STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525326	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Nursing Home	2100 E Sixth St Merrill, WI 54452

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interviews and record reviews, the facility did not notify provider as indicated for development of a skin wound for 1 of 18 residents, (R) R43, reviewed. This is evidenced by: R43 was admitted to the facility on [DATE]. R43's current diagnoses include, congestive heart failure, cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection, dementia, and muscle weakness. Minimum Data Set (MDS) admission assessment dated [DATE] documented R43's Brief Interview for Mental Status (BIMS) score of 5/15 indicating severe cognitive impairment. R43 requires maximum assistance from staff for lower body dressing, transfers, and showers. R43 is at risk for pressure injuries. Initial care plan was developed for potential for skin breakdown related to dementia, limitations in mobility, occasional bowel incontinence, cardiac diagnosis, and pain. On 03/25/25, a temporary care plan was developed for alteration in skin integrity related to self-inflicted scratching evidenced by a wound to left lower extremity. Interventions include: wound will resolve without complications, complete treatment as ordered by MD, monitor for signs of infection, update MD with any changes in wound status. Progress notes documented on 03/8/25 at 7:01 PM, Health Status Note, Note Text: Resident scratched her lower left leg; outer aspect above her left ankle. She had a skin tear measuring approx 2 cm x 2 cm. This writer approximated the skin tear with 4 steri strips. The physician was not notified of the new skin breakdown. On 03/20/25 at 6:46 PM, Health Status Note, Note Text: This writer was called to resident's room by CNA. Resident wants to scratch her scab on her left lower leg/out aspect. This writer applied a non-adherent 3 in x 4 inch pad and lightly secured with Coban. Educated resident on necessity of not scratching her skin as she is prone to skin breakdown. On 03/22/25 at 5:11 PM, Health Status Note, Note Text: Residents scab on her left lower leg (outer aspect) came off as it was attached to her sock. The scabbed area is now open again. This writer applied a 4x4 non-adherent pad and secured it with Coban. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/23/25 at 1:58 PM, COMMUNICATION - with Family/NOK/POA Note Text: [R43] has a 1.5cm x 1cm open area on her left, lower, lateral leg. It has a pink wound base and a black scab edge at the top perimeter of the area . The facility had not notified the physician of the skin breakdown and to obtain order for treatment. On 03/25/25, the progress notes documented an open oval area that had small amount purulent drainage and peri area red. The physician was updated at this time and orders were obtained for a culture of the wound. On 04/30/25 at 8:29 AM, Surveyor interviewed Licensed Practical Nurse (LPN) D asking about the process of when an open area of a skin tear is identified and steri strips are applied. LPN D indicated fax the MD and ask for orders. If worsens would get wound nurse involved and take it from there. On 05/01/25 at 9:34 AM, Surveyor interviewed Director of Nursing (DON) B about notifying the physician of the open area when it occurred. DON B indicated the provider should have been notified of the open area.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52382 Based on observation, interview, and record review, the facility failed to recognize and assess an inability to perform Activities of Daily Living (ADL)s and implement interventions in accordance with the residents' assessed needs for 2 of 2 residents reviewed (R55, R65). Findings include: Standard ADL Protocol dated 03/28/24 states in part, Monitor for changes in Resident's ADL participation routinely. It also states in part, Report to your nurse if resident has a decline in ADL status or has been requiring increased assist with cares. Standard Nutrition Protocol dated 03/28/24 states in part, Encourage adequate intake of foods and fluids. Example 1 R55 was admitted to the facility on [DATE]. Pertinent diagnoses include unspecified dementia, unspecified severity, with agitation, age related cognitive decline, and depression, unspecified. R55's Minimum Data Set (MDS) assessment, dated 02/04/25, reads in part, Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Assessment reflects a Brief Interview for Mental Status (BIMS) score of 01/15 indicating a severe cognitive deficit. Significant change assessment started on 04/29/25 noted decline in BIMS score to a 00. R55's care plan last reviewed on 02/19/25 includes in part: The resident has a potential for alteration in cognition/mood Resident to participate in activities as able. At nutrition risk for altered nutrition status related to advanced age, comorbidities, cognition with history of refusal of cares and medications that can impact weight/appetite. Provide supervision/oversight with meal/tray set up assist as needed. Dining - set up assist/supervision Adhere to standard ADL protocol Reapproach as needed with decline of care delivery Record review did not indicate any significant weight loss. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/25 at 12:15 PM, Surveyor observed R55 receiving her lunch. Surveyor observed R55 sitting approximately a foot from the table with no encouragement or assistance from staff to move closer. On 04/28/25 at 12:20 PM, Surveyor observed R55 leaning forward to reach her brownie and having a difficult time. On 04/28/25 at 12:32PM, Surveyor observed R55 eating food with her fingers from the table that dropped off her plate. On 04/28/25 at 12:44 PM, Surveyor observed Registered Nurse (RN) L ask R55 and tablemate how lunch was but did not offer assistance and walked away. On 04/28/25 at 12:50 PM, Surveyor observed RN L ask R55 if she was done and took her plate. Surveyor observed RN L offering to hand R55 her apple juice and then left the table. No assistance was offered to R55 the entire meal. Surveyor observed R55 had eaten less than 25% of her meal. On 04/29/25 at 11:45 AM, Surveyor observed R55 receive her lunch. Surveyor observed Licensed Practical Nurse (LPN) K set up plate for R55 and explain what she had in front of her to eat. Surveyor observed LPN K then go to deliver another resident's food. On 04/29/25 at 11:56 AM, Surveyor observed R55 sitting at the dining room table watching TV and attempting to eat her dessert. On 04/29/25 at 12:27 PM, Surveyor observed R55 had eaten approximately 25% of her meal before dishes were removed from the table. No further assistance was offered. On 04/30/25 at 11:52 AM, Surveyor observed R55 receive lunch and Certified Nursing Assistant (CNA) I set up her lunch in front of her. On 04/30/25 at 12:00 PM, Surveyor observed R55 sitting at table with her eyes closed and not eating. On 04/30/25 at 12:26 PM, Surveyor observed R55 awake and sitting at table with plate untouched. On 04/30/25 at 12:29 PM, Surveyor observed RN P walk by and ask R55 if the food was good but did not stop. Surveyor observed R55 begin to eat independently at this time. Surveyor observed R55 had eaten approximately 25% of her meal. On 04/30/25 at 3:30 PM, Surveyor interviewed CNA M. CNA M stated if they need to know if a resident requires ADL assistance, they can look in the Kardex. It will tell them if the resident requires setup for meals and what their diet is. CNA M also stated if a resident is independent and she notices the resident is not eating, she would explain to the resident what she is doing, offer assistance, encourage the resident to eat, and possibly offer other options. CNA M stated she would also ask the resident if there was a reason they were not eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/25 at 3:35 PM, Surveyor interviewed LPN J. LPN J stated if staff needed to know what assistance was required, they would look in the care plan or Kardex. The Kardex and/or care plan would list if a resident required cuing, encouraging, setup, assistance, or if they were independent. LPN J stated if she observed a resident that was independent that was not eating or unable to eat, she would offer assistance and if warranted, update therapy for possible evaluation. Example 2 R65 was admitted to the facility on [DATE]. Pertinent diagnoses includes unspecified dementia, moderate, with other behavioral disturbance. No Brief Interview for Mental Status (BIMS) score available. R65's care plan, last reviewed on 04/15/25, includes in part: Adhere to standard Activities of Daily Living (ADL) protocol Dining: set up assist, provide cuing. At nutrition risk for altered nutrition status related to advanced age, comorbidities and cognition w/ behaviors that can impact weight/appetite. Provide meal/tray set up assist, provide cuing as needed during meal intake On 04/28/25 at 12:13 PM, Surveyor observed R65 receive her meal. On 04/28/25 at 12:18 PM, Surveyor observed R65 sitting at the table with her meal in front of her but not making any attempt to eat. On 04/28/25 at 12:46 PM, Surveyor observed RN L look at R65, say nothing, and walk away. On 04/28/25 at 12:48 PM, Surveyor observed RN L say to R65 You didn't like that chicken huh? and then offered R65 water. On 04/28/25 at 12:51 PM, Surveyor observed RN L offer to cut up R65's brownie and again offered to get her some water but not to assist her with eating or eating her main entree. On 04/28/25 at 12:56 PM, Surveyor walked around the loop in the hallway and returned immediately to the dining room. R65's tray had been removed from the table. On 04/29/25 at 12:00 PM, Surveyor observed CNA I. CNA I attempted to assist R65 with lunch. R65 responded, Yes, when asked if she wanted a drink of juice or