STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435069	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tieszen Memorial Home	312 East State St Marion, SD 57043

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on interview, record review, and policy review, the provider failed to effectively implement and follow their policy related to grievances for three of three sampled residents (18, 19, and 24) with unresolved reported concerns. They failed to ensure: *Residents were informed and information was available on how to file a grievance. *All grievances were documented and included the date received, summary statement of resident's grievance, steps taken to investigate and keep resident informed of progress, summary of pertinent findings or conclusion, any necessary corrective action, and date the grievance was resolved. *Documentation of grievances and their resolution was maintained. *Resident council notification of group-reported grievance progress and resolution. Findings include: 1. Interview on 12/17/24 at 9:32 a.m. with resident 19 in his room revealed he: *Reported he had requested that his bed be taken out of his room because he slept in his recliner and wanted more room to use his electric wheelchair. *Stated he had asked the maintenance man and anyone who will listen about it and it still hasn't been done. *Was not sure how to file a grievance regarding his unresolved request to have his bed removed from his room. 2. Interview on 12/17/24 at 3:08 p.m. with resident 24 revealed: *She sometimes waited 30 to 45 minutes in the dining room for her meal. -The wait for supper was the worst. *It was difficult for her to wait that long because she had back pain and her legs would go numb. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had reported her concern at the resident council meeting a couple of weeks ago. *She was told that there was new staff in the dietary department but nothing had improved. 3. Interview with the residents during a resident group meeting on 12/18/24 at 1:00 p.m. revealed: *The resident council met monthly. *Eight residents attended the group meeting who regularly attended the resident council meetings. *They reported that they did not know how to file grievances. -Each department was to address reported concerns related to that specific department. -They verbally expressed their concerns to those department staff members. -If those staff were not at the resident council meeting, activities coordinator (AC) C would pass on their concerns. *There was no follow-up with the residents when they brought their concerns to each department outside of the resident council meeting. *Concerns about the food and long wait times for meal service had been brought up at resident council meeting. -Concerns were discussed verbally, and the residents stated there was no follow-up at the next meeting regarding those concerns. --Resident 3 stated she seeks out the answers because she knew where to find the department heads. -Resident 18 stated that she felt like her table was always served last and that she had told the cook Multiple times, but she felt that there was no communication in that department. -There had been turnover in the dietary department and previous concerns were not followed up on. --One resident stated, We have to start all over. -A resident shared a concern about meals and vegetables being repeated and that they lacked variety. *Resident 17 confirmed their concerns were conveyed verbally and that there was no form they filled out when they had a complaint or concern. 4. Interview on 12/19/24 at 10:16 a.m. with AC C revealed she: *Organized the resident council meetings, took the minutes, and emailed the minutes to each department head after the meeting. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Confirmed residents often shared concerns about the long wait times and the food during resident council meetings. *Stated that most concerns were addressed by that department's staff that attended the resident council meeting. -If staff from those departments of expressed concern were not in attendance, social services coordinator (SSC) J would email those concerns to the applicable department head. *Had not included the resident concerns in the resident council minutes. *Had not assisted a resident in filing a grievance. 5. Interview and review of emails on 12/19/24 at 10:32 a.m. with SSC J revealed: *She was the grievance coordinator. *She had worked there for three years. *She was aware of one resident grievance since she had worked there and that was handled by her and administrator (ADMIN) A. *There was no specific form to fill out when a resident had a complaint, concern, or a grievance. *Resident concerns were brought to her by the resident, the families, and facility staff in person, by email, or over the phone. -Sometimes she received a note that a specific resident wanted to talk to her. -She did not have a specific documented tracking system of resident concerns. --Some were documented in her emails, or the resident's electronic medical record (EMR), but most were addressed verbally. *She would notify each department involved if a resident had a concern with that department. -This was done verbally or by email. *Only very serious concerns were brought to the administrator if they could not be resolved. *She was aware of the resident's concerns regarding the food and long wait times