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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Jenkin's Living Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 215 South Maple Street Watertown, SD 57201 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52098</p> <p>Based on observation and interview, the provider failed to maintain resident rooms and resident common areas in a clean manner free from strong odors, sticky floors, and damage to the walls and bathroom tiles for at least seven resident rooms, at least one resident common area, and at least one shower and one tub room.</p> <p>Findings include:</p> <p>1. Observations on 1/28/25 from 9:53 a.m. to 10:36 a.m. in the Pine Village memory care unit on the second floor revealed:</p> <p>*In resident room [ROOM NUMBER]:</p> <ul style="list-style-type: none"> -There were gouges in the corner with exposed drywall. -Phone cords were in a tangled pile on the floor behind the resident's rocking chair. <p>*In resident room [ROOM NUMBER]:</p> <ul style="list-style-type: none"> -There were at least five vertical gouges in the wall behind the tan recliner, ranging from approximately two to six inches in size. <p>*In resident room [ROOM NUMBER]:</p> <ul style="list-style-type: none"> -Drywall was exposed on the out-[NAME] corner. -Painter's tape had been left on the baseboard. -The wall next to the bed had at least eight quarter-sized gouges, with drywall exposed. -The wall behind the light brown recliner had a gouge approximately two inches by one inch in size with exposed drywall. -There was a scrape approximately six inches above the baseboard that extended about three feet along another wall with exposed drywall. <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-The bathroom floor was sticky and had a strong urine odor.</p> <p>*In resident room [ROOM NUMBER]:</p> <p>-There was exposed drywall near the baseboard in a corner.</p> <p>*In resident room [ROOM NUMBER]:</p> <p>-The bathroom sink was leaking a steady flow of water, even though the faucet paddles were in the off position.</p> <p>*In resident room [ROOM NUMBER]:</p> <p>-The wall behind the bed had vertical gouges with drywall exposed.</p> <p>-There was a gouge on a corner of a wall with exposed drywall.</p> <p>-The hand sanitizer dispenser was not functioning.</p> <p>*In the resident day room:</p> <p>-At least five gouges were in the walls behind the recliners.</p> <p>* The above conditions remained unchanged during additional observations on 1/29/25 from 9:33 a.m. to 10:05 a.m., and on 1/30/25 at 9:05 a.m.</p> <p>2. Observations on 1/29/25 at 2:21 p.m. and on 1/30/25 at 7:59 a.m. in the North Oak care unit on the third floor revealed:</p> <p>*In resident room [ROOM NUMBER]:</p> <p>-A corner of wall tile in the bathroom was chipped and had jagged edges with exposed cement.</p> <p>-There was a missing piece of tile located just outside the doorway to the left of the sink.</p> <p>-The hand sanitizer dispenser was not functioning.</p> <p>*Outside the doorway of resident room [ROOM NUMBER]:</p> <p>-There were three small gouges in the wall above the railing with exposed drywall.</p> <p>-There was an approximate two-foot scrape on the wall below the railing with exposed drywall.</p> <p>3. Interview on 1/30/25 at 3:12 p.m. with activity aide Z about what staff would do if something was not working or needed repair revealed she stated, I would have to ask the nurse to verify or go to maintenance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. Interview on 1/30/25 at 3:19 p.m. with CNA W about what staff would do if something was not working or needed repair revealed she stated, I would call maintenance for a repair because its faster, but we can use a maintenance green slip and send that to maintenance.</p> <p>5. Interview 1/30/25 at 3:27 p.m. with LPN R about what staff would do if something was not working or needed repair revealed he stated, I would call maintenance or use a maintenance green slip.</p> <p>6. Interview on 1/30/25 at 5:19 p.m. with administrator A revealed:</p> <p>*He explained there was no policy for submitting maintenance requests.</p> <p>*He expected staff to submit a green maintenance request slip, talk with someone from the maintenance department directly, or call immediate maintenance requests over the radio.</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for:</p> <p>A. One of one sampled resident (19) who received hospice services.</p> <p>B. Five of five residents (6, 7, 15, 19, and 41) who received a pureed diet and were included in the paid feeding assistants program.</p> <p>C. Five of five sampled residents (6, 25, 62, 66, and 68) who required transmission-based precautions (TBP).</p> <p>D. Three of three sampled residents (40, 45, and 70) who required monitoring for medications they received.</p> <p>E. One of one sampled resident (10) who required placement on a secure memory unit.</p> <p>Findings include:</p> <p>A.</p> <p>1. Interview on 1/29/25 at 11:34 a.m. with licensed practical nurse (LPN) L regarding resident 19 revealed resident 19 had gallstones, no surgery was recommended, and she began receiving hospice services about two weeks ago.</p> <p>2. Interview on 1/30/25 at 8:52 a.m. certified nursing assistant (CNA) FF regarding identifying residents who received hospice services revealed:</p> <p>*She identified resident 19 received hospice services.</p> <p>*That information was provided to her by the nurse, and it would be on the pocket care plan.</p> <p>*Hospice visited resident 19 one to two times a week to take her vitals and provide a bed bath.</p> <p>3. Review of the provided pocket care plan did not indicate that the resident received hospice services.</p> <p>4. Review of resident 19's care plan revealed:</p> <p>*She admitted to the facility on [DATE].</p> <p>*Her diagnoses included mild intellectual disabilities, osteoarthritis, anemia, heart failure, fracture of left patella (kneecap), acute kidney failure, anorexia, and anxiety disorder.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*A nutrition focus area indicated, Currently on hospice was revised on 1/28/25.</p> <p>*The nutrition goal indicated, Comfort Care Nutrition provided due to hospice.</p> <p>*The nutrition interventions included, 1/28/24: admitted to hospice on 1/17 [2025] due to recent diagnosis of Calculus of Gallbladder with Acute Cholelith [Cholelith, gallstones] with back pain. General surgeon recommends comfort cares over surgical intervention.</p> <p>*There were no other focus areas, goals or interventions related to resident 19's hospice care.</p> <p>5. Interview on 1/30/25 at 4:19 p.m. with administrator A and director of nursing (DON) B regarding resident 19's hospice care revealed:</p> <p>*There had been a delay in getting the hospice admitting diagnosis for resident 19.</p> <p>*She was admitted to hospice on 1/17/25.</p> <p>*During the interview DON B called the hospice provider to request a copy of the physician's order and the hospice care plan.</p> <p>*DON B stated she updated the facility care plan to reflect that resident 19 had been admitted to hospice and the services she received.</p> <p>*She expected the care plan to reflect the specific care resident 19 received.</p> <p>6. Review of resident 19's 1/30/25 updated care plan revealed:</p> <p>*Her care plan included a focus area, See the MAR/TAR [medication administration record/treatment administration record], Physician orders/protocol, CNA flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered. [Resident 19] was admitted to Hospice on 1/17/25 revised on 1/30/25.</p> <p>*There was no resident-centered goal, it directed to See Focus revised on 4/16/24.</p> <p>*There were no specific interventions, it directed to See Focus initiated on 5/9/18.</p> <p>B.</p> <p>1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed:</p> <p>*Cosmetologist AA assisted resident 19 in eating with a spoon and assisted her in drinking from a cup with two handles and a lid.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*Her care plan revealed, Nutrition risks include: cognition, dysphagia [difficulty swallowing].</p> <p>*Dependent assist of 1 [one] for eating.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>7. Review of resident 15's EMR revealed:</p> <p>*She received a pureed diet.</p> <p>*Her care plan revealed, Nutrition Risk factors include: cerebral Infarction [a stroke], dementia, hemiplegia [paralysis of one side of the body], dysphagia [dysphagia, difficulty swallowing].</p> <p>*It was documented that she had some difficulties with eating when her dentures are in.</p> <p>*A care plan intervention included Monitor/document ability to chew and swallow.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>8. Review of resident 19's EMR revealed:</p> <p>*She received a pureed diet.</p> <p>*A 1/24/25 speech therapy screen indicated a referral was made due to the resident was pocketing solids [solid foods].</p> <p>*A 1/28/25 progress note indicated the feeding assistant reported patient was a little gaggy this morning.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>9. Review of resident 41's EMR revealed:</p> <p>*She received a pureed diet.</p> <p>*She had a diagnosis of dysphagia.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>10. Interview on 1/30/25 at 8:43 a.m. with AA EE revealed:</p> <p>*She was an activities assistant and had completed the paid feeding assistant training.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*She assisted residents with eating about once a month.</p> <p>*She was allowed to assist any resident who needed assistance with eating.</p> <p>*No one told her which residents to assist with eating.</p> <p>11. Interview on 1/30/25 at 4:41 p.m. administrator A, DON B, and SDC H regarding the paid feeding assistant program revealed:</p> <p>*The Feeding Assistant List that was provided included all the residents within the facility who required assistance with eating.</p> <p>*SDC H stated that paid feeding assistants were able to assist any resident not deemed by the speech therapist, to need assistance from a CNA.</p> <p>*Administrator A stated that a feeding assistant could assist any resident in the facility except those who have been excluded.</p> <p>*At that time there were no residents who should have been excluded.</p> <p>*DON B stated care plans did not indicate which residents were in the paid feeding assistant program because it could change.