STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435105	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatcrest Hills Healthcare Center	1311 Vander Horck St Britton, SD 57430

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the provider failed to identify and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) preventative interventions for residents identified at risk for developing pressure ulcers for:*One of one sampled resident (9) who developed a stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible) pressure ulcer to her right buttocks.*One of one sampled resident (27) who developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to the side of her right foot. Findings include:1. Observation on 12/1/25 at 2:42 p.m. of resident 27 in her room revealed:*She was sitting in her recliner with her feet elevated.*She had Prevalon boots (a cushioned boot that floats the heel off the surface of the mattress, to help reduce pressure) on both of her feet.*There was an air-mattress with elevated sides on her bed.*She had a heel floatation cushion (a triangle shaped wedge used to float the heels off the mattress, to help reduce pressure) on her bed.Observation and interview on 12/3/25 at 3:13 p.m. of resident 27's right foot with licensed practical nurse (LPN) D revealed:*LPN D stated resident 27 had recurring blisters and skin issues on her feet and legs.*Resident 27's right foot had a pinpoint area of light red surrounded by a pale skin color that was located on the middle outer part of her foot.*LPN D verified that was the location the blister and pressure ulcer had been located.*She had the heel floatation cushion to elevate her feet off the mattress for a long time.*The Prevalon boots were started after the blister was identified on the side of her right foot.*LPN D stated that resident 278 could not have raise her feet or adjust her positioning independently and without assistance from the staff.Review of resident 27's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her 12/3/25 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated she was severely cognitively impaired.*Her diagnoses included weakness, polymyalgia rheumatica (muscle pain and stiffness mainly in the neck, shoulders, and hips), and dementia (a group of symptoms affecting memory, thinking, and social abilities).*A 10/17/25 progress note stated, CNA [certified nursing assistant] reported resident had blister to right foot located on outer foot. Residents [Resident's] foot was resting on heel lift wedge [heel floatation cushion]. Assessed resident, fluid filled blister located on outer right foot with darkened area to the side that was non-blanchable [skin redness that does not change to white when pressed]. Area measured 1 cm [centimeter]x [by] 2.5 cm. Applied betadine [a product used to prevent infection]. Resident foot was resting on the heel lift wedge. Educated staff to make sure feet are placed properly on wedge and feet are floating. Notified [medical provider] and daughter.*The Prevalon boots were initiated on 10/21/25.-These were initiated three days after the identification of the pressure ulcer to her right foot.*Review of her 12/2/25 care plan revealed:- She was identified as requiring substantial assistance or being dependent on one to two staff with her bed mobility, dressing, personal hygiene, and toileting.-She required a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) with assistance of two staff members for all transfers.*An undated skin report of resident 27's right outer foot documented the wound was a stage II pressure ulcer to her right outer foot that measured 2.5 cm x 1 cm.*10/28/25 and 11/5/25 the staff documented on the skin reports that the wound was a stage (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	II pressure ulcer and measured 2 cm x 1 cm.*11/12/25 the staff documented on the skin report that the wound was 100 percent eschar (a thick dark leathery scab of dead tissue) and measured 2 cm x 2 cm and the wound status was improving.*On 11/19/25 the staff documented on the skin report that the wound was 100 percent eschar and measured 2 cm x 1 cm.*On 11/26/25 the staff documented on the skin report that the pressure ulcer was resolved.2. Observation on 12/1/25 at 4:51 p.m. of resident 9's room revealed:*She had an air mattress on her bed.*There was a pressure-relieving cushion in her wheelchair and recliner.Observation and Interview on 12/2/25 at 1:46 p.m. with resident 9 revealed:*She was sitting in her recliner, leaning back with her feet on the floor.*She had a wound on her right buttocks that the wound clinic monitoring to advise treatment.*She was at the wound clinic on 12/1/25 and was told by the nurse that the tunneling of her wound (a deep, narrow channel that extends from an open sore beneath the skin's surface, affecting deeper tissue like fat or muscle, making it harder to heal than typical surface wounds) was deeper than the week before.*She had three surgeries to remove dead tissue in an attempt to improve wound healing.*The wound on her right buttocks started after she was scratched by the chair in the whirlpool tub.*The wound started to improve and then became red and then it turned black.*After it turned black, she had to have the wound debrided (the medical removal of dead, damaged, or infected tissue to improve the healing potential).*She stated there were no interventions such as her air mattress or the cushion in her recliner until after the wound had turned black.*After she started seeing the wound clinic, she received the cushion for her recliner.*After she received her air mattress, she had told the staff that there was a hole in the air mattress, and she would sink to the bed frame when she would lie on it.*The air mattress was not replaced until several months after she told them it was not holding the proper amount of air.*She had a wound vac (a negative pressure system using a sealed dressing and a small pump to create gentle suction, drawing fluid away, reducing bacteria, and stimulating new tissue to help wounds heal faster) for a few weeks.