in the dining room. -She had emailed the dietary department about concerns related to the food and long wait times on 11/15/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Review of that email confirmed that she wrote, .several residents tell me the meal was not good last night and it's become a regular thing. They are also telling me they are being served later and later and later . several didn't wasn't o go because they weren't served until well after 6pm. *She was aware that resident 19 had requested to have his bed removed. -She confirmed she had documented his request in the EMR during his care conference held on 10/23/24. -She stated she had emailed maintenance about his request several times and that the last email she sent was 12/10/24. --Review of that email confirmed she wrote, .he wants the bed taken out as he refuses to sleep in it. -She was not sure if that situation had been resolved. 6. Interview on 12/19/24 at 11:20 a.m. with ADMIN A regarding resident concerns and the grievance process revealed: *She considered a grievance to be very serious in nature concerning abuse, neglect, or mistreatment. *She expected issues like missing items, food complaints, and resident concerns to be handled immediately. -That was a verbal process. --She confirmed they did not have a specific form to be filled out, but said that residents could write a note and slip it under the door if they wanted to. *Department heads would learn of resident concerns at resident council meetings, or they would be emailed concerns after the meeting. *She confirmed that SSC J was the grievance official. *She stated, Residents were told [SSC J] was their person if they had concerns or complaints. *She was not aware of the process for tracking or following up with resident concerns as this was handled by SSD J. *She stated there were no grievances available to be reviewed as there had been no grievances filed in the past three years because nothing rose to the level of a grievance. 7. Review of the provider's Resident Grievance: 2024 sheet revealed: *There were nine concerns listed between 4/4/24 and 11/1/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two of those concerns had no documented follow-up provided. *There was one concern regarding the food made by resident 1 on 7/2/24. Review of the provider's Resident Council minutes from July 2024 through December 2024 revealed: *Each month's meeting minutes included: -The date and time the meeting was held. -Motions to open and close the meetings. -The number of residents in attendance. -A statement that the previous month's council notes were reviewed. -Names of staff members present. -Old Business: NONE - New Business: included: --A resident's right was reviewed each month. -Special things residents have interest in doing throughout the month of -The dessert of the month. *The September minutes revealed: Residents want more fresh fruit for meals. They would like watermelon, cantaloupe, and strawberries that are ready to eat. They also stated the scalloped potatoes have no flavor. -There was no documented follow-up of that concern for October, November, or December of 2024. Review of the provider's revised July 2003 Resident Council policy revealed: *The resident council is an open meeting opportunity for residents to let their voices be heard. *Time is spent covering areas of concern including nursing care, dietary services, activities available, general comfort, etc . *No definitions or guidance was provided regarding the difference between a concern and a grievance. Review of the provider's May 2019 Resident Grievances policy revealed: *Responsible Party: Social Services Coordinator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*It is the policy of the [NAME] Memorial Home to provide a grievance procedure for any resident who feels they have a grievance. *If a resident has a grievance, the following procedure will be used: (This is the exact language from the resident policy manual). *See the review of the provider's 6/1/21 [NAME] Memorial Home Resident Policy Manual below. Review of the provider's 6/1/21 [NAME] Memorial Home Resident Policy Manual revealed: *Grievances. If you have a grievance, please use the following procedure. Each grievance will be recognized and resolved within a time frame as indicated within the procedure. This procedure is in no way designated to discourage the registration of a grievance. A grievance may be related to treatment provided or treatment not provided, the behavior of other residents, the infringement of the residence rights, or other areas of treatment or care. *If you have a grievance, contact the Administrator or the Social Service Coordinator. The grievance can be oral or in writing. You have a right to engage and be represented by your own legal counsel. If the grievance has not been resolved with a meeting of the resident/responsible party/appointed representative within 5 days, the grievance should be given to the Administrator. At this point the grievance will need to be in writing to assure that the problem remains the same as what was presented at the on-set. The Administrator may ask that the resident or appointed representative meet with him/her to discuss the problem. If the problem is not solved within 10 days, the grievance can be registered with the governing board of the nursing home. This must be in writing. Or, you may contact the State