STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415039	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hills Nursing & Rehabilitation Center	80 Douglas Pike Smithfield, RI 02917

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 46539 Based on surveyor observation, record review, staff and resident interview, it has been determined that the facility failed to meet professional standards of quality for 1 of 1 resident reviewed for the utilization of a Freestyle Libre sensor (a continuous glucose monitoring system that is designed to replace finger sticks and lessen the need for test strips for persons with diabetes), Resident ID #194, following a physicians order for daily dressing changes on a surgical site and daily weights for 1 of 1 resident reviewed, Resident ID #192 and 2 of 2 residents reviewed with non-pressure wounds, Resident ID #s 8 and 194. Findings are as follows: 1. Review of the Freestyle Libre 2 User Manual revealed that the sensor is to be changed every 14 days. Record review revealed that the resident was admitted to the facility in September of 2024 with diagnoses including, but not limited to, diabetes and acute kidney failure. During a surveyor interview with the resident on 9/11/2024 at 8:54 AM, s/he revealed that s/he has a Freestyle Libre sensor. Additionally, s/he revealed that the Freestyle Libre sensor needs to be changed every 14 days. Record review failed to reveal evidence of a physician's order for a Freestyle Libre sensor. Record review failed to reveal evidence of documentation indicating when to change the resident's Freestyle Libre sensor or the last time it had been changed. During a surveyor interview with Licensed Practical Nurse (LPN), Staff A, on 9/12/2024 at 7:55 AM, she revealed that there was no documentation indicating that the resident had a Freestyle Libre sensor, when to change the Freestyle Libre sensor, or the last time it was changed, and indicated that staff utilize the sensor to obtain the resident's blood glucose levels. Additionally, she revealed that there should be a physician's order for the Freestyle Libre sensor and an order to change it. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview with the Director of Nursing Services (DNS) on 9/12/2024 at 8:29 AM, she was unable to provide evidence of documentation indicating that the resident had a Freestyle Libre sensor, when to change the Freestyle Libre sensor, or the last time it was changed. Additionally, she revealed that there should be a physician's order for the Freestyle Libre sensor and an order to change it. 2. Mosby's 4th Edition, Fundamentals of Nursing page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. a) Record review revealed that Resident ID #192 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of prosthetic heart valve and heart failure. Review of the hospital discharge summary dated 9/1/2024 revealed an order to complete daily weights following cardiac surgery and to report an increase in weight over 2 pounds for 2 days to the cardiac team. Record review revealed a physician's order with a start date of 9/10/2024 for daily weights, 9 days after admission to the facility. Record review revealed the following weights were obtained: - 9/1/2024 299.0 pounds (lbs) - 9/5/2024 299.0 lbs - 9/11/2024 303.6 lbs Record review failed to reveal evidence of daily weights being obtained from 9/1/2024 until 9/12/2024, for 8 of 11 opportunities to obtain daily weights. Record review revealed that on 9/11/2024 the resident had new 3+ pitting edema (excess fluid builds up in the body, causing swelling) to his/her bilateral lower extremities and a 4 pound weight gain since 9/1/2024. Record review revealed the resident attended a cardiology appointment on 9/12/2024 with an order to start Lasix (a medication to help with edema) 40 milligrams (mg) twice a day for a week and then decrease to Lasix 40 mg daily. During a surveyor interview on 9/12/2024 at 8:05 AM with the Registered Nurse, Staff B, she revealed that the resident has an order to obtain daily weights, but the weight is not reflected in the resident's record. She further revealed it should be documented somewhere. During a surveyor interview on 9/12/2024 at 8:27 AM with the DNS, she revealed that daily weights should have been obtained per the physician's order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Record review revealed an order with a start date of 9/3/2024 to cleanse the right chest wound with normal saline, pat dry, apply xeroform (sterile wound dressing) to the surgical site, followed by gauze and a tegaderm (transparent dressing) daily. Record review revealed an order with a start date of 9/3/2024 to cleanse the surgical wound to the abdomen with wound wash, pat dry, apply xeroform to the surgical site, and cover with a clean dressing daily. During a surveyor observation on 9/10/2024 at 11:15 AM with Staff A, she revealed that the surgical wound dressing on the right chest wall and abdomen were dated 9/8/2024. During a follow up surveyor interview on 9/10/2024 at 11:40 AM with Staff A, she acknowledged that the wound dressing was dated 9/8/2024 and should have been changed on 9/9/2024. She further revealed that she worked on 9/9/2024 and didn't have time to change the dressing and states she passed it on. Record review failed to reveal evidence that the dressing change was completed on 9/9/2024 to the right chest wall surgical site and abdominal surgical site. During a surveyor interview on 9/10/2024 at 12:18 PM with the Regional Nurse and the DNS, they revealed that would investigate the dressing dated 9/8/2024 on the right chest wall and the abdomen. Additionally, they were unable to provide evidence that the dressing changes to the right chest wall and abdomen surgical sites were changed as ordered on 9/9/2024. 3. Review of a facility policy titled, Wound Care dated October 2010 states in part, The following should be recorded in the resident's medical record: .All assessment data (i.e., wound bed, color, size, drainage, etc) obtained when inspecting the wound . According to Wound Care Education Institute, 2020, wound care documentation should be carried out weekly including type of wound, measurements, type of tissue, symptoms of infection, presence of drainage, wound edges, pain, and current treatment. a) Record review revealed that Resident ID #8 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and heart failure. Record review revealed that the resident has a vascular wound to his/her right lower extremity with a daily treatment in place. Record review failed to reveal evidence of documentation which included wound bed characteristics, color, size, and drainage documented from 6/20/2024 until it was brought to the facility's attention on 9/12/2024, per the facility policy and the standard of practice. Additionally, the facility was unable to obtain wound care paperwork from the outside wound care provider from 8/23/2024 when the surveyor requested the documentation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/13/2024 at 8:20 AM with the DNS, she revealed that the resident was seen by an outside wound provider but was unable to obtain the wound care consultation notes, as of yet. Additionally, she was unable to provide evidence that wound evaluations were being completed from 6/20/2024 through 9/12/2024. b) Record review revealed that Resident ID #194 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and orthopedic aftercare following surgical amputation. Record review of the resident's discharge summary from the hospital dated 9/3/2024 revealed that the resident has a wound to his/her right 2nd toe with serosanguineous (thin, clear, or pink fluid from a wound) drainage, unattached wound edges, and a pink/red wound bed with a dressing in place. Further review revealed that the resident presented to the hospital due to his/her toe becoming blueish in color and that the wound was debrided (removal of damaged tissue) in the hospital, and the resident was started on antibiotics for a right toe diabetic foot infection. Record review revealed that the resident had an admission skin check on 9/3/2024 which documented a diabetic neuropathic ulcer (preventable ulcers associated with diabetes mellitus) to the resident's right toe(s). Further review of the skin assessment failed to identify any characteristics of the wound. Further record review revealed a physician's order with a start date of 9/5/2024 for daily dressing changes to the resident's right second toe. Record review failed to reveal evidence at the time of admission that the wound was documented in the medical record to include the underlying condition contributing to the wound, wound edges, and the wound bed, location, shape and the condition of surrounding tissue per the regulation, policy, and standard of practice. During a surveyor interview on 9/13/2024 at approximately 8:24 AM with LPN, Staff C, he revealed that he was a float nurse and is unsure about the wound treatments and that he would not be completing them today as another nurse is coming to do them. During a surveyor interview on 9/13/2024 at 8:26 AM with the DNS, she revealed that the resident does have a skin impairment to his/her right second toe and will investigate measurements and characteristics of the wound. Additionally, she was unable to provide evidence of an initial wound evaluation for this resident related to his/her right second toe wound.