STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16692 Based on observation, interview and record review, the facility did not ensure each resident (R) was treated with dignity and respect and cared for in a manner that enhanced their quality of life for 2 residents (R16 and R24). Staff were observed feeding R16 and R24 part of their meals while standing over them. This was evidenced by: The facility policy titled The Dining Experience: Staff Responsibilities, dated 4/10/20, states in part: The dining experience will enhance each individual's quality of life through person centered dining. Example 1 R24 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and anemia. R24's care plan states in part: Eating - assist with set up. Encourage and assist as needed to consume foods and/or supplements and fluids offered. On 10/22/24 at 8:39 AM, Surveyor observed R24 trying to eat her meal. R24 had been using a knife to eat with when Certified Nursing Assistant (CNA) F approached, gave R24 a spoon instead of a knife, and stated this might be easier. CNA F then stood over R24 and began feeding her. CNA F stood and fed R24 the rest of her meal. Example 2 R16 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and legal blindness. R16's care plan states in part: Eating - independent after set up, uses a lip plate, Clock method to make aware of where food is, Assist of 1 as needed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 12:36 PM, Surveyor observed CNA F feed R16 some bites of asparagus and an entire bowl of fruit while standing. On 10/24/24 at 11:07 AM, Surveyor interviewed Director of Nursing (DON) B. When Surveyor relayed the above observations to DON B, DON B stated, Staff should not do that; staff should be sitting when assisting residents with their meals.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47657 Based on interview and record review, the facility did not send a copy of the discharge notice to the Office of the State Long Term Care Ombudsman for 4 of 4 residents (R) reviewed who were discharged to hospital (R12, R35, R50, and R4). The Ombudsman was not notified when R12, R35, R50, and R4 were discharged /transferred to the hospital. This was evidenced by: Example 1 R12 was hospitalized from 7/17/24 to 7/22/24, 7/29/24 to 8/2/24, and 8/7/24 to 8/16/24 for a change in condition. On 10/23/24 at 1:42 PM, Surveyor requested information of notification to the State Long Term Care Ombudsman for R12's discharges to the hospital. Director of Nursing (DON) B stated the facility did not have documentation of the notices. 31086 Example 2 R35 was admitted to the facility on [DATE] with diagnoses including Crohn's disease, chronic kidney disease stage 4, osteoporosis, type 2 diabetes mellitus, atherosclerotic heart disease, and transient ischemic attack. A Quarterly Minimum Data Set (MDS) assessment, dated 9/10/24, documented R35 had no impairments to the extremities, and required partial to moderate assist of staff for activities of daily living (ADLs) including toileting, dressing, and hygiene. A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated R35 was cognitively intact. A review of MDS records documented on 5/15/24, R35 was discharged with return anticipated and returned to the facility on [DATE]. On 5/26/24, R35 was discharged with return anticipated and returned to the facility on [DATE]. On 10/21/24 at 10:51 AM, Surveyor interviewed R35 about her transfers to hospital. R35 indicated in June she had complications from surgery for colon cancer, was sent to [NAME] to have surgery, and was able to come back to the same room. On 10/23/24, Surveyor requested from Director of Nursing (DON) B copies of the May 2024 notices given to the Ombudsman for R35's transfers to the hospital. On 10/25/24, Nursing Home Administrator (NHA) A provided Surveyor with an e-mail of the notice sent to the Ombudsman. The e-mail documented admissions, discharges from the facility, and deaths. The e-mail did not contain residents that were transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 R50 was admitted to the facility on [DATE] with diagnoses including duodenal ulcer with hemorrhage, muscle weakness, type 2 diabetes mellitus, pressure ulcer of left heel stage 3 (dated 3/28/24), pressure ulcer sacral region stage 3 (dated 3/28/24), sleep apnea, posthemorrhagic anemia, restless legs syndrome, chronic kidney disease stage 3, depression, personal history of transient ischemic attack and cerebral infarction without residual deficits. An Admission MDS assessment, dated 2/25/24, documented a BIMS score of 13 out of 15 which indicated R50 was cognitively intact. A review of MDS records documented on 3/16/24, R50 was discharged with return anticipated and returned to the facility on [DATE]. A progress note documented on 3/16/24 at 12:11 AM indicated R50 was transferred to the hospital for a gastrointestinal (GI) bleed. An Interact tool documented R50 was aware of the clinical situation and notified of the transfer. On 10/23/24, Surveyor requested from DON B the March 2024 notices given to the Ombudsman of R50's transfers to the hospital. On 10/25/24, NHA A provided Surveyor with an e-mail of the notice sent to the Ombudsman. The e-mail documented admissions, discharges from the facility, and deaths. The e-mail did not contain residents who were transferred to the hospital. 40590 Example 4 R4 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus type 2 with foot ulcer. R4 had an unplanned discharge to the hospital on 7/5/24 and returned to the facility on [DATE]. R4 had another unplanned discharge on 9/23/24 and returned to the facility on [DATE]. The facility did not notify the Ombudsman of R4's discharges to the hospital. On 10/23/24 at 11:16 AM, Surveyor received a copy of an e-mail from Social Services Director (SSD) I that was sent on 10/23/24 to the Ombudsman notifying the Ombudsman of unplanned discharges from May-October 2024. On 10/28/24 at 4:40 PM, Surveyor conducted an exit interview with NHA A, DON B and [NAME] President of Success (VP) R about Ombudsman notification. VP R indicated the Ombudsman notices did not contain residents who were transferred to the hospital and education was provided to the Social Worker.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interview and record review, the facility did not complete and submit a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days after determining a SCS had occurred for 1 of 15 residents (R) (R48) reviewed. R48 was admitted to Hospice services on 6/24/24. A Significant Change MDS assessment was not completed. This was evidenced by: R48 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy ischemic, hypertension, and congestive heart failure. In reviewing the medical record of R48, Surveyor noted the most recent MDS assessment completed was a Medicare - 5 day assessment dated [DATE]. R48 was admitted to Hospice services on 6/24/24. A Significant Change MDS assessment had not been completed. On 10/22/24 at 2:41 PM, Surveyor interviewed Director of Nursing (DON) B to provide evidence of a Significant Change MDS assessment completed when R48 transitioned to Hospice services. DON B stated DON B confirmed with the MDS Coordinator that a Significant Change MDS assessment was not completed for R48. On 10/23/24 at 1:42 PM, Surveyor requested a policy on Significant Change MDS assessments from DON B who stated the facility did not have a policy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented for each resident (R) within 48 hours of admission for 1 of 14 residents reviewed (R49). R49 was admitted to the facility on [DATE]. A baseline care plan was not implemented in a timely manner. This was evidenced by: R49 was admitted to the facility on [DATE] and was discharged on [DATE]. R49's diagnoses included encounter for other orthopedic aftercare, diabetes mellitus type 2, weakness abnormalities of gait and mobility, emphysema, cervical disc disorder with myelopathy, hypertension, paroxysmal atrial fibrillation, anxiety disorders, behavioral and emotional disorder, social phobia, stress incontinence, history of malignant neoplasm of breast, and nicotine dependence. Surveyor reviewed R49's medical record and was not able to identify that a baseline care plan was developed. On 10/24/24 at 1:43 PM, Surveyor interviewed Director of Nursing (DON) B about the development of R49's baseline care plan. DON B indicated she could not find the documents. When Surveyor asked if a baseline care plan should have been completed within 48 hours, DON B indicated a baseline care plan should have been completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31086 Based on interview and record review, the facility did not develop and implement a comprehensive care plan for each resident (R) to meet medical, nursing, and psychosocial needs identified for 2 of 15 sampled residents (R35 and R23). R35 did not have a sleep hygiene care plan developed when R35 was prescribed medication to promote sleep. R23 did not have a comprehensive care plan for skin integrity. This was evidenced by: The facility's policy titled Comprehensive Care Plan, revised 9/23/22, states in part: .