Ombudsman, telephone # [redacted], or other client advocate. Their name and addresses can be found elsewhere in this manual. *The telephone number provided in that manual for the States Ombudsman was not the correct telephone number. Review of the provider's resident rights document A Matter of Rights, in their Admission Handbook revealed: *Grievances. You have the right to speak up about grievances and have them responded to promptly and fairly. * All residents have the right: -[T]o voice concerns and complaints, spoken, in writing, or anonymously, about the treatment and care we provide or the behavior of other residents. -[T]o information on how to file a grievance or complaint. -[T]o timely response by us in which we agree to consider the issue or issues you raise and to act upon them as may be appropriate. -[T]o be free from any pressure intended to discourage you from voicing your concerns or complaints. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Residents have the right to voice grievances without fear of discrimination or reprisal for doing so. *A grievance of a resident or someone acting on behalf of a resident should be directed to our administrator, to an appropriate department head, or to a designated grievance contact person. It will be helpful if you include: your name, the date, how to reach you, if you are not the resident, details of the situation or event. * Please be as specific as possible in describing the what, where, when, and who involved in your concern or complaint. *No definitions or guidance was provided regarding the difference between a concern and a grievance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, record review, interview, and policy review, the provider failed to: *Adequately assess, reassess, and monitor for resident changes in cognition and safety awareness for self and others for one of eight sampled resident (19) who used a power wheelchair for mobility. *Obtain a physician's order for use with cognitive ability acknowledged for that resident. Findings include: 1. Observation on 12/17/24 at 12:18 p.m. of resident 19 while he exited the dining room while in his power wheelchair revealed he bumped into resident 210's chair, who was seated at the table. 2. Observation on 12/19/24 at 10:46 a.m. of resident 19 while in his power wheelchair revealed he hit the couch in the hallway seating area near the chapel with his power wheelchair and moved that couch by several inches. 3. Review of resident 19's paper chart and electronic medical record revealed: *He was admitted on [DATE]. *His diagnosis included *He received an occupational therapy (OT) evaluation for the initial use of the power wheelchair on 6/21/23 and was discharged from OT on 7/5/23. -That evaluation indicated: --Pt [patient] has demo [demonstrated] independent and safe operation of his power wc [wheelchair] within the SNF [skilled nursing facility] and outside the SNF/ALF [assisted living facility]. --His safety awareness was Intact. --His decision-making ability for routine activities was independent. *His 7/16/24 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact. *His 10/15/24 BIMS assessment score was 9, which indicated he was moderately cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*An 11/22/24 progress note (PN) indicated, . resident will make a point to follow the [floor cleaning] machine multiple times throughout the duration of cleaning. Most times, resident passes the machine extremely close where maintenance has had to move out of resident's way. Other times when resident passes the machine the motorized wheelchair with [would] get hooked on the floor machines wheel resulting in maintenance having to stop to wait until resident becomes unhooked from machine. Resident's wheelchair is swung around to the side once wheels are hooked and that is when resident is able to unhook himself after [the cleaning] machine is stopped. Per staff, this happens often when floor are being washed by motorized machine. At this point, no injuries have been conducted by staff or resident. Resident was spoken to by writer regarding safety and proper use of his electric wheelchair, resident acknowledged writer with a head nod. Will continue to monitor PRN [as needed]. Social services verbally notified. *An 11/29/24 PN indicated, Resident has been riding in electric wheelchair most of the day and getting close to other staff, residents, and visitors when passing by. Writer asked resident to be mindful of where he is driving and make sure he is not getting too close or running into people. Resident made a few remarks to rider about not looking out for others and that he drives just fine. Later resident came to writer and mentioned how many people he had ran over today with his wheelchair. Writer repeated for resident to be mindful of others and cautious about getting too close. Writer explained poor decision making could impact his ability to keep his electric wheelchair if he does not practice safe driving. Resident told writer no and drove wheelchair away. *An 11/30/24 PN indicated, Resident yelling out at staff about getting other residents, Out of his way and demanding that he gets cared for prior to other residents. *A 12/2/24 PN indicated, Resident was in electric wheelchair and got very close to one of our staff members. Staff made a comment about resident getting too close and resident laughed at staff and continued riding around in wheelchair. *A 12/13/24 PN indicated, Secretary reported that resident was driving his electric wheelchair around the entry way this morning when he ran into the face mask dispenser. Resident also continues to get very close to writer and other staff in the hallway when driving around. Rude to staff when they mention he is getting too close. *There was no physician order for resident 19's use of the power wheelchair. 