STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435119	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4th St Wilmot, SD 57279

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50015 Based on record review, observation, interview and policy review the provider failed to implement prescribed and care-planned preventative pressure injury interventions for one of one (2) sampled resident who developed pressure ulcers to both of her heels. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *Her admitted was 6/19/23. *Her 12/21/24 Brief Interview for Mental Status (BIMS) assessment score was 11 which indicated she had moderate cognitive impairment. *She was legally blind. *Her Braden assessment score was 19 on 12/21/24 which indicated she was as risk for developing pressure ulcers. *A left heel pressure ulcer was first documented in care plan on 2/2/23. *A 11/27/24 doctor's order to paint left heel pressure ulcer with betadine, leave open to air, every day until healed. *On 12/12/24 a new area to her right heel was observed measuring 1 cm by 1 cm black in color and unopened. *A 12/4/24 doctor's order for Prevalon (boots for pressure relief) boots, at all times, and to monitor heels. *A 12/20/24 doctor's order to paint right heel SDTI (suspected deep tissue injury) with betadine daily, leave OTA (open to air), until healed. *A 2/10/25 order for house supplement with meals for wound healing. *Weekly documentation of wound on day shift every Thursday was initiated on 7/17/24. (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 - Minimal harm or potential for actual harm Residents Affected - Few	*A care plan focus area indicated she had a pressure ulcer to her left heel and right heel due to immobility. -An intervention for that focus area indicated she required pillow boots on both feet at all times. That was dated 2/2/23 and was revised on 12/4/24. *She needed the assistance of one staff person with all transfers, toileting, bathing, and dressing tasks. *The 3/4/25 nurse documentation on her treatment administration record (TAR) indicated she had her Prevalon boots on. *The kardex (a report of resident care needs) for resident 2 indicated she required pillow boots on both feet at all times. 2. Observation on 3/04/25 at 10:10 a.m. revealed: *Resident 2 was sleeping in her recliner in her room. *She did not have Prevalon boots on. 3. Observation on 3/04/25 at 11:09 a.m. revealed: *Resident 2 had her slippers and did not have Prevalon boots on. 4. Observation on 3/04/25 at 1:39 p.m. revealed: *Resident 2 was sitting in a wheelchair with slipper booties on. *Her Prevalan boots were on the end of her bed. 5. Observation on 3/05/25 at 2:53 p.m. revealed: *Resident 2 was lying in her bed, on her back, with no Prevalon boots on her heels. *One boot was in her recliner. *One boot was on her walker. 6. Interview and observation on 3/5/25 at 2:57 p.m. with certified nursing assistant (CNA) G in resident 2 room revealed: *She had gotten resident 2 up from bed on the morning of 3/4/25. *Resident 2 had the Prevalon boots on when she got her up. *Resident 2 had a bath on 3/4/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She transferred resident 2 from her recliner to her wheelchair for lunch on 3/4/25. *She forgot to put her Prevalon boots on. *She was aware resident 2 had wounds on her heels. *She then placed the Prevalon boots on resident 2 as they were not on her. 7. Interview on 3/5/25 at 3:02 p.m. with CNA H regarding resident 2 revealed: She knew resident 2 was to wear Prevalon boots but she forgot to put them on her when she put her in bed. *She was aware she had pressure sores on her heels. 8. Interview on 3/5/25 at 3:42 p.m. with registered nurse (RN) I regarding resident 2 revealed: *The nurses were to document that Prevalon boots were on in the resident's TAR. *She checked to see if they were on when she saw resident 2 outside of her room. *She did not check on resident 2 after they laid her down for her nap today (3/5/25). *She would complete her TAR documentation at the end of her shift. 9. Interview on 3/6/25 at 10:40 a.m. with director of nursing (DON) B revealed: *Her expectation for heel lift boots, Prevalon boots or other preventative measures for residents was for staff to: -Follow doctor's orders. -Follow the care plan for the resident. 10. Review of the provider's revised 6/21/24 Pressure injury prevention policy revealed: *The CNA will follow through with skin care interventions implemented for prevention and treatment of skin concerns per resident's care plan. *Routine care should include: redistribute pressure (repositioning, protecting and or offloading, minimize exposure to moisture and keep skin clean, provide appropriate pressure redistributing support surfaces, provide non irritating surfaces, maintain or improve nutrition and hydration status where feasible).