STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415063	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Rehabilitation and Healthcare Center	860 North Quidnessett Road North Kingstown, RI 02852

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47279 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to protect the residents' right to be free from abuse for 1 of 1 resident reviewed for abuse, Resident ID #46. Findings are as follows: Review of a facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated October of 2022 states in part, .Residents have the right to be free from abuse .This includes but is not limited to .physical abuse .Protect residents from abuse .by anyone including .other residents . Review of a facility reported incident submitted to the Rhode Island Department of Health on 5/8/2024 alleges that Resident ID #42 approached Resident ID #46, began yelling at him/her and hit his/her left arm several times which resulted in a skin tear. Record review revealed that the victim, Resident ID #46, was admitted to the facility in November of 2023 with a diagnoses including, but not limited to, dementia. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. Record review revealed that the perpetrator, Resident ID #42, was admitted to the facility in June of 2023 with diagnoses including, but not limited to, cerebral infarction (stroke), dysarthria (difficulty speaking,) and cognitive social or emotional deficits following a stroke. Record review of a progress note dated 5/8/2024 at 10:38 PM, revealed that Resident ID #46 hit Resident ID #42. The note further indicates that Resident ID #46 was sitting quietly in his/her wheelchair when Resident ID #42 suddenly began to yell at Resident ID #46 and proceeded to hit him/her, striking Resident ID #46 on his/her left arm. Resident ID #46 sustained 2 skin tears which measured 1.0 centimeter (cm) by 0.5 cm and 0. 5 cm by 0.5 cm. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's 5-Day investigation report titled, Conclusion dated 5/14/2024, revealed that Resident ID #42 had a BIMS score of 15 out of 15, indicating intact cognition. Additionally, it indicated that Resident ID #42 has impulse control issues following his/her stroke and became frustrated when Resident ID #46 did not move his/her feet. During a surveyor interview on 8/21/2024 at 10:22 AM with Nursing Assistant, Staff L, she revealed that she witnessed the incident between Resident ID #s 42 and 46. She indicated that Resident ID #42 is alert and oriented and can be verbally aggressive towards others. She further indicated that Resident ID #46 was sitting in front of the Nurse's station when Resident ID #42 began yelling at Resident ID #46 and then struck Resident ID #46 approximately 3 times in his/her arm, resulting in skin tears. Lastly, she indicated that the incident was unprovoked. During a surveyor interview on 8/21/2024 at 1:36 PM with the Director of Nursing Services, she revealed that Resident ID #42 can be verbally aggressive at times due to his/her speech impairment. Additionally, she acknowledged that Resident ID #46 was not kept free from physical abuse.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46539 Based on record review and staff interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 2 residents reviewed relative to Post-traumatic stress disorder (PTSD, occurs in some individuals who have encountered a shocking, scary, or dangerous situation) Resident ID #49 and 1 of 1 resident reviewed for wandering, Resident ID #65. Findings are as follows: 1. Review of a facility provided policy titled, Wandering and Elopements states in part, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for resident .If identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety . Record review revealed that Resident ID #65 was readmitted to the facility in April of 2024 with diagnoses including, but not limited to, adjustment disorder and psychosis. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was documented as wandering 1 to 3 days during the 7 day look back period. Record review revealed the resident resides on a secured unit. Record review revealed the following progress notes regarding the resident wandering behavoirs from the facility: - [DATE] which states in part, .Nursing reports patient has had a technical elopement. Patient went outside with activities and did not come back in with staff and was missing. Patient has come back in and in no acute distress . - [DATE] which states in part, Resident self propelled outside of east doors, resident self propelled outside [approximately] 50 feet [away] from building. Resident easily redirected back into building without difficulty. No injuries noted, resident pleasant and cooperative time of redirection. - [DATE] Resident again exited building from the east day room, but was successfully redirected back inside Record review failed to reveal evidence of a care plan that includes strategies and interventions to maintain the resident's safety and prevent future wandering behaviors. During a surveyor interview with Licensed Practical Nurse, Staff A, on [DATE] at 2:02 PM and [DATE] at 8:09 AM, she revealed that the resident does wander and needs frequent redirection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on [DATE] at 1:12 PM with the Director of Nursing Services (DNS) and the Regional Registered Nurse, they acknowledged that there was not a care plan in place related to the residents wandering behaviors and indicated that there should be one in place. 