</p> <p>-The care plans may include if they could not be fed by a feeding assistant, but because there was not anyone excluded, no care plans contained that information.</p> <p>C.</p> <p>1. Observation and interview on 1/28/25 at 2:47 p.m. with resident 25 revealed:</p> <p>*There was a stop sign on her door and a cart outside that room contained gowns and gloves.</p> <p>*She wore a boot on her left foot from a recent surgery on her toe.</p> <p>Observation on 1/30/25 at 8:03 a.m. with resident 25 revealed:</p> <p>*There had not been any signage on her door that indicated she was on enhanced barrier precautions (EBP).</p> <p>*She stated she had one toe with a wound and a dressing on it, but the nurse had not looked at it today (1/30/25).</p> <p>*She stated that staff had worn gloves but not gowns when they assisted her.</p> <p>Interview on 1/30/25 at 2:21 p.m. with wound care nurse (WCN) I and infection preventionist (IP) C who participated by phone revealed:</p> <p>*Resident 25 had an open wound to her left toe.</p> <p>(continued on next page)</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*WCN I was unsure if resident 25 was on EBP for wound care and stated she would need to consult with the infection preventionist.</p> <p>*WCN I called IP C at home to join the interview.</p> <p>*IP C stated she had removed resident 25 from EBP because she did not think a Band-Aid was a dressing that required EBP.</p> <p>*WCN I confirmed that resident 25 had an open wound on her left toe with a Medihoney (wound healing) dressing.</p> <p>*IPC stated, I would put her back on EBP with that information.</p> <p>Review of resident 25's EMR revealed:</p> <p>*A 1/24/25 weekly wound observation tool indicated resident 25 had a four millimeter (mm) by four mm unstageable wound to her left second toe with an undeterminable depth.</p> <p>*There was no documentation in the care plan that indicated that resident 25 required EBP.</p> <p>2. Observation on 1/28/25 at 11:12 a.m. with resident 62 and certified nursing assistant (CNA) X revealed:</p> <p>*There were two signs on her door and a cart outside that room that contained gowns and gloves.</p> <p>*One sign indicated, STOP please see nurse, and the other indicated, Steps to put on PPE 1. Put on Gown and tie 2. Put on gloves.</p> <p>Interview on 1/30/25 at 7:49 a.m. with WCN I revealed resident 62 was on EBP for a foot wound.</p> <p>Interview on 1/30/25 at 8:10 a.m. with CNA U revealed:</p> <p>*The sign on resident 62's door indicated that staff needed to wear a gown and gloves when providing direct care, but it was okay to go in to talk to her or deliver items to her room.</p> <p>*Resident 62 had an infection in her leg.</p> <p>*There would be a sign on the resident's door, and she used a pocket care plan to know which residents required staff to wear gowns and gloves when providing their direct care.</p> <p>*She stated that information was also in the residents' care plans in the EMR.</p> <p>Interview on 1/30/25 between 8:31 a.m. and 8:40 a.m. with LPN M and WCN I revealed:</p> <p>*LPN M stated resident 62 was on EBP for a heel wound and staff were to wear a gown and gloves when providing her direct care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*Her diagnoses included extended spectrum beta lactamase (ESBL, enzymes that breakdown some antibiotics) resistance.</p> <p>*A 12/20/24 active contact precaution order.</p> <p>*An order to clean her arterial ulcers on her right lower extremity (RLE) daily with soap and water and to cover them with an appropriate dressing.</p> <p>*There was no documentation that indicated she was on contact precaution or EBP in her care plan.</p> <p>4. Observation and Interview on 1/28/25 at 3:02 p.m. of resident 6 in her room revealed:</p> <p>*There was a sign with a stop sign on it next to her name badge outside of her room.</p> <p>*There was a three-drawer bin with PPE supplies in it outside of her room.</p> <p>*She was lying in bed, with a pillow propped under her left side, and a call light button on the moveable tray table in front of her.</p> <p>*She stated she had a sore on her coccyx, but staff had told her it was healing.</p> <p>*Staff changed the pressure ulcer (PU) dressing every day.</p> <p>Review of resident 6's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*She had a BIMS assessment score of 14 which indicated she was cognitively intact.</p> <p>*She had an order for a wound dressing change daily and as needed that began on 12/6/24 for her PU.</p> <p>*There was no documentation that indicated she was on EBP in her care plan.</p> <p>5. Observation on 1/30/25 at 7:56 a.m. of resident 66's room revealed:</p> <p>*There was no PPE inside or outside of her room.</p> <p>*There was a sign by the resident's name badge on her door with a stop sign on it.</p> <p>Review of resident 66's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*She had an active order for wound care related to her PU that began on 1/13/25.</p> <p>*There was no documentation that indicated she was on EBP in her care plan.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>43021</p> <p>D.</p> <p>1. Observation on 1/28/25 at 4:09 p.m. of resident 70 revealed she was in her room lying on her bed's alternating air mattress and appeared comfortable with no facial indicators of pain.</p> <p>Review of resident 70's EMR revealed:</p> <p>*She admitted to the facility on [DATE].</p> <p>*Her BIMS was scored at 4 indicating severe cognitive impairment.</p> <p>*She had an Alzheimer's Disease diagnosis.</p> <p>*Her medications included:</p> <p>-An antipsychotic medication QUETiapine Fumarate [antipsychotic] Oral Tablet: --25 MG [milligrams] (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for hallucinations. --25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth at bedtime for hallucinations.</p> <p>-Two controlled (medications with risk for abuse of addiction) pain medications: --oxyCODONE-Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 12 hours as needed for pain control. --fentaNYL Transdermal Patch 72 Hour 12 MCG/HR [mg per hour] (Fentanyl) Apply 1 patch transdermally every 72 hours for Pain and remove per schedule.</p> <p>-A hypnotic medication Zolpidem Tartrate Oral Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime for Insomnia.</p> <p>Review of resident 70's current care plan printed on 1/30/25 revealed:</p> <p>*Her care plan did not address her antipsychotic, opioid (pain), and hypnotic medications.</p> <p>*Her care plan included a focus area that was initiated on 1/8/25 See the MAR/TAR, Physician orders/protocol, pocket care plan and the Long-term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the direction of the resident and their wishes for their plan of care. Administer medications as ordered.</p> <p>*There was no resident centered goal, it directed to See Focus initiated on 1/8/25.</p> <p>*There were no specific interventions, it directed to See Focus initiated on 1/8/25.</p> <p>(continued on next page)</p> | | |

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| F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | <p>*The focus area regarding her medications did not include:</p> <ul style="list-style-type: none"> -A goal regarding her high-risk medications. -Specific interventions including the medications' side effects that assisted her to meet that goal. <p>46453</p> <p>2. Review of resident 40's current care plan revealed:</p> <p>*A focus area: See the MAR/TAR, Physician orders/protocol, pocket care plans and the Long Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment if applicable. Care plans are written by exception reflecting facility standards. Administer medications as ordered. Initiated on 2/25/19. Revised on 4/25/24.</p> <p>-Goal: See Focus. Initiated on 2/25/19. Revised on 10/29/23.</p> <p>-Interventions: See Focus. Initiated on 2/25/19.</p> <p>*There were two separate focus areas relating to altered skin integrity due to incontinence. The interventions on one of those focus areas had not been updated since 5/13/21.</p> <p>*There were several interventions in other focus areas that appeared to be a copy/paste and summaries of progress notes from the resident's electronic medical record.</p> <p>-For example, there was an intervention under the skin focus area that read:</p> <ul style="list-style-type: none"> --4/3/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions at the time were appropriate - will keep in place. --5/7/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions revised. --6/18/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions revised. --8/6/24: Interventions were assessed at a skin meeting. The care plan interventions were reviewed and interventions at the time were appropriate - will keep in place. --Initiated on 8/19/24, revised on 8/19/24. <p>*A focus area related to a diagnosis of depression was initiated on 12/8/24.</p> <p>(continued on next page)</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-An intervention was added on 12/8/24 that read, Administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>-Review of resident 40's medication administration records from July 2024 through January 2025 revealed she had not taken any type of antidepressant or mood-altering medication.</p> <p>*A focus area related to pain was initiated on 7/30/20 and revised on 4/3/24. [Resident 40] has a history of taking scheduled analgesic [a category of pain-relieving medications]. Staff will monitor for s/s of generalized pain and stiffness.</p> <p>-An intervention was added on 2/25/19 related to pain that read, Administer analgesia as per ordered.</p> <p>-Review of resident 40's medication administration records from July 2024 through January 2025 revealed she had not taken any type of analgesic medication.</p> <p>Interview on 1/30/25 at 5:19 p.m. with administrator A and DON B revealed:</p> <p>*They tried to rework their resident care plan policy because of the previous recertification survey.</p> <p>*DON B was not aware that the interventions for depression and pain medications were still included on resident 40's care plan.</p> <p>*The nurse manager for the memory care units was responsible for those residents' care plans.</p> <p>*They had no explanation as to why the resident care plans included goals and interventions of See Focus.</p> <p>3. Interview on 1/28/25 at 10:53 a.m. with resident 45 revealed that she thought she was on an antibiotic but did not know if she took an anticoagulant (a blood thinner).