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51471 Based on observation, interview, record review, and policy review, the provider failed to ensure that one of one whirlpool tub was free of environmental hazards due to an active water leak next to an electrical box in the control panel of the tub. Failure to do so increased the potential risk for immediate serious injury, serious harm, serious impairment, or death as a result of potential electric shock to a resident and staff. Findings include: 1. IMMEDIATE JEOPARDY Observation on 3/6/25 at 7:57 a.m. in the tub room revealed an active water leak that was dripping behind a 120-volt electrical box within the whirlpool's control panel. Standing water covered the floor under the electrical wires and piping of that control panel. An electrical cord extended from above that control panel to the floor and was lying in the standing water. That whirlpool was being used to provide resident bathing. Interviews with administrator A, director of nursing (DON) B, and facility manager/laundry/housekeeping (FM) P indicated that none of them were aware of the leaking water from the whirlpool tub near the electrical box in the control panel. CNA F was told to refrain from using the whirlpool tub until further notice. At the time of the survey, staff could not accurately verify that the whirlpool tub was safe to use. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing via email on 3/6/25 at 11:52 a.m. to administrator A, and DON B related to the leaking whirlpool tub with water dripping near a 120-volt electrical box, potentially creating an environment where someone could be shocked. They were asked for an immediate jeopardy removal plan. IMMEDIATE JEOPARDY REMOVAL PLAN On 3/6/25 at 1:29 p.m. DON B provided the survey team a written immediate jeopardy removal plan via email. The removal plan, after agreed-upon revisions, with guidance from the long-term care advisor for the South Dakota Department of Health (SD DOH), was approved on 3/6/25 at 1:36 p.m. F689: Response Plan for Removal of Immediate Jeopardy 3/06/25 3/6/25 at [8:28 a.m.]: Whirlpool tub was inspected by maintenance found to be leaking around the voltage box. Two surveyors, DON, and Administrator were present during the inspection. Surveyors left the tub room at approximately 8:45 a.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3/6/25 at [8:45 a.m.] Pennar Whirlpool was unplugged after maintenance took note of area that was leaking. The Whirlpool Tub will remain unplugged and not in use. Bath aide was informed that the Whirlpool tub will not be used and at this time it is unplugged. The shower area can be safely used. 3/06/25 at [8:55 a.m.] Potential for injury has been removed. The shower room is operable and safe. As of 3/6/25 at [9:00 a.m.]: Calls were made to the Board of Directors informing them that quotes will be coming in for a new whirlpool tub and it will need to be replaced as soon as the new one arrives. A quote was received, and the Board of Directors are reviewing. Extended security measures to ensure that the whirlpool tub cannot be used: An Out of Order Sign has been placed on the door of the tub door and the face of the tub. The cord has been secured so that it is not usable, and no power will be in that area. The tub reservoir has been emptied, and the water has been shut off going to the tub so there will not be standing water around the tub. When the new tub is installed weekly inspections of the Whirlpool/tub room will be completed to ensure it remains safe and functioning properly. Staff will be educated to complete work orders to ensure the maintenance has a record of any and all issues in the facility. Education will be given by the Director of Nursing to all certified nursing assistants/mediation [medication] aides/bath aide and nurses by 3/14/25 regarding how to complete a work order, what needs to be put on a work order, and where the work order goes. They will also be educated that maintenance has been instructed to inform those employees giving him verbal issues will be told to complete a work order. If the work order is not completed there is a concern that the issue will not be resolved. On 3/6/25 at 1:28 p.m. administrator A verified that the whirlpool yellow electrical cord had been cut in half, therefore no longer could provide power to the whirlpool tub. On 3/6/25 at 1:45 p.m. after on-site verification, the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope of the citation level was F with guidance from the long-term care advisor for the South Dakota Department of Health. The resident census was 23. 2. Observation and interview on 3/6/25 at 7:57 a.m. of the whirlpool tub in the tub room that was located on the [NAME] hallway of the facility with certified nursing assistant (CNA) F revealed: *The whirlpool tub had an active leak that was dripping just behind a 120-volt electrical box within the control panel. -There was an unidentified green sludge noted to the polyvinyl chloride (PVC) piping where the water had been dripping down. -There was standing water that had covered the floor under the electrical wires and piping of the control panel of the whirlpool tub. -There was a dirt substance that was on the floor within the standing water. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-There was a yellow electrical cord that was found to be above the electrical wiring of the control panel area that extended downward towards the floor and had been lying in the standing water. -There was a dried dirt substance on top of all the piping and electrical wiring within the control panel. -There was a nine-inch by thirteen-inch cake pan that was sitting directly under one of the PVC pipes. -The inside of the cake pan was dry and did not have any water in it. -The pan was corroded and looked as if it had been there for quite some time. -The whirlpool tub metal frame had rust noted to it and the paint was chipping. *CNA F had indicated that the doors for the control panels had been removed, due to the doors continuously falling off. -The control panel doors were found resting next to the whirlpool tub with a blue piece of tape on them. *CNA F stated, I typically have a mop in here to mop up all the water in between giving baths to residents. *CNA F had just given a resident a bath, prior to the observation of the active leaking water. *She indicated she first started as a bath aide in November of 2024 and the whirlpool tub was broken then and was not able to be used. *There was a standing shower and shower chair available in the bathing room that was operable if needed. -She stated, I used the shower and shower chair to give baths when I first started as a bath aide. -She stated, The tub was fixed in December of 2024 and then I was able to start using it. *CNA F indicated that she had told FM P on several different occasions about the whirlpool tub leaking but did not know the specific dates that she had told him. -She indicated that she did not fill out a work order to give to the maintenance department to notify them of the tub leaking. 3. Observation and interview on 3/6/25 at 8:28 a.m. of the whirlpool tub in the bathing room with Administrator A, DON B, and FM P revealed: *Administrator A and DON B were not aware of the whirlpool tub actively leaking directly behind the 120-voltage electrical box. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-DON B had stated, Sometimes the whirlpool tub shuts down on its own. *FM P stated, That's not from me, when asked if he knew why the nine-inch by thirteen-inch cake pan had been placed on the floor under the whirlpool PVC piping. *At 8:45 a.m., administrator A had directed FM P to unplug the yellow cord that supplied the electrical power to the whirlpool tub. -The yellow electrical cord was unplugged at that time. 4. Interview on 3/6/25 at 9:32 a.m. with DON B revealed: *DON B provided the maintenance log sheets for the last 6 months. -She stated, Everything may not be on the maintenance log, as some staff confront him in the hallway and don't fill out the little slip. *Review of the log sheets at that time revealed there had been one log entry indicating that the whirlpool tub needed maintenance. Work order repairs: Tub pump short circuit, Area- Tub Room, Origination date: 11/14/24, Completed date: 11/20/24- Parts ordered: Part ordered. 5. Interview on 3/6/25 at 10:52 a.m. with FM P revealed: *He confirmed that CNA F informed him of the leaking whirlpool tub on several occasions. *He had indicated he may have forgotten about that because it had not been written down on the maintenance log sheets. *He stated, Sometimes I just fix it right away, indicating that he tended to the maintenance request immediately if something was not working correctly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51370 Based on observation, interview, and record review, the provider failed to ensure they provided residents' adequate nutrition needs and followed the dietician-approved menu. Findings include: 1. Observation of the kitchen on 3/4/25 from 11:00 a.m. to 12:30 p.m. revealed: *Cook L plated one cup (c) of chicken and rice casserole, a half c of peas and carrots, and a piece of cake. *The menu called for one c chicken and rice casserole, one half c of peas and carrots, one half c of coleslaw and piece of cake. 2. Interview with dietary manager (DM) K on 3/4/25 at 12:30 p.m. about the lunch meal service revealed: *She did not know the coleslaw had not been delivered. *She had not checked if staff had served the residents' meals as identified on the approved menu. *She expected the cook to come to her if a menu item was unavailable and she would make the food substitution. *They did not have a policy about menu changes. 