a bite of dessert but would not open mouth and receive either one. Surveyor observed CNA I then remove tray from room. On 04/30/25 at 12:00 PM, Surveyor observed R65's lunch tray delivered to her room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/25 at 12:12 PM, Surveyor observed lunch tray sitting in R65's room. No staff present. Resident was sitting up with eyes closed. Surveyor observed RN P standing down the hallway near the dining room. On 04/30/25 at 12:13 PM, Surveyor observed RN P instruct Hospitality aide (HA) O to look to see if CNA H was assisting R65 with lunch. HA O told Surveyor CNA H would be to R65's room to assist her shortly. On 04/30/25 at 12:15 PM, Surveyor observed RN P talking to CNA H and advised her to go assist R65. On 04/30/25 at 12:17 PM, Surveyor observed CNA H apply PPE and enter room. On 04/30/25 at 12:19 PM, Surveyor observed CNA H attempt to clean R65's hand with a moist towelette. R65 was swinging her arms and batting the towelette away. CNA H attempted to assist her with a bite of food. Resident declined. Surveyor observed a couple more attempts made by CNA H to offer R65 a bite/drink before removing tray from room. On 04/30/25 at 3:45 PM, Surveyor interviewed Director of Nursing (DON) B, asking about assisting dependent residents with meals. DON B stated if staff needed to know if a resident required assistances with ADLs, specifically meals, they could look in the care plan or Kardex. DON B stated if a resident was served a meal and not eating, she would offer assistance, assess the situation, and offer oral care if needed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, record review and interview, the facility did not report and respond to resident pain promptly to ensure prompt assessment and treatment of pain for 1 of 3 residents reviewed for pain. R25 expressed pain and need for medication during care. Certified Nursing Assistant (CNA) F did not stop care and summon a nurse for assessment and treatment of R25's pain. Nursing assessment of R25's pain was not initiated until 4 hours after R25's expressed pain. This is evidenced by: Surveyor requested and received the facility policy titled Pain Management dated 10/24/23. The policy in part read: Purpose: Nursing homes residents are at high risk for having pain that may affect function, impaired mobility, impaired mood, disturb sleep and diminish quality of life. Policy: It is the responsibility of (facility) to ensure that pain management is provided to residents who require such services . Recognition and Management of Pain: In order to help a resident attain or maintain their highest practicable level of well being and to prevent or manage pain .to the extent possible: ~Recognize when the resident is experiencing pain . ~Evaluates the existing pain and the cause . ~Manages or prevents pain . ~Pain is .evaluated when there is a change in condition and whenever new pain or an exacerbation of pain is suspected. Surveyor reviewed R25's record and noted R25's diagnosis included: ~Pain, unspecified. ~Dementia R25's record also showed R25 was enrolled in hospice 4/18/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's most recent Minimum Data Set (MDS) dated [DATE] notes R25 usually understands and is usually understood. R25 is cognitively intact. R25 required substantial staff assistance for bed mobility, transfer and hygiene. R25 was frequently incontinent of bladder and occasionally incontinent of bowel. R25 had pneumonia and a urinary tract infection. R25 had no pain. R25 experienced falls with no injury or minor injury. R25 had no weight loss. R25 was at risk for pressure injury. R25 did not take opioid medication. Surveyor reviewed R25's care plan and noted the following: Focus: Alteration in comfort related to dementia. Goal: Residents PCL will remain at acceptable level for resident. Date Initiated: 5/14/24 Target Date: 4/29/25 Intervention/Task: Adhere to standard pain protocol. Surveyor requested and reviewed the facility's standard pain protocol and noted the following: Interventions as follows: RN/LPN (Registered Nurse/Licensed Practical Nurse): ~Monitor pain (PCL)q (every) 4 hours and prn (as needed) using numeric scale unless otherwise indicated in care plan. ~Monitor for impact of pain on daily function including but not limited to ADL's (activities of daily living) . CNA (Certified Nursing Assistant) ~Report to nurse if resident verbalizes or shows signs of symptoms of pain. R25's most recent comprehensive pain assessment dated [DATE] indicated no pain with rest or with movement. R25's physician orders included: NEW: Pain assessment to start on (4/29/25 PMs) and conclude on (5/5/25 PMs). Complete QD UDA x7 days in the evening for Pain assessment for 7 Days Complete pain assessment in UDA. Ensure correct dates/selection for initial, continuation and conclusion. When concluding, review previous 6 days of assessments. 