-During that time, she had told the staff the wound vac was not working and when she went to the wound clinic the canister that collected the fluid from the wound was full and the wound smelled foul.*She was told by the wound clinic that her wound had developed from an abrasion to a pressure ulcer.Review of resident 9's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her 11/8/25 BIMS assessment score was 15, which indicated she was cognitively intact.*Her diagnoses included seizures, tremors, polyneuropathy (damaged nerves outside the brain and spinal cord that leads to symptoms such as numbness, tingling, pain, and muscle weakness), diabetes (a condition involving disruptions in how the body regulates blood sugar), and weakness.*Review of resident 9's Braden Scale for Predicting Pressure Sore Risk assessments revealed:-1/8/25, 4/7/25, and 4/8/25 she was identified as not at risk for the development of a pressure ulcer.-On 5/30/25, 6/5/25, 8/16/25, and 11/18/25 she was identified as at risk for the development of a pressure ulcer. That was identified after she had developed a pressure ulcer.*A 4/7/25 progress note stated, Resident reported that she had a sore on her buttocks as she bumped it. Scab noted to R [right] upper buttocks. No odor or drainage noted at this time. Assessed and cleansed the area. Will have a house wound nurse assess. Measures 1.5 cm x 1.5cm, Notified [medical provider] and husband.*The air mattress was placed on resident 9's bed on 6/2/25.-That was two months after the identification of the wound to her right buttocks.*Review of resident 9's 12/3/25 care plan revealed she required partial assistance of one staff member to assist her with dressing her upper body and required substantial assistance with lower body dressing, she used a side rail to assist herself with turning in her bed, she required supervision or the assistance of one staff member for transfers and using the toilet. Review of resident 9's Weekly Skin Evaluations revealed:*On 4/22/25 the wound was identified as an abrasion to her right buttocks that measured 3 cm [length] x 2 cm [width] x 0.2 cm [depth] with moderate drainage.-Description stated, Resident obtained an abrasion on her buttocks which got infected- MRSA [methicillin-resistant staphylococcus aureus, a bacteria resistant to common antibiotics] and Ecoli [a diverse group of bacteria that live in the intestines] reported from the wound culture. Slough [dead or dying tissue that hinders healing by (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	trapping bacteria and preventing new tissue growth] is clearing out of the wound nicely. Some depth noted after slough has come out.-The wound was documented as improving and was treated with calcium alginate with silver and a dressing to cover the wound.*On 4/29/25 the wound was identified as an abrasion to her right buttocks that measured 4 cm x 3 cm x 0.5 cm with moderate drainage.- The wound was documented as improving and was treated with Aquacel Ag and a dressing to cover the wound that was being changed to Dermafoam Blue.*On 5/6/25 the wound was identified as an abrasion to her right buttocks that was open and measured 3 cm x 3 cm x 1.5 cm with moderate drainage.-The wound was documented as unchanged.* On 5/12/25 the wound was identified as an abrasion to her right gluteal fold that was open and measured 4 cm x 3 cm x 5 cm with heavy drainage.-The wound was documented as involving the dermis (skin) and subcutaneous fat.-Description of the wound, Depth has worsened as the wound cleans out. Healthy granulated tissue to the wound bed. No visible bone observed. Lump observed above the wound.-An appointment was made for the resident to be seen at the clinic for evaluation of her wound.-The status of the wound was documented as worsening and the treatment for the wound was calcium alginate with silver and to cover with a dressing.*On 5/19/25 the wound was identified as an abrasion to her right buttocks that was open and measured 3 cm x 1 cm x 5.9 cm with minimal drainage and tunneling (a pathway under the skin's surface , creating a channel extending from the main wound into deeper tissue like muscle, often due to infection, pressure, or poor healing) at of 5.9 cm at the 12 o'clock position of the wound.-The wound status was documented as unchanged.-The treatment of the wound was to pack with Dankins soaked Kerlix two times a day. Resident 9 was scheduled for surgery on her wound on 5/21/25.*On 6/4/25 the wound was identified as a surgical incision to her right buttocks that measured 7 cm x 4 cm x 3.5 cm with moderate drainage.-A wound vac was in place and the wound status was documented as unchanged.*On 6/10/25 the wound was identified as a surgical incision to her right buttocks that was open and measured 5.5 cm x 2.5 cm x 2 cm with moderate drainage.-A wound vac was in place.-Wound status documented as improving.*On 6/17/25 the wound was identified as a surgical incision to her right buttocks that was open and measured 5.5 cm x 2 cm x 5.5 cm with moderate drainage.-The edges around the wound had been rolled.-A wound vac was in place and the status of the wound was documented as unchanged.*On 6/25/25 the wound was identified as a surgical incision to her right buttocks that was open and measured 5 cm x 3 cm x 5.5 cm with moderate drainage.-The wound had rolled edges, a wound vac was in place, and the wound status was documented as improving.*On 7/1/25 the wound was identified as a surgical incision to her right buttocks that was open and measured 5 cm x 2 cm x 5 cm with minimal drainage.-The wound had rolled edges, a wound vac was in place, and the wound status was documented as improving.*On 7/10/25 the wound was identified as a surgical incision to her right buttocks that was not measured and had serosanguinous ([NAME], thin, watery pale pink or reddish fluid) moderate drainage.-The wound vac was on hold and DAKIN'S solution dressings were being applied per a 7/9/25 physician's order.-Wound status was documented as improving.*On 7/18/25 the wound was identified as a surgical incision to her right buttocks that was open and measured 4 cm x 2 cm x na [not applicable] cm with moderate drainage.-Wound status was documented as improving.