STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375556	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Manor Nursing Home	2416 West 51stsouth Tulsa, OK 74107

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46703 Based on record review and interview, the facility failed to ensure a care plan was reviewed for one (#21) of one sampled resident reviewed for care plans. The administrator identified 73 residents resided in the facility. Findings: Resident #21 was admitted on [DATE] with diagnoses which included pressure ulcer of the sacral region, stage four. On 09/05/24 at 1:00 p.m., Resident #21's clinical record was reviewed. There was no documentation of a wound or wound care. On 09/05/24 at 2:38 p.m., MDS coordinator #1 stated there was no documentation of wound care on Resident #21's care plan, dated 07/17/24. They thought they had added it but had not.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35474 Based on observation, record review, and interview, the facility failed to ensure treatments provided for non-pressure wounds had been ordered by the physician for one (#4) of two sampled residents who were reviewed for wound care. The DON identified five residents who had non-pressure wounds in the facility. Findings: The Pressure Ulcers/Skin Breakdown - Clinical Protocol policy, dated 2021, read in part, .The physician will authorize pertinent orders related to wound treatments . Resident #4 had diagnoses which included non-pressure wound of the right third toe and non-pressure wound of the left second toe. The Care Plan, dated 08/07/24, documented the resident had wounds to their toes on their bilateral feet and to provide treatments per the current physician orders. The Wound Evaluation and Management Summary by the wound physician, dated 08/15/24, documented the resident had a non-pressure wound of the left third toe. The Wound Evaluation and Management Summary by the wound physician, dated 08/22/24, documented the resident had a non-pressure wound of the left third toe which had resolved. The Weekly Skin Condition Report, dated 08/23/24, read in part, .Has several places on toes on bilateral feet that are scabbed over. Applying Betadine daily . The report was completed by LPN #1. The Weekly Pressure Ulcer QI Logs, for August 2024, documented the resident had an unstageable area to the right great toe. The Weekly Skin Condition Report, dated 09/02/24, documented the resident did not have any skin breakdown. The report was completed by LPN #1. On 09/03/24 at 10:06 a.m., the resident was observed in the living room. The resident's white sock on the right foot was observed to have a pink-tinged area above the second and third toes. On 09/03/24 at 10:23 a.m., LPN #1 stated the discolored area on the sock was from the Betadine applied to the resident's toe. Review of the physician's orders dated 09/01/24 through 09/03/24 did not reveal any wound care orders. The Wound Evaluation and Management Summary by the wound physician, dated 09/05/24, documented the resident had a non-pressure wound of the left second toe and a non-pressure wound of the right third toe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 11:46 a.m., LPN #1 stated the resident had a couple of new wounds on their toes and Betadine was being applied. LPN #1 stated they had been putting Betadine on the newly identified areas since they had discovered them around 08/26/24 through 08/28/24. LPN #1 stated they had not obtained orders or notified the wound physician they had been treating the new wounds with Betadine because they knew that is what the wound physician would order. On 09/05/24 at 1:52 p.m., LPN #1 stated when the staff identified a new wound they were to complete an initial assessment, document in the progress notes and on the wound log, notify the DON, and obtain orders from the physician. They stated they had not notified the wound physician about the new wound they had identified for Resident #4 because they were going to consult with them on 08/29/24 when they did weekly rounds. LPN #1 stated they were off work the day the wound physician made rounds so they had not obtained treatment orders for the areas. They stated they should have documented in the progress notes and wound log but they had not completed any documentation. They stated they had not notified the DON since they were going to consult with the wound physician. On 09/05/24 at 2:02 p.m., the DON stated the nurses were to notify the physician and obtain treatment orders for any wound identified. On 09/05/24 at 2:05 p.m., LPN #1 reviewed the Weekly Skin Condition Reports dated 08/23/24 and 09/02/24 and stated they may have identified the new wound on 08/30/24 but was not sure. They stated the 09/02/24 report was not accurate. On 09/06/24 at 8:54 a.m., the DON stated LPN #1 had revised the Weekly Skin Condition Reports dated 08/23/24 and 09/02/24. They stated LPN #1 documented they had obtained treatment orders for Resident #4 from the facility's physician on 09/02/24. On 09/06/24 at 9:20 a.m., Physician #1 stated the wound physician provided treatment orders for Resident #4 and they did not remember giving an order for Betadine for wounds on Resident #4's toes. On 09/06/24 at 9:52 a.m., LPN #1 stated they thought they had called Physician #1 for treatment orders on 09/02/24 but forgot to put the orders into the electronic health record. LPN #1 stated I don't know, I think I am confused. I don't remember if I called [Physician #1].

