STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Creek Healthcare Center	4600 South Highland Drive Salt Lake City, UT 84117

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review, the facility did not develop and implement a comprehensive person-centered care plan consistent with the resident's rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Specifically, for 4 out of 33 sampled residents, a resident's care plan was not updated to reflect the resident's activities of daily living requirements as they related to the resident's toileting needs; a resident did not have a behavioral health care plan that addressed the resident behavior of disrobing in public; a resident did not have a care plan initiated that addressed the resident's activity preferences and needs; and care plan interventions were not updated after a resident's falls. Resident identifiers: 24, 31, 49, and 54. Findings included: 1. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis of left side, pneumonitis, type 2 diabetes mellitus, idiopathic epilepsy, chronic obstructive pulmonary disease, morbid obesity, dyspnea, congestive heart failure, blindness one eye, schizoaffective disorder, dissociative identity disorder, and anxiety disorder. On 1/27/25 at 10:23 AM, an interview was conducted with resident 24. Resident 24 stated that he fell out of the bed four weeks ago, and the facility had to call the paramedics to get him back into bed. Resident 24 stated that it took eight firemen to lift him back into bed. Resident 24 stated that he rolled to the left side during care and his left leg slid out of the bed. Resident 24 stated that the momentum took the rest of his body. Resident 24 stated that he had two Certified Nursing Assistants (CNAs) assisting him that day but both CNAs were located on the right side of the bed. Resident 24 stated that he bruised his buttocks and left hip from the fall. Resident 24's medical record was reviewed. On 10/16/24, resident 24's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 14/15, which indicated that the resident was cognitively intact. The assessment documented that resident 24 was a total dependence and required a two plus persons physical assist for bed mobility, transfer, and toilet use. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 2:30 AM, resident 24's incident report documented that the resident had a witnessed fall. The report documented under notes, 1/7/2025 Res [resident] had a witnessed fall during a brief change. Aide had resident on his left side clean and ready to place a chuck under him. Upon turning to her side to retrieve the chuck aide saw residents' legs off the bed sliding down onto his buttocks, landing slightly more onto his left side. The notes further documented, 1/16/2025 resident is morbidly obese, need to add to care plan 2 staff to be present to all brief changes for safety. On 10/19/22, resident 24 had a care plan initiated for Activities of Daily Living (ADLs) self-care performance deficit related to morbid obesity, major depressive disorder, anxiety, hemiplegia, and muscle weakness. The care plan was last revised on 12/21/23. Interventions identified in the care plan included: resident preferred bed baths; resident required extensive and up to total dependent assistance with most ADLs; encourage the resident to participate to the fullest extent possible with each interaction; encourage the resident to use call light for assistance; and Physical Therapy and Occupational Therapy to evaluate and treat per the physician orders. Resident 24's Kardex report documented under ADLs the resident's preferred bathing schedule. The Kardex did not document the staff support needed or the number of staff required for any ADLs. No other ADLs were addressed in the Kardex. It should be noted that the care plan and Kardex did not document that resident 24 required a two person assist with ADLs. On 1/28/25 at 1:42 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 24 needed full assistance for ADLs. CNA 2 stated that resident 24 needed one to two staff to turn and reposition the resident and he was not able to roll on his own. CNA 2 stated that resident 24 was incontinent of bowel and bladder. CNA 2 stated that resident 24 required a Hoyer lift for transfers but he did not get out of bed often. CNA 2 stated that resident 24 had fallen before, but that he was not a fall risk because he did not move a lot. CNA 2 stated that resident 24 had bed rails to assist with repositioning and they kept the bed lowered. CNA 2 stated the only way resident 24 would fall was if staff rolled him too far. CNA 2 stated that staff needed to take precautions to make sure resident 24 was centered in the bed before rolling him. CNA 2 stated that resident 24's previous fall was due to the resident being rolled too far. CNA 2 stated that she was not present for resident 24's fall but was informed of it. CNA 2 stated that the fire department had to come get resident 24 off of the floor. CNA 2 stated that the fall occurred during the night shift. On 1/30/25 at 10:09 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 24 had filed a grievance against female staff providing incontinence care and that if the staff were female then he wanted two staff to assist. CNA 3 stated that she was told that resident 24 was a two person assist for ADLs because of his grievance, but she was able to reposition and provide incontinence care by herself. CNA 3 stated that the Kardex should tell the staff what resident 24's care needs were and any interventions that were in place to prevent falls but the facility Kardex was not updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 12:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the task communicated the ADL care needs to the staff and the nurse also communicated verbally to the CNAs. The DON stated that when a resident required a two person assist with ADLs this was communicated by the nurse to the CNAs or by management to the CNAs. The DON stated that the task list would show the CNAs if a resident was a one or two person assist for ADLs and the report sheet also listed this. The DON stated that the Kardex was a work in progress and they were working on a way to communicate the information. The DON stated that the CNAs had a report sheet brain that contained the resident assistance needs with eating. The DON stated that she would need to confirm if this sheet also contained if the resident's assistance requirements for toileting, bed mobility, or repositioning. The DON stated that resident 24's fall on 1/7/25, was due to a brief change and his legs fell off the bed and his body followed. The DON confirmed that the fall occurred during incontinence care that was provided by one staff member. The DON stated that resident 24 should have two staff present for incontinence care if the MDS assessment determined he needed it. The DON stated that the care plan should reflect the recommendations from the incident report with the new intervention of two staff members for incontinence care. 2. Resident 31 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of nontraumatic subacute subdural hemorrhage, Down Syndrome, lupus erythematosus, dsyphagia, ventricular septal defect, major depressive disorder, anxiety disorder, and severe intellectual disabilities. On 1/27/25 at 10:31 AM, an observation was made of resident 31. Resident 31 was seated in a wheelchair in the hallway with her brief and trousers pulled down below her buttocks. Resident 31's shirt was pulled up and the abdomen was fully exposed. CNA 4 was observed to assist resident 31 back inside her bedroom. On 1/28/25 at 12:52 PM, resident 31 was observed wheeling herself out of her room with her brief and trousers pulled down below her buttocks. Resident 31's midsection and hips were exposed. Staff were observed to immediately redirect the resident back inside her room. Staff was observed to exit the room with the door closed. On 1/28/25 at 12:53 PM, resident 31 was observed propelling herself back out into the hallway with her brief and trousers still half down. Staff again redirected the resident back inside her room. On 1/28/25 at 1:29 PM, resident 31 was observed in the doorway to her room with her brief and trousers pulled down below the buttocks. Resident 31's abdomen and thighs were exposed. Resident 49 wheeled past resident 31 and stated, can someone help [resident 31]?. Registered Nurse (RN) 9 assisted resident 31 back inside her room. RN 9 did not assist resident 31 with dressing and the resident was still visible from the hallway exposed. RN 9 exited resident 31's room and resident 31 immediately wheeled herself out into the hallway again. RN 9 again wheeled the resident back inside her room. On 2/3/25 at 12:47 PM, resident 31 was observed seated in her wheelchair in the doorway with her brief and trousers pulled down. CNA 2 walked past and instructed resident 31 to go back inside her room to the bathroom. CNA 4 then entered resident 31's room to assist. Resident 31's medical record was reviewed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/24, resident 31's quarterly MDS assessment documented that a BIMS exam was not conducted due to the resident was rarely or never understood. The assessment documented that resident 31 required a one person extensive assist for bed mobility and transfers, and was a one person total dependence for toileting assistance. The assessment documented that resident 31 had behavioral symptoms not directed towards others (e. g. such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal symptoms like screaming or disruptive sounds) that occurred every four to six days. Resident 31 had physician's orders for monitoring negative statements to self or verbalizations of sadness, and monitoring for mood swings every shift that were initiated on 4/16/24. No documentation could be found for monitoring resident 31's episodes of disrobing in public. Resident 31's Kardex for Behavior/Mood documented, When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. No documentation or interventions could be found in the Kardex for resident 31's episodes of disrobing in public. Resident 31 had care plans initiated for the following: a. On 3/9/23, a care plan was initiated for delusions and hallucinations. Interventions identified included do not argue, criticize or correct the resident; help the resident to feel safe; and use validation techniques to redirect to another topic or activity. b. On 3/9/23, a care plan was initiated for depression. Interventions identified included social services or resident advocate to provide supportive visits as needed; identify personal strengths and abilities; praise resident for accomplishments; support positive statements made by resident; and encourage resident involvement in hobbies. c. On 9/13/23, a care plan was initiated for anxiety. Interventions identified included to redirect to other activities; assist resident to think about something calm and peaceful; and social services to provide supportive visits as needed. d. On 1/4/23, a care plan was initiated for the resident was verbally and physically aggressive at times. Interventions identified were to assess and anticipate needs for food, thirst, toileting, comfort level, body positioning, and pain; assess resident's coping skills and support system; assess resident's understanding of the situation; allow time for the resident to express self and feelings towards the situation; provider referral for increased agitation; provide positive feedback for good behavior; intervene before agitation escalates; guide away from source of distress; engage calmly in conversation and approach later. It should be noted that no care plans were identified that addressed resident 31's behavior of disrobing in public and no interventions were identified. On 1/28/25 at 1:05 PM, an interview was conducted with CNA 4. CNA 4 stated that resident 31 was able to stand and remove her pants independently. CNA 4 stated that resident 31 had behaviors of being repetitive and sometimes she did not know what she was doing. CNA 4 stated that resident 31 did not have any resident to resident altercations. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 1:42 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 31 had behaviors of hitting herself, yelling a lot, and sometimes she would grab inappropriately. CNA 2 stated that resident 31 liked to pull her pants down throughout the day. CNA 2 stated that they had to keep an eye on her to make sure her pants are pulled up. CNA 2 stated that resident 31 pulled her pants down for attention seeking and that resident 31 thought it was funny. CNA 2 stated that resident 31 did this behavior often. CNA 2 stated that sometimes she needed to be assisted with toileting. CNA 2 stated that staff just had her go back into the room and pulled the pants back up. CNA 2 stated that resident 31 could not be left unsupervised. CNA 2 stated that resident 31 was easy to redirect to her room and then they pulled her brief and trousers back up. On 1/29/25 at 2:35 PM, an interview was conducted with RN 6 and Medication Technician (MT) 1. RN 6 stated that resident 31 was alert and oriented x 4 to person, place, situation, and time. RN 6 stated that resident 31 had behaviors of being aggressive, would refuse treatment and medications, and throws things on the floor. RN 6 stated that resident 31 did not have behaviors of disrobing. RN 6 stated that resident 31 pulled her pants down when she needed assistance with dressing and toileting. MT 1 stated that resident 31 had a behavior of pulling her pants down when she needed assistance with toileting or when she wanted attention. MT 1 stated that resident 31 pulled her pants down when she wanted something and it was usually when she wanted to see her mom. MT 1 stated that on Monday resident 31 was calling out for her mom and pulling her pants down. RN 6 stated that she would look in the progress notes for any resident behaviors and the CNAs would know each resident's behavior. RN 6 stated that she would expect to see a care plan with interventions for any behaviors. On 1/30/25 at 10:15 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 31 had behaviors of being aggressive when she was bored or if she wanted food. CNA 3 stated that resident 31 would become agitated and increasingly more upset with her voice becoming louder and she would become repetitive. CNA 3 stated that resident 31 would also undress herself and then come out into the doorway with her shirt up and her pants down. CNA 3 stated that this was done to alert staff that she needed to go to the bathroom. CNA 3 stated that they just kept an eye out for the behavior and she was not aware of any interventions to prevent the behavior. CNA 3 stated that she did not think that resident 31 understood what she was doing. On 1/30/25 at 12:36 PM, an interview was conducted with the DON. The DON stated that resident 31's behaviors were yelling out and sometimes she would wheel herself out of her room with her pants pulled down. The DON stated that they then had to take her back into her room to dress her. The DON stated that behavior tracking was documented on the Treatment Administration Record. The DON stated that they also care planned behaviors. The DON stated that the purpose of the care plan was for resident safety and as a form of communication for the staff. The DON stated that care plans with interventions were accessible by the licensed nurse and interventions were on the Kardex for the CNAs to view. The DON stated that resident 31 did not have a care plan that addressed her behavior of disrobing in public and she would expect to see that behavior care planned. 3. Resident 49 was admitted to the facility on [DATE] with diagnoses which consisted of hemiplegia left side, history of traumatic brain injury, nontraumatic subarachnoid hemorrhage, post-traumatic stress disorder, insomnia, bipolar disorder, generalized anxiety disorder, stimulant abuse, attention-deficit hyperactivity disorder, autistic disorder, conduction disorder, and hypertension. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25 at 2:57 PM, an interview was conducted with resident 49. Resident 49 stated that he wished he was not so bored. Resident 49 stated that when he was bored he just hung out and watched what was going on around him. Resident 49 stated that he did not have any activities in his room and he did not participate in bingo today because it was not his style. Resident 49's room was observed with no activities identified at the bedside. On 8/7/24, the activities quarterly review was conducted. The review documented under attendance, Unknown - new Activity Director in building and paperwork not done yet - see daily participation records. The review documented to see the original data collection for interests. Resident 49's progress notes revealed the following: a. On 3/21/24 at 12:32 PM, the Social Service Note documented, [Resident 49] was happy that I took him some art supplies, and a mini chess game. b. On 5/1/24 at 2:08 PM, the Social Service Note documented, resident was having an okay day, he enjoys listening to music and coloring in his anime books. c. On 5/30/24 at 2:22 PM, the Social Service Note documented, talked with resident today to see how he was doing, and he said good. I bought him some new colored pencils and coloring markers for his book, he was very happy to get new ones. d. On 6/10/24 at 1:31 PM, the Social Service Note documented, Resident was talking to me today about his colored pencils, and coloring. e. On 6/18/24 at 1:37 PM. the Social Service Note documented, Had a care confrence [sic] with resident today. He enjoys coloring with his anime. He enjoys living here, He is excited about his birthday coming up on [date omitted]. He has no concerns about his cares or medications at this time. Resident 49's care plans were reviewed and no documentation could be found of a care plan focus area for activities. On 1/29/25 at 12:27 PM, an interview was conducted with the Activities Supervisor (AS). The AS stated that the activity program was based off the recommendations from the Recreation Therapist. The AS stated that she was responsible for completing the assessments and care plans for each resident. The AS stated that the assessment was completed upon admission and quarterly thereafter. The AS stated that resident 49 did not have an assessment completed and he should have had it done upon admission. The AS stated that she started at the facility in September 2024 and was in the process of completing all quarterly evaluations. 4. Resident 54 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of cerebral infarction, status epilepticus, difficulty walking, lack of coordination, major depressive disorder, congestive heart failure, insomnia, encephalopathy, and hypotension. On 1/29/25 at 10:22 AM, an observation was made of resident 54 asleep in bed. The left side of the bed was against the wall and a fall mat was located on the right side of the bed. The bed was lowered to the ground. No side rails were noted. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/6/24, a quarterly MDS assessment documented that the resident was a two person total dependence for transfer, one person total dependence for bed mobility and toileting. Resident 54's progress notes and incident reports revealed the following: a. On 4/6/24 at 5:42 AM, the incident report documented, During resident change the Aid [sic] rolled him and he continued to roll off the bed onto the floor hitting the cabinet on the way and causing a red area to his left cheek. No new interventions were identified on the care plan for falls. b. On 8/28/24 at 7:55 AM, the incident report documented, Resident was found on the floor near the chair laying on right side. Fall happened on 8/27 [24] @ 1900 [7:00 PM] No new interventions were identified on the care plan for falls. On 12/6/23, resident 54 had a care plan initiated for at risk for falls due to muscle weakness, unsteadiness on feet, and encephalopathy. Interventions identified included bed alarm implemented (initiated 6/12/24); educate resident to ask for staff assistance with ADLs, transfers, and ambulation (initiated 12/6/23); floor mat to right side of bed and check placement every shift (initiated 1/27/25); frequent checks on rounds (initiated 12/6/23); low bed at all times when in bed (initiated 12/6/23); and physical therapy to evaluate and treat as needed (initiated 12/6/23). On 1/28/25 at 1:42 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 54 had falls. CNA 2 stated that they had a floor mat at the bedside and the bed was lowered to the ground. CNA 2 stated that resident 54 slept throughout the day and he fell when he attempted to get out of bed on his own. CNA 2 stated that resident 54 did not use his call light to ask for help. CNA 2 stated that if they did not check on resident 54 frequently he would fall. On 1/30/25 at 10:46 AM, an interview was conducted with RN 9. RN 9 stated that resident 54 was a big fall risk and had frequently fallen. RN 9 stated that they had placed the bed in the lowest position and they reminded the resident to use his call light to ask for assistance. RN 9 stated that resident 54 did not have good vision and was not able to see the call light. RN 9 stated that he would place the call light in resident 54's hands. RN 9 stated that the staff had to constantly check on resident 54. On 1/30/25 at 2:09 PM, an interview was conducted with the DON. The DON stated that the fall protocol was to document the event, conduct an assessment, notify family and provider, complete risk management and notify management. The DON stated that she would expect to see new interventions identified after each fall to prevent future falls and those new interventions would be located on the care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review, the facility did not ensure that that services provided met professional standards of quality. Specifically, for 1 out of 33 sampled residents, a resident's nasogastric (NG) tube feed did not have the formula bag labeled with the rate of infusion or the nurse initials who initiated the infusion. Resident identifier: 173. Findings included: Resident 173 was admitted to the facility on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, congestive heart failure, and pneumonia. On 1/28/25 09:20 AM, an interview was conducted with