. There was liquid observed in the canister of the nebulizer the resident had on their face. There was no staff observed in the room with the resident while the machine was running. On 01/14/25 at 8:59 a.m., RN #1 stated Resident #57 received a duoneb once on their shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 9:00 a.m., RN #1 stated Resident #57 had not been evaluated to their knowledge to self-administer medications. They stated they stayed with the resident the whole time during a breathing treatment. On 01/14/25 at 1:55 p.m., the DON stated staff were to watch residents when administering a nebulizer treatment and give them instructions on how to do it. The administrator stated staff were to stay with them the entire treatment. The administrator stated staff were not to leave the resident and were to ensure the tubing was dated properly and changed. On 01/14/25 at 1:56 p.m., the administrator stated there were no residents in the facility with orders to self-administer medications. On 01/17/25 at 8:33 a.m., MDS coordinator #1 stated they would first develop a baseline care plan when a resident admitted to the facility. They stated they completed an admission MDS to know what CAAs triggered. MDS Coordinator #1 stated they would then create a care plan off of the CAAs and anything extra such as diagnoses and medication classification. On 01/17/25 at 8:35 a.m., MDS coordinator #1 stated they tried to go through the 24 hour reports daily and wrote down any significant things that happened such as falls to capture them. They stated after completing quarterly MDS assessments, they would update care plans as a whole. On 01/17/25 at 8:37 a.m., MDS coordinator #1 reviewed Resident #57's care plan for self- administration of medications and stated they obtained the information for the care plan based off of a self-administration assessment completed for Resident #57. MDS Coordinator #1 stated Resident #57 had a self-administration assessment completed on 06/13/22, and they did not see an order for the resident to self-administer medications for this care plan. MDS Coordinator #1 stated staff did complete an assessment and obtain an order now, but they could not locate any before 01/14/25.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35389 Based on observation, record review, and interview, the facility failed to ensure: a. wound care was provided as ordered for two (#12 and #57); b. care was coordinated for a non pressure wound for one (#12); c. an order was obtained prior to providing wound care to a resident's wound for one (#12); d. the nurse was notified when the dressing of a wound became dislodged for one (#12); e. staff documented changes in the resident's skin before leaving for the day for one (#12); and f. treatment orders were obtained at the time a new wound was identified for one (#12) of four sampled residents reviewed for non pressure skin conditions. This resulted in actual harm when Resident #12's left gluteal fold wound increased in size after the facility failed to provide treatment as ordered. The administrator identified 114 residents resided in the facility. The DON identified 10 residents with non pressure wounds resided in the facility. Findings: A Wound Care policy, revised 10/2010, read in parts, Verify that there is a physician's order for this procedure .The following information should be recorded in the resident's medical record .They type of wound care given .The date and time the wound care was given .The name and title of the individual performing the wound care .Any change in the resident's condition .All assessment data .obtained when inspecting the wound If the resident refused the treatment and the reason .The signature and title of the person recording the data. 1. Resident #12 had diagnoses which included vasculitis, MASD to the left gluteal fold, full thickness friction/ shear wound of right thigh, bipolar disorder, and schizoaffective disorder. A Physician Order, dated 12/19/24, documented to cleanse left gluteal fold with ns, pat dry, apply calcium alginate, cover with dry dressing daily and prn. The above order did not transfer onto the December 2024 or January 2025 MAR/TAR. There was no documentation this gluteal fold wound care was provided in December 2024 or January 2025. A Wound Progress Note, dated 01/02/25, documented the resident had, a. partial thickness vasculitis wound to their right lower leg that measured 13.5cm length x 4cm width x 0. 1cm depth, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b. a partial thickness vasculitis wound to their left lower leg that measured 0.7cm length x 0.7cm width x 0. 1cm depth, and c. full thickness MASD to their left gluteal fold that measured 0.4cm length x 0.3cm width x 0.1cm depth. A Wound Progress Note, dated 01/09/25, documented the resident had, a. partial thickness vasculitis wound to their right lower leg that measured 19.5cm length x 7cm width x 0. 1cm depth, b. partial thickness vasculitis wound to their left lower leg that measured 12.5cm length x 2cm width x 0.1cm depth, c. full thickness MASD to their left gluteal fold that measured 3cm length x 2cm width x 0.1 cm depth, and d. full thickness friction/shear to their right thigh (initial encounter) that measured 1.5cm length x 2cm width x 0.1cm depth. The note did not document the resident had any wounds to their feet. The note was signed by the wound NP. A Physician Order, dated 01/09/25, documented to cleanse bilateral lower leg with ns, pat dry, apply xeroform, ABD pad, and rolled gauze wrapped loosely daily and prn. A Physician Order, dated 01/09/25 with a start date 01/11/25, documented right inner thigh: cleanse with ns, pat dry, apply xeroform to wound bed, cover with dry dressing Tuesday, Thursday, and Saturday. The 24 hour report book for Resident #12's hall did not document the new wound to Resident #12's right thigh was communicated. The 24 hour report book did not communicate the wounds to Resident #12's feet were communicated when LPN #2 was made aware of the concern on 01/10/25. A Physician Order, dated 01/14/25, documented to cleanse wounds to bilateral foot with normal saline, pat dry, apply silver alginate to areas with purulent drainage, cover non-purulent area with Vaseline gauze, wrap with rolled gauze, daily and as needed. There