4/29/2025 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Icy Hot Original Pain Relief External Cream 10-30 % (Menthol-Methyl Salicylate (Liniments)) Apply to back & shoulder topically three times a day for pain 4/28/2025 No maximum daily dose on acetaminophen every shift for pain management. 4/28/2025 Acetaminophen Oral Capsule (Acetaminophen) Give 1000 mg by mouth three times a day for pain 4/28/2025 Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 5 mg by mouth every 2 hours as needed for pain Morphine Liquid 100mg/5mL, 5mg PO 4/21/2025 Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain 4/21/2025 Gaymar (Hot/Cold) Therapy as needed as needed for acute or chronic pain/comfort Max setting of 107 degrees F and min setting of 50 degrees F 5/15/2024 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 10:01 AM, Surveyor heard R25 yelling out in his room. At 10:04 AM, Surveyor observed CNA F assist R25 to sit up in bed and R25 stated, Easy, easy. CNA F asked R25, Are you hurting? R25 responded, Yes, my back, lower. CNA F proceed to use an easy stand to lift resident to stand from bed to take to the bathroom and lower R25 to toilet. R25 began yelling, Oh, oh. CNA F removed the sling from resident stand. R25 then requested a pill. CNA F expressed he will let the nurse know. R25 stated, Oh my back. R25 stated, I need a pill, which was repeated three times. R25 then stated, Don't need. A god damn pill. CNA F proceeded with washing R25's upper body and asked R25 about his pain. R25 stated, Pain in back. CNA F expressed he will let Medication Technician (MT) N know and proceeded with washing R25's back. R25 stated, Oh, feels good, with the washing of his back. CNA F then proceeded to wash R25's arms and R25 stated, No, Pain, I need a pill, I need a pill, louder. CNA F proceeded with dressing R25, and R25 stated, To hell with the god damn clothes. I need a pill. CNA F continued dressing R25, and R25 loudly stated, I need a pill. CNA F used the easy stand to lift R25 from the toilet, and R25 stated, Aww, Aww, when sling for lift was applied and stated, My pill, my pill. CNA F proceeded and lifted R25 with stand and performed peri care. R25 stated, Hurry up, Aww, aww, with washing and, Cut that out, Oh my back. Oh, my back, and CNA F continued. Surveyor asked CNA F if it is normal for R25 to yell. CNA F responded, No he is having more pain, in a lot of pain, more than usual for yelling, and proceeded to take R25 to recliner in his room with lift. CNA F lowered R25 to the recliner with R25 stating, Oh, oh, oh, oh, my back. CNA F told R25 he would tell MT N he needs something for pain pronto. CNA F removed the lift sling from R25, and R25 yelled, My pill, my pill, aww. Once transferred to recliner and sling was removed, R25's yelling stopped. After the observation, Surveyor interviewed CNA F about R25's pain and informing a nurse of R25's pain. CNA F responded nurses don't give meds in the bathroom, and he wanted to ensure in R25 was in his room and seated before letting a nurse know. Surveyor questioned if it is appropriate to continue with care when a resident is complaining of pain. CNA F expressed he was trying to hurry to meet needs and get situated to summon the nurse. Surveyor asked about resident complaint of pain. CNA F responded, Terrible, and was, Trying to make most comfortable. Surveyor asked CNA F if complaint of pain is new for R25. CNA F further expressed today was the first day taking care of R25 in a long time. CNA F indicated he had good intentions but perhaps he should have stopped care and gotten a nurse. CNA F retrieved MT N who entered R25's room with CNA F and asked R25 about his pain level. R25 responded, High. Surveyor noted the following additional observations: ~4/29/25 at 11:12 AM, R25 was seated in recliner in room and was no longer yelling. ~04/29/25 at 2:14 PM, R25 was visiting with visitor in room with no pain indicators. Surveyor reviewed R25's record and noted on 4/29/25, R25 was administered scheduled Acetaminophen 1000 MG at 12:00 PM at which time R25 rated his pain a 6; this is almost 2 hours after R25 expressed pain and a need for medication. R25 rated his pain a 0 at 4:00 PM and 8:00 PM on 4/29/25. Surveyor noted R25's pain comprehensive assessment by a nurse was not initiated until 2:12 PM on 4/29/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 10:56 AM, Surveyor interviewed Licensed Practical Nurse (LPN) D and Nurse Manager/Registered Nurse (RN) E about R25's pain and the observation. LPN D indicated she would have expected CNA F to stop care and get a nurse when R25 was indicating he was in pain and needed a pill. LPN D further indicated nursing staff should complete a pain assessment having resident rate his pain, identify where the pain is located and get details about the pain. Nursing would check the resident Medication Administration Record and see what could be