STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525064	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove New Berlin	13755 W Fieldpointe Dr New Berlin, WI 53151

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observations, interviews and record review the facility did not ensure it was safe and clinically appropriate for residents to self administer medications for 3 of 3 (R63, R75, and R56) residents observed for self administration of medications. R63 was observed to have medications at bedside. There was no assessment, physicians order or care plan for self administration of medications. R75 was observed to have medications at bedside. There was no assessment, physicians order or care plan for self administration of medications. R56 was observed to have medications at bedside. There was no assessment, physicians order or care plan for self administration of medications Findings include: The facility policy titled Self-Administration of Medications dated May 2018, documents (in part) . In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. C. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a (quarterly) basis or when there is a significant change in condition. D. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted. F. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or rooms with, residents who self-administer. 1.) R63 admitted to the facility on [DATE] with diagnoses that include surgical aftercare following surgery on the circulatory system, Myocardial Infarction, Atherosclerotic Heart Disease, Aortocoronary Bypass Graft and COPD (Chronic Obstructive Pulmonary Disease). On 1/13/25, at 9:46 AM, during initial interview with R63, Surveyor observed an Albuterol and Anoro inhaler on her bedside table. R63 reported the Albuterol inhaler is her own and she keeps both inhalers at bedside and can do them independently. R63's Brief Interview for Mental Status dated 12/19/24 documents a score of 15 indicating no cognitive impairment. R63's Physician's orders documented and order for Umeclidinium-Vilanterol Inhalation Aerosol Powder Breath Activated 62.5-25 MCG (microgram) (Anoro) 1 puff inhale orally one time a day for COPD and Albuterol Sulfate HFA (hydrofluoralkane) Inhalation Aerosol Solution 108 (90 Base) MCG - 2 puff inhale orally every 4 hours as needed for COPD. Surveyor noted neither of the above orders included an order to self administer meds or may keep medications at bedside. R63 had no assessment to determine it was safe and clinically appropriate for R63 to self administer medications and no care plan was implemented. On 1/15/25 at 3:14 PM, the facility was notified of the above concerns. No additional information was provided. 2.)On 1/15/25, at 8:43 AM, Surveyor observed RN (Registered Nurse)-P during medication pass for R75. Surveyor observed R75 walking down the hall and entered his room. While RN-P was administering R75 his Enoxaparin injection, Surveyor observed R75's breakfast tray with 2 plastic medication cups containing pills on the tray. Before leaving the room, RN-P stated to R75, Don't forget your breakfast. On 1/15/25, at 8:52 AM, Surveyor went back to R75's room and observed him taking the medications from the plastic cups on the tray. Surveyor asked about the medications. R75 stated, They are all of my morning meds. Surveyor asked if staff always leave them on the table. R75 stated, Yes, they bring them around 6:00 AM and then I take them when I eat breakfast because I heard it's better to take pills with food. Review of R75's current MAR (Medication Administration Record) documented the following: -Apalutamide Oral Tablet 60 MG (milligrams) Give 4 tablet by mouth in the morning for prostate cancer - AM 6. -Cholecalciferol Oral Tablet 25 MCG Give 1 tablet by mouth in the morning for supplement - AM 6. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Duloxetine HCl (Hydrochloride) Oral Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth in the morning for depression - AM 6. -Finasteride Oral Tablet 5 MG Give 1 tablet by mouth in them morning for BPH (Benign Prostatic Hyperplasia) - AM 6. -Multiple Vitamin Oral Tablet Give 1 tablet by mouth in the morning for supplement - AM 6. -Vitamin C Oral Tablet 500 MG Give 1 tablet by mouth in the morning for supplement - AM 6. -Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for hypotension - morning. -Methocarbamol Oral Tablet 500 MG Give 1 tablet by mouth three times a day for muscle spasms - 8 AM Surveyor noted none of the above orders included orders to self administer meds or may keep medications at bedside. R75 had no assessment to determine it was safe and clinically appropriate for R75 to self administer medications and no care plan implemented. On 1/15/25 at 3:14 PM, the facility was notified of the above concerns. No additional information was provided. 21855 3.) On 1/13/25, at 10:19 AM, R56 was observed in their room. R56 bedside table had a bottle of Tums antacids, bottle of acetaminophen 650 mg (milligrams) tablets, a bottle of Mindful Advantage tablets and a bottle of Nervive Nerve relief. The bottles did not have a pharmacy label on them. R56 stated the medications were for themselves. On 1/14/25, at 10:28 AM, R56 was observed in their room. R56 bedside table had a bottle of Tums antacids, bottle of acetaminophen 650 mg tablets, a bottle of Mindful Advantage tablets and a bottle of Nervive Nerve relief. The bottles did not have a pharmacy label on them Surveyor reviewed R56's medical record. R56 has been residing in the facility since 7/21/2023. R56 did not have a physician order for the medications observed in their room. The medical record did not contain an assessment to determine if R56 was able to administer the medications safely. R56 did not have a individualized plan of care to administer their own medication safely. The Quarterly MDS (minimum data set) assessment completed 10/18/24 indicates R56 has mild cognitive impairment and no dementia diagnosis. On 1/14/25, at 11:09 AM, Surveyor interviewed (Nurse Manager) NM-K. NM-K stated they have only been in this role a few months. R56's medical record was reviewed during this interview. NM-K confirmed there was no documentation related to R56 self administering medications. On 1/14/25, at 2:10 PM, Director of Nurses (DON)-B provided Surveyor new documentation for R56. The DON-B provided a Self-Administration of Medications assessment completed 1/14/25. This assessment was completed today and documents R56 can safely self administer medications. The DON-B also provided a physician order for R56's medications observed at bedside.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure 3 (R62, R283, R67) of 7 residents reviewed that required hospitalization s were given written reason for transfer to the hospital and the facility did not send this notification to the ombudsman. R62 was transferred to the hospital on 10/12/24 for a change in condition. R62 or their representative did not receive written notification of the reason for the transfer to the hospital and appeal rights and the State Ombudsman was not sent a copy of this notice. R283 was transferred to the hospital on 12/31/24 for a change in condition. R283 or their representative did not receive written notification of the reason for the transfer to the hospital and appeal rights and the State Ombudsman was not sent a copy of this notice. R67 was transferred to the hospital on 6/13/24 for a change in condition. R67 or their representative did not receive written notification of the reason for the transfer to the hospital and appeal rights and the State Ombudsman was not sent a copy of this notice. Findings include: 1.) R62's medical record indicates, R62 transferred to the hospital on 10/12/24 due to a change in condition. 