STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415027	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Health & Rehabilitation Center	544 Pleasant Street Pawtucket, RI 02860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 46539 46715 46241 Based on record review and staff interview, it has been determined that the facility failed to ensure that the assessment accurately reflected the resident's status for 4 of 4 residents reviewed for tobacco use, Resident ID #s 26, 40, 44, and 86 and 1 of 3 residents reviewed for limited range of motion, Resident ID #16. Findings are as follows: 1. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual last revised in October 2023 states in part, .Current Tobacco Use .Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicated that they did not use tobacco of any kind during the 7-day look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions Code 0, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicated that the resident used tobacco in some form during the look-back period . 1a. Record review revealed Resident ID #26 was readmitted to the facility in September of 2023 with a diagnosis including, but not limited to type two diabetes mellitus, with diabetic neuropathy (nerve damage). Review of a progress note dated 3/12/2024 states in part, Smoking status: Resident uses tobacco products . Review of a facility provided document titled Quality Review - Smoking Program last revised 7/11/2024 revealed Resident ID #26 is an independent smoker. Review of a Minimum Data Set (MDS) assessment dated [DATE], Section J, titled, Health Condition revealed the resident was coded a 0 for tobacco use, indicating they did not use tobacco products during the 7-day look-back period. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. Record review revealed Resident ID #40 was readmitted to the facility in May of 2024 with a diagnosis including, but not limited to, type two diabetes mellitus, with diabetic neuropathy. Review of a progress note dated 2/19/2024 states in part, Smoking status: Resident uses tobacco products . Review of a facility provided document titled Quality Review - Smoking Program last revised 7/11/2024 revealed Resident ID #40 is an independent smoker. Review of a MDS assessment dated [DATE], Section J, titled, Health Condition revealed the resident was coded a 0 for tobacco use, indicating they did not use tobacco products during the 7-day look-back period. 1c. Record review revealed Resident ID #44 was readmitted to the facility in September of 2022 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of a progress note dated 3/27/2024 states in part, Smoking status: Resident uses tobacco products . Review of a facility provided document titled Quality Review - Smoking Program last revised 7/11/2024 revealed Resident ID #44 is an independent smoker. Review of a MDS assessment dated [DATE], Section J, titled, Health Condition revealed the resident was coded a 0 for tobacco use, indicating they did not use tobacco products during the 7-day look-back period. 1d. Record review revealed Resident ID #86 was readmitted to the facility in July of 2024 with a diagnosis including, but not limited to, type one diabetes mellitus with hyperglycemia (high blood sugar). Review of a progress note dated 5/14/2024 states in part, Smoking status: Resident uses tobacco products . Review of a facility provided document titled Quality Review - Smoking Program last revised 7/11/2024 revealed Resident ID #86 is an independent smoker. Review of a MDS assessment dated [DATE], Section J, titled, Health Condition revealed the resident was coded a 0 for tobacco use, indicating they did not use tobacco products during the 7-day look-back period. During a surveyor interview on 7/17/2024 at 2:01 PM, with the MDS Coordinator, she indicated that she does not interview the residents about their smoking status. Additionally, she was unable to provide evidence of why the above-mentioned resident's tobacco use was not accurately coded on the MDS Assessments. 2. Record review revealed Resident ID #16 was admitted to the facility in November of 2023 with a diagnosis including, but not limited to, left hand contracture. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a care plan focus area initiated on 6/13/2024 relative to him/her having a left-hand contracture. Review of a MDS assessment dated [DATE], Section GG, titled, Functional Abilities and Goals revealed the resident was documented as having no impairments to his/her range of motion. During a surveyor interview on 7/18/2024 at 8:10 AM, with the MDS Coordinator, she was unable to provide evidence that the 5/21/2024 MDS Assessment for Resident ID #16 was coded accurately, to reflect his/her impaired range of motion, due to his/her left hand contracture. During a surveyor interview on 7/18/2024 at 9:42 AM, with the Director of Nursing Services, she was unable to provide evidence that Resident ID #s 16, 26, 40, 44, and 86's MDS Assessments were completed accurately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47939 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed for assistance with meals, Resident ID #42. Findings are as follows: Record review revealed that the resident was admitted to the facility in October of 2021 with diagnoses including but not limited to Parkinson's disease, dysphagia (difficulty swallowing) and, contractures of both hands (shortening or hardening of the muscles). Record review revealed a care plan, last revised on 8/16/2022, which revealed the resident has a nutritional problem related to obesity and requires the physical assistance of staff for meals and fluids. Record review revealed a physician's order dated 7/16/2022 for one to one assistance with feeding and to position the resident upright at 90 degrees during meals. During surveyor observations of the resident failed to reveal s/he was upright at 90 degrees while being assisted with his/her meal, on the following dates and times: -7/17/2024 at 12:35 PM -7/18/2024 at 8:40 AM -7/18/2024 at 12:37 PM During a surveyor interview on 7/18/2024 at 12:37 PM with Nursing Assistant, Staff C, he acknowledged that the resident was not upright at 90 degrees while being assisted with his/her meal and indicated that s/he should have been. During a surveyor interview on 7/18/2024 at 2:52 PM with Licensed Practical Nurse, Staff D, she acknowledged that the resident has a physician's order to be upright at 90 degrees at mealtimes. She revealed she was not aware that the resident's head of the bed was not at 90 degrees during the above-mentioned mealtimes and indicated s/he should have been. During a surveyor interview with the Director of Nursing Services on 7/18/2024 at 3:37 PM, she was unable to provide evidence that the resident's head of the bed was upright at 90 degrees during mealtimes per the physician's order. 46539

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47939 Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 1 of 1 resident reviewed with an indwelling foley catheter (a flexible tube that collects urine from the bladder and empties the urine into a drainage bag), Resident ID #11. Findings are as follows: According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing, Volume 2, 10th Edition, page 252 states, .the usual daily urine volume in the adult is 1-2 Liters or 1000-2000 cubic centimeters (cc). Additionally, page 1282 states, For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage . Record review revealed the resident was readmitted to the facility in July of 2024 with diagnoses including, but not limited to, acute heart failure and obstructive uropathy (a structural or function hindrance of the normal flow of urine). Review of a care plan dated 1/6/2024, revealed the resident requires an indwelling foley catheter with interventions including, but not limited to, monitor, record and report signs and symptoms of a urinary tract infection including no urine output. Record review of a hospital discharge summary dated 7/10/2024 revealed the resident was discharged following his/her hospitalization with a diagnosis of complicated urinary tract infection with bacteremia (bacertia in the blood), septic shock (life-threatening condition caused by severe localized or system wide infection), and acute kidney injury. Record review of the documented urinary output from 7/1/2024 through 7/17/2024, failed to reveal evidence that the output was measured and recorded each shift for 46 of 51 opportunities. During a surveyor interview with the Director of Nursing Services on 7/19/2024 at approximately 12:15 PM, she revealed it would be her expectation for urinary output to be documented every shift for a resident with a foley catheter. Additionally, she was unable to provide evidence that the facility provided appropriate treatment and services for a resident with a urinary catheter, including documenting the urinary output to assess for adequacy of renal function.