was no documentation related to the condition of the resident's wounds to their bilateral feet in the clinical record prior to the surveyor observing wound care on 01/14/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 10:28 a.m., LPN #2 entered Resident #12's room to provide wound care. LPN #2 was observed telling Resident #12 I can't touch your feet until wound care looks at it Thursday. Resident #12 was observed with dressings to her bilateral feet. There was no date observed on the dressings. LPN #2 stated it was their fault, and that they had completed the dressing change on 01/13/25 with the hospice nurse. LPN #2 stated they could not touch the resident's feet until wound care evaluated them. LPN #2 stated hospice did not want them to be messed with until they were evaluated. There was no dressing observed on Resident #12's left leg. LPN #2 stated it was supposed to be there. LPN #2 stated stated it was there yesterday. On 01/14/25 at 10:38 a.m., Resident #12 was observed with dressings to their bilateral feet. There was a red brown soilage observed on the underside of the resident's left foot. 01/14/25 at 10:51 a.m., LPN #2 stated the wound care to Resident #12's lower legs were to be completed every morning. LPN #2 stated the wounds would go back and forth with healing. LPN #2 stated the resident's skin was very thin. On 01/14/25 at 10:54 a.m., LPN #2 stated it was their understanding the hospice shower aide took Resident #12's sock off and the skin came off the left foot. LPN #2 stated both feet were just kind of raw and really flaky. They stated staff had been putting Aquaphor on the resident's legs for months. LPN #12 stated the issue with the resident's feet occurred Friday 01/10/25. They stated they received an order to treat the feet yesterday (01/13/25) to put silver alginate and xeroform on it. LPN #2 stated the order came from hospice, and LPN #2 helped the hospice nurse with dressing the resident's feet yesterday. LPN #2 stated hospice did not want Resident #12's feet messed with until the wound doctor could evaluate them. LPN #2 stated the undated dressings had been on the resident's feet since yesterday. LPN #2 was asked about the soilage on the resident's left foot dressing. LPN #2 stated they could change it and let hospice know they had to change it. LPN #2 stated hospice had cultured the wounds yesterday. LPN #2 stated when the hospice aide had removed Resident #12's sock, they stated the resident's skin stuck to the sock. LPN #2 stated it was just the top layer of the resident's foot like a flesh wound. LPN #2 stated they cleaned the area with normal saline, and yesterday when they were looking at it, there was some on the bottom as well. LPN #2 stated on Friday they had cleaned the area and covered it with a four by four. LPN #2 was asked if the doctor was notified and was an order received for the wound care they provided to this area on Friday. LPN #2 stated they texted the resident's hospice but, I don't know if they came out because it happened at 2:45 3:00 o'clock. There was no documentation an order was obtained to provide wound care to the resident's feet until 01/13/25. On 01/14/25 at 11:05 a.m., LPN #2 stated they were not aware of a wound on the resident's right inner thigh. LPN #2 looked in the computer and stated they did need to complete wound care to the resident's right thigh. LPN #2 stated the order had come in on the 11th and that was the reason they did not see it because it was for Tuesdays, Thursdays, and Saturdays. LPN #2 stated today was the first day they would be doing it. They stated usually staff wound report changes related to residents during shift change and wound document it in the report book as well. LPN #2 stated no one had reported this wound to them. On 01/14/25 at 11:07 a.m., LPN #2 walked over to the report book, flipped through the 24 hour report sheets, and stated staff did not document the new wound to the resident's right inner thigh in the book. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 11:08 a.m., LPN #2 stated they knew Resident #12 had a wound to the left gluteal fold in the past, but it had healed. LPN #2 stated they saw the order in the resident's record, but it was not showing up on the MAR to complete. LPN #2 stated the wound care to the left gluteal fold was supposed to be completed every day shift. LPN #2 stated the last time they had completed wound care to the area would have been in December. On 01/14/25 at 11:13 a.m., LPN #2 stated ADON #1 made wound rounds with the wound team and would let staff know if there were changes. They stated ADON #1 would also put new orders in for the wound care when needed. On 01/14/25 at 11:16 a.m., LPN #2 stated the wound NP measured resident wounds weekly on Thursdays. On 01/14/25 at 12:33 p.m., Resident #12 was observed in the main dinging area seated in their wheelchair. There was bright red soilage observed on the resident's left foot that continued over the lateral side. On 01/14/25 at 12:36 p.m., LPN #2 stated they would see if the resident would allow a dressing change to their feet after lunch. They stated there were activities from two to four the resident would not want to miss. On 01/14/25 at 1:09 p.m., the DON stated apparently Resident #12 had a stage two pressure ulcer that resolved on the left gluteal fold. The DON stated then the left gluteal fold wound came back. They stated when staff put the new order in, they put it under TAR and marked no documentation required. The DON stated the wound care had been being done, but they had no documentation to support this. The DON stated from 12/19/24 to present, there was no documentation the wound care was completed on the TAR. The DON stated there was no documentation the wound care was provided. On 01/14/25 at 2:03 p.m., ADON #1 stated if a resident experienced a change in their skin condition, staff would notify ADON #1 or get an order from the wound care NP. ADON #1 stated if staff let them know, they would notify the wound care NP. On 01/14/25 at 2:04 p.m., ADON #1 stated they made rounds with the wound care NP weekly on Thursday. On 01/14/25 at 2:05 p.m., ADON #1 stated whoever rounded with the wound care provider was responsible for putting the new orders in. On 01/14/25 at 2:06 p.m., ADON #1 stated the nurses on the floor