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46715 Based on record review, resident, and staff interview, it has been determined that the facility failed to provide services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing for 1 of 1 resident reviewed for use of an external catheter (a flexible tube that collects urine and leads to a drainage bag), Resident ID #8. Findings are as follows: Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and heart failure. Review of an Admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 10 out of 15, indicating moderate cognitive impairment. Review of a progress note dated 8/27/2024 states, Resident requesting [external] cath [catheter] at night for quality of life. [Nurse Practitioner] in agreement order entered Resident pleased. During a surveyor interview on 9/12/2024 at 11:03 AM with the resident, s/he revealed that s/he wants the external catheter overnight to stop waking up wet in the morning. Additionally, s/he revealed that s/he has only received the external catheter one night and has not received it since. The resident revealed that it would make him/her more comfortable to wear the external catheter. Review of the September 2024 Treatment Administration Record revealed the external catheter was not utilized 5 out of 10 opportunities. During a surveyor interview on 9/12/2024 at 11:26 AM with Licensed Practical Nurse, Staff D, she acknowledged that the external catheter was not signed off as in use for 5 out of 10 opportunities. Additionally, she was unable to explain why the resident had not recieved the external catheter, as ordered. During a surveyor interview on 9/12/2024 at 11:36 AM with the Director of Nursing Services, she revealed that if the resident refused use of the external catheter that there should be a progress note indicating that. Additionally, she was unable to provide evidence that the facility provided the external catheter to promote the resident's highest practicable wellbeing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46539 46715 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan relative to 3 of 4 residents reviewed for specialist appointments, Resident ID #s 74, 79, and 194. Findings are as follows: Review of a facility policy titled, Resident Rights dated February 2021 states in part, Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to .access to people and services, both inside and outside the facility . 1. Record review revealed that Resident ID #74 was admitted to the facility in June of 2024 with diagnoses including, but not limited to, traumatic brain injury and subarachnoid hemorrhage (bleeding within the area between the brain and the tissue covering the brain). Review of a hospital form titled Continuity of Care form dated 6/12/2024 revealed the resident was treated for a traumatic brain injury and started on Keppra (anticonvulsant medication) in the hospital for seizure activity. Additionally, it revealed an order to make a follow up appointment with neurology. Record review failed to reveal evidence of the resident attending an appointment with neurology or the facility attempting to make an appointment with neurology. Review of a progress note dated 9/12/2024 revealed the facility contacted the neurology office to make an appointment, after it was brought to their attention by the surveyor. During a surveyor interview on 9/12/2024 at 8:10 AM with Registered Nurse (RN), Staff B, she acknowledged that the resident was supposed to follow up with neurology after admission to the facility. Additionally, she was unable to provide evidence of an appointment being made for the resident. 2. Record review revealed that Resident ID #79 was admitted to the facility in December of 2023 with diagnoses including, but not limited to, skin cancer and hypertension. Review of a progress note dated 8/24/2024 revealed the resident complained of mouth pain and a new order was implemented for Tylenol 650 milligrams three times a day and to follow up with a dentist the following week. Record review failed to reveal evidence that the resident was seen by a dentist or that the facility attempted to make an appointment with the dentist to treat the resident's mouth pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/12/2024 with Licensed Practical Nurse (LPN), Staff D, she was unable to provide evidence that the resident had an appointment with a dentist due to his/her mouth pain. 3. Record review revealed that Resident ID #194 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and orthopedic aftercare following surgical amputation. Review of a hospital discharge document titled, Continuity of Care form dated 9/3/2024 revealed the resident was treated with intravenous antibiotics for a right toe diabetic foot infection. Additionally, it revealed an order to make a follow up appointment with a podiatrist within one week. Record review failed to reveal evidence of an appointment for the resident to follow up with a podiatrist relative to his/her right foot infection. During a surveyor interview on 9/12/2024 at 11:04 AM with LPN, Staff A, she revealed that she does not make the appointments, the scheduler does. Additionally, she was unable to provide evidence that an appointment had been made for the resident to follow up with a podiatrist relative to a right foot infection. During a surveyor interview on 9/12/2024 at 11:53 AM with the Director of Nursing Services, she acknowledged that the appointments for the above-mentioned residents were not made.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that a resident with pressure ulcers receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 2 residents reviewed for pressure ulcers, Resident ID #s 5 and 62. Findings are as follows: 1. Review of a policy titled Wound Care states in part, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physicians order for this procedure . Record review revealed that Resident ID #5 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, pressure ulcer of an unspecified site and adult failure to thrive. Record review revealed that the resident has a care plan dated 3/29/2024 that revealed the resident has actual and potential for pressure ulcer and alterations in skin integrity related to a history of pressure ulcers, immobility and incontinence of urine and is followed by a wound care team. It further revealed that there are currently pressure ulcers on the right heel, right ankle, and right medial foot. Record review revealed that the resident was seen by an in-house wound physician on 9/4/2024 with recommendations to: Cleanse the right heel, right ankle, and right medial foot pressure wounds with 1/4 strength Dakin solution (a diluted sodium hypochlorite solution, 0.125% concentration, commonly used as a topical antiseptic. It is effective in treating and preventing infections in wounds), pat dry, apply collagen powder (stimulates new tissue growth) on to the wound and cover with calcium alginate with silver (absorbent dressing with antimicrobial properties) and cover with an absorbent dressing and wrap with a gauze stretch roll daily. Record review revealed physician's orders dated 8/3/2024 to cleanse the right medial and right heel pressure wounds with 1/4 strength Dakin's solution, pat dry, sprinkle collagen powder on to the wound and cover with calcium alginate with silver and cover with an absorbent dressing and wrap with a gauze stretch roll daily to the right medial foot and right heel. Further record review failed to reveal evidence of an order to treat the right ankle wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation on 9/13/2024 at 10:37 AM with Licensed Practical Nurse (LPN), Staff E, she was observed to mix 30 milliliters (ml) of half strength Dakin's (hypochlorite solution, 0.25% concentration) in a wash basin obtained from the resident's drawer with 15 ml of sterile water. Additionally, she was observed to dress the right ankle wound by cleansing the wound with the above-mentioned mixed Dakin solution and sterile water, drying the wound, pressing the collagen powder directly into the wound with her gloved hand and covered the collagen with calcium alginate with silver. She then proceeded to cover the wound with an absorbent