3. Interview with cook L on 3/5/25 at 9:34 a.m. regarding the 3/4/25 lunch menu revealed: *The coleslaw had not arrived from the supplier. *When a food item was not available, he had not replaced it with a substituted item. *He had not brought the missing food item to the attention of the dietary manager. *He was unaware of the nutritional requirements of the menu. 4. Interview on 3/5/25 at 3:18 p.m. with registered dietician (RD) J revealed: *She provided oversight and approval of the menus served by the provider. *She expected all menu food items to be served. *If an item was not available, an appropriate substitution of like nutritional value should have been made. *She expected the dietary manager to identify the appropriate substitution. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Residents were underserved one serving of vegetables if they did not receive the coleslaw. 5. Interview on 3/6/25 with Administrator A about the menu revealed: *The kitchen staff had all been trained by the previous dietary manager. *She felt there was room for improvement in all areas of the kitchen. *She was unaware the full menu had not been served on 3/4/24. *She expected the dietary manager to be aware if the menu was not followed. *The residents did not receive the full nutritional requirement for the meal served on 3/4/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51370 Based on observation, interview, and policy review, the provider failed to label and store food products according to policy and acceptable food standards and discard food products on or before the best by date. Findings include: 1. Observation on [DATE] from 8:17 a.m. to 8:30 a.m. of the walk-in cooler in the kitchen revealed: *One sandwich in a zipper bag with no label or date. *Three quarts of lemon juice with a best by date of [DATE]. *One opened gallon of Italian dressing dated [DATE] to [DATE]. *Seven containers of sour cream with a best by date of [DATE]. *One full flat of tomatoes. Two of those tomatoes had rotted to less than half their size. *One partial flat of tomatoes with 12 of 12 tomatoes with mold in the stem area. *Seven three-pound boxes of cheese with best by dates of [DATE]. *Three gallons of skim milk with best by dates of [DATE]. 2. Observation on [DATE] from 8:35 a.m. to 8:45 a.m. of the shelf above a food preparation table revealed seven salad dressing containers that contained dry cereal with their contents written on the lids, including: *Crisped rice, with no dating on the container. *Cinnamon toast cereal with a piece of tape on it that was dated ,d+[DATE] to ,d+[DATE]. *Corn flakes with a piece of tape on it that was dated ,d+[DATE]-,d+[DATE]. 3. Observation on [DATE] at 8:43 a.m. of the shelf above a smaller food preparation table revealed: *One bottle of honey with a best buy date of ,d+[DATE]. *One bottle of apple cider vinegar with a best by date of [DATE]. 4. Observation on [DATE] at 9:30 a.m. of the walk-in cooler revealed that all but one gallon of the expired food products observed on [DATE] remained on the cooler shelves. 5. Interview on [DATE] at 8:45 a.m. with cook L revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He stated the cereal had always been kept in those salad dressing containers observed above. *He refilled them almost every day. *He did not put the dated tapes on those containers. *The dates on the tape meant the day it was opened and the day it was to be discarded. *He did not know why some of the food dates were passed. *He thought the dietary manager was responsible for checking the dates on the food products. 6. *Interview on [DATE] at 12:30 p.m. with dietary aide (DA) M and dietary manger (DM) K regarding the best by date on the skim milk that was served at lunch revealed: *DA M had not looked at the date. *DM M had not noticed that the milk was past the best by date. *DM K then poured the milk down the drain. 7. Interview on [DATE] at 10:18 a.m. with dietary manager revealed: *She expected all staff to check the the best by dates on products. *She did not have a regular schedule or a staff member assigned to inspect food products and dates. *She was unaware of the quantity of food items in the walk-in cooler that were in poor condition or outdated. 8. Interview on [DATE] at 3:55 p.m. with Administrator A revealed: *She stated she had many ongoing frustrations with the kitchen and food service. *The previous dietary manager left at the end of 2024 would not take direction given to her, and she had trained all of the current staff. *She would have expected expired food items to be discarded and not served. 9. Review of the provider's [DATE] Food Storage policy revealed: *All containers must be legibly and accurately labeled. *Leftover food is clearly labeled and dated before being refrigerated. *Food should be covered, labeled, and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*All food should be dated with the date that it was open and expires three days later unless it was frozen packaged meat then it expires in 10 days.