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on observation, record review, and interview, the facility failed to: a. ensure chemicals were secured for one (West hall) of three halls observed for storage of chemicals. LPN #1 identified three shower rooms and one nursing supply closet in the facility; b. failed to ensure residents were assessed for the use of bed rails for one (#33) of one sampled residents reviewed for bed rails. The DON identified 32 residents who utilized bed rails and; c. failed to ensure residents were safely smoking for one (#8) of one sampled residents who were reviewed for smoking. The DON identified 28 residents who smoked. Findings: The Safety Data Sheet, dated 11/20/14, read in parts, .Gel Hand Sanitizer .Keep out of reach of children . The Safety Data Sheet, dated 01/20/15, read in parts, .Aloe Vera Skin Cream .Keep out of reach of children . The Safety Data Sheet, dated 03/05/20, read in parts, .Xpress Detergent Disinfectant .Harmful if swallowed . The undated, Smoking policy, read in part, .A resident who has had a decline in status must be reassessed to ensure safety is maintained . The undated, Bed Safety and Bed Rails policy, read in part, .Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks . 1. On 09/03/24 at 9:28 a.m., the door to the [NAME] hall shower room was observed to be open. A sign on the door was observed to read Keep door closed. The open shower room was observed to contain the following: a. one-one quart bottle of Xpress detergent disinfectant approximately half full sitting on the edge of the whirlpool tub. The label documented to keep out of reach of children; b. one-7.5 ounce bottle of Derma daily moisturizing lotion with aloe vera in an unlocked cabinet. The label documented to keep out of reach of children; and c. one-two ounce bottle of Senegence hand sanitizer in an unlocked cabinet. The label documented to keep out of reach of children. On 09/03/24 at 9:48 a.m., CNA #1 walked by the open shower room door and closed it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 11:31 a.m., the door to the [NAME] hall nursing supply closet was observed to not be secured/latched. The closet contained the following items: a. two bottles of wound cleanser. The label documented to keep out of reach of children; and b. two bottles of shaving cream. The label documented to keep out of reach of children. On 09/03/24 at 11:42 a.m., LPN #1 stated the nursing supply closet stored wound care supplies. They stated the door was supposed to be kept closed and it automatically locked. On 09/04/24 at 9:30 a.m., the [NAME] hall nursing supply closet was observed to not be secured/latched. The DON stated the door was supposed to be closed fully and locked. On 09/05/24 at 11:16 a.m., the DON stated the shower room door was to be kept closed and locked. 41809 2. Resident #8 had diagnoses which included diabetes type two and end stage renal disease. A smoking assessment, dated 08/02/24, documented Resident #8 was a safe smoker. A smoking assessment, dated 08/14/24, documented Resident #8 was safe to smoke on their own. A care plan focus, dated 08/15/24, documented Resident #8 was able to smoke in designated smoking areas unsupervised. On 09/05/24 at 12:06 p.m., LPN#1 was observed to approach Resident #8 on the front porch. Resident #8 was observed with their eyes closed and a cigarette hanging out of their mouth sitting on the front porch. LPN #1 was observed to touch the resident on their back and stated don't fall asleep with that cigarette in your mouth. The nurse then stated to the surveyor, that was scary as they walked back into the facility leaving the resident on the porch. On 09/05/24 at 12:10 p.m., Resident #8 was observed on the front porch smoking and awake with maintenance staff present. On 09/06/24 at 2:09 p.m., LPN #1 stated they did not believe there was an assessment for smoking, but if there were, social services would complete it. LPN #1 stated unsafe smoking would include the resident needing assistance with exiting the door, holding the smoking material, and the ability to stay awake while smoking. LPN #1 stated, Like [Resident #8] the other day. LPN #1 stated they did not inform anyone of the incident on 09/05/24 and did not document the incident. They stated the cigarette was not lit, but had been as ash had formed on the tip. LPN #1 stated they probably should have told someone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/06/24 at 2:18 p.m., the social services director stated a smoking assessment was completed on admission, with a significant change, quarterly, and followed the care plan. They stated Resident #8 was safe to smoke unsupervised. The social services director stated staff should report if a resident drops their cigarette on their clothes, if they need assistance to light or put out the cigarette. They stated nothing had been reported about Resident #8 not smoking safely. After the social services director was informed of the incident on 09/05/24, they stated an intervention and re-assessment would need to be completed. On 09/06/24 at 2:26 p.m., the DON stated social services completed the smoking assessments and all staff were to monitor. They stated staff should report if a resident falls asleep while smoking and if they dropped ashes on their clothes. The DON stated no reports of Resident #8 smoking unsafely were brought to their attention. The DON was informed of the incident that occurred on 09/05/24. 46703 3. Resident #33 had diagnoses which included type two diabetes. On 09/03/24 at 8:57 a.m., Resident #33 was observed in bed with the bed rails in the up position. On 09/03/24 at 10:00 a.m., review of the clinical record did not [NAME] an order, consent or assessment for bed rails. On 09/06/24 at 9:15 a.m., LPN #2 stated the resident used the bed rails to reposition themselves. On 09/06/24 at 9:46 a.m., the administrator stated the resident did not have an informed consent for bedrails. On 09/06/24 at 3:18 p.m., the DON stated they usually did not use bedrails unless the resident requested them, they only performed an admission assessment, did not perform a bedrail assessment, obtain orders for bedrails, or obtain a consent form. The DON stated they need to start doing assessments and obtaining orders and consents for the use of bed rails.