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment .5. The comprehensive care plan will be reviewed and revised as appropriate by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and as needed with changes in condition. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Example 1 R35 was admitted to the facility on [DATE] with diagnoses of Crohn's disease, chronic kidney disease stage 4, osteoporosis, type 2 diabetes mellitus, atherosclerotic heart disease, and transient ischemic attack. A Quarterly Minimum Data Set (MDS) assessment, dated 9/10/24, documented R35 had no impairments to extremities and required partial to moderate assist of staff for activities of daily living (ADLs), including toileting, dressing, and hygiene. A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated R35 was cognitively intact. R35's physician orders documented an order written 6/3/24 for trazadone HCl Oral Tablet (Trazodone HCl) Give 100 mg by mouth one time a day for Insomnia. Surveyor reviewed a sleep assessment from 11/29/23 that did not contain a score or section for teaching and care planning. Surveyor reviewed R35's comprehensive care plan and was unable to identify a sleep hygiene care plan with interventions to promote sleep. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 4:30 PM, Surveyor interviewed Director of Nursing (DON) B about a sleep hygiene care plan for R35 with interventions to promote sleep. DON B indicated the 11/29/23 sleep assessment was not completed with care plan interventions. Surveyor reviewed with DON B that a care plan for sleep hygiene was not developed with non-pharmacological interventions to promote sleep when trazadone was prescribed for sleep. 46694 Example 2 R23 was admitted to the facility on [DATE] with a BIMS assessment score of 15 out of 15 which indicated R23 was cognitively intact. R23 had diagnoses including venous insufficiency (a condition in which the leg veins don't allow blood to flow back to the heart). R23 had physician orders that included: (Medical Doctor) follows resident for wound care. Wound care team to complete wound care. If wound care team is not here, floor nurses are to complete treatments; and enhanced barrier and contact precautions due to methicillin susceptible staph aureus (MSSA). A non-pressure weekly wound tracker started on 2/2/24 stated in part: Type of wound: venous stasis Length 11.6, width 12.0, depth 0.2 Granulation 70%, slough 39% Serous drainage moderate. R23's latest non-pressure weekly wound tracker dated 10/16/24 stated in part: Type of wound venous stasis ulcers to inner right ankle Length 0.7, width 0.7, depth 0.1 Wound edges healed Summary of findings healed. On 10/21/24 at 10:39 AM, Surveyor noted a wound on R23's right inner ankle with no dressing and blood stains on R23's left sock. R23 stated, That is because I have my legs crossed and the wound on my right ankle got my left sock dirty. On 10/23/24 at 8:06 AM, Surveyor asked DON B for a skin integrity care plan for R23 who had venous stasis dermatitis and open leg wounds. DON B replied, I will get that for you. On 10/23/24 at 11:00 AM, Surveyor reviewed R23's care plans and did not see a skin integrity care plan for R23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 11:07 AM, Surveyor asked DON B to show R23's skin integrity care plan to Surveyor. When DON B went on the computer, DON B realized R23's skin integrity care plan was a temporary care plan and was resolved and removed from R23's plan of care. DON B replied, That is our oversight. I will put one (care plan) in now.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility did not ensure a resident (R) who was discharged from the facility received a discharge summary that included a recapitulation of the resident's stay for 1 of 1 residents reviewed (R49). R49 was discharged from the facility on 8/9/24. R49's medical record did not contain a recapitulation of stay. This was evidenced by: R49 was admitted to the facility on [DATE] with diagnoses of other orthopedic aftercare, diabetes mellitus type 2, weakness abnormalities of gait and mobility, emphysema, cervical disc disorder with myelopathy, hypertension, paroxysmal atrial fibrillation, anxiety disorders, behavioral and emotional disorder, social phobia, stress incontinence, history of malignant neoplasm of breast, and nicotine dependence. Review of R49's medical record documented R49 was admitted to the facility from an acute hospital following a C3-C6 laminectomy and planned to discharge to home. On 8/9/24, R49 chose to discharge home prior to the end of R49's skilled services. Surveyor reviewed R49's medical record and did not identify a recapitulation of R49's stay at the facility. On 10/24/24 at 1:43 PM, Surveyor interviewed Director of Nursing (DON) B about a recapitulation of stay for R49. DON B indicated she could not find R49's recapitulation of stay and believed it was not completed. When Surveyor asked if it was expected to be completed, DON B indicated a recapitulation of stay should have been completed.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, interview and record review, the facility did not ensure 2 of 4 residents (R) reviewed for pressure injuries (PI) (R151 and R32) received care consistent with professional standards of practice to prevent the development of a new pressure injury and promote healing of existing PIs. R151 was admitted to the facility with a sacral PI and was assessed to be at risk for PI development. R151 developed one unstageable PI on 10/16/24 and three unstageable PIs on 10/18/24. R151's care plan for PI interventions was not developed until 10/18/24 and not updated until 10/23/24 with interventions to off-load pressure areas to R151's bilateral lower extremities and sacral wound. The facility's failure to develop a care plan and implement interventions to off-load pressure to a resident's bilateral lower extremities and sacral wound created a finding of immediate jeopardy that began on 10/18/24. Nursing Home Administrator (NHA) A was notified of the immediate jeopardy on 10/28/24 at 3:30 PM. The immediate jeopardy was removed on 10/28/24; however, the deficient practice continues at a scope/severity level G (actual harm/isolated) as evidenced by the following example for R32. R32 had an existing stage IV pressure injury that developed 8.5 centimeters (cm) tunneling on the left hip and a stage IV pressure injury on the coccyx. R32 had wound vac therapy and multiple surgical debridements. The facility did not complete weekly pressure injury assessments, did not complete multiple treatments, and did not offload R32 as the care plan instructed. In addition, R32 missed wound clinic appointments on 8/14/24, 9/11/24, and 10/8/24. This is evidenced by: Guidelines from the National Pressure Injury Advisory Panel (NPIAP) Quick Reference Guide 2019 indicate in part: 2.1 Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries: As soon as possible after admission/transfer to the health care service .5.1 Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated .5.5 Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved .6.3 For individuals with a Category/Stage III or greater heel pressure injury, elevate the heels using a specifically designed heel suspension device offloading the heel completely in a way as to distribute the weight of the leg along the calf .NPIAP Classification Unstageable Pressure injury: Obscured full thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed . Example 1 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151 was admitted to the facility on [DATE] with diagnoses including multiple fractures of ribs, left side, chronic obstructive pulmonary disease (COPD), emphysema, anemia, hypo-osmolality and hyponatremia, atrial fibrillation, chronic kidney disease stage 3, anticoagulants, personal history of transient ischemic attack, atherosclerotic heart disease, peripheral vascular disease, congestive heart failure, prediabetes, and cardiac pacemaker. Hospital patient demographics, dated 10/10/24, documented an active wound on the posterior sacrum first assessed on 10/03/24 with the primary wound being a skin tear. An admission evaluation completed on 10/10/24 documented no skin impairments were present. The comments section documented, Bandage on lower back clean and dry. Bruising on (right) arm. Large Bruising noted to (left) hip area. Coban on (right) FA. R151's Admission Minimum Data Set (MDS) assessment, dated 10/16/24, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated R151 had moderately impaired cognition. The MDS documented R151 had impairment to both lower legs and required partial/moderate assistance of staff for toileting, and upper and lower body cares. The MDS documented R151 was at risk for pressure injuries and had 2 unstageable pressure injuries with slough and or eschar. The MDS indicated R151 did not have a turning or repositioning schedule and did not refuse cares. R151 was discharged home on 10/26/24. The facility completed a Braden scale pressure risk skin assessment on 10/11/24 with a score of 18 which indicated R151 was at risk. (The Braden scoring scale is: 15-18 at risk, 13-14 moderate risk, 10-12 high risk, 9 or below very high risk.) The facility completed a Braden