</p> <p>Review of resident 45's EMR revealed:</p> <p>*She was admitted to the facility on [DATE].</p> <p>*Her BIMS assessment score was 14, which indicated she was cognitively intact.</p> <p>*She had a diagnosis of long-term (current use) of anticoagulants.</p> <p>*Her medications included Eliquis [an anticoagulant] Oral Tablet 2.5 MG [milligrams] (Apixaban) Give 2.5 mg by mouth two times a day for atrial fibrillation.</p> <p>Review of resident 45's current care plan printed on 1/30/25 revealed:</p> <p>*Her care plan did not address her use of anticoagulant medications.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*Her care plan included a focus area that was revised on 8/7/24, See the MAR/TAR, Physician orders/protocol, CNA flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered.</p> <p>*There was no resident-centered goal; it directed to See Focus, revised on 8/15/24.</p> <p>*There were no specific interventions; it directed to See Focus, revised on 7/25/24.</p> <p>E.</p> <p>1. Observation and interview on 1/28/25 at 5:05 p.m. with resident 10 revealed:</p> <p>*She was in her room sitting in her recliner working on a word puzzle.</p> <p>*She stated she was living at the facility because the doctor thought I needed more help.</p> <p>Review of resident 10's EMR revealed:</p> <p>*She had lived at the facility in the secure memory care unit since 7/31/24.</p> <p>*Her BIMS assessment score was 15 which indicated she was cognitively intact.</p> <p>*A 7/31/24 admission progress note stated . it was determined that she was unable to safely return to her own apartment d/t [due to] altered mental . Resident admitted to secured unit d/t [due to] dx [diagnosis] of dementia and history of wandering . in her own apartment building. Secured unit assessment initiated.</p> <p>*An 8/8/24 physician order summary stated Resident noted to have a diagnosis of Dementia, because of this condition the resident benefits from the consistent smaller therapeutic environment and the specialized care provided in a secured unit. Specific clinical indications will be reviewed by the interdisciplinary team on a quarterly and as needed basis and documented in the resident's care plan.</p> <p>*A 9/27/24 social service note stated She repeatedly commented on wanting to get some things from her old apartment, however she has been informed many times that it's been cleaned out by family/responsible party and her things donated. She was asked before things were dispersed what she wanted. She commented on hating it here and voiced confidently that she does not think she needs to be here. Doctor has documented her need for SNF [Skilled Nursing Facility] care. With her comments, she was asked about talking to someone about return to community and her response was well, if I can get outta here . Call placed to [first name], LTCO [long term care ombudsman]. Message left .</p> <p>Review of resident 10's current care plan printed on 1/29/25 revealed:</p> <p>*A focus area initiated on 8/8/24 indicated Resident noted to have a dx of Dementia, this resident benefits from the consistent smaller therapeutic environment and the specialized care provided in a secured unit.</p> <p>*There was no resident-centered goal, only the words see focus that was initiated on 8/8/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*There were no specific interventions, only two narratives in the section for the interventions:</p> <p>-1/9/25 - [resident 10] she has been noted to have the following symptoms/behaviors: rejection of cares and disorientation to time. Resident's POA [power of attorney] notes that resident has intermittent periods of increased confusion. BIMS assessment completed on 1/8/25 with result of 14.0. Secured unit order received from PCP [primary care physician] on 8/7/24. [First name of resident] does not appear to be impacted by residing in a secured unit. Writer discussed secured unit placement with POA [first name] on 1/7/25, [POA's name] in agreement to with secured unit placement. [Resident 10] has been noted to benefit from the following services provided in the secure unit: specialized care, increased security to allow for independent mobility, smaller/calming environment, therapeutic activities, and consistency. Due to above information, resident will continue secured unit placement.</p> <p>-[Resident 10] can become very agitated and often yells/swears at staff, typically related to missing her old apartment at [Name of apartment building]. She seems to calm some when staff listen quietly and redirect her towards positive aspects.</p> <p>*The focus area regarding her placement on the secured memory care unit did not include:</p> <p>-A goal regarding her placement and adjustment to living on the secure memory unit.</p> <p>-Specific interventions to assist her to adjust to living on the unit.</p> <p>Review of the provider's revised August 2024 Care Plan, Resident-Centered and Individualized Plan of Care Policy revealed:</p> <p>*To ensure that each resident receives individualized, comprehensive, and person-centered care by developing and maintaining a written care plan based on their needs, preferences, and medical conditions.</p> <p>*Care plans should include a focus, goals and interventions for the resident.</p> <p>*The resident's care plan is reviewed and/or revised frequently due to changes and updates to the plan of care.</p> <p>*Each discipline is responsible for updating the care plan as changes to the plan of care occur.</p> <p>* The care plan covers focuses related to but not limited to:</p> <p>-Medications</p> <p>-Infections</p> <p>-Pressure injuries</p> <p>-Continents and Incontinence of resident</p> <p>-Bowel function of the resident</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> -Fall risk and history -Dehydration and Risk of dehydration -Day-to-day activities and the assistance needed -Activities the resident enjoys doing. |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52098</p> <p>Based on observation, interview, and record review, the provider failed to properly store products determined to be unsafe for cognitively impaired residents for at least 10 residents (7, 9, 15, 23, 36, 38, 40, 44, 46, and 69) on one of two memory care units.</p> <p>Findings Include:</p> <p>1. Observations on 1/28/25 at 10:25 a.m. in resident 36's room revealed:</p> <p>*There was a sign posted on the mirror in the bathroom that read, Any product with 'Keep Out of Reach of Children' printed on its label needs to be kept on a closet shelf, i.e alcohol, mouthwash, [NAME] 24 [a moisturizing body cream], Baza Cleanse [a no-rinse lotion], deodorant, etc. Thanks!</p> <p>-Mouth Rinse, deodorant, and toothpaste were stored on a shelf in the bathroom and were accessible to the resident.</p> <p>*CPAP (continuous positive airway pressure) cleaning wipes were stored on top of the resident's dresser and accessible to the resident.</p> <p>-The container label read Keep out of reach of children.</p> <p>2. Interview on 1/28/25 at 3:03 p.m. with resident 36 revealed she was pleasantly confused and was not oriented to place or situation, meaning she did not understand where she was or that she was a resident in a nursing home.</p> <p>3. Interview on 1/30/25 at 9:46 a.m. with licensed practical nurse (LPN)/Nurse Manager J revealed:</p> <p>*The signs posted in the resident rooms were for the confused residents or for those who could not perform personal cares on their own.</p> <p>*The signs were placed in all resident rooms in the memory care units.</p> <p>*Products with the label Keep out of reach of children should have been stored away from the resident, such as the top shelf of a resident's closet, so the resident did not have access to those products.</p> <p>4. Observation on 1/30/25 at 9:55 a.m. in resident 36's room revealed the CPAP cleaning wipes were still accessible on top of the dresser, and the mouthwash and toothpaste were still accessible on the shelf in the resident's bathroom.</p> <p>5. Interview on 1/30/25 at 3:19 p.m. with certified nurse assistant (CNA) W revealed:</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*When asked how staff determined which residents on the secured memory care units should have their personal care products stored out-of-reach, she explained if a resident had dementia their products should be placed on the top shelf of their closet.</p> <p>-She was not aware of a policy or process to verify this practice.</p> <p>6. Interview on 1/30/25 at 3:27 p.m. with LPN R revealed:</p> <p>*Residents were screened upon admission to the memory care unit to determine if they should have their products stored out-of-reach, when labeled with Keep out of reach of children.</p> <p>-Staff were to monitor for resident safety throughout each day.</p> <p>*If there were changes in the resident's behavior or cognition, staff were to report those changes to the nurse managers.</p> <p>-He was not aware of a process for determining which residents could have products accessible and which should have been placed on the top shelf of the closet.</p> <p>7. Observation on 1/30/25 from 3:12 p.m. to 3:48 p.m. of the Pine Village memory care unit on the second floor revealed:</p> <p>*In resident rooms for residents 7, 9, 15, 23, 38, 40, 44, 46, and 69:</p> <p>-Products labeled Keep Out of Reach of Children were in various areas of each resident's rooms and accessible to those residents.</p> <p>-Products identified: mouth rinse, deodorant, Baza All-In-One Perineal Lotion, Gold Bond powder, toothpaste, Biotene mouth spray, perfume, and Head and Shoulders shampoo.</p> <p>8. Review of resident 36's electronic medical record (EMR) revealed:</p> <p>*She was admitted on [DATE].</p> <p>-The most current Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) assessment score of 4, which indicated she had severe cognitive impairment.</p> <p>*Diagnoses included unspecified dementia, adjustment disorder with depressed mood, and unspecified mood (affective) disorder.</p> <p>*Her care plan included the following:</p> <p>-She required staff supervision with personal hygiene tasks like oral cares.</p> <p>-She had impaired decision-making skills, impaired memory, impaired cognitive function and thought processes related to her dementia diagnosis.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*Her care plan did not include that she required personal care products like toothpaste, mouthwash, and lotion to be stored out of reach due to her cognitive impairment.