2.) R283's medical record indicates, R283 transferred to the hospital on 12/31/24 due to a change in condition. On 1/14/25, at 3:21 PM, Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B who indicate floor nursing is responsible for providing the written notification of transfer to the hospital if a resident is sent out to the hospital. DON- B states the facility Social Worker (SW) will provide the written notification of transfer if the resident is sent out of the facility unstable, unresponsive or 911 is called along with notifying the ombudsman. Surveyor requested the written notification of transfer, appeal rights and notification to the ombudsman for R62's hospital transfer dated 10/12/24 and R283's hospital transfer dated 12/31/24. NHA- A states the facility does not have the written notification of transfer and notification to the ombudsman for R62 or R283. Surveyor notified NHA- A and DON- B of concerns with R62 and R283 did not receive the written notification of transfer and notification to the ombudsman for their hospital transfers. 38146 3.) R67 admitted to the facility on [DATE] with diagnoses that include chronic Congestive Heart Failure, Atherosclerotic Heart Disease, Protein Calorie Malnutrition, Retention of Urine, Type 2 Diabetes Mellitus, Obstructive and Reflux Uropathy and Aortocoronary Bypass Graft. On 1/13/25 at 10:10 AM, during initial interview, R67 reported he went back to the hospital once because he was throwing up. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor review of R67's progress notes documented: On 6/13/24, at 1:10 PM, Nurse's Note Text: Change in condition - multiple coffee ground emesis: 9:05 AM Resident has had approximately 120 cc (cubic centimeters) coffee ground emesis. Emesis started PM (evening) shift 6/12/24 and through the night per shift change report. Hospice on call nurse was called and notified of resident symptoms. NOR (new order received) on the NOC (night) shift 6/13/24 to hold scheduled aspirin and PRN (as needed) Naproxen. Hospice nurse informed noc shift they would be here in the morning to further evaluate resident. Unit Manager informed of coffee ground emesis episode at this time. Call placed to hospice for re-notification and to come to facility for resident evaluation. All AM PO (by mouth) medications held at this time. 12:00 PM Resident has had another episode of large coffee ground emesis at this time. Hospice nurse here at this time to evaluate resident. New orders received to send resident to (hospital) for treatment and evaluation. Wife updated on resident condition and is agreeable for transport to ER (emergency room) for treatment and evaluation. 1:05 PM Ambulance here for resident transport to (hospital). Resident left facility on stretcher accompanied by wife. Surveyor was unable to locate evidence a transfer notice with appeal rights was provided to R67 or his representative. On 1/14/25, at 1:40 PM, the facility provided Surveyor an eInteract transfer form dated 6/13/24. The einteract transfer form did not contain the required required regulatory information and there was no evidence it was provided to R67 or his representative. On 1/14/25 at 2:00 PM, Nursing Home Administrator (NHA)-A was advised of the above concern. No additional information was provided.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure 3 (R62, R283, R67) of 7 residents received a written notice of the bed hold policy when they were transferred to the hospital. R62 was transferred to the hospital on 10/12/24 and did not receive written notice of the bed hold policy. R283 was transferred to the hospital on 12/31/24 and did not receive written notice of the bed hold policy. R67 was transferred to the hospital on 6/13/24 and did not receive written notice of the bed hold policy. Findings include: 1. The medical record indicates R62 was transferred to the hospital on 10/12/24 due to a change in condition. Surveyor requested a copy of R62's written notice of the bed hold policy. On 1/14/25, at 3:21 PM, Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B who indicate floor nursing is responsible for providing the written notice of bed hold policy if a resident is sent out to the hospital. DON- B states the facility Social Worker (SW) will provide the written notice of bed hold policy if the resident is sent out of the facility unstable, unresponsive or 911 is called. Surveyor requested the written notice of bed hold policy for R62's hospital transfer dated 10/12/24 again. NHA- A states the facility does not have the written notice of bed hold policy for R62. Surveyor notified NHA- A and DON- B of concerns with R62 did not receive the written notification of the bed hold policy for their hospital transfer on 10/12/24. 2. The medical record indicates R283 was transferred to the hospital on 12/31/24 due to a change in condition. Surveyor requested a copy of R283's written notice of the bed hold policy. On 1/14/25, at 3:21 PM, Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B who indicate floor nursing is responsible for providing the written notice of bed hold policy if a resident is sent out to the hospital. DON- B states the facility SW will provide the written notice of bed hold policy if the resident is sent out of the facility unstable, unresponsive or 911 is called. Surveyor requested the written notice of bed hold policy for R283's hospital transfer dated 12/31/24 again. NHA- A states the facility does not have the written notice of bed hold policy for R283. Surveyor notified NHA- A and DON- B of concerns with R283 did not receive the written notification of the bed hold policy for their hospital transfer on 12/31/24. 38146 3) R67 admitted to the facility on [DATE] with diagnoses that include chronic Congestive Heart Failure, Atherosclerotic Heart Disease, Protein Calorie Malnutrition, Retention of Urine, Type 2 Diabetes Mellitus, Obstructive and Reflux Uropathy and Aortocoronary Bypass Graft. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 10:10 AM, during initial interview, R67 reported he went back to the hospital once because he was throwing up. Surveyor review of R67's progress notes documented: 6/13/24 at 1:10 PM, Nurse's Note Text: Change in condition - multiple coffee ground emesis: 9:05 AM Resident has had approximately 120 cc (cubic centimeters) coffee ground emesis. Emesis started PM (evening) shift 6/12/24 and through the night per shift change report. Hospice on call nurse was called and notified of resident symptoms. NOR (new order received) on the NOC (night) shift 6/13/24 to hold scheduled aspirin and PRN (as needed) Naproxen. Hospice nurse informed noc shift they would be here in the morning to further evaluate resident. Unit Manager informed of coffee ground emesis episode at this time. Call placed to hospice for re-notification and to come to facility for resident evaluation. All AM PO (by mouth) medications held at this time. 12:00 PM Resident has had another episode of large coffee ground emesis at this time. Hospice nurse here at this time to evaluate resident. New orders received to send resident to (hospital) for treatment and evaluation. Wife updated on resident condition and is agreeable for transport to ER (emergency room) for treatment and evaluation. 