4. Interview on 12/19/24 at 9:33 a.m. with physical therapy assistant P revealed: *They communicated with nursing through email. *OT evaluated residents for use of their ability to safely use their power wheelchairs. -Residents were to be reassessed for safe operation of power wheelchairs annually or if there was an incident that involved their unsafe driving of the power wheelchair. *She confirmed resident 19 was evaluated for use of his power wheelchair in June 2023. *She was not aware of resident 19's unsafe power wheelchair driving incidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She reviewed her emails and stated she had not received any emails regarding resident 19. *Resident 19 had not been reassessed by therapy for his ability to safely operate his power wheelchair since his June 2023 evaluation. 5. Interview 12/19/24 at 10:09 a.m. with secretary E regarding resident 19 driving his power wheelchair revealed she: *Reported a concern regarding resident 19 having been observed getting too close to other residents and staff while driving his power wheelchair. *Was aware resident 19 had recently hit the mask stand in the entryway with his power wheelchair. 6. Interview on 12/19/24 at 1:16 PM with anonymous registered nurse O regarding resident 19 driving his power wheelchair revealed she: *Had concerns about resident 19's safety while driving his power wheelchair. -Stated, He gets too close, and He tries to be funny and one of these days it's not going to be funny. *Documented those concerns in the EMR and reported them to the director of nursing. *Confirmed that residents were evaluated by OT when they had a power chair they wanted to use. -She did not know how often the resident was reassessed by OT. Review of the provider's revised June 2023 Electronic Methods of Transportation (Electric Scooters, Electric Wheelchairs, etc) Policy revealed: *Any resident using an electric transportation device must be safe in the operation of the device . *Any resident who wishes to use an electric transportation device must have a physician's order to do so. *If at any time, a resident is observed to be operating their electronic transportation device in an unsafe manner, the licensed nurse will be notified. In order for the resident to continue to operate the device, an evaluation will need to be completed by the therapy department to ensure the resident is safe to use the device.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49958 Based on observation, interview, record review, and policy review the provider failed to ensure the oxygen concentrator filter was clean and the nasal cannula tubing was changed weekly, for one of three sampled residents (4) who received oxygen from four oxygen concentrators that were separately located throughout the facility. Findings include: 1. Observation and interview on 12/17/24 at 8:57 a.m. with resident 4 in her room revealed: *She was able to say hello but was unable to answer questions about her oxygen. *She wore an oxygen nasal cannula (flexible tubing with prongs that deliver oxygen into the nose) connected to an oxygen concentrator beside her chair. *The nasal cannula connected to that oxygen concentrator was not labeled or dated. *The filter on the back of that oxygen concentrator had visible gray dust. 2. Observation on 12/17/24 at 11:18 am in the sunroom revealed: *An oxygen concentrator located in the back corner labeled TMH#7. *Attached to that concentrator was a plastic bag labeled with resident 4's first name and last initial, and had date issued 10/20, and O2 tube written on it. -Inside that bag was a nasal cannula with a piece of tape attached to it that was dated 10/6. 3. Observation on 12/17/24 at 12:10 p.m. of resident 4 in the dining room revealed she wore an oxygen nasal cannula connected to an oxygen concentrator labeled #8 which was located under the window behind her chair. 4. Observation on 12/17/24 at 3:03 p.m. of oxygen concentrator #8 located in the dining room revealed a plastic bag labeled with resident 4's initials and dated 12/17/24 was attached to that concentrator. -Inside that bag was a nasal cannula with a piece of tape attached to it that was dated 11/17/24. 5. Interview and review of the treatment administration record (TAR) on 12/19/24 at 9:53 a.m. with director of nursing (DON) B regarding resident 4's oxygen revealed: *She confirmed that resident 4 used oxygen continuously and there were four separate concentrators that were located in her room, the sunroom, the chapel, and the dining room for her to use. *Those concentrators were only used by resident 4 because she was the only resident who required oxygen outside of their room at that time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Portable oxygen tanks were only used when a resident went out of the facility or if their oxygen levels dropped too quickly to be moved from one concentrator to another. -Resident 4 had not required a portable oxygen tank. *When a resident was started on oxygen an order was to be added to the TAR to change the nasal cannulas weekly. *She expected that all nasal cannulas would be changed and documented on Sunday evenings by the nurse who worked the night shift. *That nurse would know which nasal cannulas needed to be changed because it would be indicated on the residents' TAR in the electronic medical record (EMR). *Resident 4's TAR did not include to change the nasal cannulas or the location of the concentrators used by resident 4. -She stated, It looks like hers may have been missed. 