</p> <p>9. Review of resident 7's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her quarterly MDS assessment dated [DATE] included the following:</p> <p>-Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.</p> <p>--She had short-term and long-term memory issues.</p> <p>--She was able to recall staff names and faces.</p> <p>--Her daily decision-making skills were severely impaired.</p> <p>-She had the following diagnoses marked under section I: Non-traumatic brain dysfunction, Alzheimer's disease, dementia, anxiety disorder, depression, and manic depression.</p> <p>10. Review of resident 9's EMR revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His quarterly MDS assessment dated [DATE] included the following:</p> <p>- Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.</p> <p>-He had short-term and long-term memory issues.</p> <p>-He was able to recall staff names and faces.</p> <p>-His daily decision-making skills were impaired.</p> <p>-He had the following diagnoses marked under section I: Dementia, Parkinson's disease, anxiety, and depression.</p> <p>11. Review of resident 15's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her quarterly MDS assessment dated [DATE] included the following:</p> <p>- She had a BIMS assessment score of 7, which indicated she had severe cognitive impairment.</p> <p>-She had short-term and long-term memory issues.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-She was unable to recall year, month or day.</p> <p>-Her daily decision-making skills were impaired.</p> <p>-She had the following diagnoses marked under section I: Dementia.</p> <p>12. Review of resident 23's EMR revealed:</p> <p>*She was admitted on [DATE]</p> <p>*Her quarterly MDS assessment dated [DATE] included the following:</p> <p>- She had a BIMS assessment score of 4, which indicated she had severe cognitive impairment.</p> <p>-She had short-term and long-term memory issues.</p> <p>-Her daily decision-making skills were moderately impaired.</p> <p>-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression.</p> <p>13. Review of resident 38's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her significant change MDS assessment dated [DATE] included the following:</p> <p>-She had a BIMS assessment score of 11, which indicated moderate cognitive impairment</p> <p>-She required cueing on Section C; oriented to month and day, but unable to recall the year.</p> <p>-Her daily decision-making skills were moderately impaired.</p> <p>-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, Parkinson's disease, anxiety, and depression.</p> <p>14. Review of resident 40's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her quarterly MDS assessment dated [DATE] included the following:</p> <p>-Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.</p> <p>-She had short-term and long-term memory issues.</p> <p>-She was unable to recall.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Her daily decision-making skills were moderately impaired.</p> <p>-She had the following diagnoses marked under section I: Dementia, and depression.</p> <p>15. Review of resident 44's EMR revealed:</p> <p>*She was readmitted on [DATE].</p> <p>*Her quarterly MDS assessment dated [DATE] included the following:</p> <p>-Under section C for cognitive patterns, the Staff Assessment for Cognitive Patterns was utilized rather than the BIMS assessment.</p> <p>-She had short-term and long-term memory issues.</p> <p>-She was unable to recall.</p> <p>-Her daily decision-making skills were severely impaired.</p> <p>-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression.</p> <p>16. Review of resident 46's EMR revealed:</p> <p>*She was readmitted on [DATE].</p> <p>*Her significant change MDS assessment dated [DATE] included the following:</p> <p>-She had short-term and long-term memory issues.</p> <p>-She was unable to recall.</p> <p>-Her daily decision-making skills were severely impaired.</p> <p>-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, and anxiety.</p> <p>17. Review of resident 69's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her admission MDS assessment dated [DATE] included the following:</p> <p>-She had a BIMS assessment score of 9, which indicated moderate cognitive impairment</p> <p>-She had short-term and long-term memory issues.</p> <p>-She had recall impairment.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Her daily decision-making skills were moderately impaired.</p> <p>-She had the following diagnoses marked under section I: Alzheimer's disease, dementia, anxiety, and depression.</p> <p>19. Interview on 1/30/25 at 5:37 p.m. with director of nursing B revealed:</p> <p>*She stated, Products labeled with Keep Out of Reach of Children for every resident that was cognitively impaired were to be kept up on closet shelves. Like mouthwash, we don't want them to drink the entire bottle.</p> <p>*She stated, Residents more cognitively impaired are assisted in the bathroom and supervised.</p> <p>*She agreed that products in resident rooms on lower shelves in bathrooms, in 3-drawer bins, on window ledges or on the dressers were accessible to residents in the memory care unit.</p> <p>-She confirmed there was no process or policy in place to determine and what products for which residents should have been stored to ensure the environment remained as free of accident hazards as possible.</p> |

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| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Post nurse staffing information every day.</p> <p>46453</p> <p>Based on observation, interview, and record review, the provider failed to ensure the posted daily staff data:</p> <ul style="list-style-type: none"> *Was displayed in a prominent area accessible to all residents and visitors. *Included the resident census. *Included the total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift and the resident census. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 1/30/25 at 4:42 p.m. throughout the entire building revealed the nurse staffing data was located in an inconspicuous location near the visitor screening station to the right of the front desk. The staffing data was not posted anywhere else in the building, including the locked memory care units. 2. Review of the posted staffing data for 1/30/25 revealed: <ul style="list-style-type: none"> *The resident census was not included. *There were three sections for each shift. Each section was divided by resident unit. *Staff names were displayed for each shift they were working. *There was no distinction between registered nurses and licensed practical nurses. *The total number of nurse staffing hours was not included for each shift. 3. Interview on 1/30/25 at 5:18 p.m. with director of nursing B revealed: <ul style="list-style-type: none"> *The nurse staffing data was only posted at the front desk. *She indicated that the staffing data was supposed to have been posted more prominently, such as in front of the receptionist, rather than by the visitor screening station. *She agreed that not all residents had access to the posted staffing information. *She was not aware of all the requirements for the posted nurse staffing data, such as the resident census and the total hours worked per nursing discipline. *They did not have a policy regarding the posted nurse staffing data. | | |

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| <p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised.</p> <p>49958</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure five of five residents (6, 7, 15, 19, and 41) who received a pureed diet and assessed to have complicated eating problems were not assisted to eat by paid feeding assistants. Findings include:</p> <p>1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed:</p> <p>*Cosmetologist AA was seated next to resident 19 at the assisted dining table.</p> <p>*Cosmetologist AA was trained as a hair stylist, certified to assist in the kitchen, and had completed a training program for paid feeding assistants. She was not a certified nursing assistant (CNA).</p> <p>*Resident 19 had a recent weight loss, was on a pureed diet due to pocketing of food, and had recently began receiving hospice services.</p> <p>*Resident 19 was served a plate with mashed potatoes with gravy, pureed meat, and a dish that contained pureed pie.</p> <p>*Cosmetologist AA assisted resident 19 in eating with a spoon and drinking from a cup with two handles and a lid.</p> <p>*Cosmetologist AA asked another staff to reposition resident 19 in her wheelchair because she was leaning back.</p> <p>2. Observation on 1/29/25 at 11:32 a.m. in the dining room with licensed practical nurse (LPN) L revealed LPN L administered medication to resident 19 by spoon.</p> <p>3. Interview on 1/29/25 at 11:34 a.m. with LPN L and administrator A revealed:</p> <p>*LPN L confirmed that resident 19 took her medications crushed and was on a pureed diet.</p> <p>-She stated resident 19 chews and chews her food.</p> <p>*Speech therapist (ST) G had recommended a downgrade of resident 19's food textures and the pureed diet had been ordered by hospice.</p> <p>*She confirmed that cosmetologist AA assisted resident 19 in eating her meals because she had a connection with resident 19.</p> <p>*Administrator A confirmed that cosmetologist AA was a paid feeding assistant and not a CNA.</p> <p>*Staff development coordinator (SDC) H oversaw the paid feeding assistant program and was new to that role.</p> <p>(continued on next page)</p> | | |