1:05 PM Ambulance here for resident transport to (hospital). Resident left facility on stretcher accompanied by wife. Surveyor was unable to locate evidence bed hold notice was provided to R67 or his representative. On 1/14/25, at 1:40 PM, the facility provided Surveyor an eInteract transfer form dated 6/13/24. The einteract transfer form did not contain the required regulatory information regarding bed hold and there was no evidence it was provided to R67 or his representative. On 1/14/25 at 2:00 PM, Nursing Home Administrator (NHA)-A was advised of the above concern. No additional information was provided.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review, the facility did not ensure that residents remain free of accident hazards and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (R12) reviewed for accidents. R12 sustained a significant injury to her leg which required surgical intervention. The facility did not complete a thorough investigation as to how the injury occurred. Findings include: R12 admitted to the facility on [DATE] and has diagnoses that include Chronic Kidney Disease, Anemia, Atherosclerotic Heart Disease, PVD (Peripheral Vascular Disease), Hypothyroidism, Vascular Dementia with anxiety, Osteoarthritis and Neuromuscular Dysfunction of bladder. R12's BIMS (Brief Interview For Mental Status) Evaluation dated [DATE] documents a score of 4, indicating severe cognitive impairment. R12's Admission MDS (Minimum Data Set) dated [DATE] documents: Self-Care Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement - Dependent. Mobility: Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed - Dependent. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed - Dependent. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support - Dependent. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed - Dependent. Toilet transfer: The ability to get on and off a toilet or commode - Dependent. R12's care plan documents: The resident has potential for impairment to skin integrity r/t (related to) weakness, incontinence, prediabetes, fragile skin, PVD. Actual skin impairment of hematoma that burst to left shin. Resident went out to hospital and received surgical intervention for hematoma - dated [DATE]. Interventions include: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface - initiated [DATE]. Resident to wear tubi grips to BLE (Bilateral Lower Extremities) for protection - initiated [DATE]. The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t weakness, dementia date initiated [DATE]. Interventions include: Bed mobility: Dependent, assist of 1. Toileting: Dependent, assist of 1. Transfer: Sit to stand lift and assist of 2. Dressing/personal hygiene: Dependent, assist of 1. Resident to wear slippers or gripper socks, not shoes. Encourage the resident to use bell to call for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident is at risk for falls r/t weakness, dementia, vision impairment, potential medication side effects, incontinence. Interventions: Resident not to be put in room alone when in w/c (wheelchair) dated [DATE]. The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia initiated [DATE]. Interventions: Anticipate and meet needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Call before you fall sign placed in room to remind resident to use call light - initiated [DATE]. Posey grip placed under w/c (wheelchair) cushion to prevent slipping - initiated [DATE]. R12's Fall Risk Evaluation dated [DATE] documents a score of 12 - At Risk for falls. R12 sustained 2 prior falls: R12's medical record documents on [DATE], at 2:45 PM: Resident found on bathroom floor by CNA (Certified Nursing Assistant). Resident assessed by nurse. Neuro checks negative ROM (range of motion) WNL (within normal limits). No injuries noted. On [DATE], at 3:25 PM, R12's medical record documents: Called to room by CNA. Upon entering room, resident was observed sitting upright on her buttocks in front of her w/c (wheelchair) on the floor. Daughter of room [room number] was present in room visiting with her mother at time of incident per her statement to this writer. Visitor stated resident was sitting in her w/c in her room and was leaning forward in her w/c. Resident was attempting to self transfer herself into her recliner chair across from her w/c. Resident slid out of her w/c onto the floor landing on her buttocks. Resident did not hit her head. No injury noted. ROM WNL. Denies pain/discomfort. Posey grip placed on top of and underneath w/c cushion to help prevent slipping. On [DATE], at 11:19 AM, Surveyor observed R12 sitting in the common area with her son. R12 was well groomed, wearing socks and slippers and foot pedals were observed on the wheelchair. Surveyor spoke with R12's son who reported R12 bumped her left leg with therapy, adding It was an accident, I don't blame anyone for what happened. She was in the hospital for weeks for the wound on her leg, it took a long time to heal, I think it's pretty much healed now. Surveyor reviewed R12's progress notes entered by LPN (Licensed Practical Nurse)-J which documented: On [DATE], at 1:50 PM, Nurse's Note Text: Called to room by CNA (Certified Nursing Assistant). CNA reported to writer that resident hit her left shin on the sit to stand lift prior to transfer. Some bruising present. Ice applied. Skin is intact. No bleeding noted. On [DATE], at 2:30 PM, Nurse's Note Text: APNP (Advanced Practice Nurse Practitioner) in the building. Notified of resident left shin injury from sit to stand lift prior to transfer. APNP assessed resident. No new orders at this time. Monitor and administer PRN (as needed) Tylenol and Biofreeze as ordered. Call placed (son) POA-HC (Power of Attorney for Health Care). Notified of resident injury to left shin. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 3:55 PM, Nurse's Note Text: F/U (follow up) Left lower shin hematoma: Writer called to room by CNA. Hematoma had ruptured. Blood gushing. Large gash present to left lower shin. Left leg wrapped with towel and pressure applied. 