were responsible for providing wound care. ADON #1 stated when there were changes, they would put the order into the electronic record, and then printed the new order out, and placed it at the nurses' station. On 01/14/25 at 2:09 p.m., ADON #1 stated the left gluteal fold was MASD and the right thigh was a shear wound. They stated the gluteal fold was to receive wound care daily and the right thigh was Tuesdays, Thursdays and Saturdays. On 01/14/25 at 2:12 p.m., ADON #1 stated they were off when the left gluteal fold wound care started on 12/19/24. They stated the staff member had put it in without requiring documentation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 2:14 p.m., ADON #1 stated the wound care NP saw the resident on 01/09/25 and started wound care for the resident's left thigh. On 01/14/25 at 2:15 p.m., ADON #1 stated they should have put the new wound on the report sheet. On 01/14/25 at 2:29 p.m., Resident #12 was observed in the main dining area with a red tinged dressing present to their left foot. Resident #12 did not permit the dressing change to their feet prior to the surveyors leaving on 01/14/25. On 01/15/25 at 10:08 a.m., LPN #2 stated they did not document the findings of Resident #12's skin to their feet after the event involving the hospice aide removing the resident's socks and the skin coming off. LPN #2 stated they were on their way out and forgot to put a note it. LPN #2 stated they remembered what the feet looked like, but they did not put a note in at the time. LPN #2 stated they put a note in yesterday because their supervisor had informed them they did not document it, so they completed a late entry. On 01/15/25 at 10:14 a.m., LPN #2 stated they were a new nurse and might have the policy wrong. They stated to their understanding they were supposed to contact the hospice nurse to get orders from them. LPN #2 stated with wounds they usually told the hospice nurse and they usually told ADON #1. They stated on Friday they were running out of the facility and it was their fault. They stated normally on wounds they would tell ADON #1 and they would contact the wound care doctor. LPN #2 stated on Friday, they dropped the ball. LPN #2 stated the wound was superficial and there was nothing on the bottom. On 01/15/25 at 12:14 p.m., LPN #2 and CNA #4 turned Resident #12 to their right side for wound care. There was no dressing present to the resident's left gluteal fold. LPN #2 stated, There is not even a bandage on it, so it probably came off when they changed it. LPN #2 stated normally when a bandage came off, staff would inform the nurse so they could replace it. LPN #2 stated they were not informed the bandage had come off. On 01/15/25 at 12:16 p.m., Resident #12's left gluteal fold was observed to have an open area with red beefy skin present with light pink tissue surrounding the edges of the wound. The wound appeared to be approximately a half dollar in size. On 01/15/25 at 12:19 p.m., LPN #2 placed the 2 inch x 2 inch calcium alginate dressing over the left gluteal fold wound which barely covered the edges of the wound. On 01/15/25 at 12:27 p.m., the DON stated they would have to get the facility policy for what do do if staff identified a change in the resident's skin. On 01/15/25 at 1:14 p.m., the DON chose for the surveyor to ask policy questions in the presence of the regional clinical director, the administrator, the regional nurse. On 01/15/25 at 1:16 p.m., the regional clinical director stated if a resident had a brand new wound, the staff wound notify the provider. They stated if the resident was an established wound care provider patient, they would call and notify them. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/15/25 at 1:18 p.m., the regional clinical director stated if the resident was a hospice resident and there was a change in the resident's skin, they would notify the hospice provider or nurse. On 01/16/25 at 8:11 a.m., the wound NP stated they came every Thursday and saw Resident #12. They stated the resident was paralyzed and stiff with a lot of autoimmune issues like vasculitis on their lower legs. They stated the leg wounds responded well to xeroform. They stated the resident had a suprapubic catheter that did not always fit well and contributed to MASD in the folds and buttocks. They stated staff had a difficult time turning the resident. They stated the buttock wounds usually healed rather quickly. They stated they believed the left gluteal fold was treated with calcium alginate and an ABD and was changed they believed three times a week, but probably more due to wetness. They stated the resident was recently put back on hospice. They stated before they left on Thursdays, a spread sheet was provided to the facility related to wounds. On 01/16/25 at 8:17 a.m., the wound NP stated they believed the resident's catheter had rubbed their right thigh causing the wound. The wound NP stated the resident did refuse wound care at times and the resident had the right to do so. The wound NP reviewed the measurements of the gluteal fold and stated it had gotten worse when comparing the last two weeks. On 01/16/25 at 8:20 a.m., the wound NP stated they spoke with ADON #1 on Tuesday who reported the resident had broke out with one between the toes. The wound NP stated they believed hospice had given them orders and they took a culture due to purulent drainage. On 01/16/25 at 8:26 a.m., the wound NP stated if staff did not provide wound care are ordered, the wounds would get much worse. They stated they had previously debrided the resident's legs to help with the vasculitis. 2. Resident #57 had diagnoses which included chronic pain syndrome and anxiety disorder. A Physician Order, dated 01/09/25, documented to cleanse posterior left shoulder with normal saline, pat dry, apply calcium alginate to wound bed, cover with dry dressing one time a day for wound care. The January 2025 TAR documented wound care to the resident's left shoulder was not provided on Sunday 01/12/25. 