6. Review of resident 4's electronic medical record revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated she was moderately cognitively impaired. *A 10/10/24 physician's order reflected oxygen at 1 to 5 liters per nasal cannula four times a day to keep oxygen greater than 90 percent. *A 9/27/24 physician's order to Check O2 sat [saturation] qid [four times a day], Document Oxygen if in use. *Resident 4's MAR and TAR did not include to change the nasal cannulas. -There was no indication when the nasal cannula had last been changed on any of the four concentrators used by resident 4. Review of the provider's revised May 2024 Oxygen Administration Policy revealed: *Tieszen Memorial Home's standard of practice for nursing staff for oxygen administration. *Infection Control: .Oxygen mask, nasal cannula and equipment storage bag will be changed weekly, labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 A. Based on observation, interview, and policy review the provider failed to ensure proper infection control practices for the cleaning of shared safety slings for two of two sampled residents (4 and 19) who required the use of a sit-to-stand lift (mechanical lift used to assist to a standing position for transfers). Findings include: 1. Observation on [DATE] at 8:21 a.m. of a sit-to-stand lift parked in the hallway revealed: *The lift had a laminated sign on the side of it that read 12. *There was a medium-sized sling draped over the lift. 2. Observation on [DATE] at 8:32 a.m. with resident 4 and nursing assistant (NA) D revealed: *NA D used a sit-to-stand lift labeled 11 to transfer resident 4 from her wheelchair to her recliner and then placed that lift in the hallway outside that room. -The lift had two green safety slings stacked on top of it, one medium-sized and one large. 3. Observation and interview on [DATE] at 9:23 a.m. with NA D revealed: *NA D brought sit-to-stand lift 11 into resident 19's room with the 2 green safety slings stacked on top of it. -She used that lift to transfer resident 19 from his electric wheelchair to his recliner. *NA D used a cleaning wipe to wipe the metal parts of lift 11 but did not wipe the sling and then parked that lift in the hallway with those two safety slings stacked on top of it. *NA D called this lift the one-person EZ stand. *She confirmed that lift 11 was used to transfer residents 4 and resident 19. *There were three or four other residents who also used that lift on the second floor. *The two green safety slings were shared by all the residents depending on what size they needed. -One was a size medium, and the other was a size large. *She stated the two safety slings were washed when they were visibly soiled, and they were sanitized once a day. 4. Interview on [DATE] at 11:33 a.m. with RN/infection control nurse M regarding the lift slings revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She indicated that each resident who used a full-body lift had their own sling. *She stated that sit-to-stand lift slings are shared between residents. -They were to be wiped with a disinfectant wipe between being used for assisting residents. -They were to be sent to the laundry when they were visibly soiled. Review of the provider's [DATE] EZ stand and mechanical lift policy revealed: *Each resident has a dedicated harness that will be laundered if soiled. *EZ stand is cleaned with disinfecting wipes between each use. 51472 B. Based on interview, observation, record review, and policy review the provider failed to ensure one of one sampled resident (20) with an open wound had been placed on enhanced barrier precautions (EBP). Findings include: 1.Interview on [DATE] at 11:32 a.m. with housekeeper F revealed there were no residents on second floor that had precautions in place which would require her wear a gown and gloves while cleaning the room. 2. Observation and interview on [DATE] at 11:40 a.m. with NA D in the hallways of the second floor revealed: *A metal cart at the nurse's station that had a box of disposable gloves, a box of straws, a plastic container with yellow gowns inside, and a binder with a sunflower on it. *NA D stated that the sunflower symbol was to be used to indicate a resident was on precautions that required them to wear a gown and gloves. -The sunflower would be posted on the resident's door or in their room on the dresser. *NA D stated when a resident was on COVID-19 precautions their door would be closed. *NA D stated contact precautions were used for residents that had catheters or any open wound or surgical site. *No resident doors or dressers were observed to have a sunflower symbol. -NA D stated there were no residents on the second floor who required any type of precautions. 