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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. 51370 A. Based on interview, observation, and record review, the provider failed to ensure appropriate infection control policies were followed for: *Use of enhanced barrier precautions (gloves and gown use when providing contact care) for one of one sampled resident (14) with a diagnosis of methicillin resistant staphylococcus aureus infection (MRSA) infection. *Use of personal protective equipment (PPE) for two of two sampled residents (17 and 6) with indwelling catheters. Findings include: 1. Interview on 3/4/25 at 9:45 a.m. with resident 14 in her room revealed: *She had a left below knee amputation (LBKA) on 4/18/24. *She stated that the incision had not healed properly. *She had tested positive for MRSA in the wound before Thanksgiving. 2. Observation on 3/4/25 at 9:45 a.m. and 10:26 a.m. of resident 14's room, door, and the hallway outside of the room revealed no symbols or signage that indicated enhanced barrier precautions were required when providing care to resident 14. 3. *Interview on 3/5/25 at 11:20 a.m. with resident 14 in her room revealed: *The wound care nurse used a gown, face shield, and gloves when she had MRSA in November but just uses gloves now. * Facility staff used gloves when they provided her wound care. *Caregiver staff had not used gloves or other items of PPE when they assisted her with dressing, transferring, or bathing. 4. Interview on 3/5/25 at 11:25 a.m. with CNA N revealed she was not aware that she should have used any precautions when providing care or having close contact with resident 14. 5. Interview on 3/5/25 at 4:00 p.m. with RN I regarding enhanced barrier precaution (EBP) with resident 14 revealed: *She would have expected staff to use EBP when providing her care that required contact. *She considered resident 14 to be an accurate historian and if she stated that staff only used gloves when dressing her wound, that was likely accurate. (continued on next page)

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	435119	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmot Care Center Inc	501 4th St Wilmot, SD 57279

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 14 was receiving antibiotics because previous attempts to stop the antibiotic resulted in increased drainage of her wound and decreased wound healing. 6. Interview on 3/5/25 at 4:40 p.m. with Infection Preventionist C revealed: *She had initiated EBP in the facility that week for the four residents who required it. *She expected staff to use EBP when having any close contact with those identified residents, but not for activities such as delivering water to the room. *In response to what she meant by recently, she stated that it had been started this week. *She hung EBP posters in those four residents/ rooms. *She emailed all staff to be use EBP when appropriate. *She had provided a staff in-service on PPE in October, 2024. *She expected all staff to know when and how to properly use EBP. *She was not surprised that staff were not using EBP as they had just initiated it that week. *She considered EBP was required for resident 14's care because she had MRSA. 7. Interview on 3/5/25 at 4:58 p.m. with director of nursing (DON) B revealed: *She would expect staff to have used gown and gloves with resident 14 when working with her wound. *She would not expect staff to use EBP when performing daily tasks that did not expose the wound drainage. *The wound was covered with an occlusive dressing, which she described as creating a seal over the wound. *Resident 14's wound care was provided by contracted company staff who saw her weekly. 8. Review of resident 14's electronic medical record (EMR) on 3/5/25 revealed: *On 11/5/24, she was diagnosed with a MRSA infection in the drainage from her LBKA wound. *No further lab results to indicate that presence or absence of MRSA were located. *On 1/29/25, her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated that she was cognitively intact. 9. Review of the Kardex (pocket care plan) dated 2/28/25 for resident 14 revealed no information regarding her wound or the need for staff to use EBP when providing cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of the care plan showed the most recent revision on 12/20/24 contained no information regarding her MRSA diagnosis, wound care, or use of EBP. Review of the facility's enhanced barrier precaution policy and procedure policy dated 10/2/24 revealed that use of EBPs was indicated for residents with: * Infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply. *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 51471 B. Based on record review, observation, interview, and policy review the provider failed to ensure proper use of personal protective equipment (PPE) for two of two sampled resident (17 and 6) who had indwelling catheters. 