assessment on 10/23/24 with a score of 20 which indicated R151 was not at risk. The facility did not develop a care plan addressing this risk until 10/18/24. A pressure injury weekly tracker, dated 10/13/24, documented an unstageable pressure injury on the left buttock that measured 3.5 cm x 4.5 cm with slough and light serosanguinous drainage. A physician order, dated 10/13/24, documented, Reposition every 2 hours and prn (as needed). The order did not mention offloading the buttock PI when repositioning R151. A wound clinic note, dated 10/16/24 at 9:56 AM, documented, Pressure sacrum unstageable due to necrosis, measuring 3.0 cm X 3.5 cm x 0.1 cm with moderate serous drainage. Pressure left lateral foot unstageable DTI (deep tissue injury) with intact skin undetermined thickness. Noted to be present on admission per staff. The PI measured 1.3 cm x 1.5 cm and the depth not measurable. Skin is intact with purple/maroon discoloration. Apply skin prep twice daily for 30 days. This is the first documentation of the wound. A Pressure Injury Weekly Tracker, dated 10/16/24 at 2:07 PM, indicated: Sacrum PI measured 3 cm x 3.5 cm x 0.1 cm, unstageable with necrotic tissue, 20% granulation tissue, 80% slough, 100% necrotic tissue, and had moderate serous drainage. On 10/16/24 at 2:30 PM, date acquired 10/16/24 in-house, R151's left lateral foot PI measured 1.3 cm x 1.5 cm unstageable with 100% necrotic tissue with no drainage, dark red or purple and/or non-blanchable. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151 had the following physician orders: 10/16/24: Heel protectors to be on while in bed. 10/16/24: Air mattress needed for resident. 10/16/24: Wound type: Pressure wound. Location: left buttock/sacrum. Wound cleansing agent: normal saline or wound cleanser. Primary dressing type: Calcium alginate with silver, zinc to peri-wound. Cover dressing: Foam dressing. Frequency of dressing changes: Three times per week Monday-Wednesday-Friday and PRN. Expected duration of need: TBD (to be determined) one time a day every Mon, Wed, Fri for Wound Care and PRN AND as needed for if dressing is soiled or no longer intact. The facility ordered an alternating low air loss mattress on 10/16/24 which was placed on R151's bed on 10/17/24. On 10/16/24, the facility ordered liquid protein 30 milliliters (mls) two times per day. A Pressure Injury Weekly Tracker, dated 10/18/24, indicated: Left lateral foot (acquired on admission), unstageable PI measured 4.3 cm x 2.2 cm with 50% necrotic tissue with no drainage. The first PI weekly tracker assessment of the left lateral foot on 10/16/24 documented the PI was acquired in the facility. On 10/18/24, left plantar foot (acquired on admission), unstageable PI measured 2.2 cm x 1.7 cm, with necrotic tissue and no drainage. This is the first documentation of this PI. On 10/18/24, left heel (acquired admission), unstageable PI measured 1.6 cm x 0.7 cm with necrotic tissue and no drainage. This is the first documentation of this PI. On 10/18/24, right plantar foot (acquired on admission), unstageable PI measured 3.5 cm x 6.5 cm with necrotic tissue and no drainage. This is the first documentation of this PI. R151's care plan was first developed on 10/18/24 with the focus area: The resident has unstageable to heel and unstageable to sacrum pressure ulcer or potential for pressure ulcer development (related to) immobility. Interventions implemented on 10/18/24 included: Administer medications as ordered; Administer treatments as ordered; and Monitor for effectiveness. Interventions implemented on 10/23/24 included: Elevate bilateral lower extremities up on pillow to off load pressure area; Reposition to right side with pillow to off load sacral wound; Please chart refusals from resident; Follow facility policies/protocols for the prevention/treatment of skin breakdown. (The repositioning and heel interventions were added 13 days after R151's admission.) A physician order, dated 10/19/24, stated to apply skin prep to right plantar foot, left plantar foot, left heel, and left lateral foot for wound care two times a day. A nursing note, dated 10/19/24 at 10:00 PM, stated, Behavior Note: Note Text: Resident refused to be turned and repositioned on the evening shift. Went in at least every 2 hours but was in there more than that to ask him to be repositioned and he was refusing. Talked to him about the importance of being repositioned and he said that he already has a sore bottom so what is going to make the difference now. Explained to him that if he just stays in one position then the sore is going to get worse. He said for right now he does not want to be turned or repositioned. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151's medical record did not contain a risk versus benefits statement for refusals of repositioning. R151's behavior monitoring charting indicated no refusals of cares and no documented behaviors. R151's nursing documentation did not indicate R151 refused care or treatments. On 10/21/24 at 11:22 AM, Surveyor interviewed R151's family member about his care. The family member stated R151 came into the facility with one PI on the butt and developed one PI on his foot. The facility changed R151's mattress, but the pillows are on the chair and staff don't elevate his heels. The wound doctor comes in to do the dressing. On 10/22/24 at 5:20 AM, Surveyor observed R151 in bed with his feet directly on the mattress and the pillows on his dresser. On 10/22/24 at 5:39 AM, Surveyor interviewed Registered Nurse (RN) P about R151's positioning and heel protectors. When Surveyor asked RN P to verify if heel protectors were on R151, RN P verified R151 did not have heel protectors on and there were none in the room. RN P checked R151's feet which were pressing on the foot board of the bed and directly on the mattress. When RN P asked R151 if he remembered if he had been wearing the heel boots, R151 said no. When RN P asked if R151 wanted a pillow under his legs, R151 willfully lifted his legs. RN P placed a pillow under R151's legs and stated she would get Certified Nursing Assistant (CNA) Q to assist with a boost. At 5:44 a.m., RN P and CNA Q boosted R151 so his feet were not touching the foot board. On 10/22/24 at 9:22 AM, Surveyor observed RN H provide wound care to R151's feet which were pressing on the foot board. RN H removed R151's socks and applied skin prep to the right foot plantar area, left foot plantar, lateral, and heel. Surveyor noted an area on the right foot that was small and dark with a callused area, the left lateral foot just below 5th digit was black and dry, the left plantar was small, dark, and callused, and the left heel had a small dark area. On 10/22/24 at 10:10 AM, Surveyor interviewed R151 about his feet pressing on the foot board and asked if staff elevated his heels with pillows or if he wore boots. R151 indicated staff have not put the pillows under his legs and the pillows are always sitting on the shelf. R151 indicated someone told him that he shouldn't wear the boots and his feet would heal better without them. R151 could not remember who told him. R151 stated his feet didn't hurt but they press on the foot board when the head of the bed is up and he slides down in bed. Staff boost R151 up when asked. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 1:15 PM, Surveyor observed RN M remove Mepilex from R151's buttock. The area had 100% slough and a red peri-wound. RN M stated the area was unstageable with 100% slough. The area measured 2.9 cm x 3.2 cm. RN M assessed R151's left lateral foot below the 5th digit on the pad of the foot and measured 1.8 cm x 1.3 cm. The area appeared dark in color and dry with no raised area or appearance of being open. RN M measured the left foot plantar area to be 2 cm x 1.8 cm. Surveyor observed a small red DTI area with hard skin. RN M measured the left heel to be 0.6 cm x 1.3 cm. Surveyor observed a small red DTI area with hard skin. RN M measured the right foot plantar area to be 3.0 cm x 3.0 cm. Surveyor observed a small red DTI area with hard skin. RN M indicated all the areas were unstageable. RN M looked for boots for R151. When RN M asked if he had been wearing the boots, R151 stated no. Surveyor told RN M that Surveyor observed boots in R151's closet on the top shelf. When RN M got the boots, R151 refused. When RN M asked why R151 didn't want the boots and if they were hot, R151 stated he could not remember who told him that he would be better off not wearing the boots. RN M educated R151 that wearing the boots would help his feet from hitting the foot board and causing more issues. R151 agreed to wear the boots. RN M applied the boots and placed a pillow under R151's calves. On 10/23/24 at 1:40 PM, Surveyor interviewed RN M about R151's documentation of PIs and asked if the PIs were facility-acquired. RN M indicated that she was not sure if the PIs were facility-acquired and thought the PIs were initially assessed upon admission. Surveyor stated the left lateral foot was initially noted to be facility-acquired but the assessments after that documented the PIs were present upon admission. RN M indicated she wasn't sure when she did the assessment so she marked the wounds