administered for a PRN (as needed) medication to address resident pain. LPN D expressed CNA F came to LPN D this morning and asked if a pre-medication was available prior to R25's care as CNA F was shaken by R25's pain with care yesterday. RN D expressed hospice was in to see R25 on Monday due to a fall R25 had over the weekend. Hospice increased R1's Tylenol and added icy hot to shoulders and back three times a day in addition to R25's as needed morphine as R25 had increased pain since his fall on the weekend. RN E further expressed she would expect R25's safety to be maintained first, then certified nursing assistants to summon a nurse to assess resident pain and treat as needed. Surveyor asked RN E if a pain assessment was completed by a nurse for R25 after his expression of pain during the observation. RN E expressed she would look for an assessment and let Surveyor know. RN E expressed a hospital bed has been provided instead of R25's standard bed to increase R25's comfort. On 4/30/25 at 2:37 PM, Surveyor interviewed Director of Nursing (DON) B about the observation and her expectations. DON B expressed she would expect staff to stop care and notify nurse. She would expect a nurse to complete a comprehensive pain assessment and administer medications as ordered. DON B indicated a comprehensive pain assessment was not started until PM shift and is not yet completed. DON B further indicated MT N should have notified a nurse right away when R25 reported high pain level so an assessment could be completed. DON B expressed R25 was administered his scheduled Tylenol at 12:00 PM but he has as needed morphine that was available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47657 Based on observation, interview and record review, the facility did not ensure the daily nurse staffing information was posted at the beginning of each shift. This has the potential to affect all 73 residents in the building. The facility did not update the daily nursing staff postings when there were schedule changes. Evidenced by: The facility policy titled: Sufficient Nursing Home Services: dated 09/01/2000, states: 4.1 Nurse Staffing information. NCHC must post the following information on a daily basis: -Facility name -The current date -The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. According to federal regulations, the facility must post the nurse staffing data on a daily basis at the beginning of each shift. Data must be posted as follows: -Clear and readable format. -In a prominent place readily accessible to residents and visitors. -Resident census. -The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The information should reflect staff absences on that shift due to callouts and illness. On 04/28/25 at 8:46 AM, upon entrance, Surveyor observed the staff posting in lobby which was dated 04/25/25 and indicated the facility census was 74. On 04/28/25 at 9:04 AM, Surveyor asked Administrative Assistant (AA) C where to locate the updated staff posting. AA C pointed to where the staff posting was located and stated, It is probably still Friday's posting as I hadn't gotten to it yet today. On 04/28/25 at 12:15 PM, Surveyor reviewed staff schedules and staff postings for period of 04/15/25 through 04/29/25 which reflected no changes made when staff absences occur. (continued on next page)

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	525326	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Nursing Home	2100 E Sixth St Merrill, WI 54452

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 04/28/25 at 1:15 PM, Surveyor interviewed AA C who told Surveyor the staff posting was updated with today's posting around 10:45 AM. AA C stated she receives an email from schedulers with staffing information and enters the information and current census on a form in the computer, prints and posts on wall. Surveyor asked Administrative Assistant C if the posting is updated as staffing levels change including on weekends. Administrative Assistant C stated that the form is not updated when staffing ratios change nor posted on weekends, stating, We try, but I am not here on weekends. On 04/30/25 at 11:14 AM, Surveyor interviewed Director of Nursing (DON) B regarding process of staff postings. DON B stated the schedulers will email AA C the information and AA C will fill out the posting template, print and post in lobby area. Surveyor shared findings upon initial entrance of survey on 04/28/25 of posting that was dated Friday 04/25/25 and indicated incorrect census. DON B believes that the weekend postings are printed and placed behind Friday's posting, but unable to provide information on how the postings are updated to ensure the correct date/census. Surveyor asked DON B regarding process of updating current staffing ratio if there was a call in, etc. DON B indicated there was not a process to ensure posting reflects updated staffing ratios.