3. Observation on [DATE] at 9:10 a.m. of resident 20 revealed: *He had aa air mattress to relieve pressure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He had a cushion in his recliner and wheelchair. *There were multiple open areas of skin on his mid-buttocks. *No wound dressings were present. *No drainage was visualized. *The skin areas were covered with a white cream. 4. Interview on [DATE] at 9:10 a.m. with RN/skin nurse L revealed: *She did not monitor all skin issues. *She monitored all pressure ulcers. *She had been monitoring resident 20's stage II pressure ulcer (partial thickness skin loss that results from pressure). *She stated that she would have considered resident 20's wound as an open wound. *Resident 20's open areas to his buttocks were a result of pressure. *Resident 20's pressure ulcer was not present when he was admitted to the facility. *Resident 20's pressure ulcer had been improving and on [DATE] the treatment to the area had changed due to suspected yeast near the wounds. *She indicated that she would have placed a resident on Enhanced Barrier Precautions (EBP) (the use of gown and gloves with high contact resident care activities) if the wound was draining. *There were no residents with draining wounds. *She stated that she worked with the infection control nurse when deciding when to initiate precautions. 5. Interview on [DATE] at 9:50 a.m. with RN/infection control nurse M regarding EBP revealed: *A resident would be placed on EBP if there was an indwelling medical device, a major wound or open skin area, or if the resident was a carrier of a multi-drug resistant organism (MDRO). *She stated the size of the wound and the ability to cover it would determine if EBP was needed. *She would have expected a resident with a stage II pressure ulcer for an extended period would need to be on EBP. 6. Review of resident 20's electronic medical record (EMR) revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was admitted on [DATE]. *He had a [DATE] Brief Interview of Mental Status (BIMS) assessment score of 12 which indicated he was moderately cognitively impaired. *His [DATE] care plan included: -A [DATE] initial focus area that indicated he had a pressure ulcer to his left buttock and a pressure ulcer to his right buttock r/t [related to] decreased mobility. -A [DATE] initial focus area that indicated activities of daily living performance deficit. The intervention included: --He was not able to ambulate and required assistance to wheel his wheelchair. --He used a sit-to-stand lift to assist with his transfers. --He required substantial to maximum assistance to turn in bed, as well as lay down in the bed and sit up in the bed. --He required substantial to maximum assistance with putting on and taking off his clothes. --He required substantial to maximum assistance to use the toilet and perform his hygiene. *His [DATE] care plan did not include the need for EBP. *Weekly wound documentation indicated he had a stage II pressure ulcer. Review of the provider's ,d+[DATE] Enhanced Barrier Precaution policy revealed: *Use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status. *Residents shall remain on these precautions the duration of their stay or until the indwelling medical device is removed or wound is healed. *If a resident was placed on EBP It will be communicated by an orange sunflower placed on the resident's door. C. Based on observation, interview, and policy review the provider failed to ensure the alcohol-based hand sanitizers used throughout the facility were not expired. Findings include: 1. Observation on [DATE] from 8:54 a.m. to 9:05 a.m. of the alcohol-based hand sanitizers (ABHS) hanging on the walls outside the resident rooms in the second-floor hallway revealed: *There was a dispenser hanging outside each resident room below the nameplate. -Seven outdated on ,d+[DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One outdated on ,d+[DATE]. -Three outdated on ,d+[DATE]. -Three outdated on ,d+[DATE]. -One outdated on ,d+[DATE]. 2. Continued observation on [DATE] at 9:00 a.m. of the second floor revealed: *A large pump-style bottle of ABHS on a medication cart that was labeled as outdated on ,d+[DATE]. *There was no ABHS available in the resident rooms. 3. Observation on [DATE] between 9:01 a.m. and 9:03 am with registered nurse (RN) I revealed: *RN I cleaned her hands with the ABHS located on the medication cart then entered resident room [ROOM NUMBER]. *RN I used the wall-hanging hand sanitizer located outside of room [ROOM NUMBER] to clean her hands then entered resident room [ROOM NUMBER]. 4. Observation on [DATE] at 9:08 a.m. of the first floor revealed: *The wall-hanging dispenser outside room W101 that contained ABHS that was labeled with an outdate of , d+[DATE]. *The wall-hanging dispenser outside a public bathroom adjacent to the conference room that contained ABHS that was labeled with an outdate of ,d+[DATE]. *The pump Purell ABHS located outside the chapel was labeled as outdated on ,d+[DATE]. 5. Interview on [DATE] at 10:53 a.m. with housekeeper F regarding the wall-mounted ABHS dispensers revealed: *Housekeepers were to check those ABHS dispensers and replace the ABHS when there was very little left in them. *Wall-mounted ABHS refills were provided by the maintenance department. *She had been working there five months and had not checked the expiration dates of the ABHS refills. 