911 emergency services called. On [DATE] APNP note: [R12's], . female with a history of multiple chronic conditions, was seen today in her usual social situation for a routine SNF (Skilled Nursing Facility) follow-up. She was found sitting up in her wheelchair, appearing comfortable without complaints of pain. She states she is doing well and reports her appetite as okay. She denies experiencing cough, shortness of breath, nausea, vomiting, diarrhea, or constipation. However, towards the end of the shift, nursing staff reported that the patient had an injury during a sit-to-stand transfer, resulting in a hematoma on the medial aspect of her left leg, causing significant pain. An ice pack was applied, and Tylenol was administered for pain relief. The nursing staff was instructed to hold Plavix for two days and to notify the patient's family. Subsequently, the hematoma ruptured, and the patient was sent out via 911 for further evaluation and treatment. The Hospital Discharge Summary dated: [DATE] documented: admitted with left leg wound with traumatic laceration with bleeding and large hematoma. S/P (status post) excisional debridement of the left leg wound necrotic skin, subcutaneous fat and fascia 8 cm (centimeters) x 10 cm on [DATE]. Started on wound vac [DATE]. Acute blood loss anemia due to left leg hematoma on top of chronic anemia. She received 2 units PRBC (packed red blood cells) on this admission. The facility Skin & Wound Evaluation dated [DATE] documented the wound healed. Surveyor asked for the facility investigation involving the injury to R12's leg. Surveyor was provided the Facility Investigation Report dated [DATE] which documented: Summary of alleged incident: Injury of known cause [DATE], 1:50 PM. CNA alerted nurse that resident had hit her left shin on sit to stand lift and developed a bruise that then became a hematoma. RN (Registered Nurse) assessed resident and noted bruise at that time. Later developed to a hematoma to left shin. Resident c/o (complained of) pain. PRN Tylenol given and ice pack applied. APNP in house and aware. Resident's POA notified. Pertinent diagnoses include Peripheral Vascular Disease and Vascular Dementia with anxiety. IDT (Interdisciplinary Team) discussed. Determined root cause to be resident moved leg and bumped on sit to stand machine. Care plan updated to have resident wear tubi grips to BLE (bilateral lower extremities) for protection. Nursing description: CNA notified writer and floor nurse that resident had hit her left shin on the sit to stand lift prior to transfer and that there was a bruise. Bruise was originally noted to left shin. Ten minutes later a large hematoma was present to LLE (left lower extremity). Resident also stated that her leg bumped the sit to stand lift. CNA-O's statement on [DATE] documented only: Hit shin bone left on sit to stand. Nurse was notified. On [DATE], at 3:30 PM, during the daily exit meeting with the facility, Surveyor asked if the investigation report provided was the entire investigation completed. DON (Director of Nursing)-B stated, Yes, what I gave you is everything, the whole investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted the investigation was not thorough to determine how the accident happened. CNA-O's statement did not include details or information of how R12 hit her shin bone on the sit to stand. On [DATE], at 10:08 AM, Surveyor interviewed CNA-O and asked her to walk through what happened regarding R12's leg injury. CNA-O stated, We were getting her up (Surveyor asked who she meant by we) me and the other aide. She (R12) was sitting on the side of the bed and we got her hooked up to the stand up lift. She said she had to go to the bathroom, so we took her. Surveyor clarified; so (R12) had no injury at this time before you took her to the bathroom. CNA-O stated, No. Surveyor asked CNA-O if she could see R12's legs. CNA-O stated, Yes. She had her pants on at her ankles, but when she said she had to go to the bathroom, we took her. We didn't pull them up because she had to go to the bathroom. Surveyor asked if the leg leg strap was in place on the sit to stand. CNA-O stated, Yes. When we got her onto the toilet, the other aide left and she was on the toilet while I stayed in the room, making her bed, and stuff. Surveyor clarified; so (R12) was alone on the toilet. CNA-O stated, Yes. When I went back into the bathroom I saw that she had kicked her leg out to the left and she must've bumped it on the lift frame and it was bleeding, so I got the nurse. Surveyor asked how R12 bumped her leg on the lift frame if the leg strap was on. CNA-O stated, We had the leg strap on when we took her to the bathroom, but then I unhooked it when she was on the toilet because she likes to move her legs around when she's sitting on the toilet. Surveyor confirmed; so everything else was still hooked up while she was alone on the toilet, but you undid the leg strap. CNA-O stated. Yes. Surveyor asked CNA-O if she received any education after the incident. CNA-O stated, We were told that she (referring to R12) shouldn't be left alone when on the toilet and stand up lift anymore and that we need to watch her legs closely. Surveyor asked CNA-O if R12 was wearing tubigrips. CNA-O stated, No, those were for her swelling, but she doesn't have swelling anymore, so she hasn't worn the tubi grips for some time. Surveyor informed CNA-O R12's care plan indicates the tubi grips are to be worn for protection because of the incident. CNA-O stated, I don't know about that, but if they want them put on again, I have no problem cutting her some more. On [DATE], at 10:34 AM, Surveyor asked Nursing Home Administrator (NHA)-A for the facility policy and procedure for the use of the stand up lift. NHA-A stated, I know we don't have a policy specific to the stand up lift, because I remember a complaint awhile back and they (referring to Surveyors) asked for it and we don't have one. Surveyor asked what is the expectation for staff regarding use of the stand up lift. NHA-A stated, Two people to transfer with stand up lift, that's my official statement. On [DATE], at 12:14 PM, Surveyor observed R12 sitting in her wheelchair in the dining room waiting for lunch to be served. R12 was wearing socks and slippers, no tubi grips. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 12:48 PM, Surveyor interviewed LPN (Licensed Practical Nurse)-J about the accident and injury involving R12. LPN-J reported she remembers the incident. LPN-J stated, The CNA came and told me the resident bumped her leg on the sit to stand. I think it was toward the end of the day, near change of shift, so I didn't look at it right away, but did go down shortly after. She was in her wheelchair in her room and she had a large bruise with swelling, so I elevated her leg and gave some ice for comfort. I remember her son was here in the room and he said this happened before and it burst open. He no sooner left, and like 15 minutes after he left the CNA told me it ruptured. So I immediately wrapped it, applied pressure and stayed in the room with her. 911 was called and she was sent out. Surveyor asked if, when the CNA first told her the resident bumped her leg on the stand up lift, did she give any other information of how it happened? LPN-J stated, No, I think it was when they were transferring her to the toilet, but I'm not sure. Surveyor asked, if leg straps are supposed to be used when transferring residents with a stand up lift, how did she think R12 bumped her leg? LPN-J reported she did not know. Surveyor asked LPN-J if she asked the CNA for details or inquired how it happened. LPN-J stated, No, I think it was close to shift change, she just told me she bumped it and then left I think. Surveyor noted CNA-O's interview of the incident and LPN-J's interview of the incident differ in significant