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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. 46715 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents that are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed receiving nutrition and medications via a gastrostomy tube (g-tube; (a tube that provides direct access to the stomach for supplemental feeding, hydration or medication), Resident ID #38. Findings are as follows: Review of a facility provided policy titled, Enteral Tube Medication Administration dated 12/2019 states in part, The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes .check for proper tube placement using air and auscultation [listening] .check gastric content for resident feeding. Return residual volumes to the stomach . Record review revealed that the resident was readmitted to the facility in January of 2024 with a diagnosis including, but not limited to, gastrostomy status. Record review revealed a physician's order dated 7/21/2023 to check g-tube placement every shift before and after any feeds and before and after any medication administration. During a surveyor observation of the medication administration task on 7/18/2024 at 8:45 AM with Licensed Practical Nurse, Staff A, she was observed to disconnect the resident's feeding. She then administered the medications and reconnected the tube feeding to the resident. Staff A, failed to check for proper g-tube placement after disconnecting the feeding, prior to administering medications or before reattaching the feeding to the resident. During a surveyor interview on 7/18/2024 at 9:10 AM with Staff A, she acknowledged that she did not check for proper g-tube placement at any time during the medication administration task. Additionally, she acknowledged that she did not follow the physician order to check for placement. During a surveyor interview of 7/18/2024 at 10:35 AM with the Director of Nursing Services she was unable to provide evidence that the resident received the appropriate treatment and services to prevent complications relative to checking for placement of the tube prior to medication administration.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 46241 Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders Based on record review and staff interview it has been determined that the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the treatment of mental disorders for 1 of 2 residents reviewed for trauma informed care, Resident ID #40. Findings are as follows: Record review revealed that the resident was admitted to the facility in March of 2023 with diagnoses including, but not limited to, post-traumatic stress disorder, bipolar disorder, major depressive disorder, and anxiety disorder. Review of a document titled PSYCHIATRIC EVALUATION & CONSULTATION dated 3/26/2024 revealed that the resident endorses flashbacks and spoke openly about a trigger. It further revealed a plan to increase his/her buspirone 15 milligrams (mg) twice a day (BID) (anxiety medication) and add hydroxyzine 25mg as needed (PRN) for anxiety to manage acute symptoms. Review of a progress note dated 3/26/2024 authored by the Nurse Practitioner (NP), states in part, .agree to increase buspirone to 15mg bid and start hydroxyzine 25mg bid prn for anxiety . Record review revealed a physician's order with a start date of 3/26/2024 for buspirone 15 mg once a day for anxiety. Further review revealed a physician's order for hydroxyzine 25 mg every 12 hours as needed for anxiety with a start date and end date of 3/26/2024. Record review failed to reveal evidence that the resident was receiving buspirone 15mg BID and hydroxyzine 25mg BID PRN for anxiety as ordered. Record review revealed that the resident had a Patient Health Questionnaire (PHQ-9; a tool for screening, diagnosing, monitoring, and measuring the severity of depression) completed on the following dates, which resulted in the following scores: - 1/12/2024 with a score of 9 indicating mild depression - 4/5/2024 with a score of 12 indicating moderate depression (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/16/2024 with a score of 10 indicating moderate depression - 5/18/2024 with a score of 15 indicating moderately severe depression - 6/10/2024 with a score of 19 indicating moderately severe depression Further review of the progress notes revealed on the following dates the resident was experiencing anxiety or depressive symptoms: -3/4/2024 baseline anxiety present -4/9/2024 I'm having a hard time with sleep, anxiety and depression. [S/he] also scored positive for little interest in doing things, feeling tired, low appetite and feeling bad about [him/herself]. [S/he] states [s/he] feels this way due to [his/her] health and adjustment to the facility. [S/he] also reported ongoing daily flashbacks of the trauma [s/he] has experienced in [his/her] past -5/20/2024 [S/he] is unable to tolerate imaging without medication due to anxiety, has taken Ativan [anxiety medication] in the past for anxiety r/t [related to] imaging -6/7/2024 At 2pm [the resident] called writer into room to state [s/he's] having increased anxiety r/t urine specimen. writer asked [him/her] to elaborate to which [s/he] then stated, 'can you have psych talk to me this week'. writer placed resident on Psych list -6/10/2024 [Social Worker] reached out to supportive care .to inform her of high PHQ9 and .stating [the resident] was having nightmare and panic attacks causing [the resident] not to sleep. She states she will come in tomorrow to see [the resident] . 7/16/2024 .new recommendations Clonidine 0.1 mg BID PRN for anxiety/panic x28days (pt [patient] has taken in past with good effect). reported to .NP with approval of recommendations . During a surveyor interview on 7/18/2024 at 9:40 AM with the Director of Nursing Services, she was unable to explain why the medications were not transcribed as ordered. Additionally, she was unable to provide evidence that the resident was provided with the necessary behavioral health care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Review of an additional PSYCHIATRIC EVALUATION & CONSULTATION dated 7/16/2024 revealed that the psychiatric provider documented that the resident was currently receiving buspirone 15 mg twice a day and hydroxyzine 25 mg every 12 hours as needed for anxiety when the resident was not, the resident wasonly receiving buspirone 15 mg once a day. During a surveyor interview with the Psychiatric provider on 7/19/2024 at 9:37 am, she revealed that the resident was started on clonidine on 7/16/2024 as the as needed because the hydroxyzine was ineffective. She was unaware that the order for hydroxyzine was not transcribed correctly, resulting in the resident only receiving it for one day. Additionally, she revealed that she was unaware that the resident was only receiving buspirone 15mg once daily, not twice a day as ordered. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A surveyor interview was attempted with the NP on 7/18 and 7/19/2024, but were unsuccessful as the NP did not return the phone calls. 46539