*On 7/23/25 the wound was identified as a surgical incision to her right gluteal fold that was open and measured 4 cm x 1.7 cm x 4.5 cm with minimal drainage.-The dressing applied was Dankins-soaked gauze to wound bed, cover with ABD pad (a highly absorbent dressing used for heavy-draining wounds).-Wound status was documented as improving.*On 7/30/25 the wound description was documented as Unable to assess wound as has a wound vac in place to not be removed at this time.-A wound vac was in place.-Wound status was documented as improving.*On 8/13/25 Resident has a wound vac to her right buttock. Area was assessed and changed on 8/12/25 by [surgeon's] clinic.*On 8/26/25 the wound was identified as a surgical incision to her right buttocks that measured 1.8 cm x 1.2 cm x 3 cm with minimal to moderate drainage.-A wound vac was in place.*On 9/2/25 the wound was identified as a surgical incision to her right buttocks that measured 1.5 cm x 0.7 cm x 3 cm with minimal to moderate (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	drainage.-Wound edges were rolled and a wound vac was in place.*On 9/9/25 the wound was identified as a surgical incision to her right buttocks that measured 3.2 cm x 1.7 cm x 2.3 cm with minimal drainage.-A wound vac was in place and the wound status was documented as improving.*On 9/16/25 the wound was identified as a surgical incision to her right buttocks that measured 2 cm x 0.8 cm x 2.2 cm with moderate drainage.-A wound vac was in place.*On 9/23/25 the wound was identified as a surgical incision to her right buttocks that measured 1.5 cm x 1.3 cm x 1.7 cm with minimal drainage.-A wound vac was in place.*On 9/30/25 the wound was identified as an abrasion to her right buttocks that measured 1 cm x 1 cm x 1 cm with minimal drainage.-A wound vac was in place.*On 10/6/25 the wound was identified as an abrasion to her right buttocks that measured 1.5 cm x 0.8 cm x 1.4 cm with minimal drainage.-A wound vac was in place and the wound status was documented as improving.*On 10/13/25 the wound was identified as an abrasion to her right buttocks that measured 1.3 cm x 0.7 cm x 1 cm with minimal drainage.-A wound vac was in place and the wound status documented as improving.*On 10/20/25 the wound was identified as an abrasion to her right buttocks that measured 1 cm x 0.5 cm x 0.1 cm with minimal drainage.-Description of the wound documented the open area tunneled 3.5 cm at the 12 o'clock position of the wound.-Dressing changed to pack with iodoform (type of gauze dressing) and covered with a dressing.-Wound status documented as improving.*On 10/27/25 the wound was identified as an abrasion to her right buttocks that measured 1 cm x 0.2 cm x 1 cm with minimal drainage.-There was no documentation to support the status of tunneling of the wound that was identified on 10/20/25.-Dressing changed to pack with iodoform and cover with a dressing.-Wound status was documented as improving.*On 11/3/25 the wound was identified as an abrasion to her right buttocks that measured 1 cm x 0.5 cm x 0.4 cm with minimal drainage.-The documentation continued to not support the status of the tunneling identified on 10/20/25.-Dressing was to pack with iodoform and cover with a dressing.-Wound status was documented as improving.*On 11/10/25 the wound was identified as an abrasion to her right buttocks that measured 0.5 cm x 0.5 cm x 0.5 cm with minimal drainage.-It did not support the status of the tunneling identified on 10/20/25.-The dressing was to be packed with iodoform and covered with a foam dressing.-Wound status was documented as improving.*On 11/17/25 the wound was identified as an abrasion to her right buttocks that measured 0.5 cm x 0.2 cm with minimal drainage.-The dressing was to be packed with iodoform and covered with a foam dressing.-Wound status was documented as improving.*On 11/24/25 the wound was identified as an abrasion to her right buttocks that measured 0.1 cm x 0.1 cm x 0.5 cm with minimal drainage.-The tunneling was 4.5 cm at the 1 o'clock position of the wound.-The dressing was to be packed with iodoform and cover with a dressing.-Wound status was documented as unchanged.*On 12/1/25 the wound was identified as an abrasion to her right buttocks that measured 0.2 cm x 0.2 cm x 2.5 cm with minimal drainage.-There was no documentation to support the status of tunneling that was identified on 11/24/25.-Dressing was to be packed with iodoform and covered with a dressing.-Wound status was documented as unchanged.Review of the wound clinic notes from 7/8/25 through 11/4/25 revealed:*The wound to resident 9's right buttocks was identified as a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure ulcer from 7/8/25 until 8/19/25.*From 9/9/25 through 11/4/25 resident 9's right buttocks wound was identified as a stage IV pressure ulcer.3. Interview on 12/3/25 at 11:15 a.m. with LPN D regarding resident 9 and 27 revealed:*She was the nurse who originally documented the wound.*At that time the resident told her she was scraped by the chair in the whirlpool tub.*She had asked the bath aide about the scabbed area and the bath aide stated she was not aware of the resident having been scraped by the whirlpool tub chair.*The wound was a scabbed area, and she documented it as an abrasion (a partial-thickness wound caused by damage to the skin).*She verified that before the wound the resident did not have an air mattress and she was not sure if the resident had a pressure-relieving cushion in her recliner.4. Interview on 12/4/25 at 9:52 a.m. with registered nurse (RN) C regarding resident 9 revealed:*The resident told staff the wound to her right buttocks was from the whirlpool bath chair.*She had inspected the whirlpool bath chair and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	was unable to identify an area on the chair that would have caused the abrasion.*She had thought there was a pressure component after it opened due to the location of the wound being over a bony prominence.*The resident often leaned to her right side when she was seated, and the wound was on her right buttocks.*She had charted the wound as an abrasion because that was what it was initially identified as, and she was told to document it as that by the former director of nursing (DON).