details. CNA-O reported when she returned to the bathroom after leaving R12 alone on the toilet and removing the leg strap, she saw R12 had kicked her leg out to the left and she must've bumped it on the lift frame and it was bleeding. LPN-J reported the CNA reported the bruise, ice was applied and it later (approximately 2 hours per progress notes) burst open with bleeding. Surveyor notes LPN-J did not report any bleeding until the bruise burst open and CNA-O identified bleeding noted upon returning to the bathroom after R12 was left alone. R12's CNA care card dated [DATE] (on the door of R12's closet) includes no documentation regarding safety of the sit to stand/not to be left alone on the toilet, ensuring leg straps are in place or watching her legs closely when using the sit to stand or during transfers. R12's care plan included no interventions to prevent further incidents other than implementing tubi grips to protect her skin. On [DATE], at 3:10 PM, Surveyor asked CNA-M to walk me through how to perform a stand up lift transfer. CNA-M showed Surveyor the stand up lift used for R12. CNA-M demonstrated and stated, We hook them up with the straps, put the leg straps on and then raise them up. Surveyor noted blue padded knee area for legs to rest against during transfer. Surveyor noted there are no metal bars or metal areas on either side of the stand up lift. Surveyor asked CNA-M if he knew how R12 would have bumped her shin on stand up lift. CNA-M stated, I don't know how that would be possible, there's no metal bars to bump the leg on. She must have bumped it on something else. She does try to self transfer, which is why we try to keep her out in the open where we can see her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 3:42 PM, Surveyor met with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked if a facility self report was completed regarding R12's leg injury. NHA-A stated, No. I believe what probably happened was the aide told the nurse what happened, that she bumped her leg on the lift and the nurse went with it. Surveyor notified NHA-A of the concern R12 sustained a significant injury to her leg, which required a hospital stay, surgical intervention and a wound vac and there was not a thorough investigation as to how the injury occurred. For example was the transfer completed correctly, was the leg strap in place, how/what did she bump her leg on (as Surveyor located no area on lift which correlates with CNA's interview). The CNA statement documents only that the resident hit her shin bone on the sit to stand but does not indicate how this occurred. In addition, R12 is at risk for falls, had 2 prior falls and was left alone on the toilet with the leg straps not attached. DON-B stated, I'm sure the nurse manager did more of an investigation, I can get a statement from her. Surveyor clarified; I was told this is the entirety of the investigation. DON-B reported she can see if the nurse manager did anything else and get a statement. Surveyor notified NHA-A and DON-B of the interview with CNA-O and how the injury occurred is different than progress note documentation . Surveyor read CNA-O's interview and progress note documentation and LPN-J's interview. Surveyor notified NHA-A and DON-B of concern it is not clear how the injury actually occurred and due to the extent of the injury a thorough investigation would expect to be completed. Surveyor notified NHA-A and DON-B the only intervention documented was to implement tubi grips to protect the skin, but no interventions were implemented to prevent further incident with the sit to stand, transfers or toileting assistance/supervision. Surveyor notified NHA-A and DON-B R12 was not observed wearing tubi grips during the time of survey. Surveyor asked if an assessment was completed upon R12's re-admission to determine if R12 is safe/appropriate for stand up lift use. NHA-A reported he did not know. Surveyor asked if education or audits were completed to ensure proper/safe transfer using the stand up lift. NHA-A stated, Probably not. I think what happed was the aide told the nurse the resident bumped her leg, so it was a known injury and there wasn't much to investigate. On [DATE], at 9:13 AM, DON-B reported she spoke to CNA-O and provided Surveyor a revised statement by CNA-O which documented: Addendum: Myself and another aide (no longer works here) sat (resident) up on side of bed and got her up with the sit to stand and put her on the toilet. We undid the leg straps once she was seated on the toilet. When we came back, she had shifted her legs off the lift and a bruise was noted to her left shin. (R12) said she bumped her leg on the lift. I notified the nurse of the bruise. Surveyor asked what did CNA-O report R12 bumped her leg on. DON-B stated, The blue knee rest padding, and I was reading her H&P (History and Physical) and the same thing happened the previous year, she bumped her leg on her wheelchair and needed surgical intervention for a hematoma, so she does have very fragile skin. Surveyor notified DON-B of the concern the addendum statement by CNA-O is different than the statement CNA-O provided to Surveyor earlier. Surveyor notified DON-B the concern remains that R12 sustained a significant injury and there was not a thorough investigation as to how the injury occurred and interventions were not put in place that address the root cause of the injury and to prevent future injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor read R12's H&P which documented exactly 1 year previous, on [DATE] RLE (Right Lower Extremity) hematoma from trauma/wheelchair transfer. EMS (Emergency Medical Services) was called and she required CPR (Cardiopulmonary Resuscitation). She required surgical evacuation of the hematoma on [DATE]. Laceration was complicated by paper thin skin limiting ability for suture closure. On [DATE], at 9:30 AM, Surveyor spoke with Clinical Nurse Consultant-G. Surveyor was informed the facility does not have a policy and procedure for the stand up lift. Surveyor asked for evidence of education or training with the CNA's. Surveyor was provided evidence of the skills fair on [DATE] in which CNA's demonstrated competence. Surveyor reviewed the manufacturer recommendations for the stand up lift, no additional information was obtained. Surveyor notified Clinical Nurse Consultant-G of concerns R12 sustained a significant injury to her leg, requiring surgical intervention. There was not a thorough investigation as to how the injury happened. R12 is at risk for falls, sustained 2 prior falls and was left alone on the toilet with the leg strap not fastened. Clinical Nurse Consultant-G stated, I'm sorry, I don't know this person at all. I understand your concerns, with the severity of the injury there should have been more digging into what happened. No additional information was provided.