01/09/25 at 11:14 a.m., Resident #57 stated they recently had a suspicious mole removed from their shoulder. They stated staff were supposed to clean and dress the wound every day. Resident #57 stated their dressing change did not always happen as ordered. They stated last weekend it was not changed Saturday or Sunday. On 01/14/25 at 8:53 a.m., RN #1 was observed removing a dressing from Resident #57's left shoulder. There was an approximately dime sized wound with minimal yellow drainage observed. The wound had a pink center with white outer edges. On 01/14/25 at 8:57 a.m., RN #1 stated Resident #57 had a history of skin cancer. They stated the resident had an appointment with the dermatologist approximately 15 days ago and they removed an area to the resident's left shoulder. RN #1 stated there was an order for wound care until the area was resolved. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 8:58 a.m., RN #1 stated Resident #57's wound care was provided daily. On 01/21/25 at 11:10 a.m. ADON #1 stated staff would document wound care was provided in progress notes. ADON #1 reviewed Resident #57's January 2025 TAR for the blank on the 12th and stated apparently staff did not mark it. They stated, I don't know if they didn't do it. On 01/21/25 at 2:11 p.m., the DON stated if the wound care area for documentation was blank, if staff did not write a note and it was not documented, it was not done.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35389 Based on record review and interview, the facility failed to ensure wound care was provided as ordered for one (#17) of two sampled residents reviewed for pressure ulcers. ADON #2 identified three residents with pressure ulcers resided in the the facility. Findings: A Pressure Ulcers/Skin Breakdown policy, revised 04/2018, read in parts, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings .and application of topical agents. Resident #17 had diagnoses which included an unstageable pressure injury to the left heel and a deep tissue pressure injury to the right lateral heel. A Physician Order, dated 10/26/24, documented to cleanse left heel with ns, pat dry, apply santyl to wound bed, cover with calcium alginate, apply ABD pad, and wrap with rolled gauze and tape daily and PRN for soilage. A Physician Order, dated 12/20/24, documented to cleanse right lateral heel with ns, pat dry, apply calcium alginate to wound bed, cover with ABD pad, secure with tape daily and PRN. A Wound Progress Note, dated 12/26/24, documented Resident #17 had an unstageable pressure injury to the left heel and a stage three pressure injury to the right lateral heel. The December 2024 TAR did not document the treatment to the right lateral heel or left heel was completed on the 31st. A Physician Order, dated 01/02/25, documented to cleanse right lateral heel with ns, pat dry, apply Betadine BID and PRN. A Wound Progress Note, dated 01/09/25, documented Resident #17 had an unstageable pressure injury to the left heel and a deep tissue pressure injury to the right lateral heel. A Physician Order, dated 01/16/25, documented to cleanse right heel with normal saline pat dry, apply Betadine to area BID and PRN. The January 2025 TAR did not document the treatment was completed to the left heel on the 6th, the right lateral heel on the day shift of the 6th, or the right heel on the evening shift of 18th. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/21/25 at 5:40 p.m., ADON #1 was identified as familiar with Resident #17's wounds. ADON #1 stated Resident #17 had a left heel unstageable wound that was grafted last week. They stated the resident had poor circulation in their legs. ADON #1 stated the resident had a little spot on their outer right foot by the heel from a deep tissue injury. ADON #1 stated due to the recent graft, staff were to change the outer dressing on the left daily and PRN. They stated the right had a treatment of Betadine daily and leave open to air. ADON #1 stated wound care was documented in the TAR. On 01/21/25 at 5:46 p.m., ADON #1 reviewed the January 2025 TAR and stated the blanks on the 6th for the left heel the staff did not Click it off. ADON #1 stated, I'm hoping they did it. They stated it was the same for the right heel on the 6th and 18th. They stated, It doesn't look like it was done because it wasn't clicked off. On 01/21/25 at 5:48 p.m., ADON #1 reviewed the December 2024 TAR and stated the left and right heel on the 31st was red. ADON #1 stated, They probably didn't do it.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35389 Based on observation, record review, and interview, the facility failed to ensure qualified staff were present during medication administration for one (#57) of one sampled resident observed self-administering a medication. The administrator identifed no residents with orders to self-administer medications resided in the facility. Findings: An Administering Medications policy, revised 04/2019, read in parts, Medications are administered in a safe and timely manner, as prescribed .Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so .Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Resident #57 had diagnoses which included chronic obstructive pulmonary disease with acute exacerbation and acute and chronic respiratory failure with hypoxia. A Physician Order, dated 09/10/24, documented ipratropium-albuterol inhalation solution (bronchodilator) 0.5-2.5 3MG/3ML one application inhale orally every six hours as needed for shortness of breath. There was no physician's order to self-administer medications in the resident's clinical record. On 01/14/25 at 8:32 a.m., Resident #57 was observed seated on the side of their bed with a nebulizer mask on and the machine running. The resident stated they did breathing treatments once every six hours. They stated staff gave it to them and they did not keep the medication in their room. On 01/14/25 at 8:33 a.m., Resident #57 stated they turned the nebulizer machine off themselves. There was liquid observed in the canister of the nebulizer the resident had on their face. There was no staff observed in the room with the resident while the machine was running. On 01/14/25 at 8:59 a.m., RN #1 stated Resident #57 received a duoneb once on their shift. On 01/14/25 at 9:00 a.m., RN #1 stated Resident #57 had not been evaluated to their knowledge to self-administer medications. They stated they stayed with the resident the whole time during a breathing treatment. On 01/14/25 at 1:55 p.m., the DON stated staff were to watch residents when administering a nebulizer treatment and