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview, the facility failed to ensure weights were obtained per the physician's order for one (#8) of three sampled residents who were reviewed for nutrition. The DON identified one resident who was ordered daily weights. Findings: The Weight Assessment and Intervention policy, dated March 2022, read in parts, .Residents are weighed upon admission and at intervals established by the interdisciplinary team .Weights are recorded in each unit's weight record chart and in the individual's medical record . Resident #8 had diagnoses which included end stage renal disease. A Physician's Order, dated 08/01/24, documented, starting 08/02/24 the staff were to obtain daily weights every day shift. Review of the electronic clinical record and the weight logs documented on paper, dated 08/02/24 through 09/05/24, revealed daily weights had been obtained 19 times out of 35 opportunities for Resident #8. The Care Plan, dated 08/15/24, documented the resident had cardiac issues and staff were to refer to the physician's order and obtain weights as ordered. On 09/06/24 at 12:23 p.m., LPN #1 stated the restorative aide was responsible to obtain daily weights. On 09/06/24 at 12:32 p.m., the DON stated the restorative aide obtained weights, documented on paper logs, and provided the information to the MDS coordinator to be entered into the electronic clinical record. The DON stated if the restorative aide was off work, the charge nurse was to obtain or assign a CNA to obtain the daily weights. On 09/06/24 at 12:53 p.m., the DON stated the MDS coordinator monitored to ensure weights were obtained as ordered by the physician. The DON stated they did not know why daily weights had not been obtained for Resident #8. On 09/06/24 at 12:55 p.m., the MDS coordinator stated they entered and monitored the weekly and monthly weights. They stated they did not enter or monitor the daily weights. They stated they felt there was confusion on if the charge nurse or the restorative aide was to obtain the daily weights.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 35474 Based on observation, record review, and interview, the facility failed to ensure enteral formula was administered as ordered by the physician for one (#53) of one sampled residents who were reviewed for tube feeding. The DON identified seven residents who required enteral feeding. Findings: Resident #53 had diagnoses which included encounter for attention to gastrostomy. The Care Plan, dated 02/12/24, documented to administer enteral feeding as ordered and to refer the the current physician's orders for details. The Physician's Order, dated 07/02/24, documented Resident #53 was ordered Nutren 1.5 continuous at 60ml/hr. On 09/03/24 at 8:35 a.m., Nutren 1.5 at 50 ml/hr was observed infusing for Resident #53. On 09/04/24 at 10:01 a.m., Nutren 1.5 at 50 ml/hr was observed infusing for Resident #53. On 09/05/24 at 9:15 a.m., Nutren 1.5 at 50 ml/hr was observed infusing for Resident #53. On 09/05/24 at 11:01 a.m., LPN #1 observed the enteral feeding pump for Resident #53 and stated they were to receive Nutren 1.5 at 50 ml/hr. They reviewed the label on the bag of formula and stated they would need to review the orders because the label documented Nutren 1.5 at 60 ml/hr. LPN #1 reviewed the electronic clinical record and stated the resident was ordered Nutren 1.5 at 60 ml/hr. They stated they did not know why Resident #53 was receiving 50 ml/hr. On 09/05/24 at 11:09 a.m., the DON reviewed the electronic clinical record and stated Resident #53 was ordered Nutren 1.5 at 60 ml/hr. The DON stated the nurses on each shift were to verify the correct formula and rate were being administered. They stated they did not know why Resident #53 had been receiving 50 ml/hr rather than the ordered 60 ml/hr.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35474 Based on record review and interview, the facility failed to ensure pre and post dialysis assessments were conducted for one (#8) of one sampled residents who were reviewed for dialysis. The DON identified one resident who required dialysis. Findings: The End-Stage Renal Disease, Care of a Resident with policy, dated September 2010, read in part, . Resident with end-stage renal disease [ESRD] will be cared for according to currently recognized standards of care . Resident #8 had diagnoses which included end stage renal disease. A Physician's Order, dated 08/01/24, documented the resident was to receive dialysis weekly on Tuesday, Thursday, and Saturday. The Care Plan, dated 08/01/24, documented the resident required dialysis three times a week, staff were to monitor and report signs of infection, renal insufficiency, and monitor the shunt access site. The admission assessment, dated 08/14/24, documented the resident received dialysis. Review of the electronic clinical record did not reveal pre or post dialysis assessments had been completed for Resident #8. On 09/06/24 at 9:23 a.m., LPN #1 stated they did not perform pre and post dialysis assessments. They stated they monitored for bleeding, nausea, and asked how the resident was feeling but did not document. On 09/06/24 at 9:27 a.m., the DON stated they were to check on the resident after dialysis, obtain vital signs, and implement any new orders from the dialysis center. The DON stated the CMAs obtained vital signs if medications the resident was ordered required a blood pressure or a heart rate. They stated having residents who required dialysis was new to the facility and they were not aware pre and post dialysis assessments were required. On 09/06/24 at 9:32 a.m., the administrator stated they recently began admitting residents who required dialysis. They stated they would need to review the policy.