as present upon admission. RN M indicated she would change the assessments to indicate the PIs were facility-acquired. On 10/24/24 at 8:24 AM, Surveyor interviewed Director of Nursing (DON) B and asked if R151's PIs were avoidable or unavoidable. DON B indicated all PIs are avoidable. On 10/28/24 at 11:57 AM, Surveyor interviewed RN O (the facility's MDS Coordinator) about R151's 10/16/24 Admission MDS assessment that coded 2 PIs on admission. RN O indicated the coding was based on information in the chart from admission and the wound clinic note. Surveyor and RN O reviewed the facility's admission evaluation documentation that indicated R151 did not have any skin impairments. There was a PI weekly tracker completed on 10/13/24 of the left buttock and a non-pressure injury to the right buttock. On 10/16/24, the PI weekly tracker assessments stated a sacrum PI and left lateral foot PI were acquired on 10/16/24 in house. A hospital demographics note on 10/10/24 documented the sacrum but did not document the left lateral foot. RN O indicated the wound clinic note documented the left lateral foot was present upon admission. Surveyor stated the wound note documented noted to be present on admission per staff but there was no documentation that staff assessed a left lateral foot PI until 10/16/24 after the wound clinic evaluation. RN O indicated she understood and stated the MDS should have been coded with 1 PI to the sacrum on admission and 1 PI to the left lateral foot facility-acquired and indicated the MDS would be updated. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/28/24 at 12:46 PM, Surveyor interviewed Nurse Practitioner (NP) N about R151 having PIs on admission. NP N reviewed R151's admission notes and did not see any documentation of R151 having PIs on his feet. NP N indicated she would have reviewed the hospital discharge note and would follow-up with R151 when next seen. NP N reviewed the hospital discharge note and noted there were no PIs on R151's feet and the only skin area noted was the sacrum. NP N indicated she should be notified by the facility if there was a change in condition and expected to be notified of the start of a PI. NP N reviewed her communication with the facility and dictation and stated there was no documentation of R151 having any PIs. NP N indicated she was not aware that R151 had any PIs on his feet. NP N indicated she would have reviewed the wound clinic orders, ensured the facility was following the orders, and would have assessed R151 on her next visit. NP N indicated the only time R151 refused care was related to the use of oxygen upon discharge. NP N indicated R151 told her everything was fine and he had no pain or concerns. The failure to initiate a care plan and implement interventions to prevent pressure injuries resulted in serious harm for R151 and led to a finding of immediate jeopardy. The facility removed the jeopardy on 10/28/24 when it completed the following: 1. Completed wound assessments for residents with pressure injuries and skin assessments for all in-house residents. 2. Updated care plans with pressure prevention interventions. 3. Educated licensed nursing staff on the facility's policy, assessing residents upon admission, implementing pressure injury prevention interventions, implementing treatment orders, documentation, and provider notification. 4. Educated nursing and therapy staff on implementing pressure injury prevention interventions. 5. Implemented audits to ensure compliance. 40590 Example 2 R32 had diagnoses including fracture of left pubis (admission diagnosis), moderate protein calorie malnutrition, and diabetes mellitus type 2. R32's MDS assessment, dated 9/5/24, indicated R32 had no behaviors or rejection of care and had two stage 4 unhealed pressure injuries. R32 had a BIMS score of 14 which indicated R32 was cognitively intact; however, R32 was a poor historian. R32's care plan, initiated 4/11/24, indicated R32 had potential/actual impairment to skin integrity and was at high-risk due to multiple open wounds (revised 10/22/24). Care plan interventions on admission included: The resident will maintain or develop clean and intact skin by the review date; Keep skin clean and dry. Use lotion on dry skin as ordered/desired/needed; Meds/labs/treatments as ordered. An active physician order with a start date of 5/23/24 stated, Reposition every hour, document refusals, three time a day for repositioning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Braden Scale assessment, dated 9/1/24, had a score of 12.0 which indicated R32 was at high risk for pressure injuries. R32 had wound care to be done every Monday and Friday by the facility and every Wednesday in the wound clinic. On 7/24/24, R32 was noted to have stage 4 pressure injuries on the coccyx/sacrum and left trochanter/hip. A facility Pressure Injury Weekly Tracker showed: Sacrum 2.4 x 1.4 x 4.2 stage 4, necrotic Left hip: No wound measurements on assessment by the facility Wound Clinic (WC) measurements indicated: Coccyx: 2.4 x 1.4 x 4.2, foul odor, exposed bone and muscle, stage 4 Left hip: 4.0 x 3.7 x 5.1, with tunnel, stage 4 (there was no measurement of the tunnel) WC treatment orders indicated: Wash with Dakin's 0.25% solution. Skin prep to peri-wounds. Bridge wound vac to cover both wounds. Wound vac set to -125 mmHg (millimeters of mercury). To be changed Monday and Friday at the nursing home and Wednesdays in the wound clinic. A WC physician note indicated: No wound vac was applied or came with the patient today. We will do a dakin's wet to dry covered with 4x4 Allevyn in clinic but Nursing Home, please get the wound vac applied today. R32's Treatment Administration Record (TAR) indicated: Wet to dry dressing with normal saline and Kerlix. Skin prep around wound to protect healthy skin and cover with foam adherent dressing. To be completed TID (three times daily) and as needed until wound vac supplies arrive. The treatment was not signed out on 7/22 noon, 7/23 PM, or 7/24 PM. R32's medical record did not indicate the WC physician was updated that R32's wound vac was removed. On 7/31/24, a Pressure Injury Weekly Tracker indicated: Sacrum: 2.2 x 1.4 x 2.5 stage 4, granulation Left hip: 3.2 x 3.2 x 6.3 stage 4, granulation (increased depth of left hip) There were no new interventions on R32's care plan. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	WC treatment orders indicated: Wound vac-wash with Dakin's 0.25% solution. Apply vacuum-assisted closure device at -125 mmHg. With green foam to left hip and coccyx (note change in treatment to green foam). With bridge dressing to cover both wounds. Apply skin prep to peri-wound and transparent semi-permeable cover dressing. One time a day every Monday, Wednesday, Friday for wound care. Wound clinic to change wound vac on Wednesdays. On 8/7/24, WC measurements indicated: Coccyx: 2.2 x 1.9 x 2.8, with foul odor Left hip: 3.3 x 3.4 x 3.5, with tunnel 8.0 cm A nurses note, dated 8/11/24 at 5:40 PM, stated, Resident refused repositioning at 1600 (4:00 PM); agreed to lift up on arms to give buttocks a break from sitting but refused to lay down and get off buttocks. This was the first documented refusal by R32 since admission on 4/11/24. There were no facility weekly wound assessments with measurements or wound clinic notes in R32's record for 8/14/24. R32 was supposed to have a wound clinic appointment on 8/14/24. A Nursing Skin/Wound Note, dated 8/15/24, stated, Note Text: wound care completed by wound care nurse. Wound vac dressing to hip and coccyx changed. Measurements taken. Coccyx measures 2.3 cm x 3.5 cm x 2.0 cm. Left hip measures 3.1 cm x 3.1 cm x 8.4 cm. (increased depth) On 8/21/24, a Pressure Injury Weekly Tracker indicated: Sacrum: 2.2 x 1.9 x 2.8 stage 4, granulation Left hip: 3.3 x 6.4 x 3.5 stage 4, granulation, necrotic fat, necrotic muscle, debrided, with tunnel at 11:00, strong odor (increased width) WC measurements indicated: Coccyx: 1.8 x 1.3 x 2.5 with foul odor Left hip: 2.5 x 2.6 x 3.5 with tunnel 6 cm (Inconsistent measurements from wound clinic compared to facility weekly PI tracker) A WC treatment order on 8/21/24 indicated: Wash with Dakin's 0.25% solution. Skin prep peri-wounds. Apply Puracol collagen to the base of the wounds (whole pack to each wound). [NAME] foam to areas that are visible. Black foam on top of white foam (foams must be touching within the wound). Bridge vac to cover both wounds. Wound vac set to -125 mmHg. To be changed Monday and Friday at the nursing home and Wednesdays in the wound clinic. The wound care treatment was changed on 8/21/24 when the wound increased in size. Puracol collagen was added. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R32's treatment was not signed out on 8/23/24. A Nursing Skin/Wound Note, dated 8/25/24,stated, Note Text: Wound vac alarming with a leak alert. Wound vac removed and wounds to right hip and coccyx packed with dakins soaked gauze and to be changed BID (twice daily). Wound vac canisters ordered. There was no evidence the wound physician was updated. On 8/28/24, Pressure Injury Weekly Tracker measurements were the same as the wound clinic and indicated: Coccyx: 2.2 x 1.6 x 2.5 foul odor Left hip: 2.7 x 2.7 x 3.5 with tunnel 8.5 cm The wound care treatment order was the same as 8/21/24. R32's TAR indicated: Pack coccyx and right hip wounds with Kerlix damp with quarter strength Dakin's BID until wound vac is able to be put back on. The treatment was not signed out on the 8/30 PM shift and the order identified the wrong hip. A Nursing Skin/Wound Note, dated 8/29/24, stated, Note Text: Wound care completed by wound care nurse. Wound Vac not on, waiting on white foam, wet to dry applied. A Nursing Skin/Wound Note, dated 8/31/24, stated, Note Text: Wound care completed by this writer. Wound Vac applied. On 9/4/24, a Pressure Injury Weekly Tracker indicated: Sacrum 2.4 x 2.1 x 2.5 stage 4, granulation Left hip: 2.3 x 2.4 x 6.0 stage 4, undermined 6 cm (improved) A WC physician note indicated: Left hip with undermining has a 6 cm tunnel going cranially. The ulcer is stage 4 with necrotic muscle, necrotic fat, necrotic connective tissue. The coccygeal ulcer has some necrotic muscle, necrotic fat present but improved and does not probe to bone but only muscle. A Wound Debridement physician note indicated: Wound debridement to remove necrotic fat, necrotic muscle, necrotic connective tissue, tenacious yellowish slough, necrotic fascia, and fibrin from base of coccyx and left ischium wound. Coccyx pre-debridement measurement: 2.4 x 2.1 x 2.5 with foul odor Left hip pre-debridement measurement: 2.3 x 2.4 x 6.0 with tunnel. WC measurements post debridement indicated: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Coccyx: 2.1 x 1.9 x 2.5 stage 4 with foul odor Left hip: 2.1 x 2.1 x 9.0 with tunnel The WC treatment order was the same as 8/21/24. R32's treatment was not signed out on 9/2, 9/6, 9/11, or 9/16. A nurses note, dated 9/7/24 at 5:08 AM, stated, Resident refused to be toileted or repositioned on last rounds. This was the second documented refusal and last documented refusal R32's medical record. On 9/11/24, there were no weekly in-house wound assessments or at the wound clinic. On 9/18/24, a Pressure Injury Weekly Tracker indicated: Sacrum 2.1 x 1.9 x 2.5 stage 4 Left hip: 2.1 x 2.1 x 9.0 stage 4, granulation with foul odor, tunnel 9 cm deep R32's treatment was not signed out on 9/20, 9/23, or 9/25. On 9/25/24, a Pressure Injury Weekly Tracker showed same measurements as the wound clinic: Coccyx: 2.1 x 1.9 x 2.0 with foul odor (improved) Left hip: 1.9 x 2.0 x 9.0 with tunnel (improved) On 9/30/24, a Pressure Injury Weekly Tracker indicated: Sacrum 1.0 x 0.9 x 3.0 stage 4, granulation 34-66%, necrotic 34-66% Left hip: 1.2 x 1.5 x 9.0 stage 4, granulation tissue 34-66%, necrotic tissue 34-66% WC measurements indicated: Coccyx: 1.0 x 0.9 x 3.0 with foul odor (improved length x width) Left hip: 1.2 x 1.5 x 9.0 with tunnel (improved length x width) A WC treatment order indicated: Left hip wound vac is on hold for left hip 9/25/24. Wash with Dakin's 0.25% solution. Pack with gauze soaked in Dakin's 0.25% solution (wring out so it's damp but not dripping). Apply 6 x 6 Allevyn or similar dressing over the wound. Clean and change dressing daily. On 10/2/24, WC measurements indicated: Coccyx: 1.1 x 1.2 x 2.5 with foul odor (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Left hip: 3.6 x 3.1 x 4.0 with 7.5 cm tunnel R32's treatment was not signed out on 10/3, 10/5, 10/9, or 10/10. On 10/9/24, there was no in-house weekly wound assessment or wound clinic note in R32's medical record. R32 was supposed to have a wound clinic appointment on 10/9/24. On 10/16/24, WC measurements indicated: Coccyx: 0.9 x 0.6 x 1.5 foul odor (improved) Left hip: 2.2 x 2.1 x 3.2 with tunnel 6.0 cm (improved) A WC physician note indicated: Continue wound vac for both wounds but the hip ulcer may have to be opened up further. On 10/22/24, DON B was made aware that Surveyor wanted to observe R32's dressing change on 10/23/24. DON B stated the dressing change would not done in-house on 10/23/24 because R32 had a wound clinic appointment. On 10/23/24, WC measurements indicated: Coccyx: 0.7 x 0.8 x 2.0 foul odor Left hip: 3.1 x 1.9 x 3.5 with tunnel 6.5 cm A WC Surgical Debridement note indicated: Sacrum: Necrotic muscle, necrotic fat, necrotic connective tissue, tenacious yellowish slough, necrotic fascia, and fibrin from the base of the wound removed. Left Hip: Necrotic muscle, necrotic fat, necrotic connective tissue, yellowish slough, and fibrin from the base of the wound removed. Has tunneling at 7.5 cm deep. Left hip measurement pre-debridement: 3.1 x 1.9 x 3.5 Coccyx measurement pre-debridement: 0.7 x 0.8 x 2.0 A WC treatment order indicated staff should continue the same left hip/coccyx treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/22/24 at 7:03 AM, Surveyor observed R32 in bed asleep. R32 was positioned on the right side facing the doorway. At 7:37 AM, Surveyor observed Certified Nursing Assistant (CNA) L exit R32's room with R32 in a wheelchair and take R32 to the dining area for breakfast. At 7:42 AM, Surveyor observed R32 in the dining room eating breakfast independently. At 8:05 AM, Surveyor observed staff take R32 to therapy. At 9:10 AM, R32 returned from therapy. At 9:16 AM, Surveyor observed CNA L enter R32's room and ask if she needed anything. R32 stated she needed to go to the bathroom. CNA L retrieved gloves from a bin in the hallway. At 9:18 AM, Surveyor observed CNA L exit R32's room and don personal protective equipment (PPE) in the hallway. R32 was not repositioned during those 2 minutes. At 9:21 AM, Surveyor observed CNA L state to R32, I will come back for you and exit R32's room. At 9:44 AM, Surveyor observed staff take R32 to a resident council meeting. At 11:00 AM, Surveyor observed R32 in a wheelchair watching TV in her room. At 11:15 AM, Surveyor observed a CNA take R32 to the dining room. At 12:19 PM, Surveyor observed a CNA take R32 back to her room. Surveyor observed R32 in her wheelchair watching TV from 12:20 PM to 2:45 PM and noted R32 was sitting in her chair from 7:37 AM until she was last observed at 2:45 PM which was approximately 7 hours. An observation of R32's wheelchair cushion on 10/24/24 at 6:49 AM indicated R32 did not have a pressure reducing cushion. The cushion was labeled Comfort Curve. Key specs of Comfort Curve cushion use state, Your Risk of Skin Breakdown: Low. The cushion was not a pressure relieving cushion for the prevention of or promotion of healing pressure injuries. On 10/24/24 at 7:55 AM, Surveyor interviewed R32 regarding wound care and repositioning. R32 stated, The wound is on my butt, and they are changing the bandages on my butt. R32 also stated, They change the bandage on Wednesday, and they use a ruler to take measurements. When asked if staff educated R32 on the risks and benefits of repositioning, R32 stated, Yes. R32 had a poor memory and could not distinguish between facility and wound clinic staff regarding measurements and dressing changes. R32 also could not recall how staff repositioned her in bed or how often. On 10/24/24 at 8:05 AM, Surveyor interviewed CNA L and CNA K regarding R32's wound care and repositioning. CNA L stated, We wash her up. We lotion her and reposition her every 2 hours. CNA K stated, We wash her and lotion her skin, do skin inspections on her bottom to make sure she doesn't have pressure sores. We reposition her from her left side to her right side and keep her dry. On 10/28/24 at 3:35 PM, Surveyor interviewed DON B and Assistant Director of Nursing (ADON) J regarding R32's wound care and assessments. Surveyor shared concerns that the facility's PI measurements were identical to the wound clinic's measurements each week. ADON J stated the facility used the wound clinic physician's wound assessments and measurements for their weekly wound assessments and indicated they had not been doing their own weekly PI assessments on Mondays or Fridays with dressing changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/29/24 at 12:00 PM, Surveyor interviewed Registered Nurse (RN) Q who was R32's wound clinic case manager. RN Q confirmed R32 saw the wound clinic physician every Wednesday for wound care and debridement. RN Q stated there were three wound physicians and they rotated for R32's wound care. RN Q stated R32 missed wound care appointments on 8/14, 9/11, and 10/8. RN Q stated she felt R32's wounds had gotten better recently but had concerns about wounds in the past. RN Q stated the wound clinic was not updated by the facility that R32's wound vac was removed or that there were concerns with R32's wound care. RN Q stated she could not give an opinion on why the wounds had worsened from 7/24 to 9/18. RN Q stated she put suggestions for better off-loading on R32's wound clinic follow-up instructions.