2. Record review revealed that Resident ID #49 was readmitted to the facility in March of 2022 with a diagnosis including, but is not limited to, PTSD. Review of a Comprehensive MDS assessment dated [DATE] revealed the resident is coded as having a diagnosis of PTSD, anxiety, and depression. Record review revealed the resident was seen by psychiatric services with the following concerns: - [DATE] The resident goes on to repeat the sad story of losing so many of [his/her] children in life and dealing with a 'vicious' aunt. The resident endorses that [s/he] has trouble falling asleep at night sometimes related to having intrusive memories. [The resident] denies formal depression or anxiety and explains that is normal for [him/her] to feel this way because of [his/her] past traumas, and thus continues to appear mildly sad and anxious . - [DATE] The resident .reports similarly to last month and denies any major problems or concerns and again repeats [his/her] story of the loss of [his/her] children. [The resident] denies major depression or anxiety, or significant appetite or sleep concerns. [The resident] is pleasant, cooperative, mood and affect appear brighter today . - [DATE] Provided brief supportive therapy to [the resident]. [The resident] is alert, easy to engage. Purpose of session is to evaluate mood and accompanied symptoms. Speech tends to be hyperverbal. I do not belong here but I am. Perseverates on [his/her] eight children, most of whom are now deceased . Two are currently living. Tends to focus on the same issues, being 96 now, staying in a nursing home. Prefers to stay alone vs engage with others. Responsive to support and encouragement offered; [The resident] should continue to be followed regularly to provide support . - [DATE] revealed psychiatric services met with the resident for behavioral health services. The resident . Endorsed anxiety, depression and lack of appetite. States does not attend activities and mostly stays in room. Provided emotional support and coping skills training - effects of depression on physical and mental health. Identified activities to elevate mood and encouraged [the resident] to engage [with] others/activities. Introduced mindfulness to self soothe and increase calm/peace . - [DATE] Current Assessment/Plan [the resident] is sitting up in [his/her] room, sleepy this morning but rousable, alert, confused/forgetful, pleasant. [The resident] presents with stable mood and affect, good eye contact Will continue to monitor .PTSD . Record review revealed the physician saw the resident on [DATE] at 1:01 PM and noted the resident's diagnosis of PTSD, with psychiatric services involved. Record review failed to reveal evidence of a trauma informed care plan that identifies trauma triggers and interventions to implement related to the diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on [DATE] at 9:18 AM with the Social Worker, she revealed that when she meets with the resident s/he talks to her about his/her children passing away. She further revealed that she was unaware that the resident had a diagnosis of PTSD. Additionally, she acknowledged that the resident did not have a care plan related to PTSD and indicated that there should be one. During a surveyor interview on [DATE] at approximately 3:00 PM, with the DNS, she was unable to provide evidence that a comprehensive person-centered care plan was developed and implemented to address the resident's PTSD. 47279

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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. 46241 Based on record review and staff interview, it has been determined that the facility failed to provided services that meet professional standards of quality for 1 of 3 residents reviewed for behaviors, Resident ID #66. Findings are as follows: Record review revealed the resident was readmitted to the facility in April of 2024 with diagnoses including, but not limited to, bipolar disorder and schizophrenia. a) Review of a document titled, PSYCHIATRIC EVALUATION & CONSULTATION dated 8/12/2024 states in part, Chief Complaint: Pt [patient] reports + HI [homicidal ideations] and + AH [auditory hallucinations] .Pt reports 'I want to stab people' and complains [his/her] HI has returned and that s/he is hearing voices. Pt reports that there is no specific person [s/he] wants to hurt, 'just anyone' Pt reports [his/her] mood is worsening in response to [his/her] psychosis . Additionally, the resident was documented as being a danger to him/herself or others. Review of a progress note dated 8/12/2024, authored by Nurse Practitioner (NP), Staff B, states in part, . [S/he] is seen in [follow up], has been having homicidal ideations. Per nursing, pt missed [his/her] last IM [intramuscular] Risperidone dose. PT with plan to stab people, does not have means to do so. Able to contract for safety. Seen by psych .today . Further review revealed recommendations for 15-minute safety checks and plastic utensils with meals. Record review failed to reveal evidence that the physician's recommendation for the use of plastic utensils with meals was implemented. During a surveyor observation on 8/19/2024 at 12:42 PM, the resident was observed eating lunch in his/her room and was noted to be using metal utensils, including a fork, spoon, and knife. Review of his/her dietary slip did not reveal plastic utensils were to be used. During a surveyor interview on 8/19/2024 at 1:35 PM, with the Food Service Director, she revealed that she was unaware that the resident required plastic utensils and indicated that nursing is supposed to inform her. She acknowledged that the dietary slip did not reveal plastic utensils and acknowledged that the resident received metal utensils. During a surveyor interview on 8/20/2024 at 9:27 AM, with Staff B, she revealed that she would have expected the resident to receive plastic utensils for all meals while on 15-minute safety checks, due to his/her HI. During a surveyor interview on 8/20/2024 at 11:55 AM with the Assistant Director of Nursing Services, she revealed that the resident should have received plastic utensils while on 15-minute safety checks as that is an intervention that they typically utilize. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Further review of a document titled, PSYCHIATRIC EVALUATION & CONSULTATION dated 8/12/2024 revealed a recommendation to obtain the residents orthostatic blood pressure (changes in blood pressure when a person moves from lying down to standing up), once a week, for four weeks. Record review failed to reveal evidence that the resident's orthostatic blood pressure was obtained weekly, as ordered. During a surveyor interview on 8/22/2024 at 11:21 AM, with Staff B, she revealed that she approved the psychiatric recommendations from 8/12/2024 and would have expected nursing to transcribe and obtain the resident's orthostatic blood pressure weekly, as ordered. During a surveyor interview on 8/22/2024 at 12:08 PM, with Licensed Practical Nurse (LPN), Staff A, she acknowledged that there was not an order to obtain the resident's orthostatic blood pressure weekly, for four weeks. She further acknowledged that there were no documented weekly orthostatic blood pressures, as ordered by the NP. During a surveyor interview on 8/22/2024 at 12:15 PM, with Unit Manager, LPN, Staff C, she revealed that once psychiatric services makes recommendations, nursing will notify the NP who approves the orders, and nursing will transcribe the orders. She indicated that the recommendation to obtain the resident's orthostatic blood pressure was overlooked and acknowledged that there was no order. During a surveyor interview on 8/22/2024 at 1:18 PM, with the Director of Nursing Services, she revealed that she would have expected nursing to obtain the resident's orthostatic blood pressure, as ordered. Cross reference F 740