*She agreed that an abrasion would not have the depth that resident 9's wound had.*At the time the wound was identified the resident was using a donut cushion in her recliner.-RN C had removed the donut cushion after she explained it would not have provided the pressure relief that was needed for her wound.The staff had given the donut cushion back to the resident and told her she needed it.*The resident had not stopped using the donut cushion until after the wound clinic advised her against it.*Resident 27 had the heel floatation cushion to float her heels while she was in bed as long as she could remember.*The day the blister and pressure ulcer were identified on resident 27's right foot her right foot had been resting on the heel floatation cushion rather than being suspended by the heel floatation cushion.-Where resident 27's foot was resting on the heel flotation cushion was where the pressure ulcer developed.*Resident 27 was unable to reposition herself without staff assistance and was dependent on the staff to meet all her mobility needs.*She verified the Prevalon boots were not in place as a pressure reduction measure until after the pressure injury to her right foot had already been identified.5. Interview on 12/4/25 at 11:03 a.m. with administrator A revealed she:*Was aware the wound clinic had been documenting resident 9's wound as a pressure ulcer. She stated she was told that was how they documented wounds.*Agreed resident 9's wound should not have been documented as an abrasion after it became an open wound.*Verified resident 27's pressure ulcer was the result of the misplacement of her heel floatation cushion and was preventable.6. Interview on 12/4/25 at 11:54 a.m. with medical director O revealed:*He was resident 9's primary care provider.*He said resident 9 was being cared for by the wound clinic after her pressure ulcer began to tunnel and required surgery.*He was not aware resident 9's wound was being documented as an abrasion. He stated it could have started as an abrasion and with pressure developed into a pressure ulcer.*He considered it a pressure ulcer due to the location and the characteristics of the wound.7. Review of the provider's July 2025 Skin Integrity policy revealed:* In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/wounds, the facility has a systematic approach and monitoring process for evaluating and documenting skin integrity. In the event that a resident I admitted or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds.* The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, weekly for three weeks, and then annually. The Braden Scale is a guide to determine risk stratification for skin impairment.-a. Residents are at a level of risk per the Braden scale and the completion is merely guides the practitioner to determine if further intervention is required.* The resident's skin is inspected daily with completion of ADL's [activities of daily living].Changes in the resident's skin are reported to the licensed nurse (LN).* Ongoing evaluations continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the treatment administration record (TAR) with their initials.* If skin impairment is noted after admission (in addition to the above steps). The LN:a. Initiated alert charting.b. Completes (and documents) notifications to the medical provider and resident or resident representative.c. Implements new interventions as needed. Documents on the resident's care plan.e. Notifies Director of Nursing Services (DNS) of skin Impairments that indicate a potential significant change in condition (Stage II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, of bruise on an area of the body not usually vulnerable to trauma (e.g. head, breast, inner thighs, groin).f. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the pressure injury was avoidable or unavoidable. This evaluation is documented in the nurse's notes.* Wounds are evaluated weekly by facility clinicians. Arterial, pressure, stasis, and venous ulcers, significant surgical wounds, and burns are evaluated, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measured, and findings documented in the medical record. This evaluation includes pain associated with the wound during wound care. If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Medical provider and Resident's Representative are notified. If a new treatment order is obtained the LN:-a. Re-evaluates plan of care and resident's condition (e.g. off-loading pressure from skin impairment area, nutritional intake, blood sugars, and lab values).* Evaluate resident's compliance with plan of care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review the provider failed to ensure proper hand washing and glove use was followed during two of two observed meal services in the kitchen and dining room.Finding include: 1. Observation on 12/1/25 at 5:21 p.m. in the kitchen revealed: *Food and Nutrition Services (FANS) [NAME] I had gloves on, measured the temperature of the peas boiling on the stove, opened a sanitizer wipe and wiped off the thermometer. *He: -Threw the wipe away and removed his gloves. -Did not wash his hands. -Put on a new pair of gloves. -Measured the temperature of the pot roast at 174 degrees, put a pair of oven mitts over his gloves and moved the pot roast into the warming table. -Took off the oven mitts and opened the oven door with the same gloved hands he measured the temperature of the baked potatoes at 207 degrees. -Put another oven mitt over his left gloved hand and put the baked potatoes on the steam table. -Removed the oven mitt and then picked up the thermometer with the same gloves on and measured the temperature of the peas at 201 degrees. -Removed his gloves and through them into the garbage. -He did not wash his hands. *Without washing his hands he put on another pair of gloves and started removing the tinfoil from around the baked potatoes. *He removed his gloves and did not wash his hands. *Put on a new pair of gloves and sliced the homemade buns. *With the same gloves on he opened a drawer and took the serving utensils