give them instructions on how to do it. The administrator stated staff were to stay with them the entire treatment. The administrator stated staff were not to leave the resident and were to ensure the tubing was dated properly and changed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 1:56 p.m., the administrator stated there were no residents in the facility with orders to self-administer medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on observation and interview, the facility failed to ensure the low temperature dishwasher had the appropriate amount of chemicals to sanitize dishes for three of four observations of dishwasher chemical sanitization level checks. ADON #1 identified 112 residents ate meals from the kitchen. Findings: An undated Dishwashing by Use of a Machine policy, read in part, check the machine during each procedure to determine if detergent, wetting agent, and chemical sanitizer is being dispensed properly. On 01/07/25 at 7:49 a.m., the DM measured the chemical sanitizer in the dishwasher and it did not register on the chemical strip. The DM realized the sanitizer was empty and added about two gallons to the five gallon bucket attached to the dishwasher. They then primed the dishwasher several times and was still unable to get a reading on the chemical strip. They stated the chemical strip should register between 50 parts per million of chloride (ppm) and 100 ppm. They stated they had not checked it this morning, but last night it was fine. They stated they were going to call the dishwash company to have them come check it. They stated they could sanitize dishes in the sink. On 01/07/25 at 11:30 a.m., staff were observed continuing to use the dishes that were ran through the low temperature dishwasher. They were not sanitizing the dishes in the sink. On 01/07/25 at 11:39 a.m., the DM tried different strips due to realizing the correct strips that maintenance had provided. Those strips were for [NAME] chloride checking and registered at 1ppm. The highest number they checked for was 20 ppm. They stated they did realize the [NAME] strips could not be used to check for appropriate amounts of chloride required to sanitize dishes. On 01/07/25 at 11:45 a.m., both the maintenance director and administrator were made aware that the [NAME] strips were not appropriate to check for chloride levels in a low temperature dishwasher. On 01/08/25 at 10:36 a.m., the DM once again checked with different chemical strips provided by the maintenance director. Those chemical strips were also not able to appropriately check for proper chloride ppm for a low temp dishwasher. On 01/08/25 at 10:43 a.m., the administrator was informed that it had now been over 24 hours of using a low temperature dishwasher without being able to check for proper sanitization. They stated they would shut down the dishwasher and use paper products until the dishwasher was fixed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35389 Based on observation, record review, and interview, the facility failed to ensure medical records were accurately documented for one (#57) of 26 sampled residents reviewed for medical record accuracy. The administrator identified 114 residents resided in the facility. The DON identified 10 residents with non pressure wounds resided in the facility. Findings: A Charting and Documentation policy, revised 07/2017, read in parts, Documentation in the medical record will be objective .complete, and accurate. Resident #57 had diagnoses which included chronic pain syndrome and anxiety disorder. A Physician Order, dated 12/09/24, documented weekly skin assessment on Tuesday on the evening shift, place under skin assessment for skin integrity. A Physician Order, dated 01/09/25, documented to cleanse posterior left shoulder with normal saline, pat dry, apply calcium alginate to wound bed, cover with dry dressing one time a day for wound care. Two Skin Assessment by Charge Nurse records, both dated 01/14/25, documented Resident #57 had no open areas. One of the assessments was completed by LPN #3. 01/09/25 at 11:14 a.m., Resident #57 stated they recently had a suspicious mole removed from their shoulder. They stated staff were supposed to clean and dress the wound every day. On 01/14/25 at 8:53 a.m., RN #1 was observed removing a dressing from Resident #57's left shoulder. There was an approximately dime sized wound with minimal yellow drainage observed. The wound had a pink center with white outer edges. On 01/14/25 at 8:57 a.m., RN #1 stated Resident #57 had a history of skin cancer. They stated the resident had an appointment with the dermatologist approximately 15 days ago and they removed an area to the resident's left shoulder. RN #1 stated there was an order for wound care until the area was resolved. On 01/14/25 at 8:58 a.m., RN #1 stated Resident #57's wound care was provided daily. On 01/17/25 at 8:46 a.m., LPN #3 stated the process of completing the skin assessment by the charge nurse was to go look the resident over. They stated they would look for lumps, bumps, bruises, and skin tears. They stated they would take the information and put it into the skin assessment sheet. LPN #3 stated if the resident was all there, they would ask the resident if they had any open areas. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/17/25 at 8:49 a.m., LPN #3 stated they had completed the skin assessment for Resident #57 on 01/14/25. They stated they had given the resident a score of 22 and documented no open areas. LPN #3 reviewed the resident's orders and stated the resident was being treated for a wound on their left shoulder. On 01/17/25 at 8:54 a.m., the DON stated whatever nurse completed the skin assessment would complete the documentation. They stated they would also send a text to ADON #1 so they could go and assess the wound. They stated ADON #1 was who made rounds with the wound care team. The DON stated to see if it was accurately documented was subjective because it was what the staff saw and recorded. The DON stated staff charted what they saw.