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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. 51095 Based on observation, interview and record review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional practice. This occurred for 1 of 3 medication storage rooms/carts observed, resulting in the potential to affect all 44 residents that reside on the north wing out of 73 residents that reside in the facility. This is evidenced by: On 4/30/25 at 6:49 AM, during inspection of north storage med room, Surveyor noted expired medications in the resident stock medications that included: Two bottles of Molnupiravir 200 mg (antiviral medication) one bottle unopened expired 8/23/24 and another bottle of Molnupiravir 200 mg unopened exp. 10/8/24. Surveyor interviewed Assistant Director of Nursing (ADON) G, who stated those should not be on the shelf. ADON G reported pharmacy is supposed to inspect stock medications and remove them. ADON G removed expired medication from the shelf and put in a bin to go back to pharmacy. Upon inspection of the medication fridge, Surveyor observed an opened multi-use vial of Aplisol -Tuberculin Purified Protein Derivative, Diluted (PPD) with no open date on box or the bottle. Surveyor interviewed ADON G, who reported the expectation would be that the vial and box would both be dated with the opened date and the vial only be used for 28 days. On 4/30/25 at 7:29 AM, Surveyor inspected the medication cart on north wing with Licensed Practical Nurse (LPN) V. Surveyor noted an open bottle of Clear Lax (liquid laxative) and Geri-Lanta (heartburn medication) not dated. LPN V reported these are for use of all residents on the north wing. LPN V stated she just opened the Clear Lax this morning and didn't have a sharpie to put the open date on it. LPN V could not identify when the Geri-Lanta was opened. LPN V put both opened medications back in the medication cart, opened and not dated. On 4/30/25 at 2:40 PM, Surveyor interviewed Director of Nursing (DON) B regarding medication storage, labeling of stock medication and opened multi-use vials. DON B stated she would expect multi-use vials to be dated when opened and to be disposed of within 28 days after opening and expired medications should not have been in stock medications. Record review indicated the bottle of multi-use vial of Aplisol-Tuberculin Purified Protein Derivative, Diluted (PPD) was opened on 2/14/25. This solution was expired as of 3/14/25 (28 days after opening). Nine doses were used on seven residents after medication had expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/01/25 at 8:41 AM, Surveyor interviewed DON B, who reported the medication room is the main medication room for stock supplies for the entire facility. However, the PPD solution kept in the north wing would only be for the north wing residents as the facility keeps another PPD solution in the south wing for residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 4 residents reviewed. (R43, R53, R27, R76) R43 is on contact precautions and staff did not wear the proper personal protective equipment (PPE) when providing cares. Hand hygiene was not performed for R53 as required for catheter cares, or during medication pass for R27 and R76. This is evidenced by: Example 1 R43 was admitted to the facility on [DATE]. R43's current diagnoses include, congestive heart failure, cellulitis of left lower limb, methicillin resistant staphylococcus aureus infection (MRSA), dementia, and muscle weakness. Minimum Data Set (MDS) admission assessment dated [DATE] documented R43's Brief Interview for Mental Status (BIMS) score of 5/15 indicating severe cognitive impairment. R43 requires maximum assistance from staff for lower body dressing, transfers, and showers. R43 is at risk for pressure injuries. During initial tour Surveyor observed a sign to the left of R43's door stating contact precautions and to wear gloves and gown. No personal protective equipment (PPE) bin was at entrance of the door. On 04/28/25 at 11:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA) Q about the need for contact precautions for R43. CNA indicated R43 had a history of MRSA. On 04/30/25 at 7:10 AM, Surveyor observed CNA R enter R43's room asking R43 if she wanted to get up for breakfast. CNA R did not apply a gown while completing R43's personal cares. On 04/30/25 at 7:24 AM, Surveyor observed Licensed Practical Nurse (LPN) D