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46715 Based on surveyor observation, record review, and staff interview it has been determined that the facility failed to ensure each resident's medication regimen is free from a medication error rate of 5% or greater. Based on 30 opportunities for errors observed during the medication administration task, there were 5 errors resulting in an error rate of 16.67% relative to enteral medication administration via gastrostomy tube (g-tube; (a tube that provides direct access to the stomach for supplemental feeding, hydration or medication). Findings are as follows: Review of a facility policy titled, Enteral Tube Medication Administration dated 12/2019 states in part, The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes . Administer each medication separately and flush the tubing between each medication .Pour dissolved/dilute medication in syringe and unclamp tubing, allowing medication to flow by gravity . Record review revealed Resident ID #38 has the following physician orders: - Nortriptyline HCl Oral Capsule 10 milligrams (MG) via g-tube one time a day for depression - Cyanocobalamin Tablet 1000 micrograms (MCG) 1 tablet via g-tube one time a day for supplement - Cholecalciferol Tablet 1000 UNIT Give 2 tablets via g-tube one time a day for supplement - Folic Acid Tablet 1 MG Give 1 tablet via g-tube one time a day for supplement - Metoprolol Tartrate Tablet 25 MG give one tablet via g-tube two times a day for hypertension During a surveyor observation of the medication administration task on 7/18/2024 at 8:45 AM with Licensed Practical Nurse, Staff A, she was observed to crush all of the above mentioned medication together. She was then observed to administer the mixed medications to the resident via his/her g-tube. Staff A, was also observed to push medication with a piston syringe into the g-tube and not via gravity per the facility's policy. During a surveyor interview on 7/18/2024 at 9:10 AM with Staff A, she acknowledged that she did not administer each medication separately and did not flush the tubing between each medication. Additionally, she revealed that she did not let the medication flow via gravity and pushed all the medications. During a surveyor interview of 7/18/2024 at 10:35 AM with the Director of Nursing Services (DNS) she revealed that she would have expected Staff A, to administer each medication separately via the g-tube and allow the medication to run via gravity per the facility policy. The DNS was unable to provide evidence that the facility ensured each resident's medication regimen is free from a medication error rate of 5% or greater.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 47939 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to accommodate residents' food preferences for 1 of 1 resident reviewed, Resident ID #42. Findings are as follows: Record review revealed that the resident was admitted to the facility in October of 2021 with diagnoses including, but not limited to, Parkinson's disease, dysphagia, (difficulty swallowing) and contractures of both hands (shortening or hardening of the muscles). Record review of a care plan, last revised on 8/16/2022, which revealed the resident has a nutritional problem related to obesity and requires physical assistance of staff for meal and fluids. The intervention includes, but is not limited to, identify and honor food preferences. Record review revealed a progress note, authored by the Registered Dietitian, dated 7/18/2024 which revealed, the resident will have soft salad sandwiches offered at lunch and dinner, per the resident's preference. Review of the resident's tray ticket revealed Notes: Soft salad sandwich and large portions. Surveyor observations of the resident during the lunch meals revealed the following: -7/17/2024 at 12:35 PM the sandwich was crossed off of the tray ticket and the resident did not receive a sandwich -7/18/2024 at 12:37 PM the sandwich was listed on the tray ticket, but there was no sandwich on the resident's lunch tray During a surveyor interview on 7/17/2024 at 12:40 PM with Licensed Practical Nurse, Staff B, she acknowledged that the sandwich was not provided to the resident and should have been. Additionally, she could not explain why the sandwich was crossed off of the resident's meal tray ticket. During a simultaneous interview and observation of the resident while being assisted with eating by Nursing Assistant, Staff C, on 7/18/2024 at 12:37 PM revealed with the resident was being fed chicken. The resident revealed s/he likes a sandwich because s/he often does not eat chicken because it does not taste good to him/her. The resident further revealed s/he would like a sandwich and was unaware of why s/he did not receive one for his/her lunch meal that day. Staff C acknowledged that the resident did not receive a sandwich on his/her lunch tray and continued to feed the resident the chicken that was on his/her tray and did not provide him/her with a salad sandwich, although s/he expressed his/her displeasure with the meal. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the Registered Dietitian on 7/18/2024 at approximately 1:00 PM, she revealed that the resident prefers sandwiches, and indicated that she added this preference into the meal tray system, to print to his/her meal tray ticket, so s/he would receive the sandwiches. Additionally, she revealed that the facility has sandwiches available for the lunch meal. During a surveyor interview with the Administrator on 7/18/2024 at 2:52 PM, he was unable to provide evidence that the resident received meals according to his/her preference.