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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. 47279 Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice for 1 of 2 residents reviewed for skin abrasions, Resident ID #83. Findings are as follows: Review of a facility policy titled Wound Care last revised October 2010 states in part, .The following information 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. Record review revealed the resident was initially admitted to the facility in February of 2022 with a diagnosis including, but not limited to, dementia. Review of the resident's care plan revealed a focus area initiated on 8/15/2024, which indicated the resident has impaired skin integrity related to an abrasion. Interventions include, but are not limited to, evaluate and document healing process, report significant changes and declines to the provider, and monitor for new or worsening signs or symptoms of complications and infection, such as necrosis (dead tissue), erythema (abnormal redness), warmth, edema (swelling), exudate (drainage), foul odor, maceration (the softening or breaking down of skin due to moisture), pain/tenderness, fever/chills, etc. Review of a progress note dated 4/7/2024 revealed the resident returned to the facility following a hospitalization , and was noted to have a new open area to his/her mid/upper back, measuring 0.3 centimeters (cm) by 0.4 cm. It further revealed there was no drainage or foul odor noted, wound bed was pink and the area surrounding the wound was blanchable (skin that remains white or pale for longer than normal when pressed). Record review revealed a physicians order dated 4/7/2024 for a wound care consult. Record review failed to reveal evidence that a wound care consult was obtained until 8/15/2024, approximately four months after it was initially ordered. Record review revealed the following physician wound treatment orders relative to the above-mentioned wound: - 4/7/2024 - 5/17/2024 Cleanse open area to mid upper back with wound cleanser, apply bacitracin (wound ointment) to wound bed and cover with bordered gauze once daily. - 5/17/2024 - 5/20/2024 Cleanse open area to mid upper back with wound cleanser, apply xeroform (wound dressing) to wound bed and cover with bordered gauze once daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/21/2024 - 7/30/2024 Cleanse open area to mid upper back with wound cleanser, apply xeroform to wound bed and cover with bordered gauze once daily. - 7/31/2024 - 8/14/2024 Cleanse open area to mid upper back with wound cleanser, apply xeroform to wound bed and cover with bordered gauze once every other day. - 8/15/2024 (current treatment) Cleanse open area to mid upper back with wound cleanser, apply alginate (wound dressing) to wound bed and cover with bordered gauze once every other day. Record review revealed the following dates a full body skin assessment was completed, following his/her readmission to the facility in April of 2024: - 4/8/2024: revealed an open lesion other than an ulcer located on his/her upper back with a treatment in place. - 4/11/2024: revealed an open lesion other than an ulcer located on his/her mid back with a treatment in place and was documented as healing. - 4/18/2024: revealed an open lesion other than an ulcer located on his/her mid back with a treatment in place and was documented as healing. - 4/25/2024: revealed an open lesion other than an ulcer located on his/her mid back with a treatment in place. - 5/2/2024: revealed an open lesion other than an ulcer located on his/her mid back with a treatment in place. - 5/9/2024: revealed an open lesion other than an ulcer located on his/her upper-mid back with a treatment in place. - 5/16/2024: revealed an abrasion located on his/her upper-mid back with a treatment in place. - 5/23/2024: revealed an open lesion other than an ulcer located on his/her upper-mid back with a treatment in place, which recently changed, and was documented as healing. - 5/30/2024: revealed an open lesion other than an ulcer located on his/her upper back with a treatment in place and was documented as improving. - 6/6/2024: revealed an excoriation to his/her upper back, with a treatment in place. - 6/13/2024: revealed an excoriation to his/her upper back, with a treatment in place. - 6/20/2024: revealed no skin impairments were noted. - 6/27/2024: revealed a new skin tear to his/her left elbow, sustained from a fall, with a treatment in place. It further revealed an open lesion other than an ulcer located on his/her upper back with a treatment in place and tolerated by the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 7/4/2024: revealed an open lesion other than an ulcer located on his/her upper back with a treatment in place. - 7/18/2024: revealed an open lesion other than an ulcer located on his/her mid back. - 7/25/2024: revealed an open lesion other than an ulcer located on his/her upper-mid back, open quarter size lesion, with a treatment in place. - 8/2/2024: revealed no skin impairments. - 8/8/2024: revealed a skin impairment was noted. - 8/15/2024: revealed a skin impairment was noted. Further review of the above-mentioned skin assessments failed to reveal documentation of the resident's wound including, but not limited to, wound bed color, size, and drainage, as per facility policy. Review of a document titled Skin & Wound Evaluation dated 8/15/2024, revealed the resident has a facility acquired abrasion to his/her right scapula (shoulder blade), measuring 2.0 cm by 2.3 cm by 0.1 cm. It further revealed the wound had moderate bloody/sanguineous (discharge that is made up of both blood and serum) discharge. During a surveyor interview on 8/21/2024 at 11:01 AM with the Wound Physician, she revealed that she comes to the facility every Wednesday and acknowledged that the resident had his/her initial