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| <p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. Continued observation and interview on 1/29/25 at 11:48 a.m. in the Dixie dining room revealed:</p> <ul style="list-style-type: none"> *Resident 19 was assisted in eating a pureed meal by cosmetologist AA. *Resident 41 was assisted in eating a pureed meal by activities aide (AA) Y. <p>-AA Y confirmed she worked in the activities department, was a paid feeding assistant and not a CNA.</p> <p>5. Interview on 1/29/25 at 12:04 p.m. with ST G, director of nursing (DON) B, and administrator A revealed they had approached the surveyor and confirmed that ST G had downgraded resident 19's diet to pureed.</p> <p>6. Interview on 1/29/25 between 12:21 p.m. and 12:35 p.m. with SDC H and ST G regarding the paid feeding assistant program revealed:</p> <ul style="list-style-type: none"> *SDC H was new in the role of staff development coordinator and oversaw the paid feeding assistant program since August 2024. *The provider had transitioned from the textbook training format to the online format during that time. *She confirmed that cosmetologist AA and AA Y were paid feeding assistants and not CNAs. *She was unsure if the training covered the topic of residents with special diets, such as pureed. *ST G stated she screened residents for swallowing difficulties at admission, quarterly, with any significant changes or when the nurse requested. *ST G stated that she determined which residents could have been assisted by paid feeding assistants. *Issues related to dental problems, oral issues, the need for altered food textures, and a pureed diet were not considered complicated feeding issues. *Issues like a feeding tube, choking, pocketing food, requiring to be fed on one side of the mouth, aspiration, and the need for special strategies to swallow would have been considered complicated feeding issues. *The decision for resident participation in the feeding assistant program was made by the interdisciplinary team based on ST G's recommendation and it was care planned. <p>7. Review of the provider's 1/27/25 Feeding Assistant List revealed:</p> <ul style="list-style-type: none"> *Sixteen residents were participating in the Feeding Assistant program. *There were no residents listed under the Requiring CNA's [CNAs] to Feed. <p>(continued on next page)</p> | | |

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| <p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>8. Review of resident 6's electronic medical record (EMR) revealed:</p> <ul style="list-style-type: none"> *She received a pureed diet. *Her care plan indicated on 5/29/24 that she, did agree to a pureed texture for her foods. Daughter states [resident 6] can't chew the chopped-up food even now. *She does have swallowing problems occasionally. *She was screened by speech therapy twice in April 2024 for swallowing concerns. *There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant. <p>9. Review of resident 7's EMR revealed:</p> <ul style="list-style-type: none"> *She received a pureed diet. *Her care plan revealed, Nutrition risks include: cognition, dysphagia [difficulty swallowing]. *Dependent assist of 1 [one] for eating. *There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant. <p>10. Review of resident 15's EMR revealed:</p> <ul style="list-style-type: none"> *She received a pureed diet. *Her care plan revealed, Nutrition Risk factors include: cerebral Infarction [a stroke], dementia, hemiplegia [paralysis of one side of the body], dysphagia [dysphagia]. *She had some difficulties with eating when her dentures are in. *A care plan intervention included Monitor/document ability to chew and swallow. *There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant. <p>11. Review of resident 19's EMR revealed:</p> <ul style="list-style-type: none"> *She received a pureed diet. *A 1/24/25 speech therapy screen indicated a referral was made due to pocketing solids. <p>(continued on next page)</p> | | |

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| <p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>*A 1/28/25 progress note indicated the feeding assistant reported patient was a little gaggy this morning.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>12. Review of resident 41's EMR revealed:</p> <p>*She received a pureed diet.</p> <p>*She had a diagnosis of dysphagia.</p> <p>*There was no documentation in the care plan that indicated that she was assisted by a paid feeding assistant.</p> <p>13. Interview on 1/30/25 at 8:43 a.m. with AA EE revealed:</p> <p>*She was an activities assistant and had completed the paid feeding assistant training.</p> <p>*She assisted residents with eating about once a month.</p> <p>*She was allowed to assist any resident who needed assistance with eating.</p> <p>*No one told her which residents to assist with eating.</p> <p>14. Interview on 1/30/25 at 9:41 a.m. with AA Z revealed:</p> <p>*She was a paid feeding assistant.</p> <p>*Resident 15 was on a pureed diet, required assistance to eat, and sometimes coughed with liquids.</p> <p>*Resident 7 was on a pureed diet, required assistance to eat, and AA Z did not think resident 7 had any swallowing issues.</p> <p>15. Interview on 1/30/25 at 3:35 p.m. with SDC H and ST G regarding the paid feeding assistant program revealed:</p> <p>*ST G had assessed residents 6, 7,15, 19, and 41 who had pureed diets and had deemed them safe to participate in that program because They no longer need specific strategies.</p> <p>*ST G stated that a paid feeding assistant could assist a resident who had pocketed regular food but did not pocket pureed food because they no longer had a problem.</p> <p>*Only residents with a feeding tube or who require a very specific feeding strategy would be disqualified from the paid feeding assistant program.</p> <p>*Residents who placed food on one side of their mouth needed to have a CNA feed them.</p> <p>(continued on next page)</p> | | |

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| <p>F 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>16. Interview on 1/30/25 at 4:41 p.m. administrator A, DON B, and SDC H regarding the paid feeding assistant program revealed:</p> <p>*The Feeding Assistant List that was provided included all the residents within the facility who required assistance with eating.</p> <p>*SDC H stated that paid feeding assistants were able to assist any resident not deemed by the speech therapist, to need assistance from a CNA.</p> <p>*Administrator A stated that a feeding assistant could assist any resident in the facility except those who have been excluded.</p> <p>*At that time there were no residents that should have been excluded.</p> <p>*DON B stated care plans did not indicate which residents were in the paid feeding assistant program because it could change.</p> <p>-The care plan may include if they could not be fed by a feeding assistant, but because there was not anyone excluded, no care plans contained that information.</p> <p>17. Review of the provider's revised April 2020 Assisted Dining: The Role and Skills of Feeding Assistants textbook revealed:</p> <p>*Paid feeding assistants are only permitted to assist residents who have no complicated eating or drinking problems as determined by their comprehensive assessment. Examples of residents that a paid feeding assistant may assist include residents who are independent in eating and/or those who have some degree of minimal dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems.</p> <p>*Important! Feeding assistants are not permitted to feed residents with dysphagia.</p> <p>*Residents with dysphagia have difficulty or discomfort when swallowing.</p> <p>*Symptoms of dysphagia include: Coughing before, during or after swallowing food, liquid or medication . Pocketing food in the side of the mouth .</p> <p>18. Review of the provider's February 2010 Dining Assistants policy revealed:</p> <p>*Assisted dining will be provided to appropriate residents when necessary in accordance with applicable federal and state requirements regarding Feeding Assistants.</p> <p>*An [A] FA [feeding assistant] is to feed only those residents who have no complicated eating problems. Complicated eating problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, tube or parenteral/IV [intravenous] feedings, paralysis, trauma or facial, oral or neck surgery or any other complicating condition as, high risk for choking, depressed cough or gag reflex, needing positioning during feeding or decreased gastric motility.</p> |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958</p> <p>Based on observation, interview, record review, and review of the Hospice and Nursing Facility Services Agreement, the provider failed to ensure an integrated plan of care had been developed and made accessible between the provider's nursing staff and hospice agency for one of one sampled resident (19) who received hospice services. Findings include:</p> <p>1. Observation and interview on 1/28/25 between 11:42 a.m. and 12:08 a.m. with cosmetologist AA in the Dixie dining room revealed:</p> <p>*Cosmetologist AA was seated next to resident 19 at the assisted dining table.</p> <p>*Resident 19 had a recent weight loss, was on a pureed diet due to pocketing of food, and had recently began receiving hospice services.</p> <p>2. Interview on 1/29/25 at 11:34 a.m. with licensed practical nurse (LPN) L revealed resident 19 had gallstones, no surgery was recommended, and she began receiving hospice services about two weeks ago.</p> <p>3. Interview on 1/29/25 at 3:07 p.m. with registered nurse (RN) K and staff development coordinator (SDC) H at the North Oak nurses' station regarding hospice revealed:</p> <p>*There was only one hospice provider the facility used, and they were available by phone 24 hours a day seven days a week.</p> <p>*Communication of when the hospice nurse would return to complete wound care or baths was provided verbally and in the electronic medical record (EMR) system.</p> <p>*There was no specific binder or paper records available at that nurse's station regarding resident 19's hospice plan.</p> <p>4. Review of resident 19's EMR revealed there was no documentation that a physician's order for hospice had been received.</p> <p>5. Interview on 1/29/25 at 3:38 p.m. with hospice RN GG revealed:</p> <p>*Consent forms were kept in the resident's paper medical record.</p> <p>*She documented her assessments, phone number, and the date of the next visit directly in the resident's EMR.</p> <p>6. Review of resident 19's current facility care plan revealed:</p> <p>*She had been admitted to the facility on [DATE].</p> <p>(continued on next page)</p> | | |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>*Her diagnoses included mild intellectual disabilities, osteoarthritis, anemia, heart failure, fracture of left patella, acute kidney failure, anorexia, and anxiety disorder.</p> <p>*A nutrition focus area indicated, Currently on hospice was revised on 1/28/25.</p> <p>*The nutrition goal indicated, Comfort Care Nutrition provided due to hospice.</p> <p>*The nutrition interventions included, 1/28/24: admitted to hospice on 1/17 [2025] due to recent diagnosis of Calculus of Gallbladder with Acute Cholelith [Cholelith (gallstones)] with back pain. General surgeon recommends comfort cares over surgical intervention.