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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** 38146 Based on observation, interviews and record review the facility did not ensure that residents who enter the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary for 1 of 2 (R12) residents reviewed for catheters. R12 admitted to the facility without a catheter. R12 was hospitalized and returned to the facility with a Foley catheter. R12 did not have a diagnosis or clinical condition indicating the necessity of the catheter. Findings include: The facility policy titled: Standard Indwelling Catheter Protocol, undated, documents (in part) . Problem: Individual has Indwelling Catheter. RN (Registered Nurse)/LPN (Licensed Practical Nurse): Obtain order for indwelling catheter. Document type, size, balloon inflation size and indication for use (Neurogenic Bladder, Obstructive Uropathy, for promotion of healing pressure injuries related to incontinence and urinary retention for short term only). Post catheter removal, monitor intake/outputs x (for) 3 days; monitor for urinary retention i.e.: pain, pressure, distention, etcetera. R12 admitted to the facility on [DATE] and has diagnoses that include Hypertensive Chronic Kidney Disease, Anemia, Atherosclerotic Heart Disease, Peripheral Vascular Disease, Hypothyroidism, Vascular Dementia with anxiety, Osteoarthritis and Neuromuscular Dysfunction of Bladder (diagnosis added 10/10/24). On 1/13/25, at 11:16 AM, Surveyor observed R12 sitting in the common area near the fish tank with her son. Surveyor observed a catheter in a bag under her wheelchair and asked R12's son about the catheter. R12's son stated, She didn't have a catheter before. I think she has it now because they don't want to take her to the bathroom. R12's son added, I get it, she goes a lot, I mean a lot. I used to take her out to eat and she'd have to go to the bathroom [ROOM NUMBER]-3 times. R12's hospital discharge summary dated 11/15/23 documents: Does not have active GU (genitourinary) problems. Has bladder incontinence - uses incontinence briefs. R12's Admission MDS (Minimum Data Set) dated 11/23/23 documents: Indwelling catheter (including suprapubic catheter and nephrostomy tube) NO Urinary continence: Select the one category that best describes the resident - frequently incontinent. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Significant Change in Status MDS dated [DATE] documents: Indwelling catheter (including suprapubic catheter and nephrostomy tube) - YES. Genitourinary: Neurogenic bladder - NO. Obstructive uropathy - NO. R12's Annual MDS dated [DATE] documents: Indwelling catheter (including suprapubic catheter and nephrostomy tube) - YES. Genitourinary: Neurogenic bladder - NO. Obstructive uropathy - NO. Surveyor review of R12's medical record which documented R12 was hospitalized and readmitted to the facility on [DATE] with a Foley catheter in place. Surveyor notes R12 did not have a catheter prior to hospitalization . She was admitted to Hospice care on 12/21/23. The hospital discharge summary dated 12/13/23 included no documentation regarding the Foley catheter, and no diagnosis or clinical indication for use. Review of R12's medical record revealed the facility did not assess R12 for removal of the catheter or obtain valid medical justification for use of the catheter. Surveyor located a Hospice progress note dated 6/13/24, at 1:04 PM, which documented: Foley catheter to remain, no voiding trial. Catheter necessary for end of life care. Surveyor noted a Physicians order dated 10/10/24 which documented: Neuromuscular Dysfunction of bladder, unspecified. Medical Management. On 1/15/25, at 9:57 AM, Surveyor spoke with Nursing Home Administrator (NHA)-A. Surveyor informed NHA-A of the concern R12 admitted to the facility without a Foley catheter, was hospitalized , and returned to the facility with the catheter on 12/18/23. R12's History and Physical and Hospital Discharge Summary includes no history of GU (genitourinary) problems besides incontinence. R12's catheter remained in place with no diagnosis or indication for use, and there was no trial removal of the catheter. The Hospice note in June 2024 documented the catheter was necessary for end of life care, which is not an appropriate diagnosis, and Physician's orders in October, 2024 added the diagnosis of neuromuscular dysfunction of bladder. Surveyor asked where this diagnosis came from. NHA-A stated, We looked into this all yesterday and could find no additional information regarding the catheter. I understand what your saying and you gotta do what you gotta do. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38146 Based on observations, interviews and record review the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles, and include the expiration date when applicable for 3 of 4 medication carts and 2 of 2 medication rooms reviewed. Insulin vials and pens were not dated when opened. Findings include: The Facility Policy titled: Vials and Ampules of Injectable Medications dated May 2018, documents (in part) . Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. A. Vials and ampules dispensed by the pharmacy are maintained in the box or container, with the pharmacy label, in which they are dispensed. B. Expiration dates: Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this shortened expiration date are both important to be recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. The shortened expiration date for multidose vials that have been opened or accessed is 28 days unless the manufacturer specifies a shorter or longer interval for the shortened expiration date. F. Medication in multidose vials may be used (until the manufacturer's expiration date/or facility policy) if inspection reveals no problems during that time. USP guidelines recommend discarding multidose vials (other than some insulins) at 28 days after opened. The date opened and the shortened expiration date should be recorded on a label for such purpose affixed to the vial. Shortened expiration dates triggered by opening should be available either in the manufacturer's labeling or package insert, on a chart provided by the pharmacy, or from the pharmacist. On 1/15/25, at 9:04 AM, Surveyor observed the 2nd floor left hall medication cart. In the top drawer of the cart, Surveyor located the following: 2 Novolog insulin vials belonging to R44, which were open and used, but not dated when opened. 1 Lantus insulin vial which was not labeled with a name, open and used, but not dated when opened. Medication Assistant-Q was notified of the above insulins that were not dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25, at 9:27 AM, Surveyor observed the 1st floor unit B medication cart. In the top drawer of the cart, Surveyor located an Insulin 70/30 vial belonging to R68 which was open and used, but not dated when opened. On 1/15/25, at 9:30 AM, Surveyor observed the 1st floor unit A medication cart. In the top drawer of the cart, Surveyor located 2 Lantus insulin vials belonging to R18 which were open and used, but not dated when opened. The label on the vials read, expires 28 days after opening. LPN (Licensed Practical Nurse)-J was notified of the above insulins that were not dated when opened. On 1/15/25, at 9:09 AM, Surveyor observed the 2nd floor Cottage Unit medication room. Inside the refrigerator, Surveyor located the following: 2 Lantus insulin vials belonging to R283 which were open and used, but not dated when opened. The labels read, expires 28 days after opening. 