wound consult for the above-mentioned wound on 8/14/2024. She further revealed that she would expect the facility to be measuring the resident's wound weekly in her absence. During a surveyor interview on 8/21/2024 at 11:26 AM with the Unit Manager, Licensed Practical Nurse, Staff C, she revealed that she was unaware of the order for a wound consult back in April. Additionally, she revealed that she obtained a wound consult for the resident's wound because the nursing staff indicated to her that the wound was worsening. Furthermore, she revealed that she does not obtain wound measurements for abrasions unless it is non-healing or worsening. During a surveyor interview on 8/21/2024 at 1:27 PM with the Director of Nursing Services, she revealed that she would expect wound measurements and wound descriptions to be documented upon conducting weekly skin assessments. Further, she revealed that she would have expected a wound consult to have been obtained when it was initially recommended in April of 2024. 46241

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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. 47279 Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services for 1 of 2 residents 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 #83. Findings are as follows: Review of a policy titled, Catheter Care, Urinary last revised August 2022 states in part, .Changing Catheters .Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised . Record review revealed the resident was readmitted to the facility in March of 2022 with diagnoses including, but not limited to, obstructive (a structural or functional hindrance of normal urine flow) and reflux (a condition where there is a back-flow of urine into the kidney) uropathy and retention of urine. Review of the resident's care plan revealed a focus area initiated on 12/1/2022, for an indwelling urinary catheter related to his/her diagnosis of obstructive uropathy. Interventions include, but are not limited to, monitor, record, and report signs and symptoms of a urinary tract infection (UTI). Review of a physician progress note dated 8/16/2024 revealed the resident was seen by the physician due to a recurrent UTI and increased behaviors, with a recommendation to obtain a urinalysis with urine culture (UA/C&S). Record review revealed a physicians order dated 8/16/2024 which states, Obtain urine to dipstick [a process that involves dipping a specially treated paper strip into a sample of urine], and if positive send UA C&S. Record review revealed a medication administration note dated 8/19/2024 which revealed the resident's urine was obtained and the dipstick was positive. Further review revealed a sample of urine was obtained and was placed in a bag for the lab. Review of a progress note dated 8/19/2024 at 7:08 PM revealed the order for the UA C&S was discontinued. During a surveyor interview on 8/22/2024 at 9:04 AM with Licensed Practical Nurse, Staff A, she revealed that the resident's urinalysis came back contaminated, and indicated that Nurse Practitioner (NP), Staff B, was made aware of the contaminated specimen and the order was discontinued. Record review failed to reveal evidence that the resident's indwelling catheter was changed prior to obtaining a urine sample, to prevent the contamination of the resident's urine specimen. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview on 8/22/2024 at 10:00 AM with Staff B, she revealed that she was made aware of the contaminated urine specimen and indicated that she would expect staff to change the resident's catheter, prior to obtaining a urine specimen. During a surveyor interview on 8/22/2024 at 1:16 PM, with the Director of Nursing Services in the presence of the Regional Registered Nurse, she revealed that should would have expected the resident's catheter to have been replaced prior to obtaining the urine specimen. Additionally, she was unable to provide evidence that the catheter was replaced prior to obtaining the urine specimen. 46241

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46241 Based on record review and staff interview, it has been determined that the facility failed to complete an annual performance review for every Nursing Assistant (NA), at least once every 12 months, for 3 of 3 NA personnel records reviewed, Staff D, E, and F. Findings are as follows: Record review of the personnel files failed to reveal evidence that an annual performance evaluation was completed for the following NA's: -Staff D, hired in February of 2023 -Staff E, hired in July of 2022 -Staff F, hired in July of 2023 During a surveyor interview with the Administrator on 8/21/2024 at 2:20 PM, he acknowledged that the above-mentioned NA's have not had a yearly performance evaluation and indicated it will be added to Quality Assurance and Performance Improvement (QAPI) as of 8/29/2024. Further, he was unable to provide evidence that performance evaluations were completed within the last 12 months for the above-mentioned NA's.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 47279 46241 Based on record review and staff interview, it has been determined that the facility failed to ensure that each resident receives and is provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, or psychosocial well-being, for 1 of 3 residents reviewed for behaviors, Resident ID #66. Findings are as follows: Record review revealed the resident was readmitted to the facility in April of 2024 with diagnoses including, but not limited to, bipolar disorder and schizophrenia. Review of the resident's care plan revealed a focus area initiated on 2/24/2024, for the use of anti-psychotic medications related to his/her diagnosis of schizophrenia. Interventions include, but are not limited to, administer anti-psychotic medication as ordered. Record review revealed a physicians order dated 7/11/2024 for Risperdal (Risperidone, an antipsychotic medication), 50 milligrams (mg), with instructions to inject intramuscularly (IM), one time a day, every 14 days. Review of the August 2024 Medication Administration Record (MAR) revealed the resident's IM Risperdal was documented with a 22, which indicates Drug / Treatment Not Administered, on 8/8/2024. Additionally, the order was discontinued on 8/8/2024. Review of a progress note dated 8/8/2024 which states in part, [Pharmacy] notified of Risperdal .expected late this evening .RNP [Registered Nurse