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review, and interview, the facility failed to ensure: a. wound care was provided in a manner to prevent cross contamination for two (#12 and #57) of three sampled residents observed for wound care; b. a urinary catheter was stored in a manner to prevent cross contamination for one (#12) of one sampled resident observed with a urinary catheter; and c. infection control logs were completed for five (#22, 25, 54, 81, and #86) of five sampled residents reviewed for staph infections. The administrator identified 114 residents resided in the facility. The DON identified 10 residents with non pressure wounds, two residents with staph infections, and two residents with urinary catheters resided in the facility. Findings: A Handwashing/Hand Hygiene policy, revised 08/2019, read in parts, This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Hand hygiene products and supplies .shall be readily accessible .Use alcohol-based hand rub .before moving from a contaminated body site to a clean body site during resident care. An Infection Prevention and Control Program policy, dated 2023, read in part, A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases of all residents. 1. Resident #12 had diagnoses which included vasculitis, MASD to the left gluteal fold, full thickness friction/ shear wound of right thigh, bipolar disorder, and schizoaffective disorder. A Physician Order, dated 06/15/24, documented to change foley catheter every month on the day shift on the 15th. A Wound Progress Note, dated 01/09/25, documented the resident had, a. partial thickness vasculitis wound to their right lower leg that measured 19.5cm length x 7cm width x 0. 1cm depth, b. partial thickness vasculitis wound to their left lower leg that measured 12.5cm length x 2cm width x 0.1cm depth, c. full thickness MASD to their left gluteal fold that measured 3cm length x 2cm width x 0.1cm depth, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. full thickness friction/shear to their right thigh (initial encounter) that measured 1.5cm length x 2cm width x 0.1cm depth. The note was signed by the wound NP. A Physician Order, dated 01/09/25, documented to cleanse bilateral lower leg with ns, pat dry, apply xeroform, ABD pad, and rolled gauze wrapped loosely daily and prn. On 01/14/25 at 10:21 a.m., LPN #2 was observed getting the following items ready for Resident #12's wound care: rolled gauze, five-five by nine xeroform petroleum dressings, three-five packs of normal saline vials, four by four gauze, a plastic cup, four five by nine ABD dressings and gloves and sat them on the wound care tray. On 01/14/25 at 10:28 a.m., LPN #2 obtained a gown from the cart, entered Resident #12's room, and placed the tray on the bedside table. LPN #2 placed a bag of gloves on the table and opened a biohazard bag and placed it on the bed. LPN #2 donned a pair of gloves and a gown. LPN #2 removed the dressing to the right leg and threw in the biohazard bag. LPN #2 pointed to the resident's left leg that did not have a dressing and stated it was supposed to be there. On 01/14/25 at 10:33 a.m., LPN #2 removed their gloves, obtained keys from their pocket, opened the door, removed their gown, and obtained a bottle of sanitizer from their treatment cart in the hall. LPN #2 sanitized their hands and placed the bottle back in their pocket. LPN #2 donned another gown and gloves. LPN #2 then squirted normal saline on the right leg wound and wiped the wound up and down using the same piece of gauze. LPN #2 then squirted the wound again two more times with saline, and used the same gauze to pat all over the wound back and forth and threw it in the biohazard bag. On 01/14/25 at 10:35 a.m., LPN #2 got more saline, squirted it on the wound, and used a new gauze and wiped all over the wound again. LPN #2 removed their gloves and threw them in the biohazard bag. On 01/14/25 at 10:36 a.m., LPN #2 obtained the bottle of hand sanitizer out of their pocket, used it, then placed it back in their pocket. LPN #2 donned gloves, placed xeroform on the right shin, then ABD pads, then rolled the dressing with rolled gauze and secured it with tape. On 01/14/25 at 10:39 a.m., LPN #2 removed their gloves placed them in the biohazard bag, removed hand sanitizer from their pocket, used the sanitizer, then placed it back in their pocket. On 01/14/25 at 10:40 a.m., LPN #2 got the vial of normal saline, squirted it on the left leg wound, and used gauze to wipe up and down over the same open area back and forth with the same piece of gauze. LPN #2 obtained more saline and another piece of gauze and wiped up the wound and back down the wound with the same piece of gauze. LPN #2 stated they were a new nurse and just got their license in March. On 01/14/25 at 10:41 a.m., LPN #2 removed their gloves, used sanitizer from their pocket, and replaced it in their pocket. On 01/14/25 at 10:42 a.m., LPN #2 donned gloves, placed xeroform on the left leg wound, then ABD pads, then wrapped it with rolled gauze and secured it with tape. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 10:43 a.m., LPN #2 removed their gloves and placed them in the biohazard bag, obtained a pen from their pocket, and attempted to write on the tape on the dressings. The pen would not write, so LPN #2 used a marker of Resident #12's with their bare hands that was located on the bedside table to intital and date both dressings. LPN #2 did not sanitize their hands after wound care before touching the resident's marker. On 01/14/25 at 11:18 a.m., LPN #2 stated staff were to wash their hands before and after they entered a resident room. LPN #2 stated when completing wound care staff would sanitize after changing their gloves, between dirty to clean, and if visibly soiled they would wash them with soap and water. On 01/14/25 at 11:19 a.m., LPN #2 stated they would change their gloves when going from soiled to clean. They stated staff should clean a wound by patting from inner to outer areas. On 01/14/25 at 12:58 p.m., LPN #2 stated they should have placed the hand sanitizer on the table instead of taking it in and out of their pocket. LPN #2 stated they should not have used the resident's pen to write on the dressing. LPN #2 stated they forgot to date the dressing the day before and they panicked. On 01/15/25 at 12:11 p.m., Resident #12's urinary catheter bag was observed on the floor with the plastic valve piece exposed. LPN #2 stated, It's supposed to be on the bed, I'll fix it. On 01/15/25 at 1:19 p.m., the regional clinical director