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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. 35474 Based on observation, record review, and interview, the facility failed to: a. ensure infection control was maintained during blood glucose monitoring/insulin administration for two (#123 and #8) of two sampled residents observed during blood glucose monitoring. The Roster Matrix identified 16 residents who received insulin; b. ensure infection control was maintained during medication administration for two (#126 and #15) of nine sampled residents observed during medication administration. The DON identified 73 residents who received medications in the facility; c. ensure enhanced barrier precautions were utilized during medication administration via enteral tube for one (#62) of one sampled residents observed during medication administration via enteral tube. The DON identified seven residents who had enteral tubes; d. ensure infection control was maintained during wound care for two (#4 and #15) of two sampled residents observed during wound care. The DON identified ten residents who had wounds in the facility; and e. ensure infection control was maintained for indwelling urinary catheters and during catheter care for one (#123) of one sampled residents who were reviewed for indwelling urinary catheters. The Roster Matrix identified seven residents who had indwelling urinary catheters. Findings: The Administering Medications policy, dated 2001, read in part, .Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc) for the administration of medications, as applicable . The Catheter Care, Urinary policy, dated 2001, read in part, .Be sure the catheter tubing and drainage bag are kept off the floor . The Enhanced Barrier Precautions policy, dated August 2022, read in part, .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Examples of high contact resident care activities requiring the use of gown and gloves .include .device care . The undated glucometer manufacturer's booklet, read in parts, .should be cleaned and disinfected between each patient .the meter must be disinfected between patient uses by wiping it with a .EPA-registered disinfecting wipe in between tests . 1. Resident #123 had diagnoses which included diabetes mellitus. Resident #8 had diagnoses which included diabetes mellitus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/24 at 11:35 a.m., LPN #1 was observed during blood glucose monitoring for Resident #123. LPN #1 was not observed to wear gloves while obtaining the blood glucose. The LPN placed the glucometer on top of the treatment cart, drew up insulin, walked down the hall to the resident's room, and was observed to administer the insulin without donning gloves. On 09/05/24 at 11:44 a.m., LPN #1 was observed to place the glucometer into the top drawer of the treatment cart. On 09/05/24 at 12:45 p.m., LPN #1 was observed to obtain the same glucometer from the top drawer of the treatment cart and without disinfecting the glucometer, obtain a blood glucose sample from Resident #8. On 09/05/24 at 12:48 p.m., LPN #1 stated they had not donned gloves during blood glucose monitoring and insulin administration for Resident #123 because they forgot. They stated they were supposed to disinfect the glucometer with an alcohol pad after each use. On 09/05/24 at 1:40 p.m., the DON stated they had sanitizing wipes they were to use to disinfect the glucometer. They stated the wipes had a two minute contact time and alcohol was not to be utilized to disinfect the glucometer. The DON stated gloves were to be utilized for blood glucose monitoring and insulin administration. 2. On 09/03/24 at 9:22 a.m., CMA #1 was observed to place their finger into the house stock bottle of Senna 8.6 mg, obtain a pill, and place it into the medication cup for Resident #15. CMA #1 was not observed to don gloves or sanitize their hands. On 09/05/24 at 3:11 p.m., CMA #2 was observed during medication administration. CMA #2 removed Carvedilol 12.5 mg from one medication cup and placed it into another medication cup with their bare hands for Resident #126. On 09/05/24 at 3:23 p.m., CMA #2 stated they should have donned gloves rather than handling the Carvedilol with their bare hands to maintain infection control. On 09/06/24 at 11:51 a.m., the DON stated staff were to utilize gloves when handling pills. They stated the staff should not touch the pills with their bare hands. 