</p> <p>On 1/29/25 a request was made to director of nursing (DON) B for resident 19's hospice care plan and physician order.</p> <p>7. Interview on 1/30/25 at 8:19 a.m. DON B regarding hospice services revealed:</p> <p>*On 1/29/25 she had contacted hospice for a copy of resident 19's care plan.</p> <p>-Hospice was to put together a care plan and review it weekly with the medical doctor.</p> <p>*A hospice care plan was to be kept in the front of resident 19's paper medical chart and contained the contact number and the services that hospice staff provided.</p> <p>*She obtained a copy of resident 19's hospice physician's order on 1/29/25.</p> <p>*The joint care plan had not been completed.</p> <p>*She expected the facility care plan to be updated with the specific hospice plan by each department when resident 19 started receiving those services.</p> <p>*Hospice documented their notes directly in the EMR if there were any concerns.</p> <p>8. Interview on 1/30/25 at 8:52 a.m. CNA FF regarding identifying residents receiving hospice revealed:</p> <p>*She identified resident 19 received hospice services.</p> <p>*That information was provided to her by the nurse, and it was to be on the pocket care plan.</p> <p>*Hospice visited resident 19 one to two times a week to take her vitals and complete a bed bath.</p> <p>9. The provided pocket care plan did not indicate that the resident received hospice services.</p> <p>10. Interview on 1/30/25 at 4:19 p.m. with administrator A and DON B regarding resident 19's hospice care revealed:</p> <p>*There had been a delay in getting the hospice admitting diagnosis for resident 19.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435036 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Jenkin's Living Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 215 South Maple Street Watertown, SD 57201 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>*She was admitted to hospice on 1/17/25.</p> <p>*During the interview DON B called the hospice provider to request a copy of the physician's order and the hospice care plan.</p> <p>*DON B stated she updated the facility care plan to reflect that resident 19 had been admitted to hospice and the services she received.</p> <p>*She expected the care plan to reflect the specific care resident 19 received.</p> <p>11. Review of resident 19's 1/30/25 updated care plan revealed:</p> <p>*Her care plan included a focus area that was revised on 1/30/25, See the MAR/TAR, Physician orders/protocol, CNA [certified nursing assistant] flow sheets and the Short Term Care Plan. Also, see the restorative nursing flow sheet and therapy plan of treatment in integrated therapy reports if applicable. Care plans are written by the exception reflecting facility standards. Administer medications as ordered. [Resident 19] was admitted to Hospice on 1/17/25.</p> <p>*There was no resident-centered goal, it directed to See Focus revised on 4/16/24.</p> <p>*There were no specific interventions, it directed to See Focus initiated on 5/9/18.</p> <p>12. Review of resident 19's hospice care plan revealed:</p> <p>*It was dated 1/17/25.</p> <p>*The progressive disease process was gallbladder with acute cholyolith (cholelith).</p> <p>*Ongoing updates will be communicated by Hospice to LTC [long-term care] and LTC will integrate changes into their care planning system. The Hospice care plan is the Plan of Treatment/485 with ongoing MD [medical doctor] orders being part of that plan. Hospice does not utilize a separate nursing plan of care [POC]. The LTC plan of care will reflect the most current POC at the LTC facility. That was marked with the responsibility code for hospice and long-term care.</p> <p>14. A review of the provider's 1/8/13 Hospice and Nursing Facility Services Agreement revealed:</p> <p>*Joint Plan of Care . means a coordinated joint plan of care for an individual Patient for the palliation or management of the Patient's terminal illness and related conditions that (a) clearly delineates the services to be provided by Hospice and Facility; (b) is consistent with Hospice's philosophy; (c) is based on the assessment of the Patient's current medical, physical, psychological and social needs, and unique living situation; (d) reflects the participation of Hospice, Facility, the Patient and the Patient's family, as appropriate; and Euro complies with applicable federal and state laws and regulations.</p> <p>*Facility responsibilities included:</p> <p>-Participate in Development of JPOC</p> <p>(continued on next page)</p> | | |

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| <p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-Coordination with Hospice Staff in implementation and update of Joint Plan of Care.</p> <p>*Joint Responsibilities/Mutual Promises. Development and Implementation of Plan of Care Hospice and Facility shall jointly develop and agree upon the Patient's Joint Plan of Care Hospice and Facility each shall maintain a copy of each Patient's JPOC in the respective clinical records maintained by each Party.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for:</p> <p>*The maintenance and disposal of resident care items in one of one shower room.</p> <p>*Transmission based precautions by four of four staff (certified nursing assistant (CNA) T, CNA X, licensed practical nurse (LPN) P, and wound care nurse (WCN) I) for five of five sampled residents (62, 68, 25, 6, and 66) who had care concerns requiring personal protective equipment (PPE).</p> <p>*Hand hygiene and glove use by five of five staff (CNA W, LPN P, LPN DD, LPN N, and staff development coordinator (SDC) H) for four of four observed sampled residents (6, 66, 59, and 328).</p> <p>Findings include:</p> <p>1. Observation on 1/28/25 from 9:53 a.m. to 10:36 a.m. in the shower room [ROOM NUMBER] on the Pine Village memory care unit on the second floor revealed there was:</p> <p>*A used nail file and a dirty hair pick with visible hair and lint sitting on top of the wall-mounted glove box to the left of the entrance.</p> <p>*A soiled plastic cup with a small amount of an unidentifiable dried green paste on top of the soap dispenser in the shower.</p> <p>2. Observation and interview on 1/28/25 at 2:47 p.m. with resident 25 revealed:</p> <p>*There was a stop sign on her door and a cart outside that room that contained gowns and gloves.</p> <p>*She wore a boot on her left foot from a recent surgery on her toe.</p> <p>*She was frustrated that she shared a bathroom with the female resident next door.</p> <p>Observation and interview on 1/30/25 at 8:03 a.m. with resident 25 revealed:</p> <p>*There had not been any signage on her door that indicated she was on enhanced barrier precautions (EBP).</p> <p>*She stated she had one toe with a wound and a dressing on it, but the nurse had not looked at it today (1/30/25).</p> <p>*She stated that staff had worn gloves but not gowns when they assisted her.</p> <p>Review of her 1/24/25 weekly wound observation tool revealed resident 25 had a four millimeter (mm) by four-mm unstageable wound to her left second toe with an undeterminable depth.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Review of resident 25's care plan revealed no indication that resident 25 required EBP.</p> <p>Interview on 1/30/25 at 2:21 p.m. with wound care nurse (WCN) I and infection preventionist (IP) C who participated by phone revealed:</p> <p>*Resident 25 had an open wound to her left toe.</p> <p>*WCN I was unsure if resident 25 was on EBP for wound care and stated she would need to consult with the infection preventionist.</p> <p>*WCN I called IP C at home to join the interview.</p> <p>*IP C stated she had removed resident 25 from EBP because she did not think a Band-Aid was a dressing that required EBP.</p> <p>*WCN I confirmed that resident 25 had an open wound on her left toe with a Medihoney (wound healing) dressing.</p> <p>*IPC stated, I would put her back on EBP with that information.</p> <p>3. Observation on 1/28/25 at 11:12 a.m. with resident 62 and certified nursing assistant (CNA) X revealed:</p> <p>*There were two signs on resident 62's door and a cart outside that room contained gowns and gloves.</p> <p>-One sign indicated, STOP please see nurse, and the other indicated, Steps to put on PPE 1. Put on Gown and tie 2. Put on gloves.</p> <p>*Resident 62 was in her room calling out, Please come.</p> <p>*CNA X entered resident 62 room and closed the door.</p> <p>*The surveyor then entered the room. Resident 62 was seated on the toilet and CNA X was not wearing a gown or gloves.</p> <p>*CNA X exited the bathroom and without completing hand hygiene, put on a pair of gloves and finished assisting resident 62.</p> <p>Interview on 1/30/25 at 7:49 a.m. with WCN I revealed resident 62 was on enhanced barrier precautions (EBP) for a foot wound.</p> <p>Interview on 1/30/25 at 8:07 a.m. with resident 62 who used a whiteboard for communication revealed:</p> <p>*Staff sometimes wore a gown and gloves when they assisted her, but some times she had to get to the toilet so fast that they did not.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*She indicated she had to use the shared bathroom frequently, had difficulty waiting, and sometimes had to wait for the other resident to be done in the bathroom.</p> <p>Interview on 1/30/25 at 8:10 a.m. with CNA U regarding precautions revealed:</p> <p>*The sign on resident 62's door indicated that staff needed to wear a gown and gloves while providing her direct care, but it was okay to go in to talk to her or deliver items to her room.</p> <p>*Resident 62 had an infection in her leg.</p> <p>*A sign was to be on a resident's door, and she used a pocket care plan to know which residents required staff to wear gowns and gloves while providing their direct care.</p> <p>*She stated that information was also in the residents' care plans in the EMR.</p> <p>The provided pocket care plan did not indicate that resident 62 required EBP.</p> <p>Observation on 1/30/25 at 8:15 a.m. at the North Oak nurses' station revealed:</p> <p>*A sign with a list indicated what residents in that area were on EBP.</p> <p>-There were two residents on that list however resident 25 and resident 62 were not listed.</p> <p>Interview on 1/30/25 between 8:31 a.m. and 8:40 a.m. with licensed practical nurse (LPN) M and WCN I revealed:</p> <p>*LPN M stated resident 62 was on EBP for a heel wound and staff were to wear a gown and gloves when providing direct care.