stated urinary catheters were to be placed in a privacy bag, then at a level lower than the bladder. They stated the catheter bag should never be on the floor. On 01/14/25 at 10:38 a.m., Resident #12 was observed with dressings to their bilateral feet. There was a red brown soilage observed on the underside of the resident's left foot. 01/14/25 at 10:51 a.m., LPN #2 stated the wound care to Resident #12's lower legs were to be completed every morning. LPN #2 stated the wounds would go back and forth with healing. LPN #2 stated the resident's skin was very thin. On 01/14/25 at 1:50 p.m., the DON stated for wound care, staff should wash hands prior to getting their supplies set up and whenever wound care was completed. The DON stated staff could sanitize their hands between glove changes. On 01/14/25 at 1:52 p.m., the DON stated staff should change their gloves when going from dirty to clean. The DON stated they should sanitize their hands and change their gloves. On 01/14/25 at 1:53 p.m., the DON stated they would change their gloves and sanitize or wash their hands and put new gloves on after cleaning a wound. The administrator stated on average, staff would need to change their gloves around four times during wound care. The DON stated staff should start at the center and work their way out when cleaning a wound. 2. Resident #57 had diagnoses which included chronic pain syndrome and anxiety disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician Order, dated 01/09/25, documented to cleanse posterior left shoulder with normal saline, pat dry, apply calcium alginate to wound bed, cover with dry dressing one time a day for wound care. The January 2025 TAR documented wound care to the resident's left shoulder was not provided on Sunday 01/12/25. 01/09/25 at 11:14 a.m., Resident #57 stated they recently had a suspicious mole removed from their shoulder. They stated staff were supposed to clean and dress the wound every day. Resident #57 stated their dressing change did not always happen as ordered. They stated last weekend it was not changed Saturday or Sunday. On 01/14/25 at 8:50 a.m., RN #1 entered Resident #57's room and donned a pair of gloves for wound care. On 01/14/25 at 8:51 a.m., RN #1 moved the resident's bedside table with their gloved hands, moved a sheet of wax paper to the resident's bed, opened a 4 inch by 5 inch super absorbent dressing, opened a vial of saline, squirted it on four by four gauze, then opened another saline vial and squirted it on the same four by four gauze. On 01/14/25 at 8:53 a.m., RN #1 opened the calcium alginate 2 inch by 2 inch dressing and removed the old dressing to Resident #57's left shoulder with the same gloved hands. RN #1 threw the old dressing in the trash bag, removed their gloves, and sanitized their hands. There was an approximately dime sized wound with minimal yellow drainage observed. The wound had a pink center with white outer edges. On 01/14/25 at 8:54 a.m., RN #1 donned a new pair of gloves, cleaned the wound three times with saline and gauze, dried the area with gauze, then placed the new calcium alginate and 4 inch by 5 inch super absorbent dressing on the resident's wounds. RN #1 failed to change gloves or wash/sanitize hands after cleaning the wound prior to placing a clean dressing. On 01/14/25 at 8:57 a.m., RN #1 stated Resident #57 had a history of skin cancer. They stated the resident had an appointment with the dermatologist approximately 15 days ago and they removed an area to the resident's left shoulder. RN #1 stated there was an order for wound care until the area was resolved. On 01/14/25 at 8:58 a.m., RN #1 stated Resident #57's wound had not experienced an infection and was improving. On 01/14/25 at 9:02 a.m., RN #1 stated staff were to use hand sanitizer between resident care as long as they were not visibly soiled. They stated they usually washed their hands about the third use. RN #1 stated they used gloves for everything. On 01/14/25 at 9:03 a.m., RN #1 stated for changing gloves, they would remove gloves prior to coming out of a resident's room. They stated as far as during a procedure, they would take multiple gloves in the room and discard them when they got dirty and put on clean gloves like they did during wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 9:04 a.m., RN #1 stated usually they would change gloves after cleaning a wound before placing the clean dressing on. 3. A State Reportable Incident form, dated 12/12/24, documented the facility had experienced a staph infection outbreak and cultures were completed. It documented the outbreak included Residents #22, 25, 54, 81, and #86. The December 2024 infection control log contained the following entries, a. Resident #25 admitted ,d+[DATE] onset date skin, the site section was blank, infection related diagnoses skin, culture no, the organism section was blank, the date resolved section was blank, b. Resident #54 admitted ,d+[DATE], onset date skin, the site section was blank, infection related diagnoses wound, culture 12/19, the organism section was blank, the date resolved documented EBP, c. Resident #86 admitted ,d+[DATE], onset date skin, infection related diagnoses wound, culture 12/20, the organism section was blank, the date resolved section was blank, d. Resident #81 admitted ,d+[DATE], onset date skin, infection related diagnoses wound, culture 12/26, the organism section was blank, the date resolved section documented EBP, and e. Resident #22 admitted ,d+[DATE], onset date skin, infection related diagnoses wound, organism hosp, date resolved EBP. The facility map for infections for December 2024 did not identify organisms of infection to identify a trend. On 01/16/25 at 1:39 p.m., ADON #1 stated when a resident was placed on an antibiotic, they would put the information in antibiotic book and an infection screening would be completed. On 01/16/25 at 1:43 p.m., ADON #1 stated they would identify a trend occurred if two or three people had the infection. The DON stated if they had the same organism and how it was transmitted, the facilty would take the steps to address the transmission throughout all departments. On 01/16/25 at 1:45 p.m., the DON stated if a trend was identified, the facility would put a plan in place to disrupt the transmission. The DON stated the