STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525445	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Health and Rehab	825 Western Ave Columbus, WI 53925

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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 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** 49434 Based on interview and record review, the facility failed to immediately consult with a physician when needing to alter treatment for 1 of 13 (R8) residents reviewed for physician notification. R8 experienced an episode of coughing so much phlegm it caused him to have emesis (vomiting) in October 2024. Additionally, R8 had a 4-pound weight increase in one day in February 2025, which is a significant change in relation to R8's medical conditions, which can indicate worsening respiratory symptoms. The facility did not call the on-call physician to allow for alteration of treatment if the physician deemed it necessary. This is evidenced by: The facility policy titled, Guidelines for Notifying Physicians of Clinical Problems, dated 10/2024, states, in part: . The immediate (acute) and non-immediate (sub-acute) problems listed below are not meant to be all-inclusive. The Charge Nurse or supervisor should contact the Attending Physician at any time if they feel a clinical situation requires immediate discussion and management . Immediate Notification (Acute) Problems: The following symptoms, signs and laboratory values should prompt immediate notification of the Physician, after an appropriate nursing evaluation. Immediate implies that the Physician should be notified as soon as possible, either by phone or by pager. These situations include: . 3. The following symptoms: a. Sudden onset OR a marked change (for example, much more severe) compared to usual (baseline) status, AND are b. Unrelieved by measures which have already been prescribed (e.g. Nitroglycerin (lowers blood pressure) for chest pain, antacid for abdominal discomfort) . The facility uses eINTERACT as their standard of practice. According to INTERACT, dated 2017, a cough with new sputum production requires immediate MD (Medical Doctor) notification. R8 was admitted to the facility on [DATE], with an initial admitted [DATE], with diagnoses that include, in part: Acute on Chronic Systolic Heart Failure with intermittent and sudden acute symptoms, Chronic Obstructive Pulmonary Disease (a condition caused by damage to the lungs and limits airflow), Type 2 Diabetes, Cirrhosis of liver, and hypertension (high blood pressure). R8's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/15/24 states that R8 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R8 is cognitively intact. (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 10/28/24 at 11:39 PM, a Progress Note is written that states, in part: .He stated that last night he 'Was coughing up so much phlegm' It caused him to have an emesis. He stated the phlegm has been a clear with a yellow [NAME] to it .Message left for PCP (Primary Care Provider). A fax, dated 10/28/24, from nursing home to MD S (Medical Doctor), indicates a report of R8's coughing with sputum without notification of reported emesis. The reply from the physician was sent from the clinic on 10/29/24 at 2:06 PM, after R8 had been sent to the emergency room . (Of note: The facility's standard of practice for change in condition indicates the physician should have been notified immediately. Additionally, according to regulation, the facility must consult with the resident's physician, not just notify. A fax to the physician is not immediate notification.) R8' Physician Orders indicate, in part: Daily weight in the morning related to ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE. Order status: Active. Start date: 12/7/2024 06:00. R8's Weight Documentation indicates, in part: 2/13/25 at 10:35 AM: 172.2 lbs. (Standing) 2/14/25 at 1:57 PM: 176.4 lbs. (Standing) On 2/15/25 at 6:10 PM, a Progress Note states, in part: Resident's weight increased from 172.2 to 176.2 from 2/13- 2/14. Unclear if MD was notified. Weight this AM was 175.2. Resident's breathing labored and tachypneic (High respiratory rate) in the 40s, O2 (Oxygen) saturation of 85% on 2.5 L (Liters) via NC (Nasal Cannula) . A fax, with an illegible date in February 2025, indicates a general update on the resident was provided including the weight increase. However, no response was documented. There is a mark on the bottom of the page that may be a signature that is dated 2/17/25. The response fax is dated 2/17/25 at 3:26 PM. On 2/26/25 at 3:42 PM, Surveyor interviewed LPN O (Licensed Practical Nurse) and asked what situations she would immediately notify a physician. LPN O indicated she would immediately notify a physician for a change in condition, urinary tract infection symptoms, a fall, significant bleeding, or high or low blood sugars. Surveyor asked LPN O what it means to immediately notify a physician. LPN O indicates she would call a physician within a couple of hours after she was able to assess the resident. Surveyor asked LPN O what standard of practice the facility uses for change in condition. LPN O indicates she references binders at the nurses' station to determine what requires notification. Surveyor asked LPN O if a resident is acutely coughing up sputum and reporting emesis, does this require immediate physician notification. LPN O indicates that would be pretty urgent and would call if as needed treatments were attempted and did not resolve the resident's symptoms. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 5:02 PM, Surveyor interviewed DON B (Director of Nursing) and asked what it means to immediately notify a physician. DON B stated as soon as practicable. Surveyor asked DON B in what situations should staff immediately notify a physician. DON B indicated with a change in condition or abnormal vital signs. Surveyor asked DON B if a fax would be acceptable or if a physician should be called. DON B indicated that it depends on the situation. Surveyor asked what change of condition standard of practice the facility follows. DON B stated the facility follows eINTERACT. Surveyor asked DON B if a resident is acutely coughing up sputum to the point they are having emesis, is an immediate physician notification needed. DON B stated, yes. Surveyor asked DON B if a resident who has CHF and has a weight change of 4 pounds in one day would require immediate physician notification. DON B indicated she would expect staff to call the physician immediately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review the facility did not ensure services meet professional standards of quality for 1 of 1 residents (R237) reviewed for wound vac therapy (a device that provides negative pressure wound therapy to promote healing). R237 was admitted to the facility with a wound vac, the facility failed to ensure there were physician orders for the provisions of care for the wound vac in the medical record. The facility policy titled, Guidelines for Notifying Physicians of Clinical Problems, dated 10/2024, states, in part: . The immediate (acute) and non-immediate (sub-acute) problems listed below are not meant to be all-inclusive. The Charge Nurse or supervisor should contact the Attending Physician at any time if they feel a clinical situation requires immediate discussion and management . Immediate Notification (Acute) Problems: The following symptoms, signs and laboratory values should prompt immediate notification of the Physician, after an appropriate nursing evaluation. Immediate implies that the Physician should be notified as soon as possible, either by phone or by pager. These situations include: . 3. The following symptoms: a. Sudden onset OR a marked change (for example, much more severe) compared to usual (baseline) status, AND are b. Unrelieved by measures which have already been prescribed (eg. Nitroglycerin (lowers blood pressure) for chest pain, antacid for abdominal discomfort) . Surveyor requested a policy regarding wound-vacs and the facility reported they did not have one. R237 was admitted to the facility on [DATE] with diagnosis that include, in part: sepsis (widespread infection causing damage to tissues and organs) due to methicillin resistant staphylococcus aureus (Antibiotic-resistant bacteria), infection following a procedure-deep incisional surgical site, and type 2 diabetes. R237's Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 1/17/25, indicates R237 has a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating he is cognitively intact. Surveyor reviewed R237's Physician orders. No orders, active or inactive, were able to be found regarding R237's wound-vac. Surveyor reviewed R237's Comprehensive Care Plan. Focus: [R237] is at risk for skin breakdown and pressure ulcer development related to diabetes, incontinence, limited mobility, morbid obesity, anticoagulation use. Surgical incision dehiscence to lumbar region which has interventions that include, in part, .Change wound vac dressing as ordered. Notify MD with any changes noted to area . Surveyor reviewed R237's document titled, Hospitalist Discharge Summary, dated 2/14/25, indicates: R237 was diagnosed and treated for severe sepsis secondary to lumbar surgical site infection. Additionally, a follow up appointment was scheduled for 2/26/25 for: 2 week post-op, For wound vac removal and incision check. The document also states: . Wound Care/Home Nursing: Keep wound vac in place until follow up with neurosurgery . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R237's document titled, After Visit Summary - Transition, dated 2/14/25, states, in part: . Discharge Instructions Lumbar Fusion: . Incision Care: [Brand Name] wound vac in place. Do NOT remove or get wet. For trouble shooting please[sic] call wound care clinic. Shower/Bath: May NOT shower or submerge wound vac at any time. May take sponge bath only. Do NOT get any water under wound vac . (Of note: None of this information was contained on the physician orders, plan of care, or banner in R237's electronic chart.) On 2/25/25 at 2:09 PM, Surveyor interviewed R237 regarding his ER transfer. Surveyor asked R237 how his transfer has affected him. R237 indicated he was so stressed he had an anxiety attack the day after he went to the ER and the facility had to administer oxygen to him because he was so short of breath. Surveyor asked R237 if this transfer was having any continued effects. R237 states, I'm still stressed about it talking to you today, and indicated that he wants answers, and he doesn't know why he needed to go to the ER, especially since the ER doctor said he didn't need to be there. At this time, the facility Dietician entered the room, requesting to speak to the resident. Surveyor advised the resident they would come back so the Dietician can speak with him regarding his care. The Dietician ask R237 if he was okay. R237 indicated he was very upset and didn't feel like explaining the situation to her. On 2/25/25 at 4:33 PM, Surveyor returned to interview R237 regarding his ER transfer. During this interview, R237 indicated he was stressed regarding the financial implications of his transfer. He also stated, I went through hell with this process . I just hated getting passed around like a piece of meat . On 2/22/25 at 9:22 PM, a Progress Note is written by RN P (Registered Nurse) that states, in part: . Wound vac in place. Functioning as ordered . A Progress Note is written by NP Q (Nurse Practitioner) with an effective date of 2/22/25 at 11:00 PM and a Date of Service listed as 2/23/25. The visit type is described as: Telehealth-Asynchronous. The note states: Patient has a wound vac on an infected[sic] surgical wound on his back. The[sic] wound vac quit working[sic] last night as it only had a 14 day working life and the nurse tried to call the surgeon's office, and then she was directed to infectious disease, which directed her to the ER (emergency room). He was supposed to have it changed out at his follow up, which is not until Wednesday. Nurse was unable to obtain any orders as to what to do with the wound. The ER suggested that he come back there[sic] and they could look at the wound and give new orders. Patient sent back to the ER of the hospital where he had his surgery done. Rounding team notified. On 2/23/25 at 2:41 AM, a Progress Note is written by LPN R (Licensed Practical Nurse) that states, in part: . Wound vac in place but has ceased to function. Per the therapy unit patient guide, the unit was set to function for 14 days and then turn off. The therapy life indicator on the equipment states therapy has ended and will shut off. Resident to see his surgeon on Weds (Wednesday) 2/26. Dressing left in place to contain any drainage and prevent MRSA from spreading. Will ask am (day shift) staff to contact MD (Medical Doctor) for instructions regarding earlier appointment or intermittent dressing change orders. Resident aware and states his understanding . On 2/23/25 at 9:07 AM, a Progress Note is written by RN L. This note indicates a respiratory evaluation was completed including lung sounds. Nothing is noted regarding R237's wound vac. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/25 at 4:19 PM, a Progress Note is written by LPN O that states: Sent to ER. On 2/23/25 at 5:39 PM, a Progress Note is written by LPN O that states, in part: Wound vac was not functioning when arrived on shift. [MD Name] the on-call for neurosurgeon that placed the wound vac was contacted and advised to reach out to infectious disease because he was not comfortable advising as he does not often use wound vacuums. Infectious disease contacted and stated that since they did not place the wound vac nor write the order not to change until f/u (follow up) appt (appointment) they would not advise what to do. Called on-call neurosurgeon back and was transferred to the ED (emergency department) department instead. They were unable to recommend what action to take on a wound they were unable to assess. Recommend sending to their ED so they could handle the wound today and he would be able to see [MD Name] tomorrow. Contacted on-call for [MD Name] and was also advised to send to ER by NP Q. Contacted [Ambulance Service Name] for non-emergent transport to [Hospital Name] in [Hospital Location]. Res (resident) left facility at 1550 (3:50 PM) via stretcher transport through [Ambulance Service Name] . On 2/23/25 at 9:46 PM, a Progress Note is written by LPN O that states: Spoke we ER RN [RN Name] for report. Notes from previous stay from wound care gave instruction for wound care treatment. ER completed treatment and sending detailed orders with discharge paperwork. Advised to complete on[sic] Tuesday then follow [MD Name]'s orders after Wednesday appt. Res will be returning to the facility. Surveyor reviewed a document titled, After Visit Summary, dated 2/23/25, indicated to be from R237's emergency room visit. The document states, in part: . Instructions: Wound VAC has been removed. Regular cleansing with [Brand Name] solution