dressing and wrap with a gauze stretch roll. During a surveyor interview immediately following the above-mentioned observation with Staff E, she acknowledged that there was not a physician's order in place to dress the resident's ankle wound. Additionally, she revealed that she was unsure how to make 1/4 strength Dakin's solution and indicated that she was instructed by another nurse to mix the 1/2 strength Dakin's solution with the sterile water, in order to make 1/4 strength Dakin's solution. During a surveyor interview with the Wound Physician on 9/13/2024 at 11:24 AM, he revealed that he would have to ask a pharmacist on how to mix solutions to get a 1/4 strength Dakin's from a 1/2 strength Dakin's solution. Additionally, he revealed he would expect there to be a treatment for the ankle pressure wound. During a surveyor interview on 9/13/2024 at 11:40 AM with the Director of Nursing Services (DNS), she revealed that she would look in to why there was no order to dress the ankle wound since 9/10/2024. Additionally, she revealed that she was unsure on how to mix 1/2 strength Dakin's solution to make 1/4 strength Dakin's solution. During a surveyor interview with the Nurse Practitioner on 9/13/2024 at 12:25 PM, she revealed that she was unfamiliar with Dakin's solution and was unaware of how to mix it to make 1/4 strength Dakin's. Furthermore, she revealed that she would expect there to be an order in place for the ankle pressure wound. 2. Record review revealed that Resident ID #62 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, right femur fracture and muscle wasting. Record review revealed the resident is being followed by an in-house wound physician. Record review revealed the following wound recommendations on 8/14/2024, 8/21/2024, 8/28/2024 and 9/11/2024: Cleanse the left and right buttocks pressure wounds with 1/4 strength Dakin solution, pat dry, and cover the wound with calcium alginate (absorbent dressing) and cover with a gentall blue (hydrofera blue; wound care product used to improve epithelialization (new skin growth) while wicking drainage and debris from the wound bed) three times a week. Further review of the 8/14/2024 recommendation revealed to discontinue collagen powder and calcium alginate with silver. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a physician's order dated 9/2/2024 to cleanse the right and left buttocks wounds with 1/4 strength Dakin's solution, sprinkle collagen powder into wound and on calcium alginate with silver and pack hydrofera blue into wounds and cover the wound with a dressing three times a week. During a surveyor interview on 9/13/2024 at approximately 8:24 AM with LPN, Staff C, he revealed that he was a float nurse and was unsure about the resident's wound treatments and indicated that he would not be completing them today. During a surveyor interview with the wound physician on 9/13/2024 at 11:28 AM, he revealed that he changed the order to discontinue the use of the calcium alginate with silver and collagen powder some time ago and is unsure why the order is still in place. During a surveyor interview with the Nurse Practitioner on 9/13/2024 at 12:25 PM, she revealed that she would agree with the wound recommendations from the provider as he is the specialist. During a surveyor interview on 9/13/2024 at 11:38 AM with the DNS, she revealed that she would investigate why the wound treatment did not match the wound recommendations. Additionally, she was unable to provide evidence that Resident ID #s 5 and 62 received pressure ulcer care to promote healing, prevent infection, and prevent new ulcers for developing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for oxygen use, Resident ID #58. Findings are as follows: Review of a facility policy titled, Oxygen Administration states in part, .Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated . Record review revealed that Resident ID #58 was admitted to the facility in November of 2023 with diagnoses including, but not limited to, Alzheimer's disease and dementia. Record review revealed the resident was admitted to hospice care on 7/21/2024. Record review revealed that the resident was evaluated by hospice services on 9/11/2024 and the resident was placed on oxygen therapy related to abnormal breath sounds and inability to obtain an oxygen level, with an oxygen delivery rate of 2 to 3 liters (L), per minute. Record review revealed a physician's order dated 9/11/2024 for oxygen via nasal cannula (a lightweight plastic tube that is inserted just inside a person's nostrils to provide oxygen) at 2L per minute, for comfort. Review of the September 2024 Medication Administration Record revealed the resident was initiated on the oxygen therapy on the night shift at 2L. During surveyor observations on 9/12/2024 the following was observed: - 10:29 AM The resident's oxygen tank was observed to be on empty by the surveyor. - 10:30 AM The Minimum Data Set (MDS) Coordinator was notified by the surveyor of the oxygen tank and acknowledged that the oxygen tank was empty. - 10:32 AM The MDS Coordinator asked the Certified Medication Technician (CMT), Staff F, to get the resident some oxygen, where Staff F responded, the nurse needs to do it I need to pass meds [medications]. - 10:32 AM CMT, Staff F looked in a room on the unit for oxygen and stated, we don't even have any. - 10:33 AM CMT, Staff F attempted to call someone on the phone and stated, there's no answer. The MDS Coordinator indicated to Staff F that this was a priority, where Staff F stated, I know it's a priority, but it looks like I'm the only one who is going to have to do it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10:34 AM The surveyor asked if the facility had oxygen concentrators, where the MDS Coordinator then asked the unit nurse if the facility had oxygen concentrators. Licensed Practical Nurse (LPN), Staff D stated, I don't think we have one. - 10:35 AM LPN, Staff D then stated, I need to get to work. - 10:35 AM LPN, Staff D, had a dressing change to complete on a different resident that was due on the 7:00 AM to 3:00 PM shift and was scheduled to complete this dressing change with a surveyor. Staff D continued to prioritize the dressing change with the surveyor, while Resident ID #58's oxygen tank was still empty. The surveyor had to intervene to alert the nurse that a resident's need for oxygen takes a higher priority than a dressing change. - 10:35 AM The MDS Coordinator revealed that she was not sure where the full oxygen tanks were located. - 10:36 AM LPN, Staff D stated, I guess I have to go downstairs myself. - 10:36 AM MDS Coordinator revealed that she is not in and out of the residents' rooms much and indicated that she was trying to think where another oxygen tank was located - 10:37 AM CMT, Staff F arrived on the unit and asked where the nurse is. - 10:37 AM CMT, Staff F gave the new oxygen tank to the MDS Coordinator. - 10:38 AM The MDS Coordinator attempted to switch over the oxygen tank, but was unsuccessful. - 10:39 AM The Director of Nursing Services (DNS) took over for the MDS Coordinator and switched over the tank successfully. -10:40 AM The resident was placed on 2L of oxygen. - 10:41 AM The DNS stated that the tank on 2L per minute would only last about 2 to 4 hours. - 10:46 AM The DNS instructed LPN, Staff D to obtain a set of vital signs because, that is more important than a piece of paper. - 10:47 AM The resident's oxygen level read at 78% (normal oxygen level falls between 95% and 100%) on 2L of oxygen. During a surveyor interview on 9/12/2024 at 11:57 AM with the DNS she revealed that she was aware of the situation and indicated that she will re-educate the staff on oxygen administration, importance of breathing, and storage of supplies. Additionally, she revealed there is a call out to hospice and the facility will request hospice to provide the resident with an oxygen concentrator. Furthermore, she was unable to provide evidence that the resident was provided respiratory care consistent with professional standards of practice.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 wound treatments observed, Resident ID #5. Findings are as follows: Record review revealed that Resident ID #5 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, pressure ulcer of unspecified site and adult failure to thrive. Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status Score of 1 out of 15, indicating severely impaired cognition. Review of a document titled, WOUND EVALUATION & MANAGEMENT SUMMARY dated 9/4/2024 revealed the resident has the following wounds; - Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to his/her right heel measuring 4.7 centimeters (cm) by 3.0 cm by 0.7 cm - Stage 4 pressure ulcer to his/her right ankle measuring 5.5 cm by 3.1 cm by 0.3 cm - Stage 3 pressure ulcer (full thickness of the skin and may extend into the subcutaneous [fat] tissue layer) to his/her right medial foot measuring 1.4 cm by 1.0 cm by 0.3 cm - Non-pressure wound to his/her right shin measuring 1.2 cm by 1.0 cm by 0.5 cm Review of the resident's care plan imitated on 8/11/2023 revealed that s/he has the potential to demonstrate physical behaviors related to poor impulse control when the resident is in pain or anxious. Additionally, the care plan revealed an intervention including, but not limited to, assess and anticipate his/her needs for comfort, body positioning, and pain. Additional review of the care plan dated 3/29/2024 revealed that the resident currently has pressure ulcers to the right heel, right medial foot, and right ankle, and a non-pressure wound to his/her right shin. Additionally, the care plan revealed an intervention including, but not limited to, monitor for pain and treat as needed. During a surveyor observation on 9/13/2024 at approximately 10:37 AM, revealed Licensed Practical Nurse (LPN), Staff E, performing wound care of the resident's stage 4 pressure ulcer to his/her right ankle, stage 4 pressure ulcer to his/her right heel, stage 3 pressure ulcer to his/her right medial foot and non-pressure wound to his/her right shin. Throughout the duration of the wound treatment, the resident was noted to be yelling, complaining of pain, and attempting to retract his/her right leg from the LPN who was providing care. The resident was noted to have complained of pain a minimum of 7 times during the wound treatments. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 9/13/2024 at 10:58 AM during wound care, with Staff E, the surveyor inquired if the resident received anything for pain and Staff E indicated that s/he received Tylenol around 6:00 AM and does not have anything else for pain medication available. Staff E then continued to provide wound care to the resident stating, I'm sorry hunny and I am almost done. Lastly, Staff E failed to stop the wound treatment, notify the provider of the resident's pain, or utilize any non-pharmacological interventions to manage the resident's pain such as repositioning the resident as per the care plan. Review of the September 2024 Medication Administration Record revealed that the resident receives Tylenol 1000 milligrams three times a day for pain, with the last administration at 6:00 AM on 9/13/2024. During a surveyor interview on 9/13/2024 at 11:38 AM, with the Director of Nursing Services, she was unable to provide evidence that Resident ID #5 was kept free from pain.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46539 47279 Based on surveyor observation, record review, resident, and staff interview, it has been determined that the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care affecting 2 of 3 units including, 1 of 3 residents observed to be saturated in urine prior to a wound dressing change, Resident ID #5 (on the South Unit), 1 of 1 observation made for timeliness of staff response to a call light triggered for Resident ID #291 (on the [NAME] Unit), and complaints of long response times to call lights and untimely assistance for morning care identified during the Resident Council task affecting residents on the East, West, and South Units on various shifts, including Resident ID #s 18, 27, and 196. Findings are as follows: Review of the Facility Assessment states in part, .in the event of staffing challenges, our facility may utilize contracted staff to ensure that the needs of the residents are met . 1a) During the entrance conference with the facility on 9/10/2024 at approximately 9:00 AM with the Administrator and Director of Nursing Services (DNS), they revealed that they do not utilize contracted nursing staff. During multiple surveyor interviews on 9/11/2024 at 3:01 PM with various residents in attendance during the Resident Council task, the following concerns were mentioned: - Resident ID #196 indicated long wait times for staff response to call lights on the 11:00 PM - 7:00 AM shift on the East Unit - Resident ID #18 indicated long wait times for staff response to call lights on the 3:00 PM - 11:00 PM shift on the South Unit - Resident ID #27 indicated that s/he did not receive the necessary assistance from staff to get out of bed until approximately 2:00 PM that afternoon, 9/11/2024, on the South Unit During a surveyor interview on 9/10/2024 at 12:27 PM with Nursing Assistant (NA), Staff G, working on the [NAME] Unit, she revealed that she still has 4 residents that have yet to receive morning care and will finish when she can. Additionally, she indicated that they are short-staffed and revealed they only have 3 NAs working the unit and should have 5 NAs. During a surveyor interview on 9/13/2024 at 11:28 AM with NA, Staff H, she revealed that at times she is still assisting residents with morning care around 2:30 PM - 3:00 PM. Additionally, she indicated that resident's often complain to her about long wait times before staff respond to their call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/13/2024 at 12:17 PM with NA, Staff I, working on the [NAME] Unit, she revealed that she just completed morning care and has 14 residents on her assignment. She indicated that some days she may have up to 20 residents on her assignment. During a surveyor interview on 9/13/2024 at 12:21 PM with the DNS in the presence of the Regional Nurse, she revealed that the [NAME] Unit should be staffed with 4 NAs on the 7:00 AM - 3:00 PM shift and was unable to explain why only 3 NAs were working the 7:00 AM - 3:00 PM shift on 9/13/2024. 1b) Record review revealed Resident ID #291 was admitted to the facility in September of 2024 with a diagnosis including, but not limited to, difficulty in walking. Review of a progress noted dated 9/13/2024 at 4:26 PM, revealed that the resident was admitted to the facility for a decline in activities of daily living, function, and mobility and required therapy services. During a surveyor observation and simultaneous interview on 9/13/2024 at approximately 9:47 AM of Resident ID #291, s/he was observed to have his/her call light triggered and the resident was observed to be self-toileting him/herself. S/he indicated to the surveyor that s/he had to bring him/herself to the bathroom because nobody was available to help him/her. Additionally, 3 staff members were observed to walk by the resident's room and/or interact with the resident from the doorway, however, did not provide him/her assistance and indicated that another staff member would be in shortly to help him/her. Further, at approximatley 10:00 AM a staff member entered his/her room and turned off the resident's call light. During a surveyor interview on 9/13/2024 at 12:21 PM with the Regional Nurse in the presence of the DNS, she revealed that she would expect residents to be provided assistance with morning care and be up out of bed prior to 12:00 PM. Additionally, she indicated that she expects staff to respond to resident call lights within 2 to 5 minutes. 1c) Record review revealed that Resident ID #5 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, pressure ulcer of an unspecified site and adult failure to thrive. Review of a care plan focus area dated 8/15/2023 revealed that the resident has skin breakdown related to urinary incontinence and limited mobility with an intervention to keep the resident clean and dry, and to provide incontinence care every 2-3 hours and as needed. Record review revealed that the resident has orders to provide daily wound care to his/her right heel and right medial foot wound. During a surveyor observation on 9/13/2024 at 10:37 AM of the resident, as the surveyor was waiting to observe staff conduct the above-mentioned wound dressing changes, the resident's brief, clothes, and bed linens were all observed to be saturated with urine. Additionally, Staff E proceeded to complete wound care without having provided incontinence care. Staff E completed wound care at 11:09 AM indicating that the resident remained soiled during wound care with Staff E aware for approximately 33 minutes. Additionally, she was unsure when the resident was last provided incontinence care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/13/2024 at 11:11 AM with NA, Staff J, she acknowledged that the resident's clothes and bed linens were saturated with urine and revealed that she had yet to change the resident since she began her shift at 7:00 AM. Additionally, she was unsure when the resident was last provided incontinence care. During a surveyor interview on 9/13/2024 at 11:40 AM with the DNS, she was unable to explain why the resident was found to be saturated in his/her urine and had not been provided incontinence care that morning, or prior to the dressing change, at the time of the surveyor's observation. She was unable to provide evidence that the facility has sufficient nursing staff to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47279 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident relative to the administration of hypodermoclysis (a method of infusing fluids into the fatty tissue below the skin by means of gravity and a dial flow meter to approximate the infusion rate) for Resident ID #191 for 3 of 3 staff reviewed, Staff A, B, E, and 2 of 3 staff reviewed for wound dressing changes observed for Resident ID #s 5 and 192, Staff A and E. Findings are as follows: Review of the Facility Assessment revealed that the facility provides services including hypodermoclysis and wound care. Additionally, it indicates that department specific training and competencies are completed with staff throughout employment to ensure that they can safely and competently provide the level and types of care required by the resident population. 