1. Review of resident 17's electronic medical record (EMR) on 3/4/25 at 8:00 a.m. revealed: *She had a urinary catheter. *Review of her most recent care plan did not indicate that she was on enhanced barrier precautions (EBP). *On 2/1/25, her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated that she was cognitively intact. 2. Observation of resident 17's room on 3/4/25 at 8:17 a.m. revealed: *There was no sign that indicated she was on EBP. -There was no personal protective equipment (PPE) outside of her room for staff to don. 3. Observation on 3/5/25 at 3:53 p.m. of resident 17 revealed: *CNA F was assisting resident 17 with her cares with glove use only. *She had a urinary catheter. *There was an EBP sign hanging on the wall above the light switch in the resident's room. -There was a box of gloves sitting on a shelf in resident 17's room along with personal items. 4. Interview on 3/5/25 with certified nursing assistant (CNA) G regarding EBP for resident 17 revealed: *She had never been on EBP and stated, I had always wondered about that. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation and interview on 3/5/25 at 5:25 p.m. with resident 17 revealed: *She had indicated nursing staff assist her with her catheter. -A urinary catheter bag was hung on the frame of the resident's bed. -She stated, I have had a catheter the whole time I have been here. -She stated, They wear gloves but not a gown. 6. Interview on 3/6/25 at 2:10 p.m. with resident 17 revealed: *She stated, There are usually gowns in the bottom drawer the bottom drawer is within resident 17's personal closet door in her room. -There were no gowns in the drawer at that time for staff to don. *She stated, Just today they started wearing gowns when doing cares with my catheter. 7. Review of resident 6's EMR on 3/4/25 at 8:00 a.m. revealed: *She had a urinary catheter. *Review of her most recent care plan did not indicate that she was one either EBP or contact isolation (CI) precautions. *On 1/15/25, she was diagnosed with MRSA infection that was identified in her urine. *On 1/21/25, her Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated that she was cognitively intact. *She had colonization of Methicillin-resistant Staphylococcus aureus (MRSA) in urine and on antibiotic therapy. This could cause confusion for staff. 8. Observation of resident 6's room on 3/4/25 at 8:17 a.m. revealed: *There was a sign on the inside of her room that was visual upon entrance to room, indicating she was on CI. -PPE was outside of her room for staff to don. 9. Observation and interview on 3/6/25 at 3:23 p.m. with resident 6 revealed: *Nursing staff assisted her with her catheter. -A urinary catheter leg bag was attached to the resident's lower right leg and ankle. (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, They only wear gloves when working with my catheter, they maybe have worn a gown once or twice. 10. Observation on 3/6/25 at 3:27 p.m. with resident 6 revealed: *CNA N had worn a gown, shoe covers, and gloves when caring for the resident's catheter. -She did not wear face protection. -The urine had been disposed of in resident 6's personal toilet in her room. -She used a spray hose attached to the toilet in the resident's bathroom to clean out the container she collected the urine in. -There was notable water that had sprayed back out from the container when she initiated the sprayer to release water to clean it. 11. Observation on 3/5/25 at 3:53 p.m. of resident 6 revealed: *She had a urinary catheter. *She had an EBP and a CI sign hanging in her room. 12. Interview on 3/4/25 at 8:30 a.m. with housekeeper O revealed: *She was not aware of how to clean residents' rooms who were on EBP. -She stated, I would clean them like I would any other room and wear gloves. -She stated, When they have the extra stuff outside of their rooms like the gowns, then I know I need to wear that. 13. Interview on 3/5/25 with director of nursing (DON) B revealed: *She would expect staff to follow the EBP policy when caring for a resident with an indwelling catheter. Review of the provider's enhanced barrier precautions policy and procedure dated 10/2/24 revealed that the use of EBPs was indicated for residents with: * Infection or colonization with a centers for disease control and prevention (CDC) targeted multi-drug-resistant organisms (MDRO) when contact precautions do not otherwise apply. * Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. EBP does not apply to shorter-lasting wounds such as skin breaks and skin tears covered by a bandage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. *EBP is used when performing the following high-contact resident care activities: *Dressing. *Bathing/Showering. *Transferring. *Providing Hygiene. *Changing linens. *Changing briefs or assisting with toileting. *Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. *Wound care: any skin opening requiring a dressing.