enter R43's room. LPN D applied gloves and did not apply PPE of a gown. LPN D then applied the medication cream to both of R43's heels. LPN D removed gloves and sanitized hands. On 04/30/25 at 8:28 AM, Surveyor observed Licensed Practical Nurse (LPN) D speaking to CNA R. CNA R asked what PPE is to be worn. LPN D stated gowns only need to be worn when working with the infected area and when the area is draining and not contained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/25 at 8:35 AM, Surveyor interviewed LPN D asking about contact precautions and enhanced barrier precautions (EBP). LPN D indicated contact precautions are when PPE is to be worn when working with the area that is contaminated. EBP is a step-up with a mask for when going into a room that is infected and would put all PPE on. When doing catheter care they would put PPE on. If the area is contained, then PPE would not be worn, only wear PPE when working on that area. On 04/30/25 at 8:55 AM, Surveyor interviewed Registered Nurse (RN) S about contact precautions PPE for R43. RN S indicated R43 is on contact precautions and staff are to wear gown and gloves for all contact. Staff are educated on the types of precautions and what PPE is to be worn. Surveyor reviewed the observation and interview. RN S indicated immediate education will be provided. 51095 Example 2 The facility policy titled: Hand Hygiene, reviewed on 8/8/24, states in part, .4.2. All staff shall use the hand-hygiene techniques, as set forth in the following procedure: .4.2.3. Before and after each patient/client/resident care procedure. 4.2.4. Before applying gloves; . 4.2.8 After contact with medical equipment/supplies in patient/client/resident areas, 4.2.9. Always after removing gloves . On 4/29/25 at 2:01 PM, Surveyor observed CNA T don a gown and gloves upon entering R53's room. R53 is on Enhanced Barrier Precautions (EBP) due to his Foley catheter. CNA T wheeled R53 into bathroom, assisted R53 in removal of outer clothes. and removed her gloves after helping him pull down his pants and sit back into wheelchair. CNA T did not use hand hygiene after removing her gloves and prior to donning new gloves to provide catheter cares. After CNA T emptied catheter leg bag and while CNA T was attempting to measure urine output, R53 stood up. CNA T stopped what she was doing to assist R53 to sit back in wheelchair. CNA T stated, In that instance I would have washed my hands before hand . CNA T went back to measuring urine, emptied urine in toilet, and then removed her gloves and did not use hand hygiene. CNA T applied new gloves, finished cares and doffed PPE, pushed R53's wheelchair out the door before using hand sanitizer when exiting the room. On 4/29/25 at 2:08 PM, Surveyor interviewed CNA T who was able to identify importance of EBP and infection control practices. CNA T was not aware she needed to use hand hygiene immediately after removing gloves prior to touching other surfaces. Example 3 On 4/29/25 at 3:45 PM, Surveyor observed LPN U look up medication in the electronic medical record, take medications out of the cart drawers, open packets and put meds in med cups, enter R27's room and hand R27 the medications. R27 took pills orally and handed the empty cup back to LPN U. LPN U left room and proceeded with setting up R76's medications without practicing any hand hygiene. After setting up medications, LPN U entered R76's room and handed medication cup to resident. After R76 swallowed the pills, LPN U took empty cup from resident and disposed of it in the trash. LPN U exited the room, went back to med cart and documented medications in the electronic medical record. At no time did LPN U practice any hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor then interviewed LPN U about hand hygiene. LPN U stated, Oh man, I always forget. I didn't touch anything in their rooms though. Survey pointed out observation of LPN U touching the medication cups that the residents put to their mouths, the residents' doors, the computer mouse, the medication drawers and the medication wrappers. LPN U verbalized understanding of appropriate hand hygiene when passing medications and in between patients. On 4/30/25 at 2:41 PM, Surveyor interviewed DON B, who reported the expectation of the staff is to practice hand hygiene before and after entering residents' rooms, after performing cares, and immediately prior to and after donning/doffing gloves.