Practitioner] notified, order to change date to 8/9/24 as resident received medication every 2 weeks. Further review of the August 2024 MAR failed to reveal evidence that a new IM Risperdal order was transcribed or administered to the resident on 8/9/2024, as ordered by the Nurse Practitioner (NP). Review of a document titled, PSYCHIATRIC EVALUATION & CONSULTATION dated 8/12/2024 states in part, Chief Complaint: Pt [patient] reports + HI [homicidal ideation] and + AH [auditory hallucinations] .Pt reports 'I want to stab people' and complains [his/her] HI has returned and that [s/he] is hearing voices. Pt reports that there is no specific person [s/he] wants to hurt, 'just anyone' Pt reports [his/her] mood is worsening in response to [his/her/ psychosis .After investigation and discussion with nursing staff, pt missed [his/her] scheduled injection last week .Advised that pt be restarted on Risperidone injection ASAP [As soon as possible] along with some additional oral coverage . Further review revealed the resident was considered to be a danger to him/herself or others. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 8/12/2024, authored by the NP, Staff B states in part, .[S/he] is seen in [follow up], has been having homicidal ideations. Per nursing, pt [patient] missed her last IM Risperidone dose. PT with plan to stab people, does not have means to do so. Able to contract for safety. Seen by psych . Further review of the progress note dated 8/12/2024 revealed the following recommendations were made: - Restart Risperidone Consta 50mg/2ml (milliliter) IM, every 2 weeks - Start Risperidone 2 mg at hour of sleep, for 7 days - 15 minute safety checks until further notice - Plastic utensils with meals Further review of the August 2024 MAR revealed the resident received his/her dose of IM Risperdal on 8/13/2024 and received his/her dose of 2 mg Risperdal, one time a day, from 8/12 to 8/18/2024. Further review revealed the resident was on 15-minute safety checks from 8/12 to 8/20. During a surveyor interview on 8/22/2024 at 12:49 PM, with Psychiatric Nurse Practitioner, Staff G, she revealed that had the resident not missed his/her IM dose of Risperdal, she would not have ordered the resident to receive 2 mg of Risperdal, every evening, from 8/12 to 8/18/2024. During a surveyor interview on 8/22/2024 at 1:18 PM, with the Director of Nursing Services, she revealed that she would have expected the nurses to transcribe the resident's IM Risperdal order on 8/9/2024 and administer it, as ordered. Although this concern was corrected by the facility on 8/12/2024 by reinstating the resident's IM dose of Risperdal, implementing Risperdal 2 mg every evening from 8/12 to 8/19/2024, and maintaining 15-minute safety checks, the missed dose of IM Risperdal on 8/9/2024, caused the resident to experience a relapse in psychosis and was considered to be a danger to his/herself and others. During this period of psychosis, the resident was experiencing homicidal ideations and auditory hallucinations. This the facility was unable to provide any formal in-service training that was completed in regards to this incident. Cross Reference F 658

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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. 41729 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 29 opportunities for errors observed during the medication administration task, there were 3 errors resulting in an error rate of 10.34% 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 the facility's policy titled, Administering Medications through an Enteral Tube dated November 2018 states in part, .Check the label and confirm the medication name and dose with the MAR [Medication Administration Record] Medication administration .Stop feeding and flush tubing with at least 15 Milliliter (ML) warm water or prescribed amount .Administering each medication separately and flush between medications .When the last medication begins to drain from the tubing, flush the tubing with 15 ML or prescribed amount . Record review revealed Resident ID #51 has the following physician orders: - Senna tablet give 2 tablets two times a day for constipation. - Lorazepam 0.5 Milligram (MG) three times a day for anxiety. - Oxycodone 100 MG/5 ML give 0.5 ML two times a day for pain. - Flush feeding tube with 30 ML of water before and after medication administration every shift for maintenance. During a surveyor observation of the medication administration task on 8/21/2024 at 11:09 AM with a Licensed Practical Nurse, Staff H, revealed the following: - Lorazepam 0.5 MG and Oxycodone 0.5 ML was dispensed in the same medication cup, dissolved together and administered to the resident via the g-tube. - One Senna tablet was administered instead of two tablets as ordered. - Staff H was observed flushing the g-tube with 15 ML of water before and after administering the medications instead of 30 ML, as ordered. During a surveyor interview immediately following this observation with Staff H, he acknowledged the above-mentioned observations. During a surveyor interview on 8/21/2024 at 1:21 PM with the Director of Nursing Services, she was unable to provide evidence the above-mentioned medications were administered as ordered and per the facility's policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that 1 of 3 medication carts were kept locked or kept under direct observation of authorized staff in an area where residents could access it. Additionally, the facility failed to store all drugs and biological's in accordance with currently acceptable professional principles for 3 of 4 medication carts observed, Country Two Meadow Road cart, Side Two Country cart, and Ocean Unit cart. Findings are as follows: Review of the facility's policy titled, Medication Labeling and Storage dated February 2023 states in part, The facility stores all medications and biological's in locked compartments .Only authorized personnel have access .The medication label includes, at a minimum .expiration date, when applicable . 