resident 173. Resident 173 stated that he was having a hard time swallowing and was getting a tube feed for his nutrition. Resident 173 stated that the tube feed was continuous and he could not eat anything by mouth except ice chips. Resident 173's tube feed was observed not running and no formula or water bag was hung at the bedside. Resident 173's medical record was reviewed. On 1/27/25, resident 173 had a care plan initiated for a tube feeding via NG related to aspiration risk and pneumonia infection. Interventions identified included to follow the physician orders for current tube feed and to monitor/document/report any signs and symptoms of aspiration. On 1/28/25, resident 173's physician ordered an Enteral Feed two times a day via Pump - Jevity 1.5 80 milliliter (ml) per hour for 18 hours via pump per NG tube. Free water flush 73 ml/hour for 18 hours. On 1/28/25 11:55 AM, an observation was made of Registered Nurse (RN) 9 administering resident 173's tube feed. RN 9 was observed to connect the tubing from the formula bag to resident 173's NG tube. RN 9 placed a label on the formula bag that documented the resident name, formula type, resident room number and current date. The label did not contain the licensed nurse's signature or the rate of infusion. The water flush was not labeled. On 1/29/25 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the tube feed label should contain the date and time the infusion was initiated, the initials of the nurse, and the patient's name. The DON stated that she would have to look at the policy to determine if the formula type and rate of infusion should be documented on the label. Review of the facility policy for Enteral Tube Feeding via Continuous Pump documented under Initiate Feeding that the label should contain .initials, date and time the formula was hung/administered, and initial that the label was checked against the order. The policy further documented under General Guidelines to Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID [identification] and room number; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Type of formula; c. Date and time formula was prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (mL/Hour). The policy was last revised in November 2024. Review of the Lippincott Nursing Procedures documented under Enteral Gastric, Duodenal, and Jejunal Tube Feedings for implementation to Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time the formula was hung; administration route, rate, and duration (if cycled or intermittent); initials of who prepared, hung and checked the enteral formula agianist the order; expiration date and time; dosing weight (if appropriate); and notation ENTERAL USE ONLY--NOT FOR IV USE. Wolters Kluwer. Lippincott Nursing Procedure. Ninth Edition. Philadelphia, PA. (2023), pp. 297.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38031 Based on observation, interview, and record review, the facility did not ensure that the resident's environment was as free of accident hazards as was possible and each resident received supervision and assistance devices to prevent accidents. Specifically, for 3 out of 33 sampled residents, two residents had falls while being repositioned by staff and one resident caught his hair on fire with a lighter that another resident gave him. Resident identifiers: 22, 24, and 54. Findings included: 1. Resident 24 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis of left side, pneumonitis, type 2 diabetes mellitus, idiopathic epilepsy, chronic obstructive pulmonary disease, morbid obesity, dyspnea, congestive heart failure, blindness one eye, schizoaffective disorder, dissociative identity disorder, and anxiety disorder. On 1/27/25 at 10:23 AM, an interview was conducted with resident 24. Resident 24 stated that he fell out of the bed four weeks ago, and the facility had to call the paramedics to get him back into bed. Resident 24 stated that it took eight firemen to lift him back into bed. Resident 24 stated that he rolled to the left side during care and his left leg slid out of the bed. Resident 24 stated that the momentum took the rest of his body. Resident 24 stated that he had two Certified Nursing Assistants (CNAs) assisting him that day but both CNAs were located on the right side of the bed. Resident 24 stated that he bruised his buttocks and left hip from the fall. Resident 24's medical record was reviewed. On 10/16/24, resident 24's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status score of 14/15, which indicated that the resident was cognitively intact. The assessment documented that resident 24 was a total dependence and required a two plus persons physical assist for bed mobility, transfer, and toilet use. On 1/7/25 at 2:30 AM, resident 24's incident report documented that the resident had a witnessed fall. The immediate action taken documented, Called non-emergency number for assistance with getting resident back into bed. The predisposing factor documented that the resident was incontinent and rolled from the bed. The report documented under notes, 1/7/2025 Res [resident] had a witnessed fall during a brief change. Aide [CNA] had resident on his left side clean and ready to place a chuck under him. Upon turning to her side to retrieve the chuck aide saw residents' legs off the bed sliding down onto his buttocks, landing slightly more onto his left side. Writer entered the room and saw the resident sitting up against his bed facing out his wall/window. Head to toe assessment was done. Non-emergency number was called to assist in lifting the resident back into his bed. The notes further documented, 1/16/2025 resident is morbidly obese, need to add to care plan 2 staff to be present to all brief changes for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/19/22, resident 24 had a care plan initiated for Activities of Daily Living (ADLs) self-care performance deficit related to morbid obesity, major depressive disorder, anxiety, hemiplegia, and muscle weakness. The care plan was last revised on 12/21/23. An intervention identified in the care plan was that the resident required extensive and up to total dependent assistance with most ADLs. Resident 24's Kardex report documented under ADLs the resident's preferred bathing schedule. The Kardex did not document the staff support needed or the number of staff required for any ADLs. No other ADLs were addressed in the Kardex. It should be noted that the care plan and Kardex did not document that resident 24 required a two person assist with ADLs. Review of resident 24's ADL task for toilet use from 1/1/25 through 1/30/25, documented that the resident was a one person physical assist for toileting. On 1/28/25 at 1:42 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 24 needed full assistance for ADLs. CNA 2 stated that resident 24 needed one to two staff to turn and reposition the resident and he was not able to roll on his own. CNA 2 stated that resident 24 was incontinent of bowel and bladder. CNA 2 stated that resident 24 required a Hoyer lift for transfers but he did not get out of bed often. CNA 2 stated that resident 24 had fallen before, but that he was not a fall risk because he did not move a lot. CNA 2 stated that resident 24 had bed rails to assist with repositioning and they kept the bed lowered. CNA 2 stated the only way resident 24 would fall was if staff rolled him too far. CNA 2 stated that staff needed to take precautions to make sure resident 24 was centered in the bed before rolling him. CNA 2 stated that resident 24's previous fall was due to the resident being rolled too far. CNA 2 stated that she was not present for resident 24's fall but was informed of it. CNA 2 stated that the fire department had to come get resident 24 off of the floor. CNA 2 stated that the fall occurred during the night shift. On 1/30/25 at 10:09 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 24 had filed a grievance against female staff providing incontinence care and that if the staff were female then he wanted two staff to assist. CNA 3 stated that she was told that resident 24 was a two person assist for ADLs because of his grievance, but she was able to reposition and provide incontinence care by herself. CNA 3 stated that resident 24 was not able to assist in repositioning himself. CNA 3 stated that resident 24 was able to hold onto the bedrail when he was repositioned on his side. CNA 3 stated that resident 24 had one fall in the past month, and it was due to the resident being positioned too close to the edge of the bed. CNA 3 stated that resident 24 rolled off the bed. CNA 3 stated that if she rolled him she would pull the sheet towards her before rolling away from herself so that there was more space for the resident on the other side. CNA 3 stated that she did not have any training on repositioning the resident. CNA 3 stated that fall interventions would be provided in report and sometimes they were in the electronic medical records under tasks. CNA 3 stated that the Kardex should tell the staff what resident 24's care needs were and any interventions that were in place to prevent falls but the facility Kardex was not updated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 12:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the task communicated the ADL care needs to the staff and the nurse also communicated verbally to the CNAs. The DON stated that when a resident required a two person assist with ADLs this was communicated by the nurse to the CNAs or by management to the CNAs. The DON stated that the task list would show the CNAs if a resident was a one or two person assist for ADLs and the report sheet also listed this. The DON stated that the Kardex was a work in progress and they were working on a way to communicate the information. The DON stated that the CNAs had a report sheet brain that contained the resident assistance needs with eating. The DON stated that she would need to confirm if this sheet also contained if the resident's assistance requirements for toileting, bed mobility, or repositioning. The DON stated that resident 24's fall on 1/7/25, was due to a brief change and his legs fell off the bed and his body followed. The DON confirmed that the fall occurred during incontinence care that was provided by one staff member. The DON stated that resident 24 should have two staff present for incontinence care if the MDS assessment determined he needed it. The DON stated that the care plan should reflect the recommendations from the incident report with the new intervention of two staff members for incontinence care. 2. Resident 54 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of cerebral infarction, status epilepticus, difficulty walking, lack of coordination, major depressive disorder, congestive heart failure, encephalopathy, and hypotension. On 1/27/25 at 12:59 PM, an observation was made of resident 54. Resident 54 was lying supine in bed. The bed was positioned with the left side against the wall and a fall mat was located on the right side of the bed. The bed was low to the ground. On 1/29/25 at 10:22 AM, an observation was made of resident 54 asleep in bed. The left side of the bed was against the wall and a fall