1 Lispro insulin vial belonging to R62 which was open and used, but not dated when opened. 1 Humulin R insulin vial belonging to R39 which was open and used, but not dated when opened. On 1/15/25, at 9:18 AM, Surveyor observed the 1st floor [NAME] Court medication room. Inside the refrigerator, Surveyor located the following: 1 Lispro insulin vial belonging to R83 which was open and used, but not dated when opened. 1 Basaglar insulin kwik pen which was not labeled with a name, open and used, but not dated when opened. On 1/15/25, at 9:57 AM, Surveyor advised Nursing Home Administrator (NHA)-A of the above concerns. No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21855 Based on observation, interviews, and policy review the facility did not utilize a sanitary process for the dishwashing machine. This had the potential to effect all 87 residents in the facility. - The dietary staff was observed handling dirty items and placing them into the dishwashing machine. Then handling the clean items from the dishwashing machine with performing hand hygiene and using the same contaminated hands. Findings include: The facility's policy titled: Manual Dishwashing, undated, was reviewed. The policy documents: . All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish machines will be checked prior to meals to ensure proper functioning and appropriate temperatures for cleaning and sanitization. The procedures document under #9 to allow the dishes to air dry; #10 remove the dishes, inspect for cleanliness and dryness, and put them away if clean, Be sure your hands are clean. On 1/15/25, at 1:41 PM, Surveyor observed the dishwashing machine in the main kitchen. The facility has a single dish rack machine. Surveyor observed Dietary Staff (DS)-V rinsing used meal trays with gloves on, then place the filled rack in the dishwashing machine. Once cleaned, DS-V removed the the clean rack without proper hand hygiene and changing their contaminated gloves. Surveyor also noted DS-V did not allow the items to air dry and used the same contaminated gloves from loading the dirty used trays to remove the trays once cleaned. DS-V was observed rinsing off used flatware in a dish rack and place it in the dishwashing machine. DS-V then removed the clean dish rack with the same gloves contaminated from handling the used flatware. Surveyor noted DS-V did not perform hand hygiene and change contaminated gloves between handling used items and then clean items. Surveyor then observed DS-W start to load used dishes on to a dish rack. Then DS-V would touch the used dishes rack and place it in the dish machine. Then DS-V would touch the clean items with the same contaminated gloves and not allow items to air dry. Surveyor questioned DS-V who stated they are not actually touching the items but just the rack. Surveyor left the area to interview Kitchen Lead (KL)-X. KL-X went into the dishwashing machine area with Surveyor. KL-X explained to DS-V, and DS-W, the sanitization process. The KL-X stated these are fairly new employees and KL-X will have an inservice on the proper sanitization processes. On 1/15/24, at 3:00 PM, at the facility exit meeting Surveyor shared the concerns related to the kitchen observations with Nursing Home Administrator (NHA)-A and Director of Nurses (DON)-B.

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	525064	A. Building B. Wing	01/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on observation, interview and record review, the facility did not implement an effective infection prevention and control program. This had the potential to affect all 87 residents, staff, and visitors in the facility. - The facility did not have documentation they investigated infection outbreaks in the facility. - The facility did not have a system to track all facility staff illnesses. - The facility did not implement enhanced barrier precautions for R1 and R50 identified as having wounds. Findings include: The facility's policy titled: Infection Prevention and Control Program dated 12/5/24, was reviewed. The policy documents: To prevent the development and transmission of disease and infection. The Procedure includes: Perform surveillance and investigation to prevent, to the extent possible, the onset and spread of infection. The facility's Outbreak and Isolation Procedures dated 12/5/24 were reviewed. The Procedures include: Initiate timeline documentation of outbreak management. The IP (Infection Preventionist) will provide reporting to governmental agencies per regulation as indicated. OUTBREAKS 1) On 1/16/25, at 10:35 AM, Nursing Home Administrator (NHA)-A informed Surveyor the facility has had different IP (Infection Preventionist)s in the facility. NHA-A stated Director of Nurses (DON)-B was the IP from 9/2023 -12/2023, then a different staff person from 12/2023- 2/2024, then a different staff from 3/2024-5/2024, then DON-B from 6/2024- 8/2024, and then IP-C started in 8/2024. NHA-A stated DON-B has had involvement with the facility's IP role and is training the current IP. On 1/16/25, at 9:14 AM, Surveyor interviewed DON-B. DON-B stated whatever is in the Outbreak Binder is all the information the facility has related to each outbreak. DON-B stated the facility does not have any additional information. Surveyor reviewed the facility's Outbreak Binder's documentation from the last recertification survey on 11/7/2023 to present. Surveyor notes the facility identified Covid outbreaks occurred 12/2023, 1/2024, 7/2024 and 11/2024; Influenza A outbreak in 1/2024; and a Norovirus outbreak in 2/2024. Surveyor noted there was no investigation summary pertaining to each facility outbreak. There were no investigations documented to determine the possible etiology of the outbreak onsets, along with a timeline identifying measures taken to prevent the spread of the outbreak. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted with the most recent covid outbreak,11/2024, the facility created a line list of staff and residents that was co-mingled and was not in order of illness occurrence. The line list did not identify staff by the position they held or the area/unit they were assigned to work, and the line list only identified nursing staff. It did not include staff that worked in other departments and could be in contact with residents or in resident care areas. Surveyor noted the facility did not document any control measures used to limit the spread of covid. Surveyor also noted the line list identified 3 residents (R183, R184, and R82) as testing positive for covid but no well date documented. Upon review of R183's, R184's and R82's medical records all 3 residents passed away at the facility during the outbreak and all tested positive for covid prior to their death. On 1/16/25, at 12:41 PM, Surveyor interviewed Director of Nursing (DON)-B and Infection Preventionist (IP)-C. They stated the recent facility covid outbreak identified a staff member testing positive for covid on 11/17/24 on unit B. The facility did covid testing on days 1, 3, 5 for residents and staff for that unit. DON-B stated R183 went to hospital on 11/19/24 for unrelated reasons to covid. The facility was informed R183 tested positive for covid while in the hospital. The facility expanded the covid testing to Unit