</p> <p>*LPN M expected to see resident 62's name on the list of residents that required EBP.</p> <p>*LPN M expected the CNAs to find information on which residents required EBP on the pocket care plan.</p> <p>*WCN I stated that the EBP list had been updated yesterday (1/29/25) and that residents with wounds and catheters that required the use of EBP were on that list.</p> <p>*Signs were to be on those resident room doors.</p> <p>*Residents who required precautions for COVID-19 or contact precautions would be listed on a separate sign.</p> <p>*There were no other lists or signs at that nurse's station.</p> <p>*There were no residents in the North Oak area on COVID-19 or contact precautions.</p> <p>Review of resident 62's EMR revealed:</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*She was admitted on [DATE] with a diabetic ulcer (wound) on her right foot.</p> <p>*Her care plan indicated hx [history] of MRSA [methicillin-resistant Staphylococcus aureus] from the wound on her right foot.</p> <p>*The care plan indicated, CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry.</p> <p>*There was no documentation in the care plan that indicated the staff were to use a gown or gloves with resident contact.</p> <p>Interview on 1/30/25 at 12:57 p.m. with LPN M regarding resident 62's MRSA culture revealed:</p> <p>*Resident 62's daughter stated that the last culture of that wound had been done at the hospital prior to her admission to the facility.</p> <p>*She would request those culture results from IP C.</p> <p>*She was unaware if the MRSA was and active infection.</p> <p>Review of resident 62's printed medical record documents requested revealed:</p> <p>*A 10/2/24 physician's order for Contact precautions: May leave room for meals and therapy as long as wound is covered and not draining. Resident must wash hands with soap and water prior to leaving.</p> <p>*A 9/25/24 wound culture of the right foot revealed Positive for MRSA.</p> <p>4. Observation on 1/28/25 at 2:29 p.m. of CNA T and resident 68 revealed:</p> <p>*Resident 68 had a sign posted outside of her door that stated, STOP, check with nurse before entering and signs that indicated the correct way to put on PPE.</p> <p>*There was an empty three-drawer bin in the hallway outside the resident's room, and a tub containing a clear trash bag of yellow gowns beside it.</p> <p>*Resident 68 was sitting in her recliner in her room when CNA T came in without wearing a gown or gloves and told her she would be going to a doctor's appointment.</p> <p>*CNA T positioned resident 68's wheelchair next to the recliner and assisted her in standing and transferring to her wheelchair.</p> <p>*CNA T got the residents' jacket and asked if she wanted her shoes on as well, which she declined.</p> <p>*CNA T pushed resident out of her room in her wheelchair and down the hallway.</p> <p>Interview on 1/30/25 at 8:01 a.m. with LPN Q revealed:</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*She was unsure what type of transmission-based precautions resident 68 was on.</p> <p>*She thought she was on contact precautions for extended-spectrum beta-lactamase (ESBL) (bacteria that is resistant to some antibiotics) for the ulcers on her legs.</p> <p>Observation and Interview on 1/30/25 at 9:56 a.m. with LPN N and M regarding resident 68 revealed:</p> <p>*LPN N thought she was on enhanced barrier precautions (EBP) for the ulcers on her legs.</p> <p>*LPN M thought she was on contact precautions.</p> <p>*Both LPN M and N searched the resident's electronic medical record and paper chart for the resident's current transmission-based precautions type.</p> <p>*They concluded that resident 68 was on contact precautions due to ESBL in her urine based on a positive culture they found on 1/16/25.</p> <p>*LPN M stated that residents who have a wound or a catheter will have a stop sign by their name tag on their door that indicated to staff to see the nurse for their transmission-based precautions type.</p> <p>*LPN M stated EBP is for direct patient care, contact precautions are for all cares provided to a resident.</p> <p>Observation on 1/30/25 at 11:02 a.m. at resident 68's room revealed:</p> <p>*Resident 68 shared a room with resident 11.</p> <p>*Wound care nurse I entered the resident's room without putting on any PPE.</p> <p>*She wheeled resident 11 out of the bathroom, installed the foot pedals on her wheelchair, and wheeled her out of the room.</p> <p>*When asked what type of precautions was required for the residents in that room, she indicated that resident 68 was on enhanced barrier precautions (EBP).</p> <p>Interview on 1/30/25 at 11:04 a.m. with housekeeper HH revealed:</p> <p>*The color of the stop sign coincided with the level of transmission-based precautions (TBP).</p> <p>*The yellow stop sign coincided with contact precautions.</p> <p>*There was a cheat sheet on each housekeeping cart that listed the type of TBP associated with each colored stop sign, as well as a list of diseases that the residents may have, and the level of cleaning required for each disease.</p> <p>*At the nurse's station, there was a list of residents, the type of TBP the residents were on, and the reason for the TBP.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*She confirmed that resident 68 was on contact precautions related to ESBL in her urine.</p> <p>*She explained that when cleaning the room shared by resident 11 and 68, she would put on a gown, gloves, and an eye protector.</p> <p>*The chemical she would use to clean that room was Betco brand pH7Q Dual concentrated cleaner, which killed viruses and organisms like COVID-19, Staphylococcus aureus, pseudomona, salmonella, VRE (vancomycin-resistant enterococcus) and MRSA (methicillin-resistant Staphylococcus aureus).</p> <p>Interview on 1/30/25 at 11:11 a.m. with LPN N revealed:</p> <p>*She confirmed resident 68 was on contact precautions because of what's in her urine.</p> <p>*If staff were entering the resident's room to help resident 11 instead of resident 68, they did not need to put on PPE.</p> <p>*She confirmed that both resident 11 and 68 used the same bathroom.</p> <p>Interview on 1/30/25 at 12:09 p.m. with infection preventionist (IP) C revealed:</p> <p>*Staff were to perform hand hygiene every time they removed gloves and before they put new gloves on.</p> <p>*She expected staff to know what precautions a resident was on based on a sheet of paper posted at the nurse's desk.</p> <p>*If a resident was on contact precautions, she expected staff to put on PPE (gown, gloves, goggles or face shields if there was a chance of spray back) with each entry into the resident's room.</p> <p>*If a resident had ESBL in their urine and was continent, then they would downgrade the precautions from contact precautions to EBP and the resident would be able to exit their room.</p> <p>*They would try not to room residents together when one of them was on a type of TBP and the other was not, such as the case with residents 11 and 68.</p> <p>*She expected staff to clean the residents' shared bathroom with the purple-top sanitizing wipes (Super Sani-Cloth brand) after each time resident 68 used the bathroom.</p> <p>-Usually we do not have them share a bathroom but at times it does happen.</p> <p>*She was aware that resident 68 currently had ESBL in her urine.</p> <p>-Resident 68 was continent, so they were in the process of changing her to EBP because resident 68 wished to go out of her room for meals and activities.</p> <p>*She confirmed that resident 11 was not on TBPs.</p> <p>-She indicated that staff did not need to wear a gown or gloves when assisting resident 11.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Observation and interview on 1/30/25 at 12:58 p.m. with resident 68 revealed:</p> <ul style="list-style-type: none"> *Staff wore yellow gowns while taking her to the bathroom. *Staff did not clean her bathroom after she used it. *No purple disinfectant wipes were found in her bathroom or within proximity of her room. <p>Interview on 1/30/25 at 1:00 p.m. with CNA W revealed:</p> <ul style="list-style-type: none"> *Housekeeping cleaned the residents' bathrooms once a day. *Staff would clean resident 68's bathroom if it was obviously soiled. <p>Interview on 1/30/25 at 3:05 p.m. with director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *She confirmed she was aware that resident 68 had ESBL in her urine. *She confirmed that residents 11 and 68 shared a bathroom. <p>-When asked about cleaning the residents' shared bathroom after resident 68 used it, she said, I would hope that it would be happening.</p> <ul style="list-style-type: none"> *Staff were to clean their bathroom with the purple-top wipes after each time resident 68 used the bathroom. *If the purple-top wipes were not available, staff had the option to carry around a small package of sanitizing wipes. *She stated not cleaning the residents' shared bathroom put resident 11 at risk for contracting ESBL. *She expected staff to wear PPE when providing care for residents on EBP and contact precautions. <p>Review of resident 68's electronic medical record revealed:</p> <ul style="list-style-type: none"> *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) assessment score of 12 indicating she had moderate cognitive impairment. *Her diagnoses included weakness, acute kidney injury, and ESBL resistance. *Her active contact precaution order started on 12/20/24. *There was an order for staff to clean her arterial ulcers on her right lower extremity (RLE) daily with soap and water and to cover them with an appropriate dressing. <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*There was no documentation in her care plan that indicated she was on contact precautions or EBP.</p> <p>5. Observation and Interview on 1/28/25 at 3:02 p.m. of resident 6 in her room revealed:</p> <p>*There was a sign with a stop sign on it next to her name badge outside of her room.</p> <p>*There was a three-drawer organizer with PPE supplies in it outside of her room.</p> <p>*She was lying in bed, with a pillow propped under her left side, and a call light button on the moveable tray table in front of her.</p> <p>*She stated she had a sore on her coccyx, but they had told her it was healing.</p> <p>*Staff were to change the pressure ulcer (PU) dressing every day.</p> <p>Interview on 1/29/25 at 8:35 a.m. with LPN O regarding resident 6's PU revealed:</p> <p>*She stated the PU has shown a lot of improvement.</p> <p>*It was considered a facility acquired stage 4 PU.</p> <p>Observation and interview on 1/30/25 at 10:44 a.m. of resident 6 while receiving a shower (after obtaining permission by the resident) in the bathroom with CNA W and staff development coordinator (SDC) H revealed:</p> <p>*Resident 6 was in a shower chair, CNA W and SDC H were both wearing a gown and gloves.</p> <p>*Once the shower was completed, both the staff members dried resident 6 with towels and covered her with blankets.</p> <p>*Both staff members removed their PPE (gown and gloves), but did not perform hand hygiene.</p> <p>*CNA W did not put on clean gloves before transporting resident 6 to her room.</p> <p>*SDC H and CNA W applied new gowns once inside her room.</p> <p>*SDC H performed hand hygiene and put on new gloves.</p> <p>*CNA touched the bed comforter on the residents' bed before putting on clean gloves.</p> <p>*Both staff members assisted resident 6 from the shower chair to her bed using a full body mechanical lift (lift and sling used to lift a person's full body).</p> <p>*There was a moveable tray table that had a black plastic bag that was used as a barrier for the clean wound dressing supplies.</p> <p>*LPN N entered the room wearing a gown, performed hand hygiene, and put on clean gloves.</p> <p>(continued on next page)</p> |