out, and set them on the steam table. *Opened another cupboard and took out the plates for the supper meal. *Picked up the thermometer and sanitized it, and took the temperature of a baked potato again. *With the same gloved hands he picked up a pen and documented the food temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Pulled a container of cheese slices out of the fridge, grabbed a frying pan off the shelf, and put the frying pan on the stove. *He removed his gloves and washed his hands. *Put gloves on and plated the first supper tray using tongs and a strainer. *With the same gloved hands he opened a can of chili and put it in a bowl. *He placed that bowl in the microwave. *Opened a bag of bread, and with the same gloves on, removed two pieces of bread, brushed melted butter on them, and put them in the frying pan with a piece of cheese to make a grilled cheese sandwich. *He took the bowl of chili out of the microwave and put it on a plate. *Used a spatula to plate the grilled cheese. *With the same gloves on, he held the grilled cheese sandwich down to cut it in half. *He went to a cupboard, retrieved serving bowls, and picked up a spoon to scoop peas in. *With the same gloves on, he opened a bag of buns and took one out. *He 0pened the bun, put a piece of cheese on it, and put it on a plate. *He continued to pick up each baked potato with the same gloves on as he plated the rest of the residents' meals. 2. Interview on 12/1/25 at 6:29 p.m. with FANS cook I revealed: * He knew he should not touch surfaces and then touch ready to eat foods. *He should have washed his hands every time he changed his gloves. *He agreed he had not washed his hands when he changed gloves. 3. Interview on 12/2/25 at 9:44 a.m. with FANS manager F regarding glove use and hand washing in the kitchen revealed: *She preferred that kitchen staff only use gloves when handling ready-to-eat foods. *She agreed that kitchen staff should wash their hands before, between, and after using gloves. *She confirmed the dietary staff do annual training for glove use and hand hygiene. 4. Interview on 12/2/25 at 10:06 a.m. with registered dietitian G revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She would expect dietary staff to follow the policy. *She would observe dietary staff for hand hygiene and glove use when she was at the building. *Dietary staff should wash hands before, between, and after glove use. 5. Observation on 12/1/25 at 5:51 p.m. in the dining room revealed: *Certified nursing assistant (CNA) Q set up resident 3's meal at the table, returned to the kitchen serving window, put her hands on her hips, took resident 31's food tray and prepared his meal at the table. -She did not perform hand hygiene before or after assisting resident 3 with his meal setup. -She did not perform hand hygiene after putting her hands on her hips and before assisting resident 31 with setting up his meal. 6. Observation on 12/1/25 at 6:09 p.m. in the dining room revealed: *Food and nutrition services (FANS) cook I picked up a dinner roll with his gloved hand. *With the same gloved hand, he picked up a bowl of pudding and placed it on a resident's meal tray. *He then used the same gloved hand to pick up plates and use a scoop to put food on residents' plates. 7. Observation on 12/1/25 at 6:14 p.m. in the dining room revealed: *CNA/certified medication aide (CMA) M had her hands resting on her hips and served resident 19 her meal without having performed hand hygiene. *CNA M swiped her hair out of her face, served resident 34 her food without having performed hand hygiene. *She then served another resident her food, which included applying butter to her potato, without having performed hand hygiene. 8. Observation on 12/1/25 at 6:20 p.m. in the dining room revealed: *CNA L served and set up meals for residents 13, 25, and 26 without having performed hand hygiene before or after serving each resident. *He then looked in the drawers in the dining room for sugar packets and drinking straws. *Without having performed hand hygiene he served resident 12 her meal. 9. Observation in the dining room on 12/2/25 at noon meal service revealed: *Hairdresser P was walking around, touching residents' shoulders then she gave two residents a cup (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of hot water. -She did not perform hand hygiene before or after getting hot water for the two residents. *Hairdresser P then touched resident 19's shoulder, picked up resident 19's bread with her bare hand and applied butter on resident 19's bread and set it on the table beside her plate. -She did not perform hand hygiene prior to or after touching the bread. *Hairdresser P adjusted the waistline of her pants, did not perform hand hygiene, picked up a resident's chicken leg with her bare hand and cut the meat off the chicken leg with a knife. -She wiped her hands on a paper towel and did not perform hand hygiene. *Hairdresser P walked over to resident 18's table, picked up resident 18's chicken leg with her bare hand and cut the meat off the chicken leg with a knife. -She wiped her hands with a paper towel and did not perform hand hygiene. 10. Interview on 12/3/25 at 3:20 p.m. with staff development registered nurse (RN) director of nursing (DON) B revealed: *She expected staff to perform hand hygiene after touching surfaces, before assisting a resident. *She stated it was a good idea to perform hand hygiene between each resident while passing meal trays. 11. Interview on 12/4/25 at 9:45 a.m. with RN C revealed: *She said staff were to perform hand hygiene between each resident when they served meals. *Staff were to perform hand hygiene after they touched surfaces and before serving the next meal tray to a resident. 12. Interview on 12/4/25 at 10:38 a.m. with CNA N revealed that staff should have performed hand hygiene between each resident while they passed meal trays. 13. Review of the provider's August 2025 Handwashing/Hand Hygiene policy revealed: *Personnel follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, *Hand hygiene is performed as soon as feasible, after hands become contaminated and frequently during the working day. Examples of situations when had hygiene is performed, included but is not limited to . b. When hands are visibly soiled (soap and water). c. Before and after direct contact with a resident (for which hand hygiene is indicated by standard (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions and acceptable professional practice). e. Before and after meal assistance. q. After contact with potentially contaminated surfaces or items in the resident's environment.