1a) Review of a policy titled, Wound Care states in part, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physicians order for this procedure . Record review revealed that Resident ID #5 was admitted to the facility in August of 2023 with diagnoses including, but not limited to, pressure ulcer of an unspecified site and adult failure to thrive. Review of a care plan focus area dated 3/29/2024 revealed that the resident currently has pressure ulcers on his/her right heel, right ankle, and right medial foot. Further record review failed to reveal evidence of a physician's order to treat the resident's right ankle wound. During a surveyor observation on 9/13/2024 at 10:37 AM with Licensed Practical Nurse (LPN), Staff E, was observed to be providing wound care to the resident's right ankle wound, although there was no physician's order in place. Additionally, Staff E was observed removing a wash basin from the resident's drawer and proceeded to mix a wound solution in the wash basin, without cleaning the basin prior to use, and proceeded to complete the resident's wound care using the solution mixed in the wash basin. During a surveyor interview immediately following the above-mentioned observation with Staff E, she acknowledged that there was not a physician's order to dress the ankle wound. Additionally, she acknowledged that she removed the basin from the resident's drawer and then mixed wound care solution in it and proceeded to cleanse the wound. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a completed Wound Care Competency Assessment for Staff E dated 7/25/2024 and signed by Staff E and the observer/trainer which states in part, .B) Preparation 1. Verify that there is a physician's order for this procedure .8. Pour liquid solutions directly on gauze sponges on their papers . 1b) Record review revealed that Resident ID #192 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of prosthetic heart valve and heart failure. Record review revealed the following physician's orders: - 9/3/2024: Cleanse the right chest wound with normal saline, pat dry, apply xeroform (sterile wound dressing) to the surgical site, followed by gauze and a tegaderm (transparent dressing) daily. - 9/3/2024: Cleanse the surgical wound to the abdomen with wound wash, pat dry, apply xeroform to the surgical site, and cover with a clean dressing daily. During a surveyor observation on 9/10/2024 at 11:15 AM, revealed LPN, Staff A, removed scissors and other wound care supplies from the treatment cart and entered Resident ID #192's room to provide wound care. Staff A was then observed using the scissors to cut the xeroform, where she failed to clean the scissors prior to cutting the xeroform. During a surveyor interview immediately following the above observation, Staff A acknowledged that she did not clean the scissors, prior to cutting the xeroform. Review of an undated Wound Care Competency Assessment for Staff A revealed that 2 of 4 pages were missing and lacked signatures from Staff A and the observer/trainer. 2a) Review of a facility policy titled, Hypodermoclysis - Subcutaneous Infusion states in part, .Infusion . Connect solution administration set to catheter connector. Start fluid and adjust flow to ordered rate of infusion . Record review revealed Resident ID #191 was admitted to the facility in August of 2024 with a diagnosis including, but not limited to, Alzheimer's disease. Record review revealed Resident ID #191 has a physician's order for Dextrose Solution 5% (D5 solution) to be administered via hypodermoclysis at 50 milliliters (ml) per hour (ml/hr). Review of the hypodermoclysis tubing packaging states in part, .DIRECTIONS .Check maintenance of proper flow rate at regular intervals . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor observation and simultaneous interview during the medication administration task on 9/10/2024 at 12:45 PM with Registered Nurse, Staff B, she set up hypodermoclysis with the 1 liter of D5 solution and attached it to the resident, then set the dial flow to 50ml/hr (for the D5 solution to infuse for a duration of 20 hours and finish at approximately 8:45 AM on 9/11/2024). She indicated that she checks the infusion site once a shift and failed to indicate that she assesses the drip rate (drops per minute in the fluid chamber of the tubing) and dial flow meter to ensure that the resident is receiving his/her fluids at 50ml/hr, as ordered (the drip rate to equal 50ml/hr should be approximately 17 drops per minute). Staff B failed to assess the drip rate and exited the resident's room. The drip rate was noted by surveyor at approximately 12 drops per minute. During multiple surveyor observations revealed the D5 solution was infusing at approximately 12 drops per minute instead of 17 drops per minute on the following dates and times: - 9/10/2024 at 2:44 PM - 9/11/2024 at 9:27 AM - 9/11/2024 at 2:27 PM During a surveyor observation and simultaneous interview on 9/11/2024 at 2:35 PM of the resident with Staff A, she acknowledged that the D5 solution was still infusing. She revealed that she does not calculate the drip rate when using hypodermoclysis and would need to look up how to calculate it. During a surveyor interview on 9/11/2024 at 2:43 PM with Staff B, she revealed that she began working for the facility 8 months prior and has not received any competencies or education relative to hypodermoclysis. Record review for nursing competencies for Staff A, B, and E relative to hypodermoclysis revealed the following: - Staff A: An undated competency - Staff B: A completed competency dated 7/25/2024 - Staff E: A competency dated 7/25/2024 unsigned by Staff E During a surveyor interview on 9/13/2024 at 12:17 PM with the Nurse Practitioner, she revealed that she would expect that staff would calculate the drip rate when utilizing hypodermoclysis for a resident to ensure that s/he is receiving the proper flow rate, as ordered. During a surveyor interview on 9/13/2024 at 12:21 PM with the Regional Nurse in the presence of the Director of Nursing Services, she revealed that she would expect staff to calculate the drip rate relative to hypodermoclysis and wound dressings to be completed only if there is a physician's order. She was unable to provide evidence that nursing staff are competent and have skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Cross reference F 686, 759, 880

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46539 46241 46715 Based on record review and staff interview, it has been determined that the facility failed to address pharmacy recommendations in a timely manner for 3 of 6 residents reviewed, Resident ID #s 15, 58, and 63. Findings are as follows: Review of a facility policy titled, Consultant Pharmacist Reports dated November 2021 states in part, . Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing .The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e.g., monitor blood pressure . 1. Record review revealed that Resident ID #15 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, bipolar disorder, anxiety, and depression. Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 6/26/2024 revealed to complete the diagnoses for use on orders lacking reason entered into the Electronic Medical Record (EMAR). Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 7/28/2024 revealed to complete the diagnoses for use on orders lacking reason entered into the EMAR. Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 8/28/2024 revealed to complete the diagnoses for use on orders lacking reason entered into the EMAR. Record review revealed the following physician medication orders without diagnoses or reasons for use: - Divalproex Sodium 500 milligrams (MG) give 1 tablet two times a day for. - Risperidone Oral Tablet 0.5 MG give two times a day for. - Atorvastatin Calcium 10 MG give at bedtime for. - Flomax Oral Capsule 0.4 MG give 1 capsule in the evening for. - Levothyroxine Sodium Oral Tablet 25 Micrograms (MCG) give one time a day for. - Vitamin B1 Oral Tablet give one time a day for. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Trazodone Oral Tablet 50 MG give at bedtime for. During a surveyor interview on 9/13/2024 at 11:03 AM with the Director of Nursing Services (DNS), she acknowledged that the pharmacy recommendations for Resident ID #15 had not been addressed for June, July, or August of 2024. 2. Record review revealed that Resident ID #58 was readmitted to the facility in November of 2023 with diagnoses including, but not limited to, Alzheimer's disease, anxiety, and depression. Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 7/28/2024 revealed that liquid concentrate orders should include instructions for both the dose in milligrams (MG) as well as milliliters (ML), to help avoid medication errors. Additionally, it instructs to adjust orders accordingly. Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 8/28/2024 revealed that liquid concentrate orders should include instructions both the dose in MGs as well as MLs, to help avoid medication errors. Additionally, it instructs to adjust orders accordingly. Record review revealed the following physician's orders that lack the MGs that should be administered: - Lorazepam Intensol Oral Concentrate 2 MG/ML give 0.25 ml sublingually every 4 hours for restlessness - Morphine Sulfate Concentrate Oral Solution 20 MG/ML give 0.25 ml sublingually every 2 hours as needed for pain/discomfort During a surveyor interview on 9/13/2024 at approximately 12:00 PM with the DNS, she acknowledged that the pharmacy recommendations to add the milligrams to the order had not been completed. 3. Record review revealed that Resident ID #63 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, atrial fibrillation (an irregular and often very rapid heart rhythm) and myopathy (diseases that attack your skeletal muscles and make your muscles weak). Review of a document titled, Consultant Pharmacist Recommendations to Nursing dated 8/28/2024 revealed that the resident is receiving an anticoagulant, Eliquis, and to ensure documentation of regular monitoring for signs and symptoms of bleeding. Review of a second document titled, Consultant Pharmacist Recommendations to Nursing dated 8/28/2024 revealed to adjust Eliquis order to be given every 12 hours instead of 9:00 AM and 5:00 PM. Record review revealed the following physician order for Eliquis: - Eliquis 2.5 MG twice daily, administer at 9:00 AM and 5:00 PM with a start date of 8/15/2024 Record review failed to reveal evidence of monitoring for signs and symptoms of bleeding per the pharmacy recommendation and failed to adjust the order to every 12 hours as recommended by the pharmacist. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/13/2024 at 12:06 PM with the DNS and the Regional Nurse, they acknowledged that the pharmacy recommendations for Resident ID #s 15, 58, and 63 were not completed for June, July, and August 2024.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47279 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 25 opportunities for error observed during the medication administration task, there were 14 errors resulting in a medication error rate of 56%, involving Resident ID #s: 74, 83, 191, and 241. Findings are as follows: Review of a facility policy titled, Administering Medications states in part, .Medications are administered in a safe and timely manner, and as prescribed .3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. 4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribed time . 1a) Record review revealed Resident ID #241 has physician's orders for the following medications: - Guaifenison 600 milligrams (mg) give 2 tablets for congestion at 8:00 AM and 8:00 PM - Acetaminophen 325mg give 2 tablets for pain at 9:00 AM and 5:00 PM - Aspirin 81mg give 1 tablet for congestive heart failure at 9:00 AM - Vitamin D 25 micrograms give 1 capsule for bone health at 9:00 AM - Potassium Chloride 20 millequivalents give 1 packet twice daily for low potassium at 9:00 AM and 5:00 PM - Midodrine 5mg give one tablet for low blood pressure at 8:00 AM, 1:00 PM, and 6:00 PM - Finasteride 5mg give one tablet at 9:00 AM During a surveyor observation during the medication administration task on 9/10/2024 at 11:32 AM with Licensed Practical Nurse (LPN), Staff K, she administered the above-mentioned medications to the resident at 11:47 AM, approximately 3 to 4 hours after the scheduled time. During a surveyor interview immediately following the above observation with Staff K, she acknowledged that some of the resident's medications were administered late. She revealed that medications are often administered late. 1b) Record review revealed Resident ID #83 has physician's orders for the following medications: - Zoloft 25mg give 3 tablets for depression at 8:00 AM - Sennosides 8.6mg give 2 tablets for constipation at 9:00 AM and 5:00 PM (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Calcium Carbonate (Tums) give 1 tablet for upset stomach at 9:00 AM and 5:00 PM before meals - Acetaminophen 325mg give 3 tablets for pain at 8:00 AM, 2:00 PM, and 10:00 PM During a surveyor observation during the medication administration task on 9/10/2024 at 11:52 AM with Staff K, she administered the above-mentioned medications to the resident at 11:57 AM, approximately 3 to 4 hours after the scheduled time. Additionally, she administered the resident his/her Tums although the medication is ordered to be administered before meals. 1c) Record review revealed Resident ID #191 has a physician's order for Dextrose Solution 5% (D5 solution) to be administered via hypodermoclysis (a method of infusing fluids into the fatty tissue below the skin by means of gravity and a dial flow meter to approximate the infusion rate) at 50 milliliters (ml) per hour (ml/hr). During a surveyor observation and simultaneous interview during the medication administration task on 9/10/2024 at 12:45 PM with Registered Nurse, Staff B, she set up hypodermoclysis with the D5 solution and attached it to the resident, then set the dial flow to 50ml/hr. She indicated that she checks the infusion site once a shift and failed to indicate that she assesses the drip rate (drops per minute in the fluid chamber of the tubing) and dial flow meter to ensure that the resident is receiving his/her fluids at 50ml/hr, as ordered (the drip rate to equal 50ml/hr should be approximately 17 drops per minute). Staff B failed to assess the drip rate and exited the resident's room. The drip rate was noted by surveyor at approximately 12 drops per minute. During a surveyor observation on 9/10/2024 at 2:44 PM revealed the drip rate remained at approximately 12 drops per minute. 1d) Record review revealed Resident ID #74 has physician's orders for the following medications: - Metoprolol Tartrate 50mg give 1 tablet twice daily for high blood pressure with parameters to hold the medication if the resident's apical pulse (a pulse point on your chest that is obtained by using a stethoscope) is less than 60 beats per minute - Prevacid (treats heartburn) 30mg give 1 tablet twice daily. Additionally, the instructions on the medication packaging indicated to not crush or chew the medication During a surveyor observation during the medication administration task on 9/11/2024 at approximately 9:45 AM with LPN, Staff A, she failed to obtain the resident's apical pulse prior to the administration of his/her Metroprolol Tartrate. Additionally, Staff A crushed his/her Prevacid and then administered it to the resident. During a surveyor interview on 9/11/2024 at approximately 10:20 AM and again at 2:52 PM with Staff A, she revealed that she should have obtained the resident's apical pulse and acknowledged that she did not. She further acknowledged that she crushed his/her Prevacid and indicated that she should not have crushed the medication prior to administering it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 9/11/2024 at approximately 3:00 PM with the Regional Nurse in the presence of the Director of Nursing Services, she revealed that she would expect the residents to receive their medications as ordered and within the scheduled time frame. Additionally, she 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. Cross reference F 726