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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** 46694 Based on observation, interview, and record review, the facility did not ensure residents (R) who were fed by enteral means received the appropriate treatment to prevent complications for 1 of 2 residents (R40) observed for enteral feeding. R40 received nutrition via enteral feeding. Staff did not ensure R40's gastronomy (G)-tube was appropriately placed prior to the administration of flushes and feedings. This was evidenced by: The American Association of Critical Care Nurses, April 2016, Initial and Ongoing Verification of Feeding Tube Placement in Adults advises: Unfortunately, feeding tubes can become dislocated during use. For this reason, it is necessary to monitor tube location at regular intervals while the tube is being used for feedings or medication administration. Observing for change in external tube length .Reviewing routine chest and abdominal radiography reports .Observing for changes in volume of feeding tube aspirates .Testing pH and observing the appearance of feeding tube aspirate if feedings have been off for at least 1 hour . The facility's policy titled, Verifying Placement of Tube Feeding, revised 8/10/22, states in part: .c. Verify tube placement: i. For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, or ii. Measure length of tube from insertion site to tip upon new admission to facility or with a new/change in the tube and record the length. Check and record the length of the tube prior to feeding as per facility policy. Notify supervisor and/or practitioner if abnormal finding. R40 was admitted to the facility on [DATE] with diagnoses of dysphagia (swallowing difficulties) following a stroke and esophageal obstruction (a malformation in which the esophagus is interrupted and forms a blind-ending pouch rather than connecting normally to the stomach). R40's physician orders included to check placement of the feeding tube by gently tugging on the tube and verify marking is in the same place before medication feeding and or flushing. On 10/22/24 at 12:24 PM, Surveyor observed Registered Nurse (RN) H provide a tube feeding to R40. Surveyor observed RN H inject a 60 milliliter (ml) syringe of water into R40's feeding tube. When Surveyor asked RN H how she checked the placement of the tube, RN H replied, I injected the flush water into the tube and listened for the 'whoosh' sound. When Surveyor asked RN H if RN H checked for any marking or measured the length of the tube, RN H replied, No, we listen to check placement. On 10/23/24 at 10:45 AM, Surveyor explained to Director of Nursing (DON) B the observation made of the tube feeding performed by RN H on 10/22/24. DON B replied, The nursing staff should know our policy and the checking the placement of the feeding tube. DON B also stated, I am going to start education for all of the nurses caring for this resident.

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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. 47657 Based on observation and interview, the facility did not ensure staff followed procedures for the accurate administration of insulin for 1 of 1 resident (R) (R25). R25 was prescribed insulin. During an observation on 10/23/24, staff drew insulin from a pre-filled insulin pen to administer to R25. This was evidenced by: The facility's policy titled Medication Administration - Subcutaneous Insulin, dated 1/2023, did not indicate if using an insulin syringe to draw insulin out of a pre-filled insulin pen was appropriate. The Institute for Safe Medication Practices: Guidelines for Optimizing Safe Subcutaneous Insulin Used in Adults states: Changes in an insulin regimen method of administration may affect glycemic control and predispose to hypoglycemia or hyperglycemia .An insulin pen cartridge is never used as a vial .Using an insulin pen cartridge in an unintended manner as a single or multi-dose vial can lead to contamination, as well as dosing errors, drug mix-ups, and other types of medication errors .Using an insulin cartridge as a vial is also not supported by the ASHP guidance document on safe insulin use. On 10/23/24 at 7:22 AM, Surveyor observed Registered Nurse (RN) D during medication pass. RN D used an insulin syringe to draw 10 units of insulin out of a pre-filled insulin pen provided from the pharmacy. On 10/23/24 at 9:45 AM, Surveyor interviewed R25 regarding the observation of RN D drawing insulin out of a pre-filled insulin pen. R25 indicated she felt her blood sugars were more controlled doing it that way, but now her blood sugars were going back up. R25 indicated she was aware the facility requested vials but the pharmacy kept sending pens and she was not sure why. On 10/23/24 at 10:28 AM, Surveyor interviewed Director of Nursing (DON) B regarding the practice of drawing up insulin from an insulin pen. DON B stated she thought the facility had an order for that. Surveyor requested DON B provide evidence of the order and that is was indicated on R25's plan of care. On 10/23/24 at 11:55 AM, DON B indicated the facility's policy did not recommend to draw insulin from insulin pens. On 10/23/24 at 12:12 PM, Surveyor interviewed Pharmacist (PH) E via telephone regarding Surveyor's observation of staff drawing insulin from an insulin pen with an insulin syringe to administer to R25. PH E stated PH E was not aware R25 received insulin using that technique. Upon reading the order in R25's Medication Administration Record (MAR) that stated, Please use syringes and send vials for insulins, the assumption from PH E was that R25 was getting insulin in vials. PH E stated PH E would never recommend drawing insulin out of an insulin pen as the risk was much higher for error.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility did not ensure residents (R) who were prescribed psychotropic medication were comprehensively assessed and had non-pharmacological interventions implemented to determine adequate indication for use of the medication for 1 of 5 residents reviewed (R35). R35 received trazodone (an antidepressant medication) for insomnia. The facility did not implement monitoring interventions to determine the effectiveness of the medication. This was evidenced by: The facility's policy titled Psychotropic Medications, with a reviewed/revised date of 10/24/22, reads in part: 2. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by: a. Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment. b. Identification of underlying causes (when possible) .7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs .12. The effects of the psychotropic medications on a resident's physical , mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a. During physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regimen review, c. During the Minimum Data Set (MDS) review period using the Psychotropic Med Use UDA in the electronic medical record (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters, consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care . R35 was admitted to the facility on [DATE] with a re-admission after hospital stay date of 6/4/24. R35's diagnoses included Crohn's disease, chronic kidney disease stage 4, type 2 diabetes mellitus, transient ischemic attack, fibromyalgia, restless legs syndrome, obstructive sleep apnea, polymyalgia rheumatica, and low back pain. A Quarterly MDS assessment, dated 9/10/24, documented R35 had no impairments to extremities and required partial to moderate assist of staff for activities of daily living (ADLs), including toileting, dressing, and hygiene. A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated R35 was cognitively intact. R35 had a physician order documented on 6/3/24 for Trazodone HCl Oral Tablet (Trazodone HCl) Give 100 mg (milligrams) by mouth one time a day for Insomnia. Surveyor reviewed R35's care plan and did not identify that a sleep hygiene care plan was developed to include non-pharmacological interventions to promote sleep. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R35's medical record for sleep behavior monitoring. For the last 30 days, no documentation of sleep behaviors were noted. Surveyor was unable to identify that an assessment or monitoring was completed to determine R35's sleep pattern and the effectiveness of non-pharmacological interventions. Surveyor reviewed a sleep assessment from 11/29/23 that did not contain a score or section for teaching and care planning. On 10/23/24 at 4:30 PM, Surveyor interviewed Director of Nursing (DON) B about the 11/29/23 sleep assessment. DON B indicated the assessment was not completed with a care plan and interventions. On 10/24/24 at 9:18 AM, Surveyor interviewed DON B about R35's sleep assessment and monitoring hours of sleep to determine adequate indication for the use of trazodone. DON B indicated the only sleep study conducted was in 2019 which R35 verified. When Surveyor asked what kind of sleep monitoring the facility conducted to assess the continued need for a medication to promote sleep, DON B indicated staff check on R35's ostomy bag every two hours but don't document if R35 is asleep or not. When Surveyor asked when the facility conducts audits to determine R35's sleep pattern to determine if the medication is effective, DON B indicated that would have been the last assessment and was conducted yearly. Surveyor reviewed with DON B that the last assessment completed on 11/19/23 was not completed with a care plan, did not document monitored sleep/wake times, and did not indicate if non-pharmacological interventions were effective to determine if there were adequate indications for continued use of a the medication.