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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** Based on observation, interview, record review, and policy review the provider failed to ensure:*One of one certified nursing assistant (CNA)/certified medication aide (CMA) (M) and one of one licensed practical nurse (LPN) (D) performed hand hygiene with medication administration for five of five missed opportunities.*One of one LPN (D) wore a gown while she assessed a wound on a resident (36) who was on enhanced barrier precautions (EBP) (glove and gown use when providing contact care).Findings include: 1. Observation on 12/1/25 at 2:11 p.m. of resident 36's room revealed:*On the outside of resident 36's room door was a sign that indicated she was on EBP.*There were gowns in a hanging device behind resident 36's door.*In addition to the gowns in the hanging device there were shoes in some of the compartments.2. Interview on 12/1/25 at 2:11 p.m. with resident 10 revealed:*She was resident 36's roommate.*When resident 10 was asked if staff wore gowns when they provided her cares, she stated the gowns were for her roommate.*She then stated, without having been asked a question that staff did not wear gowns when they provided care for resident 36.*She stated the shoes in the hanging device belonged to resident 36. She had placed them there thinking it was a shoe hanger and the staff did not remove them.3. Observation and interview on 12/1/25 at 4:30 p.m. with resident 36 revealed she:*Had a urinary catheter (flexible tubing placed in the bladder to drain urine) hanging below her wheelchair.*Stated she had a wound on her buttocks.*Stated staff wore gloves when they transferred her, helped her get dressed and undressed, and emptied her urinary catheter but they did not wear a gown.4. Review of resident 36's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a 9/17/25 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated she was cognitively intact.*Her care plan was updated on 9/16/25 to include her urinary catheter and on 11/19/25 to include EBP.5. Observation and interview on 12/2/25 at 1:46 p.m. with resident 9 revealed:*On the outside of resident 9's room door was a sign that indicated she was on EBP.*Inside her room were gowns and gloves in a hanging device behind her door.*Resident 9 stated she had an open wound on her buttocks.*Resident 9 stated that staff used to wear a gown and gloves when they provided care for her, but now the staff had only used gloves.*Staff had not worn a gown during the dressing changes to her wound. They only wore gloves.6. Review of resident 9's EMR revealed:*She was admitted on [DATE].*She was on EBP due to a wound her to her right buttocks.*Her 11/8/25 BIMS assessment score was 15, which indicated she was cognitively intact.*She had a scheduled dressing change to her right buttocks since 4/8/25.7. Observation and interview on 12/3/25 at 9:58 a.m. with LPN D in resident 36's room revealed she:*Entered the resident's room, washed her hands and applied gloves. She did not put on a gown.*Explained to the resident that she was there to assess the wound on her buttocks.*Rolled the resident towards her causing the resident's bare skin to come in contact with her uniform.*Explained that the wound that the was resolved but there was a new open area on resident her right buttocks.*Rolled resident 36 back onto her back, removed her gloves and washed her hands.8. Observation on 12/3/25 during morning medication pass with CNA/CMA M revealed:*At 7:59 a.m. she did not perform hand hygiene before preparing the medication for resident 32.*At 8:03 a.m. she did not perform hand hygiene before preparing the medication for resident 24.*At 8:07 a.m. she did not perform hand hygiene after administering the medications to resident 24.*At 8:08 a.m. she did not perform hand hygiene before preparing the medications for resident 19.9. Observation on 12/3/25 at 8:27 a.m. of LPN D revealed:*She applied gloves, without performing hand hygiene.*She administered an insulin injection to resident 7.*She removed her gloves, and did not perform hand hygiene.10. Interview on 12/3/25 at 3:20 p.m. with staff development registered nurse (RN)/director of nursing (DON) B revealed:*She stated residents with wounds, urinary catheters and feeding tubes were to be on EBP.*The residents on EBP were identified by a sign on the resident's room door.*When a resident was on EBP staff were to wear a gown and gloves with all high contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident cares.*Staff development RN/DON B verified assessing a resident wound would be considered a high contact resident care.*Hand hygiene was to be performed for entering a room, after leaving a room, after assisting a resident, after touching surfaces in a resident's room, and before and after the use of gloves.*Hand hygiene was to be performed before preparing medications and after administering the medication to a resident.11. Interview on 12/4/25 at 9:45 a.m. with RN C revealed:*She said staff were to perform hand hygiene when they changed gloves, left a resident room, or touched surfaces within a resident room.*A resident with a catheter or a wound were to be on EBP.*A gown and gloves were to be worn during high contact cares when a resident was on EBP.*She verified catheter care and wound care were high contact resident cares.12. Interview on 12/4/25 at 10:38 a.m. with CNA N revealed:*A resident would be on EBP if they had a wound, urinary catheter, or colostomy.