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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. 46241 46715 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records that are accurately documented in accordance with professional standards and practices for 1 of 3 residents reviewed for vascular wounds, Resident ID #8. Findings are as follows: Record review revealed the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, type II diabetes mellitus and heart failure. Record review revealed the following physician's orders to the resident's right lower extremity: - Apply Unna Boot - 2-layer compression system (a type of compression bandage that is specifically designed to treat and manage venous leg ulcers. It consists of a layer of zinc-impregnated, semi-rigid gauze wrapped around the affected leg, followed by an outer layer of cohesive compression bandage) twice weekly on Monday and Friday, with a start date of 6/24/2024. - Apply A+D ointment to leg along with clobetasol (a medicated cream). Cover with foam dressing. Apply tubi grip (an elastic bandage that provides continuous support for management of swelling) with a start date of 8/27/2024. Review of a progress note dated 8/24/2024 revealed the resident was seen at a wound clinic and new recommendations were made to change the treatment from the Unna Boot to clobetasol and a tubi grip. Review of the September 2024 Treatment Administration Record revealed the Unna Boot treatment was signed off as completed on 9/6 and 9/9/2024. During surveyor observations on 9/12/2024 and 9/13/2024 revealed the resident did not have an Unna Boot in place. During a surveyor interview on 9/13/2024 at 8:08 AM with Registered Nurse, Staff B, she revealed that the order was changed on 8/27/2024 and that the resident does not have an Unna Boot in place. Additionally, she revealed that the Unna Boot treatment should have been discontinued and she was unable to explain why it was still being signed off as completed. During a surveyor interview on 9/13/2024 at 8:20 AM with the Director of Nursing Services, she acknowledged that the order for the Unna Boot was signed off as completed although the resident did not have the Unna Boot in place. Additionally, she was unable to explain why the resident's medical record was not accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46539 46241 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, relative to scabies (an itchy skin rash caused by a tiny burrowing mite that can spread through close contact) management for 2 of 2 residents reviewed, Resident ID #s 42 and 45, and relative to Enhanced Barrier Precautions (EBP; involves using gown and gloves during high-contact resident care activities), Resident ID #s 78 and 192. Additionally, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to 2 of 3 wound care observations, Resident ID #s 5 and 192. Furthermore, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to the handling of soiled linen in the laundry room. Findings are as follows: 1. Review of a facility policy titled, Scabies, Identification, Treatment, and Environmental Cleaning last revised August 2016, states in part, .Environmental Control: Typical Scabies .Place bed linens, towels and clothing used by an affected person during the 4 days prior to the initiation of treatment in plastic bags inside the resident's room, handled by gloved and gowned staff without sorting, and washed in hot water for at [least] 10-20 minutes .Use the hot cycle of the dryer for at [least] 10-20 minutes .Place non-washable blankets and articles in a plastic bag for at least 72 hours .Change all bed linens, towels and clothes daily . Vacuum mattresses, upholstered furniture and carpeting .For non-fabric items, routine disinfection procedures are adequate . a) Record review revealed Resident ID #45 was admitted to the facility in May of 2022 with a diagnosis that includes, but not limited to, dementia. Review of a provider note dated 9/10/2024 which states in part, Member is seen today for rash. Member has small, raised, red bumps in tracks across arms, trunk and legs. Member has been observed to be scratching rash frequently. Rash is consistent with scabies . Record review revealed a physician's order dated 9/10/2024, to ensure that all the residents belongings are bagged and removed from his/her room and given to housekeeping prior to treatment. Surveyor observations on the following dates and times, failed to reveal evidence that the resident's belongings were bagged or removed from his/her room, per facility policy and physician's order: - 9/10/2024 at 9:54 AM and 12:16 PM - 9/11/2024 at 11:13 AM - 9/12/2024 at 1:23 PM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) Record review revealed Resident ID #42 was readmitted to the facility in June of 2024 with a diagnosis that includes, but not limited to, dementia. Record review revealed a physician's order dated 9/10/2024, to ensure that all the resident's belongings are bagged and removed from his/her room and given to housekeeping prior to treatment. Surveyor observations on the following dates and times, failed to reveal evidence that the resident's belongings were bagged or removed from his/her room, per facility policy and physician's order: - 9/10/2024 at 9:54 AM and 12:16 PM - 9/11/2024 at 11:13 AM - 9/12/2024 at 1:23 PM During surveyor interviews on 9/12/2024 at 1:24 PM and 1:54 PM, with Nursing Assistant, Staff H, she revealed that she was not instructed to bag the resident's belongings and indicated that she has been placing the resident's dirty linens in the unit laundry basket. During a surveyor interview on 9/12/2024 at 1:32 PM, with Registered Nurse, Staff B, she revealed that any resident with suspected scabies should have all belongings placed in black bags, removed from their rooms, and kept separate from other resident's laundry, for at least 72 hours. She further revealed that she was informed of the resident's potential scabies on 9/9/2024 and indicated that she informed all floor staff about the scabies and expected process. During a surveyor interview on 9/12/2024 at 1:46 PM, with the Director of Housekeeping, in the presence of the Regional Maintenance Director, he revealed that he was informed of the resident's potential scabies and indicated that he gave Staff B the black bags to use for the resident's belongings. He further revealed that he was unsure if the resident's belongings were bagged, indicating that no one called him to remove the bags from the resident's room, nor did he delegate the task to another staff member. Further, he revealed that after the black bags are collected from the resident's rooms, they are stored in an outside storage pod for at least 72 hours. During a surveyor observation on 9/12/2024 at 1:52 PM of the outside storage pod, no black bags were observed in the pod. During a surveyor interview on 9/12/2024 at 2:28 PM, with the Director of Nursing Services (DNS), she revealed that she would expect staff to follow the facility's scabies policy and physician's order. 2. Review of a facility policy titled, Enhanced Barrier Precautions last revised August 2022, states in part, . Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control intervention .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 for EBPs include .device care or use (.feeding tube .) .wound care (any skin opening requiring a dressing) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a) Record review revealed Resident ID #74 was readmitted to the facility in August of 2024 with a diagnosis that includes, but not limited to, respiratory failure. Record review revealed the resident has a gastrointestinal tube (G-tube [feeding tube]; inserted through the abdomen and into the stomach, which allows liquid nutrition to be given directly into the stomach). Review of the resident's care plan revealed a focus area initiated on 9/10/2024 which revealed the resident requires EBP related to his/her feeding tube. An intervention includes, but is not limited to, gloves and a gown must be worn during high-contact care activities. During a surveyor observation on 9/12/2024 at 11:00 AM, revealed Licensed Practical Nurse (LPN), Staff A, was administering Resident ID #74'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, immediately following the above observation, Staff A acknowledged the EBP signage posted at the resident's doorway and acknowledged that she was not wearing the appropriate Personal Protective Equipment (PPE), when she administered the resident's medication, through his/her feeding tube. During a surveyor interview on 9/12/2024 at 2:28 PM, with the DNS, she revealed that she would expect nurses to don full PPE, including a gown, when administering medication to a resident through a feeding tube. b) Record review revealed Resident ID #78 was readmitted to the facility in February of 2024 with a diagnosis that includes, but is not limited to, dementia. Review of the resident's care plan revealed a focus area initiated on 9/7/2024 which revealed the resident requires EBP related to wounds. An intervention includes, but is not limited to, gloves and a gown must be worn during high-contact care activities. During a surveyor observation on 9/10/2024 at 12:20 PM, revealed a Registered Nurse (RN) from Hospice services, was observed to be providing wound care