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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	Provide and implement an infection prevention and control program. 46715 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections for 2 of 2 residents reviewed relative to Multi-drug Resistant Organisms (MDRO), Resident ID #s 17 and 86, 1 of 1 resident reviewed for enhanced barrier precautions Resident ID #38, 2 of 2 residents reviewed for humidified oxygen storage, Resident ID #s 45 and 58, and 1 of 2 residents reviewed for Bilevel positive airway pressure (BiPAP; a treatment that uses mild air pressure to keep your airways open while you sleep) cleaning schedule, Resident ID #11. Findings are as follows: 1. Review of the Center for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs) last updated 7/12/2022 revealed in part, .Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities .The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions [gown and glove upon entering the room] do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization [the bacteria is living on or in the body not causing symptoms but can the bacteria can be spread to others] as well as for residents with MDRO infection or colonization .Summary of Personal Protective Equipment (PPE) Use and Room Restriction When Caring for Residents in Nursing Homes .Enhanced Barrier Precautions .All residents with any of the following .Infection or colonization with an MDRO when Contact Precautions do not otherwise apply . Review of a facility policy titled Enhanced Barrier Precautions states in part, .Enhanced Barrier Precautions is applicable for residents with any of the following: Infection or colonization with a MDRO when contact precautions do not apply . 1a. Record review revealed Resident ID #17 was admitted to the facility in May 2024 with diagnoses including, but not limited to, paraplegia and type 2 diabetes mellitus. Review of Resident ID #17's discharge summary from the hospital dated 5/17/2024 revealed that the resident was on contact isolation precautions related to a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA; a MDRO). Record review failed to reveal evidence that the resident was on Contact Precautions or Enhanced Barrier Precautions related to the diagnosis of MRSA. Surveyor observations on 7/16, 7/17, and 7/18/2024 failed to reveal evidence that the resident was on Contact or Enhanced Barrier Precautions relative to the diagnosis of a MDRO, per the facility policy or CDC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415027	A. Building B. Wing	07/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. Record review revealed Resident ID #86 was readmitted to the facility in July of 2024 with diagnoses including, but not limited to, type 1 diabetes mellitus and adjustment disorder. Record review revealed the resident was hospitalized in May of 2024 and returned from the hospital on contact precautions related to the diagnoses of MRSA and Extended-spectrum beta-lactamase (ESBL; MDRO). Review of the above-mentioned document revealed that the facility was notified that the resident was returning to the facility on MRSA/ESBL precautions. Record review revealed that the resident was hospitalized in June of 2024 and returned to the facility on contact precautions from the hospital. Additionally, it reiterated that the resident received a MRSA diagnosis on 5/14/2024. Review of Resident ID #86's July 2024 hospital documentation revealed that the resident was on contact precautions related to having a MDRO. Further review revealed that the resident was diagnosed with pneumonia with a history of MRSA and was started on antibiotics. Surveyor observations on 7/16, 7/17, 7/18 and 7/19/2024 failed to reveal evidence that the resident was on Contact or Enhanced Barrier Precautions relative to the diagnosis of a MDRO, per the facility policy or CDC. Further record review failed to reveal evidence the facility retested the resident for MRSA or ESBL prior to removing him/her from the precautions that s/he was placed on while in the hospital. During a surveyor interview on 7/18/2024 at 1:14 PM and 7/19/2024 at 10:24 AM with the Director of Nursing Services (DNS), she was unable to provide evidence that the facility maintained an infection prevention and control program to help prevent the transmission of communicable diseases. 