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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. 46694 Based on interview and record review, the facility did not ensure food was prepared in a clean and sanitary environment which had the potential to affect over 75% of the 48 residents (R) in the facility as 2 of the residents received tube feeding. Staff did not consistently test or document parts per million (PPM) of the sanitizing solution. Staff did not consistently document refrigerator temperatures. This was evidenced by: Sanitization Solution: The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Warewashing: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On 10/21/24 9:12 AM, during an initial tour with Dietary Manager (DM) G, Surveyor asked to review the facility's sanitization logs. Surveyor noted the sanitization logs were missing PPM for the sanitization bucket, sink wash temperature, and for testing on October 11th and between October 13th and 21st. Surveyor asked to view the sanitization logs from August and September of 2024. The August sanitization log was missing PPM and sink wash temperatures for the 22nd, 29th and the 31st. The September sanitization log was missing sink wash temperatures on the 21st and 25th. Refrigerator/Freezer Temperatures: The 2022 FDA Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. On 10/221/24 at 9:13 AM, during an initial tour of the kitchen with DM G, Surveyor noted missing cold storage temperatures. The temperature log for October 2024 was missing temperatures on the 15th, 16th, 18th, 19th, and 21st. Surveyor asked to view the August and September 2024 temperature logs. The August temperature log was missing temperatures on the 1st, 29th, and 31st. The September temperature log was missing temperatures from the 15th through the 18th and on the 27th.

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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** 46694 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infection. This had the potential to affect 7 of 15 sampled residents (R) (R23, R40, R32, R151, R9, R35, and R26). Staff provided care to residents on enhanced barrier precautions (EBP) and contact precautions without the proper personal protective equipment (PPE) usage (R23, R40, R32, and R151). Staff did not follow appropriate hand hygiene when providing personal cares and wound care (R9, R35, and R26). Staff emptied a contaminated basin of water in R9's sink. This was evidenced by: The facility's policy titled Transmission-Based (Isolation) Precautions, revised 9/24/24, states in part: Contact Precautions: a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. b. Make decisions regarding private room on case-by-case basis, balancing infection risks to other residents, the presence of risk factors that increase the likelihood of transmission, and the potential adverse psychological impact on the infected or colonized resident. c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. e. Residents experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, should be placed on contact precautions even before a specific organism has been identified. f. Contact precautions will be used for residents infected or colonized with multidrug-resistant organisms (MDROs) in the following situations: a. When a resident has wounds, secretions, or excretions that are unable to be covered or contained: and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring. The facility's policy titled Enhanced Barrier Precautions, revised 8/8/24, states in part: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities (described below) and may not need to be donned prior to entering the resident's room . 4. High-contact resident care activities include: a. Dressing; b. Bathing; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tube; h. Wound care: any chronic skin opening requiring a dressing .9. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The facility's policy titled Hand Hygiene, with a reviewed/revised date of 11/2/22, reads in part: 5. Hand hygiene technique when using soap and water: .d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use clean towel to turn of the faucet .Hand Hygiene Table: .After handling items potentially contaminated with blood, body fluids, secretions, or excretions use either soap and water or alcohol based hand rub . Example 1 R23 was admitted to the facility on [DATE] with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R23 was cognitively intact. R23 had a diagnosis of venous insufficiency (a condition in which the leg veins don't allow blood to flow back to the heart). R23's physician orders included: (Medical Doctor) follows resident for wound care; Wound care team to complete wound care. If wound care team is not here, floor nurses are to complete treatments; Enhanced barrier and contact precautions due to methicillin susceptible staph aureus (MSSA). A non-pressure weekly wound tracker started on 2/2/24 stated in part: Type of wound: venous stasis Length 11.6, width 12.0, depth 0.2 Granulation 70%, slough 39% Serous drainage moderate R23's latest non-pressure weekly wound tracker dated 10/16/24 stated in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Type of wound: venous stasis ulcer to inner right ankle Length 0.7, width 0.7, depth 0.1 Wound edges healed Summary of findings healed. On 10/21/24 at 10:39 AM, Surveyor noted a wound on R23's right inner ankle with no dressing and blood stains on R23's left sock. R23 stated, That is because I have my legs crossed and the wound on my right ankle got my left sock dirty. On 10/21/24 at 11:30 AM, Surveyor observed Certified Nursing Assistant (CNA) C enter R23's room without a gown and gloves and deliver a meal tray. Surveyor observed CNA C touch R23's over-the-bed table, grab bar on the bed, and bed control. When CNA C exited R23's room, Surveyor asked CNA C if a gown and gloves were needed to deliver a meal tray for a resident on contact precautions. CNA C replied, I usually do. I would put the tray down here, gown and glove, then take the tray into this room. On 10/22/24 at 9:29 AM, Surveyor observed Social Services (SS) I enter R23's room without a gown or gloves and touch R23's over-the-bed table. When Surveyor asked SS I if it was necessary to gown and glove when entering R23's room, SS I replied, Not if I am not doing personal cares. On 10/22/24 at 11:29 AM, Surveyor observed Dietary Manager (DM) G enter R23's room without a gown or gloves and touch R23's over-the-bed table when delivering a lunch tray. When Surveyor asked DM G if a gown and gloves were necessary when delivering a tray to a resident on contact precautions, DM G replied, If you are just passing the tray then you do not need to put on a gown. On 10/23/24 at 7:23 AM, Surveyor asked Director of Nursing (DON) B what guidance the facility follows for infection control. DON B indicated the facility has policies that staff follow. When Surveyor asked DON B, What guidance does your policy follow? DON B replied, CDC's (Center for Disease Control and Prevention's) guidance. When Surveyor asked DON B, What is the difference between contact precautions and EBP? DON B replied, With contact precautions, they have an MDRO. When Surveyor asked DON B, Is there any difference regarding PPE usage between contact precautions and EBP? DON B paused. Surveyor pulled out the CDC's transmission-based precautions reference guide printed from the Wisconsin Department of Health Services (DHS) website and showed DON B (who was the facility's Infection Preventionist) with contact precautions, You wear a gown and gloves for all interaction that may involve contact with the patient or potentially contaminated areas in the resident's environment. Example 2 R40 was admitted to the facility on [DATE] with diagnoses of dysphagia (swallowing difficulties) following a stroke and esophageal obstruction (a malformation in which the esophagus is interrupted and forms a blind-ending pouch rather than connecting normally to the stomach). R40's physician orders included enhanced barrier precautions due to a gastronomy (G)-tube. On 10/22/24 at 9:21 AM, Surveyor observed CNA C and Registered Nurse (RN) D enter R40's room with a Hoyer lift. CNA C and RN D were not wearing gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 9:25 AM, Surveyor interviewed RN D about the observation. RN D replied, Yeah, we probably should have placed a gown when we assisted (R40) with the Hoyer to the shower chair. CNA C exited R40's room and replied, I put a gown on when I showered (R40) in the bathroom. 