1. During a surveyor observation of the Country Two Meadow Road medication cart on 8/21/2024 at 8:00 AM in the presence of a Certified Medication Technician (CMT), Staff I, revealed the following: - Two bottles of Nitroglycerin 0.4 Milligram (MG, a medication used to treat and prevent chest pain) with expiration dates of June 2024 and July 2024. - Fluticasone Propionate and Salmeterol 100/50 Micrograms (MCG, a combination of two medications that are used to treat the symptoms of asthma such as shortness of breath, coughing, and chest tightness) inhaler, opened and not dated. Manufacturer instructions indicate to discard 30 days after opening or when the counter reaches zero or whichever comes first. - Incruse Ellipta 62.5 MCG inhaler (a medication used to treat respiratory disease), with an open date of 7/24 and discard date of 7/11/25. Manufacturer instructions indicate to discard 6 weeks after opening or when the counter reads zero or whichever comes first. During a surveyor interview immediately following this observation with Staff I, she acknowledged the above-mentioned observations. 2. During a surveyor observation of the Side-Two Country medication cart on 8/21/2024 at 8:13 AM in the presence of a CMT, Staff J, revealed a Trelegy Ellipta 100/62.5/25 MCG inhaler, opened and not dated. Manufacturer instructions indicate to discard 6 weeks after opening or when the counter reads zero or whichever comes first. During a surveyor interview immediately following this observation with Staff J, she acknowledged the inhaler was opened and not dated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a surveyor observation of the Ocean Unit on 8/21/2024 during the medication administration task with Registered Nurse, Staff K, who was utilizing this medication cart to administered medications, revealed the medication cart was observed in the hallway unlocked, unattended, and within proximity of residents during the following times: - 8:36 AM - 8:40 AM - 8:42 AM - 8:46 AM - 8:50 AM - 8:57 AM During a surveyor interview on 8/21/2024 at 8:58 AM with Staff K, she acknowledged the medication cart was left unlocked and unattended during the above-mentioned times. 4. During a surveyor observation of the Ocean medication cart on 8/21/2024 at 9:03 AM, in the presence of Staff K, revealed a bottle of liquid protein, opened, and not dated. Manufacturer instructions indicate a shelf life of three months after opening. During a surveyor interview immediately following this observation, Staff K acknowledged the liquid protein was opened and not dated. During a surveyor interview on 8/21/2024 at 1:21 PM with the Director of Nursing Services, she was unable provide evidence the above-mentioned medications were stored appropriately, as required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48928 Based on surveyor observation and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed, in accordance with professional standards for food service safety, relative to the main kitchen and 2 of 2 kitchenettes. Findings are as follows: Record review of Rhode Island Food Code, 2018 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and help in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . 1. During the initial tour of the main kitchen in the presence of the Food Service Director (FSD), on 8/19/2024 at 8:10 AM, the following was observed in the walk-in refrigerator: - A half size hotel pan approximately 1/2 full of uncooked chicken with a use by date of 8/17/2024. - A quarter size hotel pan approximately 3/4 full and labeled puree chicken with a use by date of 8/18/2024. - A package of 20 frozen prepared egg rolls, unlabeled and undated. During a surveyor interview with the FSD immediately following the above observations, she acknowledged the above items should have been labeled, dated, and discarded according to the dates. During a surveyor observation of the Ocean Unit Kitchenette on 8/21/2024 at 10:35 AM, revealed the following: - A blue soup bowl, covered, containing cooked oatmeal without a label or use by date. - A 1-quart container of vanilla ice cream with a manufacturer's use by date of 8/14/2024. During a surveyor observation of the Country Unit Kitchenette on 8/21/2024 at 10:50 AM, revealed an undated individual packaged dessert with a manufacturer's label of strawberry cream pie without a use by date. During a surveyor interview with the FSD immediately following the above observations, she revealed the above items should have been labeled, dated, and discarded according to the dates. 2. During a surveyor observation of lunch service in the main kitchen, in the presence of the FSD on 8/21/2024 at 11:35 AM, revealed a large hotel sheet pan placed on a preparation area beside the gas stove located behind the hot food service line. The tray contained several plated alternative meal options, which included cold salad plates and sandwiches. The following observations were made: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A salad plate containing two scoops of chicken salad on top of a tossed salad with a holding temperature of 51 degrees Fahrenheit (F). - A plate containing a chicken salad sandwich on wheat bread with a holding temperature of 48 degrees F. - A plate containing a tossed salad with cut up fresh fruit and a large scoop of cottage cheese with a holding temperature of 51 degrees F. During a surveyor interview with the FSD immediately following the above-mentioned observations, she acknowledged the holding temperatures of the food items were not safe to serve. Additionally, she acknowledged that cold food temperatures should not have been greater than 41 degrees F and should have been refrigerated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47279 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records on each resident that are complete and accurately documented, relative to hearing aids for 1 of 1 resident reviewed for hearing impairment, Resident ID #46. Findings are as follows: Record review revealed the resident was admitted to the facility in November of 2023 with a diagnosis including, but not limited to, dementia. Review of the resident's care plan revealed a focus area initiated on 11/14/2023 which revealed the resident is hard of hearing and wears hearing aids. Interventions include, but are not limited to, provide the resident with appropriate hearing aids, as required. Review of a Sensory and Communication Status note dated 8/14/2024 revealed the resident has bilateral hearing limitations that affects his/her ability to function. Record review revealed a physician's order dated 2/3/2024 to insert bilateral hearing aids every morning and remove at bedtime. Review of the Medication Administration Records (MAR) for July and August 2024 revealed the above-mentioned order