6. Interview on [DATE] at 9:45 a.m. with DON B regarding outdates revealed: *She expected the person who obtained the items from the basement that were not frequently used, was responsible for checking those items' outdatse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She stated all other supplies were used frequently enough that they did not outdate. 7. Interview on [DATE] at 11:33 a.m. with RN/infection control nurse M regarding ABHS revealed that maintenance was responsible for checking these outdates because maintenance oversaw housekeeping. 8. Interview on [DATE] at 12:21 p.m. with maintenance regarding ABHS outdates revealed: *He was responsible for checking the outdates on the ABHS. *He stated the labels on the wall-hanging ABHS dispensers may have indicated that they were outdated but he refilled the dispensers from a large bottle of ABHS. *He indicated that the large bottles of ABHS on the medication cart were the type of bottles he used when he would refill the wall ABHS dispensers. *He presented a large bottle of ABHS that was consistent in appearance with the bottle on the medication cart. *The large bottle of ABHS he presented outdated on ,d+[DATE]. *He stated that there was no way to identify if the ABHS in the wall-hanging dispensers were outdated. *He stated that the wall-hanging dispensers were emptied so frequently that they would not outdate. *He indicated that if a bottle contained green colored ABHS that would mean it was the old alcohol-based hand sanitizer. *He confirmed that a bottle of green colored ABHS was in the conference room, and it outdated on , d+[DATE]. Review of the providers ,d+[DATE] Hand Sanitizer policy revealed: *The Maintenance Director or his designee is responsible for refilling said dispensers as needed. *When the cartridges are refilled, the maintenance director or his designee checks the bulk container that is being used to refill the cartridges to ensure it is not outdated. D. Based on observation, interview, and policy review the provider failed to ensure proper infection control practices in the shower and whirlpool rooms include: *Shampoos, lotions, creams, and deoderants were not shared between residents to prevent cross-contamination during bathing. *Items stored in the whirlpool and shower rooms were not expired. Findings include: 1. Observation on [DATE] at 8:13 a.m. of the second-floor shower room revealed: *On the counter was a white plastic basket with an unidentified thick sticky yellow and brown substance that coated the caps of three razor caps and the bottom of the basket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A disposable bathing glove (,d+[DATE]). -A bottle of roll-on antiperspirant (,d+[DATE]). -A partially used bottle of rubbing alcohol (,d+[DATE]). -A tube of [NAME] toothpaste (,d+[DATE]). -A partial tube of Aloe Vest daily moisturizer (,d+[DATE]). -A partial tube of Cavilon barrier cream ([DATE]). -A partial bottle of Tena cleansing cream (,d+[DATE]). -A container of Sani-cloth disinfectant wipes (,d+[DATE]). *The following items were under the sink. -A container of Sani-wipes. -Three spray bottles of cleansers. -Three bottles of whirlpool disinfectant. -Two bottles of Oasis 499 HBV disinfectant. -A gallon container of shampoo. -A partial bottle of white distilled vinegar was outdated as of [DATE]. 2. Observation on [DATE] at 8:39 a.m. of the supply closet located behind the second-floor nurses' desk revealed: *A tall wooden cabinet contained thee following outdated resident supplies: -An unopened tube of Cavilon barrier cream ([DATE]). -A partial bottle of hydrogen peroxide 3% solution (,d+[DATE]). -A suction canister (,d+[DATE]). *The following items were under the sink: -A spray bottle labeled water for plants. -A spray bottle labeled Virex II256 disinfectant cleaner. -A white tub that contained an unidentified black and white flakey substance and a brown-substance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A blue pail. 3. Observation on [DATE] at 8:47 a.m. of the second-floor housekeeping closet revealed: *Purell hand sanitizer for the wall dispensers that outdated on ,d+[DATE]. *A bottle of rubbing alcohol that outdated on ,d+[DATE]. 4. Observation on [DATE] at 10:15 a.m. in the east whirlpool room revealed: *The top of the whirlpool was coated in a layer of dust. *A purple 4-drawer plastic container was coated with a layer of dust. *On the counter next to the sink there were: -An electric razor that was not labeled. -One visibly soiled elastic hair tie. -A black fan with blades and a front blade guard that was coated with a thick layer of dust. -An open COVID-19 BinaxNOW test kit that contained three unopened COVID-19 tests that had an expiration date of [DATE]. *On the whirlpool shelf there were: -Six shampoo bottles that were not labeled. -One conditioner bottle that was not labeled. -A bottle of antidandruff shampoo that was not labeled or dated. *A sign posted on the wall stated, Please perform nail care with EVERY bath. *The following items were in the tall wooden cabinet and were not labeled: -An open container of powder that was not labeled. -Five open bottles of scented lotion that were not labeled. -13 open bottles of body spray that were not labeled. -Six open containers of stick deodorant that were not labeled. -An open tube of Aquaphor that was not labeled. -Three open tubes of barrier cream that were not labeled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A tube of denture cream with an expiration date of [DATE]. *In that cabinet there was a broken plastic bin labeled Nail