staff would be inserviced related to the outbreak. On 01/16/25 from 1:57 p.m. through 2:12 p.m., ADON #1 reviewed the facilty infection control log for December 2024. ADON #1 stated it was not completed accurately. ADON #1 stated the dates under the admitted should have been under the onset date. ADON #1 stated the information under the onset date should have been under the site. ADON #1 stated Residents # 22, 25, 54, 81, and #86's logs did not document the organism or the date resolved. On 01/16/25 at 2:16 p.m., the DON stated the map should include the organism of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/16/25 at 2:18 p.m., the DON stated the map for December 2024 did not identify the organism. The DON stated it should have shown organisms such as staph and ecoli instead of just documenting skin for the infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure the facility antibiotic stewardship program was implemented for one (#25) of five sampled residents reviewed for staph infections. The DON identified two residents with a current staph infection resided in the facility. Findings: A facility Antibiotic Stewardship- Orders for Antibiotics policy, revised 12/2016, read in parts, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program .If an antibiotic is indicated, prescriber will provide complete antibiotic orders including the following elements .Indication for use .Appropriate indications for use of antibiotics include .Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). Resident #25 had diagnoses which included schizoaffective disorder, bipolar type, and unspecified open wound, right ankle. A Physician Order, start date 12/12/24, documented clindamycin (antibiotic medication) oral capsule 300 mg give one capsule by mouth every 12 hours for skin infection for seven days. The December MAR documented the last dose of this medication was administered to Resident #25 on the 19th at 8:00 a.m. A Wound Progress Note, dated 12/19/24, documented Resident #25 was evaluated by the wound NP for a readmission and wound consultation. It documented the resident was seen for a wound on the right lateral ankle. It documented the periwound skin did not exhibit signs or symptoms of infection. A Wound Progress Note, dated 12/26/24, documented Resident #25 was evaluated by the wound NP for a wound on the right lateral ankle. It documented the periwound skin did not exhibit signs or symptoms of infection, and the wound was improving. A Physician Order, dated 12/26/24, documented clindamycin oral capsule 300 mg give one capsule by mouth four times a day for wound care for 10 days. The January 2024 MAR documented the last dose of this medication was administered to Resident #25 on the 4th at 8:00 p.m. The December 2024 facility infection control log documented Resident #25 had an infection on their skin and was treated with clindamycin. It documented no under the culture section. It documented admitted , d+[DATE], onset date skin, and infection related diagnosis skin. The form did not contain a date the infection was resolved or the organism present. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound Progress Note, dated 01/02/25, documented Resident #25 had a new wound to right medial lower leg. It documented the right lateral ankle was a partial thickness staph infection and the right medial lower leg was a partial thickness staph infection. It documented the periwound skin of both wounds did not exhibit signs or symptoms of infection. It documented the resident was currently being administered clindamycin for a staph infection. On 01/16/25 at 8:27 a.m., the wound NP stated staff would gown and glove for residents with chronic wounds. They stated if they suspected staph, they would gown and glove immediately. They stated the facility had experienced several residents with a staph infection located all over the building. They stated if a resident had a staph infection , the area had to be covered. They stated if the area was draining, they would try to keep the resident in their room. The wound NP stated as long as there was no visible drainage, the dressing contained the wound. The wound NP stated two of the residents did have the same type of staph infection. They stated they spoke with the facility to determine possible common denominators among the residents. They stated the areas narrowed down were the couch and the coffee machine which the facility addressed by cleaning. The wound NP stated there was a resident with a staph infection who this would not have applied to as the resident did not hang out with other residents. The wound NP stated staff were educated on the importance of washing their hands and gowning up. The wound NP stated they felt the infection was contained very quickly. On 01/16/25 at 10:59 a.m., the DON was asked for Resident #25's laboratory results for the staph infection they received treatment for. On 01/16/25 at 11:29 a.m., the DON stated there was no laboratory results for Resident #25's staph infection. The DON stated the wound NP stated it was staph and treated it. The DON stated the wound NP did not culture it. The DON was asked how they knew what antibiotic to use if they did not complete a culture. The DON stated because that was what the provider said. The DON stated the process when staff thought a resident might need antibiotic therapy was to call the doctor if they had a suspected UTI. The DON stated the doctor would either order labs or order a broad spectrum antibiotic. The DON stated on wounds, they usually cultured them. On 01/16/25 at 1:37 p.m., the DON stated they were the IP for the facility, however, they stated ADON #1 was responsible for tracking infections in the facility. The DON stated they were starting to take over the position of tracking infections, but the facility was in a transition process. On 01/16/25 at 2:01 p.m., ADON #1 reviewed the December 2024 infection control log and stated Resident #25's infection onset date was 12/12 for a skin infection. ADON #1 stated there was no culture completed, the organism section was blank, and the date resolved was blank. ADON #1 stated the infection had resolved on 01/09/25 and it was on a different form. Both ADON #1 and the DON stated the facility knew the resident had an infection from the provider.