to the resident, without donning a gown. Further observation revealed signage posted at the resident's door which indicated to wear a gown during wound care. During a surveyor interview immediately following the above observation, the Hospice RN acknowledged the signage posted at the resident's door and acknowledged she was not wearing the appropriate PPE when providing wound care to the resident. During a surveyor interview on 9/10/2024 at 12:23 PM, with LPN, Staff K, she revealed that the Hospice RN should have worn the appropriate PPE, as described in the EBP signage, when providing wound care to the resident. c) Record review revealed that Resident ID #192 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, presence of prosthetic heart valve and heart failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed that the resident has wounds that require daily wound care. During a surveyor observation on 9/10/2024 at 11:15 AM, revealed Staff A providing wound care to the resident, without donning a gown. Further observation failed to reveal evidence of EBP signage, or a PPE bin located at the resident's door. During a surveyor interview immediately following the above observation, Staff A acknowledged that the resident was not on EBP and indicated s/he should have been on EBP. Additionally, she acknowledged that she did not wear a gown during the resident's wound treatment. Review of the resident's care plan revealed a focus area initiated on 9/10/2024, after this concern was brought to the facility's attention by the surveyor, which revealed the resident requires EBP related to wounds. An intervention includes, but is not limited to, gloves and a gown must be worn during high-contact care activities. During a surveyor interview on 9/10/2024 at 12:18 PM, with the DNS and the Regional Nurse, they acknowledged that Resident ID #192 was not on EBP and indicated that the resident should have been on EBP due to his/her wounds. 3. Review of a facility policy titled, Wound Care last revised October 2010, states in part, .Use the no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers . Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound . Wear sterile gloves when physically touching the wound or holding a moist surface over the wound .Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.) . a) During a surveyor observation on 9/10/2024 at 11:15 AM, revealed Staff A removing scissors and other wound care supplies from the treatment cart and entering Resident ID #192's room to provide wound care. Staff A was then observed using the scissors to cut xeroform (sterile wound dressing), where she failed to clean the scissors, prior to cutting the xeroform. During a surveyor interview immediately following the above observation, Staff A acknowledged that she did not clean the scissors prior to cutting the xeroform, per policy. b) Record review revealed Resident ID #5 was admitted to the facility in August of 2023 with a diagnosis that includes, but is not limited to, pressure ulcer of an unspecified site. During a surveyor observation of the resident's wound care on 9/13/2024 at 10:37 AM, with LPN, Staff E, she was observed removing a wash basin from the resident's drawer and proceeded to mix a wound solution in the wash basin, without cleaning the basin prior to use. Additionally, she was observed to dress the right ankle wound by cleansing the wound with the above-mentioned mixed solution and dried the wound with the same gloves. Further, using the gloves she cleaned the dirty wound with, she then proceeded to put her fingers into a package containing collagen powder and began pressing the collagen powder directly into the wound with her gloved hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview immediately following the above-mentioned observation with Staff E, she acknowledged that she touched the wound to press the collagen directly into the wound bed with the same gloves she used to cleanse the dirty wounds. She further acknowledged that she removed the basin from the drawer and then mixed the solution in it. During a surveyor interview with the Wound Physician on 9/13/2024 at 11:24 AM, he revealed that he would expect the staff to put the collagen powder into a cup and pour it on the wound or on to the calcium alginate with silver. During a surveyor interview on 9/13/2024 at 11:40 AM with the DNS, she was unable to explain why the nurse did not change her gloves or pre-clean the wash basin prior to use. 4. Review of a facility policy titled, Laundry and Bedding, Soiled last revised September 2022, states in part, . All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting) . During a surveyor observation of the soiled linen area of the laundry room on 9/13/2024 at 9:39 AM, failed to reveal evidence of gowns. During a surveyor interview immediately following the above observation, Housekeeper, Staff L, acknowledged that there were no gowns in the laundry room and revealed that she does not wear a gown when handling soiled linens. During a surveyor interview on 9/13/2024 at 9:44 AM, with the Director of Housekeeping, he acknowledged that the soiled linen room did not have any gowns for staff to utilize when handling soiled linens, indicating that he has not found an area to keep them. He further revealed that all laundry staff should be wearing a gown when handling soiled linens. 46715 47279

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 47279 Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic for 2 of 2 residents reviewed for antibiotic use, Resident ID #s 78 and 194. Findings are as follows: Review of a facility policy titled, Antibiotic Stewardship last revised in December of 2016, states in part, . Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program .The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents . Review of a facility policy titled, Infection Preventionist [IP] last revised in September of 2022, states in part, . Responsibilities 1. The [IP] (or designee) coordinates the development and monitoring of the [IPCP] .The [IP] collects, analyzes and provides infection and antibiotic usage data and trends to nursing staff and health care practitioners . 1. Record review revealed that Resident ID #78 was readmitted to the facility in February of 2024 with diagnoses including, but not limited to, dementia and type II diabetes mellitus. Record review revealed a physician's order dated 7/26/2024 for Keflex (an antibiotic) 500 milligrams (mg) give 1 capsule twice daily for a foot infection for 8 weeks. Record review failed to reveal evidence that the facility implemented an antibiotic review process (also referred to as an antibiotic timeout) to determine if the antibiotic is still indicated or if adjustments should be made. Record review failed to reveal evidence that the facility was formally tracking and monitoring the resident's use of antibiotics for residents, including Resident ID #78, during the months of July, August, and September of 2024. 2. Record review revealed that Resident ID #194 was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to, type II diabetes mellitus. Record review revealed a physician's order dated 9/3/2024 for Augmentin (an antibiotic) 875-125mg give 1 tablet twice daily for 7 days for a bacterial infection. Record review failed to reveal evidence that the facility implemented an antibiotic review process to determine if the antibiotic is still indicated or if adjustments should be made. Record review failed to reveal evidence that the facility was formally tracking and monitoring the resident's use of antibiotics for residents, including Resident ID #194, during the time the resident was receiving antibiotics in September of 2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 9/12/2024 at 11:02 AM with the IP, during the infection control task in the presence of the Director of Nursing Services, Administrator, and Regional Nurse, she revealed that she recently accepted the role as the IP approximately 1 month ago and does not complete antibiotic timeouts or maintain line listings of residents currently receiving antibiotics because she has yet to be shown how to do it. During an additional surveyor interview on 9/12/2024 at approximately 11:10 AM with the Regional Nurse during the infection control task, she revealed that the facility should complete an antibiotic timeout assessment in the electronic medical record and would expect the antibiotic timeouts to be completed 3 days after the antibiotic is initiated. Additionally, she revealed that the facility could be better at completing antibiotic timeouts. She was unable to provide evidence that the facility maintained an infection control and antibiotic stewardship system to monitor antibiotic use to ensure that residents who require an antibiotic are prescribed the appropriate antibiotic.