was documented as completed from July 1st through July 31st and August 1st through August 21st. During a surveyor observation on 8/21/2024 at approximately 10:08 AM, the resident was observed without his/her hearing aids in place. During a surveyor interview immediately following the above observation with Certified Medication Technician, Staff I, she acknowledged that the resident's hearing aids were not in place. Additionally, she revealed that the resident's right hearing aid had been broken for a few weeks. Further, she acknowledged that the order was inaccurately documented as being completed. During a surveyor interview on 8/21/2024 at 11:34 AM with the Unit Manager, Licensed Practical Nurse, Staff C, she revealed that the resident's hearing aid has been broken for approximately 6 weeks. During a surveyor interview on 8/21/2024 at 1:39 PM with the Director of Nursing Services, she indicated that she would expect the staff to accurately document when the resident is wearing his/her hearing aids, as ordered.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. 41729 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 Covid-19, for 1 of 2 units observed, the Country Unit, affecting Resident ID #s 2, 6, 11, 14, 15, 19, 26, 28, 30, 38, 42, 44, 46, 47, 49, 54, 55, 58, 64, 65, 67, 80, 82, 84, 87, 88, 92, 97, 104, and 109, as the facility failed to have cleaning and disinfecting wipes effective at killing Covid-19 readily accessible to staff and was using Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol, which are ineffective at killing Covid-19, to clean and disinfect multi-use resident equipment. Further, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to Enhanced Barrier Precautions (EBP), for failing to place a resident on enhanced barrier precautions (EBP) and staff who failed to don the required Personal Protective Equipment (PPE) prior to entering resident rooms that required such, for 1 of 3 residents reviewed, Resident ID #102, and 1 of 1 resident on contact precautions observed during the medication administration task in which staff failed to don the required PPE prior to entering his/her room, Resident ID #22. Findings are as follows: 1. Record review of a facility policy titled, Isolation-Categories of Transmission-Based Precautions states in part, When transmission-based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer [blood pressure cuff], or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible .If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with other residents . During a surveyor observation on 8/19/2024 at approximately at 8:00 AM, upon entering the building, signage was posted notifying staff and visitors of the required use of N95 masks due to a Covid-19 outbreak. Record review revealed that the facility's Covid-19 outbreak started on 7/30/2024 for staff and 8/2/2024 for residents. During surveyor observations on 8/19/2024 of the Country unit revealed that Resident ID #s 2, 11, 14, 15, 19, 26, 30, 38, 42, 44, 46, 47, 49, 54, 55, 58, 64, 65, 67, 80, 82, 84, 87, 88, 92, 97, 104, and 109 were on isolation precautions relative to Covid-19 with isolation bins and signage posted outside the rooms. Further observation of the Country Unit and the above resident's isolation bins failed to reveal evidence of dedicated care equipment or disinfecting wipes available for use. During a surveyor observation on 8/20/2024 at 9:09 AM revealed one container of Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol, located on one isolation cart on the Country Unit. Further observation of the Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol revealed the wipes kill 13 different infectious micro-organisms, but it failed to list Covid-19 as an infectious micro-organism that it kills. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor observation on 8/20/2024 at 9:15 AM, revealed Nursing Assistant, Staff M, entering a Covid-19 positive room, Resident IDs #46 and 64, to obtain the resident's blood pressure. Medication Technician, Staff N, entered the room and exited the room at 9:25 AM with a blood pressure cuff and stethoscope. Staff N then placed the blood pressure cuff and stethoscope on top of two open glove containers. Staff N then proceeded to pick up the equipment and clean the blood pressure cuff and the stethoscope with the Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol, and placed them back on the medication cart for reuse. Review of the List N tool: Covid -19 Disinfectants List, last updated on July 1, 2024, failed to identify Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol as a product that meets EPA's [Environmental Protection Agency] criteria for use against Covid-19. During a surveyor interview on 8/20/2024 at 9:27 AM with Medication Technician, Staff N, she acknowledged that the facility uses multiuse equipment and that Resident ID #s 46 and 64 were on precautions for Covid-19. Additionally, she acknowledged the multiuse equipment was cleaned with the Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol. During a surveyor interview on 8/20/2024 at 10:31 AM with the Infection Preventionist, she revealed that staff should use the bleach wipes for Covid-19 and not the Micro-Kill+ Disinfecting, Deodorizing Cleaning Wipes with Alcohol. Further record review revealed an additional 2 residents had tested positive for Covid-19 on 8/20/2024, Resident ID #s 6 and 28. 2. Review of signage posted for Resident ID #s 14, 19, 26, 38, 46, 65, and 97 revealed Isolation Droplet/Contact .clean hands .gowns .N95 Respirator .Eye protection (goggles or face shield) .Gloves . According to the Center for Disease Control and Prevention (CDC) titled, Infection Control Guidance: SARS-CoV-2 last revised on 6/24/2024, states in part, .use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Record review revealed a facility provided document titled, Summer '24 COVID Outbreak a line list for residents with a start date of the initial outbreak for residents of 8/2/2024. During surveyor observations on 8/19/2024 revealed Nursing Assistant, Staff O, entering the following Covid-19 positive rooms without donning eye protection and wearing a KN95 mask (not an N95): - 11:00 AM Resident ID #38's room - 12:07 PM Resident ID #s 19 and 97 room - 12:09 PM Resident ID #s 19 and 97 room Further observation revealed the room had an isolation cart outside of the room and droplet/contact precaution signage posted. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor observation on 8/19/2024 at 12:24 PM revealed the Social Worker entered Resident ID #65's room, a Covid-19 positive room, wearing a KN95 mask, gown, gloves, and eye protection. She failed to don an N95 mask. Further observation revealed the room had an isolation cart outside of the room and droplet/contact precaution signage posted. During a surveyor observation on 8/20/2024 at 8:44 AM, Medication Technician, Staff N, entered Resident ID#s 14 and 26's room, a Covid-19 positive room, wearing a KN95 mask, gown, and gloves. She failed to don an N95 mask or eye protection. Further observation revealed the room had an isolation cart outside of the room and a droplet/contact precaution signage posted. During a surveyor interview on 8/20/2024 at 8:47 AM with Staff N, she acknowledged that the resident was positive for Covid-19 and acknowledged the signage indicating the use of an N95 mask and eye protection and that she failed to don both an N95 mask and eye protection. During a surveyor observation on 8/20/2024 at 9:15 AM, Nursing Assistant, Staff M, entered a Covid-19 positive room, Resident ID #s 46 and 64, wearing a KN95 mask, gown, gloves, and eye protection. She failed to don an N95 mask. Further observation revealed the room had an isolation cart outside of the room and droplet/contact precaution signage posted. During a surveyor interview on 8/20/2024 at 10:31 AM with the Infection Preventionist, she revealed that staff should be wearing an N95 mask, not a KN95 mask, and indicated that they should wear eye protection in Covid-19 positive rooms. 3. Review of a facility policy titled, Enhanced Barrier Precautions states in part, Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents .EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices [indwelling foley catheter, a flexible tube inserted into the bladder to drain urine] regardless of MDRO colonization .signs are posted indicating the type of precautions and PPE [personal protective equipment] required .PPE is readily available . Record review revealed that Resident ID #102 was admitted to the facility in July of 2024 with diagnoses including but not limited to, urinary tract infection and cerebral infarction (stroke). Record review revealed that the resident has an indwelling foley catheter. Record review revealed an order for EBP for an indwelling foley catheter dated 8/1/2024. During surveyor observations from 8/19/2024 through 8/22/2024 failed to reveal evidence of an isolation cart or signage posted indicating that the resident was on EBP indicating the type of PPE that is required for this resident. During a surveyor observation and subsequent interview on 8/22/2024 at 11:39 AM with the Unit Manager, Registered Nurse (RN), Staff P, she acknowledged that the resident was not on EBP and indicated that she should have been. Further, she acknowledged that the resident did not have signage posted indicating that s/he was on EBP or that an isolation cart was outside of the resident's room. She further revealed that the resident was in a different room and was transferred to a new room on 8/13/2024 and that the precautions signage and isolation cart did not follow the resident to his/her new room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415063	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Rehabilitation and Healthcare Center	860 North Quidnessett Road North Kingstown, RI 02852

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of a facility provided policy titled, Isolation-Categories of Transmission-Based Precautions revealed for contact precautions, staff and visitors are to wear gloves when entering the room. Additionally, staff and visitors are to wear a disposable gown upon entering the room and remove before leaving the room and to avoid touching potentially contaminated surfaces with clothing after the gown has been removed. Record review revealed that Resident ID #22 was admitted to the facility in July of 2024 with diagnoses including, but not limited to, Methicillin Resistant Staphylococcus Aureus Infection (MRSA; a multi-drug resistant organism or MDRO) and Chronic Obstructive Pulmonary Disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review revealed a physician's order dated 7/18/2024 for Contact Precaution for MRSA of nares, blood and right shoulder. Review of a care plan initiated on 7/2/2024 revealed that Resident ID #22 has an active/colonized MDRO, MRSA with interventions which include, but are not limited to, isolation precautions per policy, and recommendation from the CDC and local Department of Health. During a surveyor observation on 8/21/2024 at 8:36 AM during the medication administration task with RN, Staff K, Resident ID #22's room revealed signage posted on the doorway indicating contact precautions were required. The signage revealed that providers and staff must also don gloves and gown before entering the resident's room. Further observation revealed Staff K entered Resident ID #22's room wearing gloves. She failed to don a gown as listed in the policy and the signage. Staff K then administered the resident's intravenous antibiotic via a peripherally inserted central catheter (PICC; a long, thin tube that's inserted through a vein in your arm and is used to deliver medications and other treatments directly to the large central veins near your heart). She then touched the resident's pillows, arrange his/her bed linens, and touched the bedside table without wearing a gown. During a surveyor interview immediately following the above-mentioned observation, she acknowledged that she did not wear a gown prior to entering the resident's room. She further acknowledged that she accessed the resident's PICC line and touched multiple potentially contaminated surfaces without wearing a gown per the facility policy and posted signage. During a surveyor interview on 8/21/2024 at 1:22 PM with the DNS, she was unable to provide evidence that the staff followed the resident's isolation precautions as ordered. During a surveyor interview on 8/22/2024 at approximately 2:00 PM with the DNS, she was unable to provide evidence the facility provided effective infection control practices to prevent the spread of Covid-19 and MDRO infections. These failures could have the potential to increase the transmission of Covid-19 and MDROs to multiple residents within the facility. 46539 48928