Care that contained: -A black elastic hair scrunchy with long gray hair in it. -Four wrapped [NAME] candies. -Three pairs of nail clippers. -Two hair picks. -A hairbrush containing a large amount of long grey hair. -A roll of white bandage gauze. -Three rolls of partially used medical tape. -An electric razor that contained gray facial hairs. -More than five hair combs. *Under the sink, in that whirlpool room, there was: -A urinal without a lid that was not labeled. -A denture cup without a lid that was not labeled. -A box containing six pairs of new compression stockings. -A metal bottle of Goof off adhesive remover. -A visibly soiled gray and white scrub brush. -Two blue scrub pads. -A red funnel. -A dry visibly soiled towel that was discolored a brown color. -An open whirlpool soap and body wash container. -A container labeled Body Fluid Cleaner that was discolored and rusted on the bottom. -Two one-gallon jugs of Whirlbath CitrusKleen. --One was open. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A half-full jug of Barbicide *Next to the whirlpool there were two uncovered white clothes basked lined with clear trash bags one contained: -Multiple visibly used gloves. -A visibly wet pull-on incontinent undergarment. -A tan-lined absorbent wound dressing with visible tan drainage on the padding. *The second uncovered white clothes basket contained multiple used washcloths and towels. *A sign above the sink that indicated instructions for enhanced barrier precautions with three residents listed by first name and last initial [residents 1, 35, and 31]. 6. Observation and interview on [DATE] at 10:37 a.m. with CNA G revealed: *CNA G was in resident 108's room, seated on his bed, and took resident 108's blood pressure. *She exited resident 108's room with a stethoscope, a pulse oximeter, and that blood pressure cuff. *Without sanitizing those items, she placed them on a metal cart in the hallway that stored contained yellow gowns, Sani wipes, and trash bags. *She indicated the equipment on that cart was shared for use with all the residents. *She confirmed she had used the blood pressure cuff, pulse oximeter, and stethoscope with the resident in room [ROOM NUMBER]. -She stated, They will need to be cleaned before they are used again and then exited the area without cleaning them. 7. Observation and interview on [DATE] at 10:45 a.m. with CNA H revealed: *She had worked as a bath aid a couple times a week for six years. *She had received additional training to be a bath aide. -That training included additional training with another bath aide. *She had used the north whirlpool room to complete baths that day. -She preferred to use the north whirlpool room but could use either whirlpool room on the first floor or the shower room on the second floor. *She stated any resident could be bathed or showered in any tub room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She identified three residents (5, 9, and 56) who received showers in the shower room on the second floor. *She stated the shampoos, body washes, and conditioners on the whirlpool were used for all residents if they did not have a name on them. *She confirmed that the Aquaphor on the counter was used as a barrier cream and was used for multiple residents who received baths in that whirlpool room. *She confirmed that the electric razors were shared for residents who used the tub room and were to be cleaned with an alcohol wipe between residents and that the remaining facial hairs were to be dumped in the trash. *She stated that resident skin assessments were completed by the bath aide with each resident's bath or shower. -She would report to the nurse any new open skin areas or areas of concern she discovered during a resident's bath. --Areas of concern were to be reported to the nurse right away and the nurse would come to observe them at that time. *She stated when there was a new open skin area or area of concern, she would document that in the electronic medical record system under the skin assessment at the end of the day. -If there were no new areas of concern she would not need to document. *She confirmed the only areas reported to the nurse were new areas. -Skin areas that the nurse already knew about were already being looked at by the nurse and were not assessed during the resient's bath time. -She confirmed that she did not check for expiration dates on products she used in the whirlpool room. 8. Interview on [DATE] at 11:33 a.m. with RN/infection control nurse M regarding the tub and shower rooms revealed: *She stated that there was no risk of cross contamination of the shared products once the product was dispensed from the bottle. Review of the provider's ,d+[DATE] Disinfection and Cleaning of Electric Razors policy revealed: *Electric razors must be cleaned and disinfected after use. This includes shared/community razors provided by the facility and resident's personal razors. *After each use the head is disassembled from the razor base. Excess whiskers, skin and debris are brushed away with a razor cleaning brush. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Razor heads should be rinsed with warm water and dried. *The entire razor including the razor head is wiped down with a EPA registered disinfection wipe. *Daily razor heads are disassembled, brushed off, rinsed with warm water and placed in a container of 70% isopropyl alcohol for a minimum of 10 minutes.