40590 Example 3 R32 was admitted to the facility on [DATE] and had a diagnosis of fracture of left pubis. A Minimum Data Set (MDS) assessment, dated 9/5/24, indicated R32 had two stage 4 unhealed pressure ulcers. R32's care plan, dated 4/11/24 with a target date of 11/20/24, stated, At risk/actual for infection r/t (related to) wounds. Will remain free of complications through review date. An intervention initiated on 5/23/24 stated, Enhanced barrier precautions when performing high-contact care activities. On 10/21/24 at 1:47 PM, Surveyor observed an EBP sign on R32's door and a PPE bin with gloves and gowns in the hallway outside R32's room. The EBP sign indicated: Everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: wear gloves and gown for the following high-contact resident care activities, dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tubes, tracheostomy, wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. On 10/21/24 at 7:18 AM, CNA L knocked on R32's door. CNA L entered R32's room without donning PPE and stated, Good morning (R32) and closed the door. At 7:37 AM, CNA L exited the room with R32 fully dressed in a wheelchair and took R32 to the dining area. At 7:40 AM, Surveyor noted there was no PPE in R32's room for staff to don while in the room. On 10/22/24 at 9:21 AM, Surveyor interviewed CNA L regarding R32 and EBP. CNA L stated EBP was for wounds on R32's bottom and left hip wound vac. CNA L stated the wound on R32's coccyx was covered. When Surveyor asked CNA L when it was appropriate to use PPE for R32, CNA L stated, Anytime we do anything hands on; personal care, bathroom, and, We do everything for her, clean her up, but she can eat independently. 31086 Example 4 R151 was admitted to the facility on [DATE] with diagnoses including multiple fractures of ribs, left side, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage 3, personal history of transient ischemic attack, peripheral vascular disease (PVD), congestive heart failure, prediabetes, and cardiac pacemaker. An Admission MDS assessment, dated 10/16/24, documented a BIMS score of 12 out of 15 which indicated R151 had moderately impaired cognition. The MDS documented R151 had impairment to both lower legs and required partial/moderate assistance of staff for toileting and upper and lower body cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R151 had a physician order dated 10/13/24 for Enhanced barrier precautions d/t (due/to) open wounds. Every shift for wound care. On 10/22/24 at 9:22 AM, Surveyor observed Registered Nurse (RN) H provide wound care for R151's feet. RN H entered R151's room, sanitized hands, and applied gloves. RN H completed treatments to both of R151's feet, removed gloves, and sanitized hands. RN H did not wear a gown while providing care. Example 5 R9 was admitted to the facility on [DATE] with diagnoses of dementia, without behavioral disturbance, pneumonia, acute kidney failure, ulcer of esophagus, and osteoporosis. R9 was enrolled in Hospice care. An MDS Part A discharge assessment, dated 10/16/24, documented a BIMS assessment was not completed. R9 required partial/moderate assistance of staff for toileting, bathing, dressing, and bed mobility. On 10/22/24 at 6:43 AM, Surveyor observed CNA K and CNA L provide personal cares for R9. CNA K and CNA L sanitized hands and applied gloves. CNA L filled a basin with warm water and placed the basin on a barrier on R9's table. CNA L unfastened R9's brief and CNA K completed frontal peri care using wipes. CNA L and CNA K rolled R9 to the right side. CNA L removed R9's brief, cleaned R9's buttocks and peri area with wipes, and placed a clean brief on R9. CNA K and CNA L did not remove gloves and complete hand hygiene. With the same gloved hands, CNA K wet a wash cloth in the basin and gave the wash cloth to R9 to wash R9's face. With the same gloved hands, CNA K put soap on the wash cloth to wash R9's upper body and then put the wash cloth in the basin of water. CNA K used another wash cloth from the basin to rinse R9's upper body. CNA K used the same wash cloth to wash R9's frontal peri area and put the wash cloth back in the basin. CNA K used the other wash cloth in the basin of water to rinse R9's peri area. CNA K squeezed out the wash cloths in the basin, emptied the basin in the bathroom sink, rinsed the basin, and emptied the basin again in the sink. With the same gloved hands, CNA L and CNA K transferred R9 from bed to recliner. CNA L touched R9's hairbrush and brushed R9's hair. Example 6 R35 was admitted to the facility on [DATE] with a re-admission after hospital stay date of 6/4/24. R35's diagnoses included Crohn's disease, chronic kidney disease stage 4, type 2 diabetes mellitus, transient ischemic attack, and fibromyalgia. A Quarterly MDS assessment, dated 9/10/24, documented R35 had no impairments to the extremities and required partial to moderate assist of staff for activities of daily living (ADLs) including toileting, dressing, and hygiene. A BIMS score of 15 out of 15 indicated R35 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 1:31 PM, Surveyor observed RN H provide wound care to R35. RN H sanitized hands and applied a gown and gloves. After RN H removed R35's dressing, RN H removed gloves, washed hands in R35's bathroom sink, and turned off the faucet with clean hands. RN H applied clean gloves, applied gauze with Dakin's solution to R35's wound, and then removed the gauze. RN H removed gloves, washed hands, turned off the faucet with clean hands, and applied clean gloves. RN H placed a plain packing strip in the wound with a cotton swab. RN H removed RN H's gown and gloves, washed hands in R35's bathroom sink, and turned off the faucet with a bare arm. RN H then left the room to find the tape R35 requested. On 10/24/24 at 8:24 AM, Surveyor interviewed Director of Nursing (DON) B about infection control, hand hygiene, and EBP. DON B indicated staff were provided education and audited for infection control practices. DON B indicated the basin of water should have been emptied in the toilet. DON B also indicated a gown must be worn during wound care and the faucet should be turned off with a paper towel after hand washing. 47657 Example 7 On 10/23/24 at 10:09 AM, Surveyor observed CNA C complete incontinence care for R26. CNA C gathered supplies, completed hand hygiene, and donned clean gloves. CNA C unfastened R26's urine-filled brief, cleansed R26's frontal peri area, assisted R26 onto the left side, and cleansed R26's buttocks. Without removing gloves and completing hand hygiene, CNA C positioned and secured R26's clean brief and pulled down R26's shirt. CNA C then removed gloves. Without completing hand hygiene, R26 picked up R26's pillow to reposition R26 on the left side, picked up additional pillows to elevate R26's feet, and adjusted the bed covers for warmth. CNA C then touched the bed remote, adjusted R26's hair and head, moved the bedside table within reach, and picked up the garbage. On 10/23/24 at 10:14 AM, Surveyor interviewed CNA C regarding the facility's expectation of when to complete hand hygiene and remove gloves. CNA C stated when going from dirty to clean areas.