2. Review of a facility policy titled Enhanced Barrier Precautions states in part, .Enhanced Barrier Precautions is applicable for residents with any of the following: Infection or colonization with a MDRO when contact precautions do not apply .wounds .and or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) regardless of MDRO colonization status. Record review revealed that Resident ID #38 was readmitted to the facility in January of 2024 with a diagnosis including, but not limited to, gastrostomy status (a tube that provides direct access to the stomach for supplemental feeding, hydration or medication). During a surveyor observation on 7/18/2024 at 8:45 AM revealed Licensed Practical Nurse (LPN), Staff A, was administering Resident ID #38's medications via a feeding tube without wearing a gown. Further observation revealed signage posted at the resident's door which indicated to wear a gown during device care or with care of the feeding tube. During a surveyor interview on 7/18/2024 at 9:10 AM with Staff A, she acknowledged that she did not wear a gown while the administration the medications via the feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 7/18/2024 at 10:35 AM with the DNS, she revealed that she would have expected the nurse to have worn a gown when administering medications via a feeding tube. 3a. Record review revealed that Resident ID #45 was admitted to the facility in March of 2018 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and heart failure. Record review revealed that the resident utilized oxygen via nasal cannula (a device that delivers oxygen through two prongs into your nostrils). During surveyor observations on 7/17 and 7/18/2024 revealed the resident was receiving humidified oxygen via nasal cannula. Further observation revealed that the oxygen humidifier container was placed on the floor instead of the shelf of the oxygen concentrator. During a surveyor interview on 7/18/2024 at 2:52 PM with LPN, Staff D, she acknowledged that the humidifier was on the floor in the resident's room and not on the shelf of the concentrator. Additionally, she revealed that it should not be on the floor. 3b. Record review revealed that Resident ID #58 was admitted to the facility in September of 2022 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and heart failure. Record review revealed that the resident utilized oxygen via nasal cannula. During surveyor observations on 7/17 and 7/18/2024 revealed the resident was receiving humidified oxygen via nasal cannula. Further observation revealed that the oxygen humidifier container was placed on the floor and not on the shelf of the oxygen concentrator. During a surveyor interview on 7/18/2024 at 2:45 PM with Staff D, she acknowledged that the humidifier was on the floor on the resident's room and not on the shelf of the oxygen concentrator. Additionally, she acknowledged that it should not be on the floor. During a surveyor interview on 7/18/2024 at 3:32 PM with the DNS, she revealed that she would expect the humidifier bottles would not be stored on the floor. 4. Review of a facility policy titled Respiratory - Pap Equipment states in part, .Equipment cleaning Daily . place the .BIPAP tubing, nasal mask or pillow and headgear into a sink with warm soapy water. (Use a small amount of mild dish detergent) Agitate these supplies in the water for approximately 5 minutes. Rinse well with warm water and allow to dry until all moisture is gone .humidifier care .clean once weekly with warm soapy water and rinse thoroughly. To disinfect, place vinegar/water solution (1 part vinegar 3-5 parts water) in clean humidifier. Soak for 30 minutes and rinse thoroughly . Record review revealed that Resident ID #11 was readmitted to the facility in July of 2024 with diagnoses including, but not limited to, chronic obstructive pulmonary disease and heart failure. Record review revealed a physician's order with a start date of 6/4/2022 for a BIPAP to be used at night. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review failed to reveal evidence of an order for daily cleaning of the BIPAP or weekly cleaning of the humidifier. Review of the July 2024 Medication Administration Record revealed that Staff D documented that she performed a cleaning of the BIPAP filter on 7/17/2024. During a surveyor observation on 7/18/2024 at 1:24 PM of the residents BIPAP machine revealed the door that holds the filter in place for the BIPAP was broken and the filter was missing. During a surveyor interview on 7/18/2024 at 3:32 PM with LPN Staff D, She revealed that she documented that she completed the filter cleaning on 7/17/2024 but acknowledged to the surveyor that she did not complete the cleaning. During a surveyor interview on 7/19/2024 at 12:18 PM with the DNS, she revealed that she would have expected the BIPAP machine to be cleaned. Additionally, she was unable to provide evidence that the resident's BIPAP was cleaned to according to the facility policy. 47939