mat was located on the right side of the bed. The bed was lowered to the ground. No side rails were noted. Resident 54's medical record was reviewed. On 12/6/24, resident 54's quarterly MDS assessment documented that the resident was a two person total dependence for transfer, one person total dependence for bed mobility and toileting. On 4/6/24 at 5:42 AM, the incident report documented, During resident change the Aid [sic] rolled him and he continued to roll off the bed onto the floor hitting the cabinet on the way and causing a red area to his left cheek. It should be noted that no new interventions were identified on the care plan for falls. On 12/6/23, resident 54 had a care plan initiated for at risk for falls due to muscle weakness, unsteadiness on feet, and encephalopathy. On 12/6/23, an intervention was identified to educate the resident to ask for staff assistance with Activities of Daily Living (ADLs), transfers, and ambulation. On 1/28/25 at 1:42 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 54 had falls. CNA 2 stated that they had a floor mat at the bedside and the bed was lowered to the ground. CNA 2 stated that resident 54 slept throughout the day and he fell when he attempted to get out of bed on his own. CNA 2 stated that resident 54 did not use his call light to ask for help. CNA 2 stated that if they did not check on resident 54 frequently he would fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 10:32 AM, an interview was conducted with CNA 3. CNA 3 stated that resident 54 had one fall from his wheelchair and he landed on his face. CNA 3 stated that she was not aware if resident 54 sustained an injury from the fall. CNA 3 stated that interventions to prevent falls were more frequent checks on the resident. CNA 3 stated that the Kardex would list the safety or fall interventions, but the facility Kardex was not updated. CNA 3 stated that the Kardex should tell you what the resident's needs were. On 1/30/25 at 10:46 AM, an interview was conducted with Registered Nurse (RN) 9. RN 9 stated that resident 54 was a big fall risk and had frequently fallen. RN 9 stated that they had placed the bed in the lowest position and they reminded the resident to use his call light to ask for assistance. RN 9 stated that resident 54 did not have good vision and was not able to see the call light. RN 9 stated that he would place the call light in resident 54's hands. RN 9 stated that the staff had to constantly check on resident 54. On 1/30/25 at 2:09 PM, an interview was conducted with the DON. The DON stated that the fall protocol was to document the event, conduct an assessment, notify family and provider, complete the risk management and notify management. The DON stated that she would expect to see new interventions identified after each fall to prevent future falls and those new interventions would be located on the care plan. On 2/3/25 at 1:36 PM, a follow-up interview was conducted with the DON. The DON stated that she would expect the staff to perform turning and repositioning using techniques learned throughout their training as a CNA. The DON stated that she would expect the staff to understand the situation and use good judgement that would not put the resident at risk when providing care. The DON stated that the staff should move the resident in a way that would not hurt the resident and was done safely. 52146 3. Resident 22 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, lack of coordination, type 2 diabetes mellitus, dementia, and nicotine dependence. Resident 22's medical record was reviewed on 1/27/25 through 2/3/25. On 9/18/24 at 6:35 AM, a Sudden change of behavior/mental status note documented Event Type: hair on fire. Date and time of event onset: 09/18/2024 0430 [4:30 AM]. Description of behavior and mental status: literally lit his hair on fire with a lighter another resident have him. Preventative measures already in place if there is a history: removed the lighter. On 9/18/24 at 11:51 AM, a Nurses Note documented Note Text: Resident was assessed for injury and lighter removed from residents possession. DON interviewed resident and assessed for injury. It was noted hair was singed to R [right] side head, no burns were noted to skin on face or scalp. When asked how event happened resident stated 'I leaned over'. When asked where he got the lighter from resident stated 'It's mine'. Resident enforced that lighters must be secured and not to be used in the building. Resident is on supervised smoking schedule. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 12:50 PM, a 72 Hour Event Charting documented Type of Event: lit hair on fire. Interventions: Confiscated lighter. Searched his room for any more lighter [sic] or matches. Instructed other residents that smoke not to give him lighter. Resident is supervised smoking only. Resident Reaction to Interventions: Upset, verbally abusive. Stated '[explicative word redacted] you for taking my lighter'. Improvement/Decline: No lighter found in his room, as of now. A Smoking Safety Evaluation dated 6/6/24, documented that resident 22 had not been deemed independent with smoking and could not safely have smoking paraphernalia on person. On 1/28/25 at 2:46 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that resident 22 was a smoker and a staff member always accompanied him. NA 1 stated that resident 22's smoking materials were located in the medication cart. On 1/28/25 at 03:29 PM, an interview was conducted with Assistant Director of Nursing (ADON) 2. ADON 2 stated that during an admission a nurse would assess physical and cognitive abilities to determine whether a resident's smoking status would be supervised or unsupervised. ADON 2 stated the smoking status should be reassessed if there was a change in a resident ' s condition. ADON 2 stated supervised smokers have scheduled smoking times with the CNAs. ADON 2 stated that residents who were supervised smokers must store their smoking supplies in the locked medication cart. ADON 2 emphasized that supervised smokers were always assisted and supervised with cigarette lighters. ADON 2 stated that unsupervised smokers could smoke outside of the scheduled smoke times, however they must ask for the cigarette lighters due to them being locked in the medication cart. ADON 2 stated that unsupervised residents could keep their cigarettes in between scheduled smoke times. On 1/28/25 at 4:04 PM, an observation was made of NA 1 assisting resident 22 in his wheelchair to the designated smoking area. NA 1 assisted resident 22 and other residents with smoke aprons and the cigarette lighter. The cigarette lighter was never out of NA 1's reach. After NA 1 assisted resident 22 back to his room NA 1 was observed giving the cigarette lighter back to ADON 2. ADON 2 was observed to place the cigarette lighter back in the medication cart. Resident 22 was seated in his wheelchair, in his room, with the door open to the hallway. On 1/30/25 at 3:06 PM, an interview was conducted with RN 2. RN 2 stated that she was on shift the morning of 9/18/24. RN 2 stated that resident 22 was a supervised smoker and should never have a lighter. RN 2 stated that after resident 22 was assisted back to his bedroom RN 2 went on her lunch break. RN 2 stated the cigarette lighter that was used during the smoke break was on RN 2's person during the break. RN 2 stated when she returned to her shift a CNA and RN 2 smelt something burning and ran to resident 22's bedroom. RN 2 stated the fire was already out when they entered the room. RN 2 stated that she had performed an assessment on resident 22 and some of his hair and one eyebrow was singed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document titled Smoking Guideline was reviewed. 4. SMOKING IS ALLOWED IN DESIGNATED SMOKING AREAS ONLY!!! . 6. All lighters/matches and cigarettes must be kept at the nurse's station when newly admitted until the Activity personnel can collect. a. This includes e-cigarettes and All smoking paraphernalia. 7. State law requires you to smoke outside and 25 feet away from any door/windows. 11. If a staff member suspects that I have smoking paraphernalia in my room, I agree to allow staff to search for the related materials and confiscate them in order to keep the building safe from fire related accidents. Lighters/matches and cigarettes brought into the facility by family, friends, etc. will be turned over to the nurse to hold for me. This is a NO SMOKING FACILITY, in that there is no smoking allowed within the building. Matches, lighters, cigarettes, e-cigarettes and all other smoking paraphernalia will be kept at the nurse's station.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview, and record review, the facility did not ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, for 2 out of 33 sampled residents, a resident had a urinary catheter collection bag kept above the level of the bladder. In addition, a resident had a urinalysis (UA) test completed with no follow up and the resident required treatment for a urinary tract infection (UTI). Resident identifiers: 2 and 60. Findings included: 1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, generalized muscle weakness, urinary tract infections, major depressive disorder, and anxiety. Resident 2's medical record was reviewed on 1/28/25 through 2/3/25. An annual Minimum Data Set (MDS) assessment dated [DATE], revealed that resident 2 was always incontinent of bowel and bladder and was not on a toileting program. The MDS assessment further revealed resident 2 required two plus person extensive assistance with toileting. A care plan dated 12/15/23, revealed [Resident 2] at risk for UTI's d/t [due to] personal history. The goal was [Resident 2] will remain free from infection through the review date. The approaches included Monitor/document/report to MD [Medical Director] s/sx [signs/symptoms] of delirium: Changes in behavior, Altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle. Monitor/document/report PRN [as needed] abnormal laboratory values (e.g. [for example] white blood cell count and differential, serum protein, serum albumin, and cultures. Monitor/document/report PRN any s/sx of infection: fever; redness; drainage or swelling around wounds or catheter sites; cough, respiratory symptoms; dysuria, hematuria, flank pain and foul smelling urine. A physician's order revealed resident 2 was to have a UA, complete blood count (CBC), and complete metabolic panel (CMP) completed on 7/8/24. The July 2024 Medication Administration Record documented the sample of urine was collected on 7/9/24 at 8:24 PM. A Sudden change of behavioral/mental status note dated 7/8/24, documented, . Resident was very confused, not at all oriented to time, place, person or situation . Stat [immediately] CBC, CMP and Urine sample were obtained as per doctors orders. Waiting for the results. The medical record contained results of the CBC and CMP that were received on 7/9/24, no results of the UA were located or provided by the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next note dated 7/20/24, in the medical record was a Lab result/Imaging result documented, the Original lab requisition and reason for lab: UA C & S [culture and