3. On 09/04/24 at 1:23 p.m., LPN #2 was observed during medication administration via enteral tube for Resident #62. LPN #2 was not observed to don a gown when administering the medications. Resident #62 requested assistance with toileting. LPN #2 donned a gown and gloves and assisted Resident #62. LPN #2 stated Resident #62 was on enhanced barrier precautions because they had an enteral tube. They stated they should have utilized a gown when administering medications via enteral tube but had forgotten. On 09/06/24 at 2:11 p.m., the infection preventionist stated nursing staff were to utilize PPE anytime they provided direct care to residents with indwelling urinary catheters, wounds, enteral tubes, or any time they may come into contact with bodily fluids. 4. Resident #4 had diagnoses which included non-pressure wound of the right third toe and non-pressure wound of the left second toe. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/24 at 11:46 a.m., LPN #1 was observed to don a gown and gloves and provide wound care to Resident #4. LPN #1 was observed to doff their gown and gloves, walk to the treatment cart, and gathered wound care supplies for Resident #15. LPN #1 was observed to don a gown and gloves, without sanitizing or washing their hands, and provided wound care to Resident #15. LPN #1 then doffed their gown and gloves and returned to the treatment cart, without sanitizing or washing their hands. On 09/06/24 at 9:37 a.m., LPN #1 stated they were to wash their hands before and after wound care. They stated they did not know why they had not sanitized or washed their hands when they provided wound care to Resident #4 and Resident #15. On 09/06/24 at 11:51 a.m., the DON stated nurses were to wash their hands before and after wound care treatments. 41809 5. Resident #123 had diagnoses which included urinary retention and acute kidney failure. On 09/04/24 at 1:41 p.m., Resident #123 was observed wheeling into their room, with the catheter bag hanging down under their chair, touching the floor. On 09/05/24 at 12:07 p.m., Resident #123 was observed to be pushed by CNA #1 down the hall with the tubing of the catheter dragging on the floor. On 09/06/24 at 12:12 p.m., LPN #1 was observed to perform catheter care for the suprapubic catheter of Resident #123. LPN #1 was observed to place a wax sheet of paper on their cart. The cart was not observed to be sanitized prior to placing the wax paper. LPN #1 was observed to place the PPE gown on the wheelchair of Resident #123 and then wash their hands in the restroom of Resident #123. During the catheter care, LPN #1 was not observed to wash or sanitize their hands between glove changes. On 09/06/24 at 2:35 p.m., LPN #1 stated hands should be washed before and after catheter care. They stated it made sense to wash their hands between glove changes but was not sure what the protocol was for washing their hands. LPN #1 stated the wax paper placed on surfaces was aseptic or sterile technique and if the surface used to place the wax paper was dirty, they would not place the wax paper on it. LPN #1 stated they did not clean to top of their cart every time they placed wax paper down for supplies. They stated the wax paper came from a package. On 09/06/24 at 2:47 p.m., the DON stated the protocol for changing gloves at anytime was to wash/sanitize their hands between glove changes when going from dirty to clean. The DON stated the protocol for surfaces used during treatments was to sanitize with disinfectant wipes then wait two minutes, even if using wax paper to place supplies on. On 09/06/24 at 4:00 p.m., the DON stated catheter tubing and bags should not touch the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375556	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 46703 Based on observation, record review, and interview, the facility failed to assess and inspect bed rails to identify any risks of entrapment for one (#33) of one sampled resident reviewed for bedrails. The DON identified 32 residents who utilized bed rails. Findings: On 09/03/24 at 8:57 a.m., Resident #33 was observed lying in bed with the bed rails in the up position. On 09/06/24 at 9:15 a.m., LPN #2 stated the resident used the bed rails to reposition themselves in bed. They stated the bed rails were re-assessed every month and it was documented under the assessments tab in the electronic clinical record. LPN #2 reviewed Resident #33's electronic clinical record and stated the last assessment was completed on 01/29/24. On 09/06/24 at 2:03 p.m., maintenance worker #1 stated they installed the bedrails or removed them, depending on the order. They stated the CNA's or the nurses notified them if one was loose and they addressed it but they did not routinely check them. On 09/06/24 at 3:18 p.m., the DON stated they did not usually utilize bed rails unless a resident requested them.