*If a resident was on EBP staff were to wear a gown and gloves for all high contact resident cares such as wound care, urinary catheter care, personal cares, transfers, toileting, or bathing that resident.13. Review of the provider's August 2025 Handwashing/Hand Hygiene policy revealed:* Personnel follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors,* Hand hygiene is performed as soon as feasible, after hands become contaminated and frequently during the working day. Examples of situations when had hygiene is performed, included but is not limited to .b. When hands are visibly soiled (soap and water).c. Before and after direct contact with a resident (for which hand hygiene is indicated by standard precautions and acceptable professional practice).d. Before and after assisting a resident with personal care activities. (e.g. oral care, incontinent care, dressing, grooming, bathing).g. Following contact with a resident's intact skin during provisions of care (e.g. obtaining vital signs, assisting with transfer of lift).h. Before preparing or handling medications.l. Before and after dressing change/wound care.m. Between body sites during provisions of care (e.g. when moving from potentially contaminated site to clean sites).n. After contact with blood or bodily fluids.q. After contact with potentially contaminated surfaces or items in the resident's environment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the safety and prevention for potential entrapment or injury for four of four sampled residents (1, 9, 15, and 27) who had side rails on their bed, and had documented alternatives attempted prior to the installation of side rails for two of two (1 and 15) sampled residents who were recently admitted .Findings include: 1. Observation on 12/1/25 at 2:50 p.m. of resident 9's room revealed: *She had a side rail on the left side of the head of her bed. *The side rail was upside down U-shaped and the opening within the side rail measured seven inches wide by 17 inches high. *The side rail was attached to a wooden board under the resident's air mattress and secured to the bed with a black strap. Observation and interview on 12/1/25 at 4:51 p.m. with resident 9 in her room revealed: *She used the side rail to reposition herself in bed and to help her sit up. *She had an air mattress on the bed, it was not secured and easily moved from side to side. *When the air mattress moved there was a five-inch space between the air mattress and the side rail. -The gap created the potential for entrapment or an injury to occur. *She denied having had a body part trapped within her side rail or between her side rail and the mattress. *She stated the facility had provided the side rail for her and installed it on her bed. Review of resident 9's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her 11/8/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *There was an informed consent signed for a side rail on 6/26/23 by resident 9. *There were no evaluations for resident safety related to potential entrapment risk documented in resident 9's EMR. 2. Observation and interview on 12/1/25 at 2:54 p.m. with resident 1 in his room revealed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*There was a white side rail on the right side of the head of his bed that had openings within the it that were not outside the recommended guidance for size of an opening within a side rail to prevent entrapment and injury. *Resident 1 was lying in his bed with the head of the bed elevated. *Resident 1 stated he used the side rail for repositioning while he was in bed and to transfer in and out of bed. *He stated the side rail was installed on his bed shortly after he was admitted . Review of resident 1's EMR revealed: *He was admitted on [DATE]. *His 11/26/25 BIMS assessment score was 15, which indicated he was cognitively intact. *Resident 1 had given verbal consent for the side rail on 8/26/25. *The 8/28/25 Device and Bed Rail/Enabler Evaluation assessment stated that the interventions attempted before the installation of the side rail were not applicable due to resident 1 having been a new admission to the facility. *There were no evaluations for resident safety related to potential entrapment risk documented in resident 1's EMR. 3. Observation and interview on 12/1/25 at 4:39 p.m. of resident 15 in her room revealed: *She was lying in her bed with the head of the bed elevated. *She had bilateral side rails. *She did not use them much, but they did help her to roll over. Review of resident 15's EMR revealed: *Her BIMS assessment score was 15, which indicated he was cognitively intact. *Device and Bed Rail/Bed Enabler Evaluations were completed on 7/25/25, 8/19/25, and 10/23/25. *The evaluations did not indicate what measures were tried before implementing the side rail. *No documentation was found for the risk of entrapment to be evaluated by the provider before implementation of side rails. 4. Observation and interview on 12/1/25 at 4:46p.m. with resident 27 in her room revealed: *There was a side rail on the left side of the head of her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The side rail was upside down U-shaped and the opening within the side rail measured seven inches wide by 17 inches high. *Resident 27 did not know if she used the side rail for repositioning in bed or to assist her in and out of bed. Review of resident 27's EMR revealed: *She was admitted on [DATE]. *She had a 9/12/25 BIMS assessment score of 8, which indicated she was moderately cognitively impaired. *Her 12/2/25 care plan stated BED MOBILITY: The resident is able to turn/reposition self. May occasionally need staff to cue. Grab bar [side rail] to bed to assist with positioning/transfers Date Initiated: 11/2/2022. *There was an informed consent signed for a side rail on 2/23/23 signed by resident 27. *There were no evaluations for resident safety related to potential entrapment risk documented in resident 27's EMR. 5. Review of the maintenance Beds- Electric December 2024 – December 2025 work history report, documents and logbook revealed: *The maintenance monthly bed check included: -Inspect connectors on rails and tighten as necessary. -Remove any burs or rough edges to prevent injury. -Verify the function of the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/ or foreign materials that could impair its function. -Ensure that the rails engage and lock as specified. -Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc. that are loose, show signs of wear or are missing. *The maintenance checklist had not included safety risk assessments to ensure the mattress and side rails fit properly for the prevention of injury or entrapment. 