D (the unit R183 lived on) for residents and staff. On 11/22/24 the facility posted signs on the facility entrance doors informing visitors of a respiratory outbreak. Surveyor noted the facility did not investigate how covid spread to other staff and residents on different units. The facility is structured with a 1st and 2nd floor with a unit on each corner. The elevators are centrally located between the units. Surveyor noted there is one employee breakroom shared by all staff. On 11/25/24 the facility implemented covid testing on all units for residents and staff due to covid spreading. Surveyor notes the facility does not have a policy and procedure related to covid outbreaks. DON-B and IP-C stated the facility follows the direction of Public Health. On 11/26/24 the facility sent an email to all facility department heads about outbreak measures and need for increased cleaning and isolation protocols for residents and staff. On 1/16/25, at 3:26 PM, at the facility exit meeting with NHA-A, DON-B and Regional Nurse Consultant (RNC)-G Surveyor shared the concerns related to the covid outbreak: there is not a thorough line list to track infections, there was no documentation to identify source and preventative measures to prevent the spread of infection, there is no documentation for resident and staff covid testing, there was not accurate tracking of facility staff illness, there was no accurate identification of the total number of residents, and staff who tested positive for covid and there was no documented investigation as to how covid spread to all 4 units in the facility. On 1/21/25, at 10:40 AM, Surveyor interviewed IP-C. IP-C stated she completed the line list, and reporting to Public Health, with the latest Covid outbreak (11/2024). IP-C informed Surveyor she is also the Nurse Supervisor on a Rehab unit. IP-C did not state how much time she allocates for infection control responsibilities at the facility. IP-C stated it varies week to week. IP-C stated DON-B is her resource person and directs the Infection Control program. The IP-C stated her goal is to keep up with the surveillance. STAFF ILLNESS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/21/25, at 8:00 AM, Nursing Home Administrator (NHA)-A provided Surveyor a typed up summary of the most recent Covid outbreak (11/2024). Surveyor notes the summary of the outbreak did not include possible source of the infection, and did not include staff illness tracking with information related to staff calling in sick to the facility. Surveyor notes the staff call-in slips did not include trending/tracking information related to staff symptoms, unit worked or job position. On 1/21/25, at 8:30 AM, Surveyor interviewed DON-B. DON-B stated the Scheduler fills out a slip for staff symptoms when they call in. DON-B stated the staff are told to test for covid prior to working and not to return to work until symptoms have resolved. On 1/21/25, at 10:25 AM, Surveyor interviewed NHA-A. NHA-A stated the facility staff call-ins go to the individual department manager and the call-ins are tracked by the DON-B and IP-C. On 1/21/24, at 10:40 AM, Surveyor interviewed IP-C. IP-C stated they did not have staff tracking information. IP-C stated they are switching to a new computer system. IP-C stated the scheduler has been calling staff back to obtain details related to the staff calling in absent. IP-C did not have any information to provide from other departments in the facility related to tracking/trending of staff call ins, symptoms, last day work and return to work days. Surveyor noted the IP-C did not conduct staff illness tracking in the facility. On 1/21/25, at 11:20 AM, Surveyor interviewed Scheduler-Y. Scheduler-Y stated they just keep track of nursing staff call-ins. Scheduler-Y stated if there is not a call-in slip completed, she will call the staff for details. Scheduler-Y stated IP-C, Nurse Managers and DON-B have access to the Onshift system. Scheduler-Y stated the system has a drop down box for notes where she can add information about the staff absence. On 1/21/25, at 12:48 PM, Surveyor interviewed DON-B. DON-B stated the department heads will email nursing if one of their staff is ill. Surveyor notes there was an Activity staff member identified with pneumonia on 12/19/24 and there is no additional information or tracking. 2.) ENHANCED BARRIER PRECAUTIONS Facility policy and procedure titled, Infection Control, documents in part: . Procedure: a. The Infection Prevention and Control Program establishes Enhanced Barrier Precautions to reduce transmission of multidrug-resistant organisms utilizing targeted gown and glove use during high contact resident care activities. b. Enhanced Barrier Precautions are used in conjunction with standard precautions and expand the use of PPE (Personal Protective Equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms to staff hands and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/15/25 at 7:35 AM, Surveyor observed Wound Nurse-D provide wound care for R50. Surveyor noted there was not an EBP sign nor a cart with PPE (Personal Protective Equipment) outside the R50's room. R50 was sitting in a wheelchair her with left leg raised resting on an extender, showing bare foot with heel dressing. Supplies were already on the bed with a barrier underneath. Wound Nurse-D sanitized hands, donned gloves and removed old dressing from wound. Surveyor observed wound on bottom of heel with a small pin-point hole. There was no redness, drainage, nor odor noted to the wound or surrounding skin. Surveyor observed no signs and symptoms of infection. Wound Nurse-D removed gloves threw them in a plastic bag, sanitized hands and donned gloves again. Wound Nurse-D wet gauze pad with saline solution and cleaned left heel wound. Wound Nurse-D cut silver Alginate wound dressing and foam boarder to size. RN labeled foam boarder with date. Wound Nurse-D removed gloves, threw them into a plastic bag, sanitized hands, donned new gloves and applied bandage to left heel. RN placed gripper slipper on left foot, removed gloves and sanitized hands. Resident reports she wears bilateral boots every night and staff take very good care of her. Surveyor noted RN did not wear a gown during wound care. On 01/15/25 at 2:40 PM, Surveyor interviewed Wound Nurse-D and asked if the facility uses EBP with residents with wounds. Wound Nurse-D stated, yes. Surveyor asked why wound care was provided today for R50 without EBC and she stated, it was missed. Surveyor asked why there were no supplies or signage for EBC outside R50's room and she stated, it just must have been missed and she would take care of it right away. On 01/15/25 at 01:13 PM, Surveyor interviewed Nurse Supervisor/IP (Infection Preventionist) -C, who stated the staff must use EBP while providing wound care for residents with open wounds. Nurse Supervisor/IP- C, also stated residents with open wounds, require a physician order for EBC and a sign is placed on door along with PPE cart placed outside of room. On 01/15/25 at 2:15 PM Surveyor informed Nursing Home Administrator (NHA) - A of the concern Wound Nurse - D, did not don a gown before entering room nor was there an EBP sign nor PPE cart outside of R50's door.