sensitivity] to rule out UTI with a result of Detected pathogens are enterococcus spp (faecalis,faecium), Escherichia Coli . Interventions put in place were for resident 2 to Start Nitrofurantoin 100 mg [milligrams] PO [by mouth] BID [twice daily] for 7 days for UTI. On 2/3/25 at 12:43 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when they got an order for labs they put it into the computer, printed off the paperwork, and then put all of that into the lab binder. RN 1 stated if a urine needed to be collected they would use a bed pan, Foley, or straight cath the resident. RN 1 stated after the urine sample was obtained it would be put in the specimen fridge in the medication room if it was not a stat order, if it was a stat order then it would be taken down to the specimen box outside after the lab had been called to inform them of the need to collect it. RN 1 stated the nurse on shift was responsible to watch the fax machine for any results and make the provider aware. RN 1 stated that resident 2 did have UTI's often and they usually had to straight cath her to obtain any samples due to her condition. RN 1 stated she could not remember what happened back in July for this incident or why the result was not in the computer. On 2/3/25 at 1:25 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses were expected to put any lab orders into the medical record, collect the sample, and call the lab company to come collect the sample(s). The DON stated that nursing management would follow up on any orders to make sure that they were put into the lab binder. The DON stated she was not here at the time of the incident so she was not aware of what happened. The DON stated the nurses watch the fax machine for any results that come through and call the doctor to make them aware and get any new orders. The DON stated the nurse on duty was responsible for following through with any orders that were given by a provider. 38031 2. Resident 60 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of acute kidney failure, hypertension, sepsis, and retention of urine. On 1/27/25 at 11:15 AM, an observation was made of resident 60 sleeping in bed. Resident 60's bed was positioned with the right side of the bed against the wall and the resident was lying in bed on the left lateral side. Resident 60's urinary catheter bag was observed on the wheelchair seat next to resident 60's foot of the bed. The urine observed in the catheter tubing was dark amber with sediment noted. The urinary catheter bag was positioned above the level of the resident's abdomen and the bed was lowered to the ground below the level of the wheelchair seat. Resident 60's medical record was reviewed. On 11/22/24, resident 60's quarterly MDS assessment documented a Brief Interview for Mental Status score of 9/15, which would indicate a moderate cognitive impairment. The assessment documented that resident 60 required a one person total dependence for toilet use. On 1/26/25, resident 60 had an order renewed to change the catheter bag every 23 hours as needed for retention and for catheter-related complications. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24, resident 60 had a care plan initiated for an indwelling urinary catheter. A goal of the care plan was that resident 60 would show no signs and symptoms of urinary infection through the review date. Interventions identified on the care plan included to change the catheter per the physician orders; monitor for signs and symptoms of discomfort on urination and frequency; and to monitor for signs and symptoms of a urinary tract infection. On 1/28/25 at 1:01 PM, an interview was conducted with Certified Nurse Assistant (CNA) 4. CNA 4 stated that they emptied resident 60's catheter bag every shift and if they observed urine in the resident's brief they would inform the nurse that there was a possible leak. CNA 4 stated that the nurse would then assess if the catheter needed to be changed. CNA 4 stated that catheter care included cleaning the catheter tubing with a wipe every time there was a brief change. CNA 4 stated that resident 60's urinary catheter bag was supposed to be hooked to the side of the bed in line with his thigh. On 1/29/25 at 2:32 PM, an observation was made of resident 60's urinary catheter bag. The catheter bag was hung on the side of the bed next to the resident's head and the head of the bed was slightly elevated. The catheter bag was above the level of resident 60's bladder. On 1/30/25 at 10:25 AM, an interview was conducted with CNA 3. CNA 3 stated that catheter care included cleaning resident 60's penis and wiping the catheter tubing where it entered the penis. CNA 3 stated the catheter bag should be positioned on the bed frame or wheelchair so the urine output flowed downward away from the body into the collection bag. CNA 3 stated that it was not okay for the catheter bag to be positioned on a chair or attached to the head of the bed if it was not in a position to allow the urine to flow downward. CNA 3 stated, If the urine doesn't flow down it could go back into their body and could cause an infection. On 1/30/25 at 12:04 PM, an interview was conducted with RN 9. RN 9 stated that catheter care was performed every shift and included cleaning the skin on the head of penis and assessing for signs of infection such as redness. RN 9 stated that he would assess the urine output for color, sediment, and odor. RN 9 stated that the urinary catheter down drain bag should be positioned on the side of the bed below the level of the bladder for gravity to assist in drainage. RN 9 stated that if the catheter bag was not positioned correctly it posed the risk of dislodging the tubing and a risk of increased infection. On 1/30/25 at 12:30 PM, an interview was conducted with the DON. The DON stated that nursing staff should provide catheter care every shift which included cleaning the tubing and the head of the penis around the insertion site. The DON stated that the down drain bag should be positioned below the bladder. The DON stated that if it was not positioned below the bladder it could cause backflow, retention, and infections.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on observation, interview, and record review, the facility did not ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Specifically, for 1 out of 33 sampled residents, a resident was provided water flushes via his nasogastric (NG) tube that exceeded the physician orders. Resident identifier: 173. Findings included: Resident 173 was admitted to the facility on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, congestive heart failure, and pneumonia. On 1/28/25 at 9:20 AM, an interview was conducted with resident 173. Resident 173 stated that he was having a hard time swallowing and was getting a tube feed for his nutrition. Resident 173 stated that the tube feed was continuous and he could not eat anything by mouth except ice chips. Resident 173's tube feed was observed not running and no formula or water bag was hung at the bedside. Resident 173's medical record was reviewed. On 1/27/25, resident 173 had a physician order initiated for enteral feed flushes with 20 to 30 milliliters (ml) of water before and after administration of medication pass. On 1/27/25, resident 173 had a care plan initiated for a tube feeding via NG related to aspiration risk and pneumonia infection. Interventions identified included to follow the physician orders for current tube feed and to monitor/document/report any signs and symptoms of aspiration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 9:25 AM, an observation was made of Registered Nurse (RN) 6. RN 6 was observed to administer medication to resident 173 via his NG tube. RN 6 stated that the morning medication included resident 173's antibiotic for his respiratory infection. RN 6 donned gloves and filled a pitcher with warm tap water. Resident 173 was observed lying flat in bed and complained of heartburn. RN 6 raised resident 173's head of the bed. Resident 173's tube feed was attached to the NG tube but had completed infusing. RN 6 found the NG tube wrapped around resident 173's leg. Resident 173 requested that the nurse hurry because he did not want to be positioned sitting up. RN 6 disconnected the tube feed from the NG tube and flushed resident 173's NG tube with 30 ml of water. Resident 173 complained of difficulty with breathing and RN 6 lowered the head of the bed slightly. RN 6 then administered approximately 45 mls of medication mixed with water. RN 6 then flushed the NG tube with another 30 ml of water. RN 6 administered another 45 ml of medication mixed with water followed by 50 ml of a water flush. RN 6 administered another 50 ml of medication mixed with water followed by 30 ml of a water flush. Resident 173 complained of shortness of breath and stated that he was fighting for air. Resident 173 requested that the head of the bed be lowered. Resident 173 complained again of heartburn and RN 6 stated that she would see what medication he had ordered for heartburn. It should be noted that RN 6 administered a total fluid volume of 140 mls of medication mixed with water and a total fluid volume of 140 mls of water flushes. An immediate interview was conducted with RN 6 after the completion of the medication administration. RN 6 stated that she assessed the NG tube by checking for placement and verifying that the tube was not dislodged. RN 6 stated that she would aspirate the NG tube prior to medication administration to check for color and volume of what was aspirated. It should be noted that RN 6 did not attempt this prior to medication administration. On 1/29/25 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the enteral feed water flush amount was determined by the physician order. The DON stated that it was not up to the nurse's discretion to give more volume than was ordered for the water flush. The DON stated if the physician order stated 20 to 30 ml before and after medication administration the nurse should be administering 60 ml per administration. The DON stated that there was a risk of aspiration if the water flushes exceeded the order parameters. The DON stated that the nurse should monitor for signs and symptoms of aspiration such as difficulty breathing, increased respiratory rate, and increased temperature.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, for 1 out of 33 sampled residents, a peripherally inserted central catheter (PICC) line had no physician orders for intravenous fluids, flushes or dressing changes, and had no indication for continued use for one resident. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included enterocolitis due to clostridium difficile, hereditary and idiopathic neuropathy, respiratory failure, and congestive heart failure. On 1/29/25 at 10:21 AM, an observation and interview with resident 9 was conducted. Resident 9 had a locked PICC line to her upper right arm, the dressing was dated 1/16/25. Resident 9 stated she was not currently receiving any medications through the PICC line and the nurses were not flushing it every day. Resident 9's medical record was reviewed from 1/28/25 through 2/3/25. A physician's order dated 1/16/25 at 1:00 PM, indicated, Ampicillin Sodium Intravenous Solution Reconstituted 2 GM [grams] (Ampicillin Sodium) Use 12 gram intravenously in the afternoon for respiratory failure for 2 days. A physician's order dated 1/23/25 at 1:30 PM, indicated, Sodium Chloride Solution 0.9% Use 1000 ml [milliliters] intravenously one time only for low renal function for 1 Day NS [normal saline] at the rate of 150 ml/hr [hour]. No physician orders for PICC line flushes or dressing changes were provided. The Medication Administration Record (MAR) dated January 2025, indicated, Ampicillin Sodium Intravenous Solution Reconstituted 2 GM (Ampicillin Sodium) Use 12 gram intravenously in the afternoon for respiratory failure for 2 Days -Start Date- 01/16/2025 1500 [3:00 PM], was administered on 1/16/25 and 1/17/25. It further indicated, Sodium Chloride Solution 0.9% Use 1000 ml intravenously one time only for low renal function for 1 Day NS at the rate of 150 ml/hr -Start Date- 01/23/2025 1330 [1:30 PM], was administered on 1/23/25 at 1:33 PM. A comprehensive care plan that included the PICC line was not provided. On 1/28/25 at 4:10 PM, an interview was conducted with Registered Nurse (RN) 6. RN 6 stated resident 9's PICC line was not currently being used for medications. RN 6 stated the PICC line needed to be flushed once a shift to maintain patency. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 10:36 AM, an interview was conducted with Medication Technician (MT) 1. MT 1 stated she did not know resident 9 had a PICC line. MT 1 stated a PICC line needed to be flushed and that she did not see any orders for flushes in the resident's medical record. On 1/29/25 at 1:13 PM, an interview was conducted with Assistant Director of Nursing (ADON) 2. ADON 2 stated management placed orders for flushes and dressing changes and assessed for continued need. ADON 2 stated that she would have to look up why resident 9's PICC line had not been discontinued. On 1/29/25 at 1:43 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses on the floor and nurse management should have contacted the doctor if the PICC line was still necessary and that they should have followed up with the doctor after the last dose of the intravenous antibiotics was administered. On 1/29/25 at 2:20 PM, a follow-up interview was conducted with the DON. The DON stated dressing changes were supposed to be done weekly and as needed. The DON stated PICC line flushes should be done before and after medication administration and at least once every shift. The DON stated she was not sure when the last time resident 9's PICC line was flushed. The facility policy was reviewed and documented, Peripheral and Midline IV [intravenous] Dressing Changes, dated 3/24, indicated, 4. Change the dressing it if becomes damp, loosened or visibly soiled and: a. at least every 7 days for TSM [transparent semi-permeable membrane] dressing .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not provide routine and emergency drugs to its residents. Specifically, for 1 out of 33 sampled residents, a resident that was prescribed a hormone based chemotherapy, antipsychotics, selective serotonin reuptake inhibitor, antibiotic, anticoagulant, and a liquid protein did not have those medications available for administration due to pending delivery. Resident identifier: 62. Findings included: Resident 62 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, malignant neoplasm of right female breast, dementia severe, delusional disorders, urinary tract infections, repeated falls, dysphagia, difficulty in walking, and unsteadiness on feet. Resident 62's medical record was reviewed on 1/28/25. On 7/10/24 at 11:24 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg [milligram] by mouth one time a day for breast cancer Pending delivery from pharmacy. On 7/25/24 at 9:20 AM, an Orders - Administration Note documented Note Text: ARIPiprazole Oral Tablet 2 MG Give 1 tablet by mouth one time a day for antipsychotic Supplement to depression medication Pending delivery from pharmacy. Provider notified. On 7/26/24 at 8:07 AM, an Orders - Administration Note documented Note Text: ARIPiprazole Oral Tablet 2 MG Give 1 tablet by mouth one time a day for antipsychotic Supplement to depression medication Pending delivery. On 7/28/24 at 9:28 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. On 7/29/24 at 11:44 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer awaiting pharmacy delivery. MD [Medical Director] and management notified. On 8/2/24 at 7:15 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. On 8/2/24 at 8:30 AM, an Orders - Administration Note documented Note Text: Sertraline HCl [hydrochloride] Oral Tablet 50 MG Give 50 mg by mouth one time a day for Depression pending delivery. On 8/3/24 at 8:35 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer Pending delivery. On 8/4/24 at 7:42 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/24 at 7:45 AM, an Orders - Administration Note documented Note Text: Sertraline HCl Oral Tablet 50 MG Give 50 mg by mouth one time a day for Depression pending delivery. On 10/27/24 at 9:57 PM, an Orders - Administration Note documented Note Text: Cephalexin Oral Tablet 500 MG Give 500 mg by mouth four times a day for Prophylaxis awaiting blood Culture results for 5 Days not available in pyxis. On 11/28/24 at 7:41 AM, an Orders - Administration Note documented Note Text: Eliquis Oral Tablet Give 5 mg by mouth two times a day for DVT [deep vein thrombosis] prevention pending delivery. On 12/17/24 at 8:02 PM, an Orders - Administration Note documented Note Text: risperiDONE Oral Tablet Give 1 mg by mouth one time a day for delusional disorder pending on delivery. On 12/21/24 at 7:58 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. On 12/22/24 at 7:20 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. On 12/23/24 at 8:57 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer med not available, pharmacy notified. On 12/24/24 at 7:19 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer Pharmacy contacted about medication. pending delivery. On 12/25/24 at 10:21 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer pending delivery. pharmacy has been contact. On 12/26/24 at 10:04 AM, an Orders - Administration Note documented Note Text: Anastrozole Oral Tablet Give 1 mg by mouth one time a day for breast cancer PHARMACY NOTIFIED, MED [medication] WILL BE HERE TODAY. On 1/24/25 at 10:22 AM, an Orders - Administration Note documented Note Text: Pro Stat one time a day for Supplement give 45 ml [milliliters] po [by mouth] daily pending delivery. On 1/25/25 at 8:35 AM, an Orders - Administration Note documented Note Text: Pro Stat one time a day for Supplement give 45 ml po daily pending delivery. On 1/26/25 at 10:20 AM, an Orders - Administration Note documented Note Text: Pro Stat one time a day for Supplement give 45 ml po daily pending delivery. On 1/30/25 at 8:45 AM, an interview was conducted with Registered Nurse (RN) 6. RN 6 stated she would call the pharmacy if she needed a medication and the pharmacy would deliver. RN 6 stated that sometimes medication refills would be missed. RN 6 stated if there were a few medications left in the medication card she would take the sticker off of the medication card and fax the refill to the pharmacy. RN 6 stated the pharmacy would deliver in an hour or so if she told them she needed it right now. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 8:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when the resident had seven days of medication left, the staff would fax the request refill to the pharmacy. The DON stated that staff would need to call the pharmacy and tell them the fax request had been sent if they did not see the medications. The DON stated the first step was to fax the request to the pharmacy and follow up with a phone call. The DON stated the pharmacy would deliver the medications in a day or two of the refill request. On 1/30/25 at 12:07 PM, an interview was conducted with Assistant Director of Nursing (ADON) 2. The ADON stated the facility had an emergency medication system that was stocked with the basic medications including pain medications and antibiotics. ADON 2 stated Prostat was ordered through a medical supply store. The ADON stated that central supply would order the Prostat with the over the counter medications. The ADON stated the central supply staff member worked nights and would do the stocking before her shift. The ADON stated the central supply staff member would order at the beginning of the week and then she had a stock day. The ADON stated the central supply staff member would order here and there if the nurses need anything.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director (MD), and the Director of Nursing (DON) were acted upon. In addition, the attending physician must document in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. Specifically, for 1 out of 33 sampled residents, a pharmacy recommendation was not acted upon by the MD and the MD did not document the identified irregularity and what action was taken in the resident's medical record. Resident identifier: 62. Findings included: Resident 62 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, malignant neoplasm of right female breast, dementia severe, delusional disorders, urinary tract infections, repeated falls, dysphagia, difficulty in walking, and unsteadiness on feet. Resident 62's medical record was reviewed on 1/28/25. The Patient Recommendations Summary dated 12/27/24, documented This resident has orders for Risperidone and Sertraline for dementia, but this is not a labeled indication for these medications. Antipsychotic medications have a black box warning when used off label. This was discussed with the attending psychiatric providers and it was agreed that symptoms of psychosis, depression, anxiety and mood instability are common behavioral symptoms of this condition, and that these medications can be useful in treating these symptoms. It was agreed that the benefits of treatment currently outweigh any potential risks, and no recommendations are needed at this time. There was no documentation from the MD in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. On 1/30/25 at 1:17 PM, an interview was conducted with the DON. The DON stated the pharmacist would review the residents and would send the recommendations in an email. The DON stated the pharmacist would review the residents remotely and would come to the facility for the psychotropic meetings. On 1/30/25 at 1:20 PM, an interview was conducted with Assistant Director of Nursing (ADON) 3. ADON 3 stated that she would receive the pharmacist recommendations. ADON 3 stated she would get the orders form the pharmacist, make the changes, and notify the resident. ADON 3 stated that she did not know if the MD signed the recommendations but she thought the recommendations might already be agreed before they came to her. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 2:20 PM, an interview was conducted with the Pharmacist. The Pharmacist stated that she did at least a monthly review on the residents. The Pharmacist stated that she reviewed the resident medical records but every month was different. The Pharmacist stated the first month of the quarter, she did anything that required lab work, made sure the labs looked good or needed to be ordered, and made sure all medications were appropriately dosed based on kidney or liver function. The Pharmacist stated if the labs looked good she would look at the drug interactions. The Pharmacist stated the second month she would do blood pressures, sliding scale insulin, anticoagulants, make sure that everything had the appropriate dosage, and get rid of unnecessary medications. The Pharmacist stated the third month was the psychotropic review. The Pharmacist stated that she would make sure she put in the note that the psychotropic medications were reviewed. The Pharmacist stated she would look to see if the provider and nursing staff were documenting the patient had dementia and discussed the risks and benefits. The Pharmacist stated that she believed the benefits outweighed the risk. The Pharmacist stated that last month she identified that resident 62's risperidone and sertraline did not have the appropriate diagnosis. The Pharmacist stated the only thing that resident 62 had was dementia and resident 62 was just admitted back in July.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation and interview, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, and included the expiration date when applicable. Specifically, for 2 out of 33 sampled residents, four opened insulin injector pens were not labeled with open dates and they were in the medication cart available for resident use. Resident identifiers: 7 and 24. Findings included: On 1/30/25 at 1:54 PM, an observation was conducted of the third floor East hallway medication cart with Registered Nurse (RN) 7. There were four insulin injector pens in the medication cart that were not labeled with an open dated. RN 7 stated as soon as we get the insulin out of the fridge we would date the insulin with an open date. RN 7 stated that insulin was all ready labeled with the residents name. RN 7 stated the insulin was good for 28 days after opening. 1. Resident 7 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy and long term use of insulin. Resident 7's Basaglar KwikPen Solution Pen injector 100 unit/milliliter (ml) (Insulin Glargine) and Humalog Solution 100 unit/ml (Insulin Lispro) were not labeled with an open date and were available for use in the medication cart. 2. Resident 24 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with diabetic neuropathy, and long term use of insulin. Resident 24's Insulin Glargineyfgn Solution 100 unit/ml and Insulin Lispro-aabc Injection Solution 100 unit/ml were not labeled with an open date and were available for use in the medication cart. On 1/30/25 at 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated when insulin was opened the staff should date the insulin with an open date and the insulin was good for 28 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, the facility did not establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 5 out of 33 sampled residents, a nurse preparing medications used their bare hand to touch the medication and the medication fell on the medication cart and was administered to a resident. Resident's with a peripherally inserted central catheter (PICC) line, urinary catheter, feeding tube, and wound care did not have Enhanced Barrier Precautions (EBP) signage posted on their door and personal protective equipment (PPE) was not available. A resident with Methicillin-resistant Staphylococcus aureus (MRSA) in their wound did not have contact precautions signage posted on their door and PPE was not available. In addition, a nurse was observed to doff their PPE into the wrong garbage receptacle and a resident's PICC line port was improperly sanitized before use. Resident identifiers: 9, 28, 60, 173, and 176. Findings included: 1. On 1/30/25 at 8:34 AM, an observation was conducted with Registered Nurse (RN) 6 preparing medications for resident 28. RN 6 was preparing the calcium tablet and one of the calcium tablets fell out of the medication cup on to the medication cart. RN 6 asked the Surveyor if she could pick up the pill and resident 28 told RN 6 no. RN 6 stated if the resident was okay with her administering the pill she would. RN 6 was observed to get another calcium tablet out of the medication bottle and RN 6 assisted the tablet out of the bottle with her bare finger. RN 6 prepared all of resident 28's medications and prior to administering the medications a calcium tablet fell out of the medication cup onto the medication cart. RN 6 picked up the tablet with a gloved hand and put the tablet in the medication cup and administered the medications to resident 28. On 1/30/25 at 12:18 PM, an interview was conducted with RN 6. RN 6 stated that every time she used the blood glucose monitor or a blood pressure cuff she would sanitize the top of the medication cart. It should be noted that RN 6 did not sanitize the medication cart during the medication administration task. On 1/30/25 at 1:35 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she would like to see the medication carts sanitized before or after every shift. The DON stated it would also depend on what happened at the medication cart. The DON stated if something spilled, were residents coughing, or possible contaminates she would expect the staff to sanitize the medication cart as needed. The DON stated that staff could not touch medications with their bare hands. The DON stated the medications must go into the medication bottle cap or the medication cup. The DON stated if a medication fell on the medication cart the staff should pick up the medication with a glove but the medication was questionable. The DON stated if the medication became dirty it had to be tossed. 48709 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included enterocolitis due to clostridium difficile, hereditary and idiopathic neuropathy, respiratory failure, and congestive heart failure. On 1/28/25 at 8:56 AM, resident 9 was observed to be in her room in bed. A PICC line to resident 9's upper right arm was observed and there was no EBP sign or PPE cart inside or outside of her room. Resident 9's medical record was reviewed on 1/28/25 through 2/3/25. A Nursing: EBP document dated 1/18/25 at 3:29 PM, indicated resident 9 had an Indwelling Medical Devices (Central Line, Urinary Catheter, Feeding Tube, Trach/Vent [tracheostomy/ventilator], etc). It further indicated, Resident is to be placed on Enhanced Barrier Precautions until Indwelling Medical Devices are resolved. Then downgrade to Standard Precautions. On 1/28/25 at 4:10 PM, an interview was conducted with RN 6. RN 6 stated resident 9 was not on any precautions. RN 6 stated she flushed the PICC line that day and that she used standard precautions to access it, which included gloves. On 1/29/25 at 10:36 AM, an interview was conducted with Medication Technician (MT) 1. MT 1 stated she was assigned to resident 9 that day and that she did not know resident 9 had a PICC line. 38031 3. Resident 60 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of acute kidney failure, hypertension, sepsis, and retention of urine. On 1/27/25 at 11:15 AM, an observation was made of resident 60 sleeping in bed. Resident 60's bed was positioned with the right side of the bed against the wall and the resident was lying in bed on the left lateral side. Resident 60's urinary catheter bag was observed on the wheelchair seat next to resident 60's foot of the bed. It should be noted that no sign was posted outside of resident 60's room indicating EBP nor PPE of gloves, gown, and mask readily available outside or inside the resident room. Resident 60's medical record was reviewed. On 11/22/24, resident 60's quarterly Minimum Data Set assessment documented that resident 60 required a one person total dependence for toilet use. On 1/26/25, resident 60 had an order renewed to change the urinary catheter as needed one time a day every 28 days and to change the catheter down drain bag every 23 hours as needed for retention and for catheter-related complications. On 8/19/24, resident 60 had a physician's order initiated for Foley catheter care each shift Start at insertion site and wipe down toward the drainage bag. For men: Start from the top of penis where the catheter goes in, making sure to pull back the foreskin, and wipe back toward your anus. For women: separate the labia, and wipe back toward your anus. For a suprapubic catheter: Wipe the area of your belly around where the catheter goes in. (continued on next page)

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	465049	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24, resident 60 had a care plan initiated for an indwelling urinary catheter. A goal of the care plan was that resident 60 would show no signs and symptoms of urinary infection through the review date. Interventions identified on the care plan included to change the catheter per the physician orders; monitor for signs and symptoms of discomfort on urination and frequency; and to monitor for signs and symptoms of a urinary tract infection. On 1/29/25 at 2:32 PM, an observation was made of resident 60's urinary catheter bag. The catheter bag was hung on the side of the bed next to the resident's head and the head of the bed was slightly elevated. The bag was above the level of the resident 60's bladder. It should be noted that no sign was posted outside of resident 60's room indicating EBP nor was PPE of gloves, gown, and mask readily available outside or inside the resident room. On 1/30/25 at 10:25 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated that catheter care included cleaning resident 60's penis and wiping the catheter tubing where it entered the penis. CNA 3 stated that while they were providing catheter care they should be wearing gloves and a gown. CNA 3 stated that she was educated today on the required PPE to use when providing catheter care. CNA 3 stated that prior to the education provided today she was using gloves and a mask when providing catheter care but did not donn a gown. 4. Resident 173 was admitted to the facility on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, congestive heart failure, and pneumonia. On 1/28/25 at 9:20 AM, an interview was conducted with resident 173. Resident 173 stated that he was having a hard time swallowing and was getting a tube feed for his nutrition. Resident 173 stated that the tube feed was continuous and he could not eat anything by mouth except ice chips. Resident 173's tube feed was observed not running and no formula or water bag was hung at the bedside. It should be noted that no sign was posted outside of resident 173's room indicating EBP nor was PPE of gloves, gown, and mask readily available outside or inside the resident room. Resident 173's medical record was reviewed. Resident 173's physician orders revealed the following: a. On 1/25/25, an order was initiated for Enteral Feed Order two times for aspiration risk promote with fiber water flush 90/25. The order was discontinued on 1/27/25. The January Medication Administration Record documented that the enteral feed was administered four times. b. On 1/28/25, an order was initiated for Enteral Feed two times a day via Pump - Jevity 1.5 80 milliliter (ml) per hour for 18 hours via pump per nasogastric (NG) tube. Free water flush 73 ml/hour for 18 hours. On 1/24/25, the Enhanced Barrier Precautions assessment documented that the resident did not have an indwelling medical device (central line, urinary catheter, feeding tube). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25, resident 173 had a care plan initiated for a tube feeding via NG related to aspiration risk and pneumonia infection. Interventions identified included to follow the physician orders for current tube feed and to monitor/document/report any signs and symptoms of aspiration. On 1/28/25 at 11:55 AM, an observation was made of RN 9 administering resident 173's tube feed. RN 9 was observed to connect the tubing from the formula bag to resident 173's NG tube. RN 9 did not donn gloves or a gown while connecting the tube feed to resident 173. RN 9 stated that the tube feed was scheduled to run for 18 hours each day. On 1/29/25 at 9:25 AM, an observation was made of RN 6. RN 6 was observed to administer medication to resident 173 via his NG tube. RN 6 donned gloves but did not donn a gown for the medication administration via the NG tube. On 1/29/25 at 12:14 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated that if a resident was admitted with an infection the staff would be provided verbal education in report of that infection and then it would be passed off to the next shift in report. The IP stated that there should be an order in the chart stating what type of infection it was. The IP stated that a Transmission Based Precautions (TBP) sign indicating the type of precautions or an EBP sign should be posted on the resident door to alert staff as to what type of PPE to wear while providing care. The IP stated that she was the person responsible for posting the sign on the resident door for TBP or EBP and for placing a PPE cart outside of the resident room. On 1/29/25 at 12:58 PM, an interview was conducted with the DON and Assistant Director of Nursing (ADON) 3. The DON stated that they initiated EBP for any infections that could be spreadable. The DON stated that she did not know if a resident with a urinary catheter, NG tube, or PICC line without other infections would require EBP. The DON stated that residents with urinary catheters, NG tubes, or PICC lines were not currently on EBP. The DON stated that any resident on EBP should have a sign posted on the door and cart with PPE should be located outside the room. The DON stated that PPE required for EBP were gloves, gowns, masks, and N95 if necessary. The DON stated that the IP was responsible for placing TBP and EBP signs on resident doors and the PPE cart outside of the room. The DON stated that a resident with a Methicillin-Resisitant Staphylococcus aureus infection should have contact precautions and staff should be donning gloves, gown, and mask. The DON stated that a Clostridium difficile infection required contact precautions and PPE worn should be gloves, gown, and mask. The DON stated that staff should wear gloves when accessing a PICC line. The DON stated that the PICC line ports should have caps on them, and the cap should be changed according to the orders but most of the time it was weekly and was documented on the Treatment Administration Record. The DON stated that the PICC lines should be flushed before and after medication administration and every shift depending on the physician orders. The DON confirmed that the PICC line lumen connectors needed to be cleaned with a new and unused alcohol swab for each connector prior to use. The DON stated that if the resident was not receiving any medication through the PICC line then she would expect the nurse to contact the physician to see if it could be discontinued. The DON stated that the nurse should wear gloves when accessing a NG tube unless the resident had another infection that required more PPE. ADON 3 stated that staff should doff used PPE in the garbage inside the resident room and should be in a separate receptacle. ADON 3 stated that the used PPE should not be doffed into a shared bathroom garbage because there was a potential for spreading the infection and cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident 176 was admitted to the facility on [DATE] with diagnoses which consisted of osteomyelitis, methicillin-resistant staphylococcus aureus infection, open wound on the right lower leg, viral hepatitis C, and stimulant and alcohol abuse. On 1/27/25 at 1:55 PM, an observation was made of resident 176's room. The door to the room did not contain a sign indicating TBP or EBP. A PPE cart was observed located next to the resident door. Inside the cart was a sign for EBP and surgical masks. The PPE cart did not contain any gloves or gown. An observation was made of MT 1 entering the resident room with only a surgical mask donned. Resident 176's physician orders revealed the following: a. On 1/24/25, an order was initiated for WOUND CARE RIGHT LATERAL CALF: Remove dressing, cleanse wound with standard wound care protocol, apply the following order and appropriate dressing: Apply Anasept and collagen followed by Cutimed Sorbact dressing. Change 3x [times] per week and PRN [as needed] for soiled or compromised wound dressing one time a day every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for wound AND every 23 hours as needed. b. On 1/10/25, an order was initiated for Change RIGHT DOUBLE LUME [sic] PICC dressing weekly on Sunday and as needed. one time a day every Sun [Sunday] for maintenance. c. On 1/9/25, an order was initiated for Flush Right Double Lumen PICC with 10 ml NS [normal saline] before and after each medication dose every shift for maintenance. d. On 1/17/25, an order was initiated for cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM [grams] (Ceftriaxone Sodium) Use 2 gram intravenously one time a day for mrsa. On 1/22/25, resident 176 had a care plan initiated for has a MRSA chronic wound to the RLE [right lower extremity] lateral calf. The care plan identified an intervention to follow the facility protocols for treatment of the injury. On 1/28/25 at 1:18 PM, a list of residents receiving wound care was provided by RN 10. Resident 176 was not listed as being seen by the outside wound care provider. On 1/28/25 at 2:06 PM, an interview was conducted with RN 6. RN 6 stated that resident 176 did not have any wounds but did have a PICC line. On 1/28/25 at 2:53 PM, an interview was conducted with Physician Assistant (PA) 1 for the outside contracted wound care providers. PA 1 stated that she was providing wound care to resident 176 today and that she had MRSA in the wound. On 1/28/25 at 3:21 PM, an interview was conducted with resident 176's wound care providers, PA 1 and Medical Assistant (MA) 1. MA 1 stated that they were using Anasept on the wound bed followed by collagen and Cutimed Sorbact. MA 1 stated that the wound was located on the right lateral calf and on 1/21/25, the wound measured 8.1 centimeters (cm) x 5.1 cm. x 0.4 cm. PA 1 stated that resident 176 had the wound for three years and she had knee and hip surgery for osteomyelitis. MA 1 stated that resident 176 was on contact precautions due to the chronic MRSA in the wound. MA 1 was observed to check the PPE cart outside of resident 176's room and stated that it did not contain the PPE required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 3:37 PM, an interview was conducted with RN 10. RN 10 stated that the wound team asked her for gowns but she did not know who they were for. RN 10 stated that resident 176 needed gowns for wound care on her legs. RN 10 also stated that resident 176 was on contact precautions but she was not sure what for. RN 10 stated that the PPE required for contact precautions were gloves and a gown and that there should be a sign posted outside the resident door indicating this. RN 10 stated that resident 176's room did not have a sign posted for contact precautions. RN 10 stated that the PPE cart outside of resident 176's room had a sign in the top drawer for EBP but not for contact precautions. RN 10 stated that it was not the correct sign. RN 10 stated that she would need to check to see if resident 176 was supposed to be on EBP or contact precautions. RN 10 stated that the PPE cart should contain gowns, gloves, masks, and red disposal bags. RN 10 stated that the PPE cart only contained surgical masks and the EBP sign. On 1/28/25 at 4:00 PM, a follow-up interview was conducted with RN 10. RN 10 stated that resident 176 should be on contact precautions for wound care and staff should be donning a gown and gloves. RN 10 stated that staff did not have to donn a gown and gloves for intravenous antibiotic treatment. It should be noted that per the facility policy on EBP staff should utilize gowns and gloves during resident care activities for central lines such as resident 176's PICC line. On 1/28/25 at 4:04 PM, an interview was conducted with the IP. The IP stated that EBP should be implemented with resident's who had a PICC line and staff should be donning a gown, gloves, and a mask for any care of the indwelling device. On 1/29/25 at 9:54 AM, an observation was made of RN 6 during medication administration for resident 176. RN 6 stated that she was going to administer resident 176 her vancomycin for sepsis. RN 6 donned a gown and gloves prior to entering resident 176's room. Resident 176 had a double lumen PICC line in her left upper arm. RN 6 cleaned the purple port with a new alcohol wipe and flushed the line with a 10 ml of NS. RN 6 picked up the used alcohol swab from the resident's bed and wiped the purple tip again prior to hooking up the intravenous infusion line. RN 6 doffed her gloves, gown, and surgical mask into the garbage bag in the shared bathroom. The garbage sack in the shared bathroom was not a red biohazard bag and a red bag was not observed in the resident room. RN 6 exited the resident room and walked down the hallway to obtain a new mask from the nurse's station. It should be noted that the PPE cart outside of resident 176's room had a supply of surgical masks available. Additionally, the facility was currently experiencing a COVID-19 outbreak and all staff were wearing surgical masks while inside the facility. On 1/29/25 at 12:05 PM, a follow-up interview was conducted with the IP. The IP stated that EBP should be utilized with any resident care of urinary catheters, PICC lines, and NG tubes. The IP stated that staff should donn a gown, gloves, and a mask. The IP stated that EBP were implemented to protect the resident. The IP stated that contact precautions were for infections that were transferred through bodily fluids and it protected the staff and reduced the cross contamination. The IP stated that there should be a sign on the door alerting staff and the PPE cart should contain masks, gloves, gowns, hand sanitizer, and alcohol wipes. The IP stated that staff should doff their used PPE inside the resident room in its own garbage bag and should not be disposed of in a bathroom garbage can that was a shared bathroom. (continued on next page)

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