6. Observation and interview on 12/3/25 at 1:19 p.m. with maintenance supervisor E revealed: *When maintenance personnel completed the monthly maintenance checks of each bed, they checked to be sure the side rail was secure, functioning properly, and there were no missing or broken items. *Maintenance personnel did not evaluate the side rails for entrapment or potential safety risks. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He was not aware that there was guidance for the size specifications of the open areas within a side rail or between the side rail and the mattress to evaluate for potential entrapment and safety risks. *Maintenance supervisor E verified there was a gap between resident 9's side rail and air mattress that was large enough that it posed a risk for a potential entrapment or resident injury. *Maintenance supervisor E grabbed resident 9's air mattress and moved it. He then stated that the air mattress was supposed to be secured to the bed, and it was no longer secure which resulted in the enlarged gap between the air mattress and the side rail. *He verified that the openings within resident 9 and 27's side rails were large enough for a resident's head or other body part to fit through and posed a potential entrapment risk. *He verified he did not have the manufacturer's instructions for resident 9 and 27's side rails. 7. Interview on 12/4/25 at 9:32 a.m. with registered nurse (RN) C related to side rails revealed: *If a resident requested a side rail the staff member would alert the interdisciplinary team (IDT). *If the IDT determined it was appropriate for the requesting resident to have a side rail a work order would be entered into the computer, which would notify maintenance to install the side rail onto that resident's bed. *RN C would then complete a restraint evaluation to determine if the side rail would be a restraint for that resident. *RN C thought the IDT completed the entrapment and safety assessment for the side rails. *RN C verified the side rails on resident 9 and 27's beds had an opening within the side rail that was large enough for a resident's head or other body part to go through and potentially become entrapped in. *She verified that the opening within the side rail had the potential to be a risk for other residents in the facility who could have wandered into resident 9 or 27's rooms. *RN C did not know alternate interventions were to be attempted prior to the installation of a bed rail. *She verified that resident 1 did not have documentation to support that alternate interventions were attempted prior to the installation of his side rail. 8. Interview on 12/4/25 at 11:03 a.m. with administrator A revealed: *If a resident requested a side rail an evaluation would have been completed by the therapy department, an order would have been obtained from the physician for the side rail, and then maintenance would have installed the side rail. *She verified the IDT was involved in the process because they would determine if the side rail was appropriate for that resident before therapy completed their evaluation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Administrator A stated that alternatives were not always attempted prior to the installation of a side rail but therapy would evaluate them before the installation. *She stated she was aware there was a requirement for alternate interventions to be attempted before the installation of a side rail on to a resident's bed. *She verified that if there was no documentation of alternate interventions attempted, she could not determine if there were alternate interventions attempted. *She verified they had not followed the provider's policy by not attempting alternate interventions before the installation of side rails on residents' beds. *Administrator A stated maintenance was responsible for the entrapment assessments related to the residents' beds, and the assessments were completed with their monthly bed checks. *She stated the entrapment assessments had previously been part of the Device and Bed Rail/Enabler Evaluation that was completed on each resident before the installation of a side rails and quarterly. *She was not aware that the Device and Bed Rail/Enabler Evaluation had changed and no longer included the entrapment assessment within it. *She was not aware that the maintenance bed checklist did not include an entrapment or safet risk assessment within it. *Administrator A verified that the openings within resident 9 and 27's side rails were large enough for a head or other body part to go through it and potentially become entrapped. 9. Review of the provider's January 2025 Physical Restraints and Enablers/Devices policy revealed: *The resident and/or resident representative is provided risk/benefits of restraint use or enabler/device use, and consent obtained prior to implementation of the device. *The care plan is updated for the device use with the goal for the least restrictive measures. The ISP is updated to identify restraint or enabler use and identifies other interventions put into place addressing the medical symptoms, environmental, safety, and psychosocial concerns. *The resident is evaluated using the Device Evaluation on admission, re-admission, annually, and with significant change in condition (as the condition change applies to the use of the restraint or device), for the continued need for the device and evaluation of the effect on the resident. Review of the undated Resident LTC Bed Service Manual revealed: *Use only accessories specifically identified for use with the Resident LTC bed. The use of accessories not identified for this bed could compromise the safety of the bed. *The side rail on resident 9 and resident 27's beds were not identified as an accessory within the Resident LTC Bed Service Manual.