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| 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) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*LPN N then:</p> <ul style="list-style-type: none"> -Removed the dirty wound dressing and discarded it. -Removed her gloves and discarded them. -Retrieved a clean package of gauze from the bedside table, opened it, and set it on the bed comforter without a barrier under it. -Performed hand hygiene and then put on clean gloves. -Retrieved the wound cleanser from the bedside table and gauze from the package on the bed comforter. -Sprayed the wound cleanser directly onto the wound and dried the wound with the gauze. -Removed her gloves, performed hand hygiene, and put on new gloves. -Applied collagen with silver to the wound bed, packed the wound with calcium alginate, and covered the wound with an adhesive dressing. -Removed her gloves and discarded them. -LPN N did not perform hand hygiene then picked up the leftover unused supplies from the resident's bedside table. <p>Review of resident 6's EMR revealed:</p> <ul style="list-style-type: none"> *She was admitted on [DATE]. *She had a BIMS assessment score of 14 which indicated she was cognitively intact. *She had an order for a wound dressing change daily and as needed started on 12/6/24 for her PU. *There was no documentation that indicated the resident was on EBP in her care plan. <p>6. Observation on 1/29/25 at 3:18 p.m. with LPN P during administration of resident 59's eye ointment revealed she did not perform hand hygiene before she put on her gloves before she administered that ointment or after she removed those gloves after she completed the administration of that eye ointment.</p> <p>7. Observation and interview on 1/29/25 at 3:50 p.m. with CNA X, LPN P, and WCN I during resident 66's wound dressing change in her bathroom revealed:</p> <ul style="list-style-type: none"> *There was a sign by the resident's name badge on her door with a stop sign on it. *There was no PPE inside or outside of resident 66's room. <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*CNA X was wearing gloves but no gown while assisting resident 66 in the bathroom with her toileting cares.</p> <p>*LPN P and WCN I both performed hand hygiene and put on gloves but no gowns.</p> <p>*After CNA X was finished helping resident 66, she removed and discarded her gloves, performed hand hygiene, and left the room.</p> <p>*While resident 66 was still in the bathroom, LPN P removed the adhesive wound covering and sprayed a disinfectant spray on the wound located on resident 66's coccyx (tailbone area).</p> <p>*LPN P blotted the area with a clean towel.</p> <p>*WCN I handed LPN P the opened wound care products that included a honey fiber pad for packing the wound and an adhesive covering.</p> <p>*LPN P applied the wound care products and then assisted resident 66 in pulling up her incontinence brief and pants and then transferred her to her wheelchair.</p> <p>*LPN P and wound care nurse I both then removed their gloves, discarded them, and performed hand hygiene.</p> <p>*They stated they should have worn a gown and gloves because the resident was on EBP due to her wound.</p> <p>*LPN P stated, I'm the one at risk so if the resident had some sort of infection, she would have put on a gown to protect herself.</p> <p>Review of resident 66's EMR revealed:</p> <p>*A 1/13/25 active order for wound care related to her PU.</p> <p>*There was no documentation that indicated she was on EBP in her care plan.</p> <p>8. Observation on 1/30/25 at 8:04 a.m. with LPN DD revealed:</p> <p>*She did not perform hand hygiene before she applied gloves prior to administering a medication to be taken by mouth to resident 328.</p> <p>9. Review of the provider's undated Enhanced Barrier Precautions Policy and Procedure revealed:</p> <p>*It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs).</p> <p>*Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>*High-contact resident activities may include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any opening requiring a dressing .</p> <p>*Examples of MDROs Targeted by CDC include: Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE) .</p> <p>*Contact precautions are recommended if the resident has acute diarrhea, draining wounds, or other sites of secretions that are unable to be covered or contained for a limited period of time during a suspected or confirmed MDRO outbreak investigation.</p> <p>*2. Gowns and gloves will be available immediately near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).</p> <p>*8. Enhanced barrier precautions should be used for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling device that placed them at a higher risk.</p> <p>10. Review of the provider's revised 9/2021 Infection Prevention and Control Manual regarding Hand Hygiene policy revealed:</p> <p>*Hand Hygiene includes hand washing with soap and water and hand hygiene with alcohol-based hand rub (ABHR.)</p> <p>*Hand hygiene continues to be the primary means of preventing the transmission of infection.</p> <p>11. Review of the provider's reviewed 9/2022 Contact Precautions policy revealed:</p> <p>*Contact Precautions will be used to prevent the healthcare acquired spread of organisms that can be transmitted by direct resident contact (hand or skin-to-skin contact that occurs when performing resident-care) or by indirect contact (touching) with environmental surfaces or contaminated resident care equipment.</p> <p>*Healthcare personnel caring for residents on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.</p> <p>12. Review of the provider's reviewed 6/2023 Guidance for Control of Extended-Spectrum Beta-Lactamase (ESBL) policy revealed:</p> <p>*The purpose of this policy is to provide guidelines for prevention and control of ESBL.</p> <p>*Prevention</p> <p>-A. Appropriate resident placement</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>-B. Gloves for all activities in resident's room</p> <p>-C. Gowns indicated for activities where skin or clothing will come in contact with the resident or their environment or when performing direct care</p> <p>-D. Dedicated equipment or adequate cleaning and disinfection of shared equipment, with particular attention to management of urinary catheters and associated equipment</p> <p>*Cohort symptomatic residents with ESBL in specific areas if possible.</p> <p>*The environment of a resident with ESBL should be cleaned thoroughly at least daily, with special attention to those items likely to be contaminated.</p> <p>49958</p> |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453</p> <p>Based on observation and interview, the provider failed to ensure call light systems were accessible to residents in two of two observed resident shower/tub rooms, and five of eleven observed resident bathrooms (rooms 273, 278, 280, 286, and 288).</p> <p>Findings include:</p> <p>1. Observation on 1/29/25 from 9:33 a.m. to 10:05 a.m. in the 2nd floor memory care unit revealed:</p> <p>*The wall-mounted call light in the bathroom of resident room [ROOM NUMBER] did not have a pull cord and was not accessible if a resident was on the floor.</p> <p>*The cord for the wall-mounted call light in the bathrooms of resident rooms 278, 280, 286, and 288 was wrapped around the call light box and was not accessible if a resident was on the floor.</p> <p>*There was no call light available in the shower room [ROOM NUMBER].</p> <p>*The wall-mounted call light in the tub room did not have a pull cord and was not accessible if a resident was on the floor.</p> <p>2. Interview on 1/30/25 at 3:12 p.m. with activity aide Z revealed:</p> <p>*The shower room was rarely used, but the toilet in that room was used for residents.</p> <p>*She was not aware that there was no call light available in that room.</p> <p>3. Interview on 1/30/25 at 3:27 p.m. with licensed practical nurse (LPN) R revealed:</p> <p>*He was not aware that the shower room did not have a call light available.</p> <p>*The shower in the shower room was never used, but the toilet was used by residents frequently.</p> <p>*He said, I don't leave them alone, but I do stand outside on the other side of the door until the resident is done.</p> <p>*He agreed there should be functioning call lights in resident areas.</p> <p>*If a call light was not functioning, he would call maintenance.</p> <p>4. Interview on 1/30/25 at 5:19 p.m. with administrator A revealed:</p> <p>*They did not have a policy regarding the minimum requirements for call lights.</p> <p>*He indicated he thought a call light was not necessarily needed in the shower room because a staff member would be in the room with the resident at all times.</p> <p>(continued on next page)</p> | | |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-He felt that staff would have used their radios if they needed help.</p> <p>*The maintenance department completed call light audits for functionality. This surveyor requested to review that documentation. That documentation was not provided by the end of the survey.</p> |