and [Brand Name] dressing as needed. Follow-up as scheduled with neurosurgery on Wednesday. Copied from wound care note on February 10, 2025: If wound VAC fails and not able to maintain suction or integrity, then VAC dressing can be removed; Wound can be cleaned with [Brand Name] and gauze. Dried. [Brand Name] dressing to be applied. Surveyor reviewed the manufacturer's guide for R237's wound vac titled, 125 Therapy Unit Patient Guide. This document provides detailed troubleshooting instructions including what to do for excessive bleeding, if there is a full canister, if there are signs and symptoms of infection, and if there are signs and symptoms of an allergic reaction. The document also provides information on daily activity, sleeping, showering and bathing, and cleaning the device. On 2/26/25 at 7:55 AM, Surveyor interviewed LPN F. Surveyor asked LPN F if she has received any recent training regarding wound vacs. LPN F indicated that she has not received any training on wound vacs recently. Surveyor asked LPN F if she has any experience with wound vacs. LPN F indicates she does. Surveyor asked LPN F if there is usually a back-up plan, in physician orders or in the care plan, in case the device fails. LPN F indicates, yes it should come with orders and phone number to call in case it malfunctions. Surveyor asked LPN F what are the things you need to do to care for someone with a wound vac. LPN F indicates you need to check that they are set appropriate and that suction remains at the ordered level. Surveyor asked LPN F if a resident has a wound vac, should it be on the care plan. LPN F states, yes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 7:59 AM, Surveyor interviewed LPN O. Surveyor asked LPN O if she has received any recent training regarding wound vacs. LPN O indicated that she has not received any training on wound vacs recently. Surveyor asked LPN O if she has any experience with wound vacs. LPN O indicates that she is an agency nurse and that most facilities have a wound nurse that cares for residents with wound vacs. Surveyor asked LPN O if there is usually a back-up plan, in physician orders or in the care plan, in case the device fails. LPN O also indicates she has not seen a lot of wound vacs in general, but that wound make sense. Surveyor asked LPN O what are the things you need to do to care for someone with a wound vac. LPN O indicates you just need to make sure they are functional and alert the RN if they are not. Surveyor asked LPN O if a resident has a wound vac, should it be on the care plan. LPN O states, yes. Surveyor asked LPN O if she was on shift on 2/23/25 when R237's wound vac malfunctioned. LPN O indicated that she was. Surveyor asked LPN O to describe what happened. LPN O describes what happened in the same way her progress note details. Surveyor asked LPN O what the device looked like when she assessed it. LPN O indicated all the lights were off, she didn't know if it just needed to be charged, attempted to turn the device back on but was unsuccessful, and that she has never seen a device like this before. Surveyor asked LPN O if she requested an RN to come to the room to assess the patient. LPN O indicated she did and RN L responded to R237's room. On 2/26/25 at 8:40 AM, Surveyor interviewed RN L. Surveyor asked RN L if she has received any recent training regarding wound vacs. RN L indicated that she has had wound vac training and estimates this training occurred around 6 months ago. Surveyor asked RN L if she has any experience with wound vacs. RN L states, yes. Surveyor asked RN L if there is usually a back-up plan, in physician orders or in the care plan, in case the device fails. RN L indicates the facility follows the doctor's directions and that there should be orders for changing dressings and if the device malfunctions, who we need to call to troubleshoot the problem. Surveyor asked RN L what are the things you need to do to care for someone with a wound vac. RN L indicates dressing changes usually occur around three times a week and sometimes you need to troubleshoot them if a seal may be broken or if the cannister needs to be changed. Surveyor asked RN L if a resident has a wound vac, should it be on the care plan. RN L states yes, and that she did care plan R237's wound vac. Surveyor asked RN L if she was on shift on 2/23/25 when R237's device malfunctioned. RN L indicates she was on shift. Surveyor asked RN L to describe what happened. RN L indicated she was very frustrated by the lack of cooperation with hospital on-call physicians. RN L indicates the wound vac shut off, indicating that therapy had ended, and the device would not turn back on. RN L indicates she requested a CNA (Certified Nursing Assistant) to assist with rolling the resident to assess wound. Surveyor asked RN L what the dressing looked like on the patient's back. RN L indicates the dressing was still sealed and intact, and that she did not observe any signs of erythema (redness) or drainage coming from the dressing. Surveyor asked RN L if she removed the dressing to assess the wound at any point. RN L indicates she did not. RN L indicated that the manufacturers guidelines book advised to call a provider, so she attempted to call the on-call physicians as described earlier without orders being provided. RN L indicates the facility's provider then provided orders for R237 to be sent to the emergency room at the hospital where he originally had his surgery. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 9:06 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if there has been any recent training provided on wound vacs. DON B indicates she has shown some nurses how to change the dressings. DON B also indicates she does informal training and that her practice is to ensure staff are comfortable caring for a resident with a wound vac. DON B also indicates staff know they can call her if they need assistance. Surveyor asked DON B if she has any previous experience with wound vacs. DON B states, yes. Surveyor asked DON B do resident's with wound vacs usually have a back up plan in the physicians orders or care plan. DON B indicates staff typically call the on call so that they can provide orders until a resolution can be made, but typically their in-house provider should be contacted. Surveyor asked DON B if a resident has a wound vac, should it be on the care plan. DON B states, yes. Surveyor what R237's care plan says about his wound vac. DON B reviewed R237's care plan and indicated she only found the intervention listed previously. Surveyor asked DON B if the care plan should have information on who to call for new orders. DON B indicates the facility would not typically put a specific phone number there, but that the intervention should say provider and not MD and list which provider to call for new orders. Surveyor asked DON B how she monitors staff to ensure they are implementing care planned interventions. DON B indicates she does not know how to answer this question, but that she checks in with staff and completes audits. Surveyor asked DON B if information on how to troubleshoot the device should be listed on the care plan. DON B indicates not in particular, and the hospital documentation states we should call the wound care clinic. Surveyor asked DON B if calling the wound care clinic should be a part of the care plan. DON B indicates she is not sure but that usually they would not have that as part of the care plan but it usually is put int the special instructions section of the dashboard of the electronic medical record. Surveyor asked DON B if those special instructions were included on the dashboard for R237. DON B indicates they were not.

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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** 36253 Based on interview and record review, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable for 1 of 2 residents reviewed for pressure injuries (R30). R30 was at risk for developing pressure injuries related to immobility and multiple fractures. The facility failed to implement aggressive pressure injury interventions; failed to complete weekly assessments per standard of practice; failed to provide risk and benefits despite knowledge of R30 refusing repositioning. Facility did not assess or measure R30's left gluteal pressure injury. R30 developed two stage three, and one unstageable facility acquired pressure injuries. Facility failure to ensure R30 received care consistent with professional standards of practice to prevent pressure injuries from developing or deteriorating, created a finding of immediate jeopardy that began on 2/18/25. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on 3/7/25 at 10:15AM. The immediate jeopardy was removed on 3/7/25. However, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan Findings include: The facility's policy, titled Pressure Injury/Skin Breakdown-Clinical Guidelines states: Assessment and Recognition: *The nursing staff will, upon admission complete an evaluation of the residents skin and resulting risk factors for developing pressure injuries; for example, immobility, recent weight loss, and a history of pressure injuries. * The staff will examine the skin of a new admission and/or re-admission for ulcerations or indications of a stage 1 pressure area that has not yet ulcerated at the surface. *A standardized tool example (ex. Braden or [NAME]) will be utilized weekly for four weeks after admission and/or readmission and at least quarterly to determine risk for clinical breakdown. * The nursing staff will complete an evaluation of the skin weekly. Treatment/Management: *Based upon need and the results of the evaluations the staff will implement interventions for the prevention and care of skin issues. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IDT will review measures upon admission, quarterly and with significant change. Note: *Although poor nutritional status is associated with increased risk of pressure injury development, no specific nutritional interventions have been proven conclusively to prevent or heal pressure injuries. There are no pressure injury dash specific nutritional measures that should be provided routinely to those with or at risk for developing a pressure injury. Nutritional supplementation should be based on realistic appraisal of need and identification of medical conditions and factors that affect appetite, weight, and overall nutritional balance. *As needed, the physician will help identify medical and ethical issues influencing wound healing; for example, because of end stage heart disease or because cause-specific treatment is not advisable, not feasible, or not desired by the resident or family. Per the NPIAP (National Pressure Injury Advisory Panel) a pressure injury is defined as .localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. NPIAP definitions include: Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. An 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. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. R30 was admitted to the facility on [DATE] and has diagnoses that include wedge compression fracture of fourth lumbar vertebra (L4 is near the tailbone and wedge indicates the vertebra collapsed inward resulting in a wedge shape), Type 2 Diabetes, and muscle weakness. His most recent MDS (Minimum Data Set), dated 12/20/24, includes a BIMS (Brief Interview for Mental Status) score of 15, indicating R30 is cognitively intact. According to section GG of R30's admission MDS, dated [DATE], R30 needed substantial/maximal assistance with rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transfer, and tub/shower transfers. On 10/16/24, the facility conducted a Braden assessment (a tool used to assess a patient's risk of developing pressure ulcers) with a resulting score of 17, indicating R30 was at risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R30's care plan states, Focus: .is at risk for skin breakdown and pressure ulcer development related to limited mobility, diabetes. Resident was admitted with multiple abrasions and open area to gluteal cleft. Refuses or removes pressure relief devices at times such as heel lifts .Goal: .will be free from new open skin concerns through the review date .Interventions: assist to turn/reposition as needed or requested (initiated 10/17/24), follow protocols for the prevention of skin breakdown (initiated 10/17/24), Roho wheelchair cushion (initiated 10/17/24), diabetic: float heels when in bed/recliner (initiated 10/17/24), inform family/caregivers of any new areas of skin breakdown (initiated 10/17/24), lotion skin PRN (initiated 10/17/24), monitor nutritional status. Serve diet as ordered and monitor and record intake (initiated 10/17/24), obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated (initiated 10/17/24). Additionally, R30's care plan states, Focus: .has an ADL self care deficit related to limited mobility, impaired balance, and weakness secondary to motor vehicle accident with fractures to multiple right ribs and L4 spine . Goal: will maintain or improve current ADL function .Interventions: Bed mobility: Requires 1 staff participation to reposition and turn in bed. On 10/15/24, as part of R30's admission assessment, it was noted that there was a 0.5cm in diameter open area to R30's intergluteal cleft (the groove or crease located between the two buttocks). No further assessment, measuring, or documentation was made of this area, nor did the facility provide any documentation that this was reported to R30's physician. On 10/24/24, the facility discovered an area on R30's coccyx/sacrum, described as MASD (Moisture Associated Skin Damage) IAD (incontinence associated dermatitis). The facility assessed the wound at this time, measuring 4.19 cm x 2.42 cm (Length x Width) with 90% slough (dead tissue within a wound) and 10% epithelial tissue (new layer of skin). treatment .soap & water Primary dressing, no dressing applied. The 10/24/24 skin assessment states, Sent message to NP on 10/24/24 requesting zinc oxide to buttocks BID (twice daily) and PRN. There is no order, documentation on facility administration records or progress notes indicating that this order was fulfilled and it was being deployed nor is there documentation that any specific order was being used to address R30's coccyx/sacrum wound until 11/6/24. Of note: Facility failed to complete a weekly assessment around 10/31/24 and the next assessment and measurement was not completed until 11/4/24. 11/4/24: coccyx/sacrum 3.95 x 5.12 (MASD, 100% granulation) Treatment: cleansing solution, soap & water. other, specify zinc oxide . no secondary dressing. Progress deteriorating .practitioner notified. 11/5/24: coccyx/sacrum6.58 x 5.11 (MASD, 100% granulation) additional care: cushion, foam mattress, nutrition/dietary supplementation. Physician order on 11/6/24 indicates Cleanse sacral ulcer with cleanser, pat dry, skin prep edges, allow to dry, cover with foam dressing every 8 hours as needed. Physician orders from 11/7/24 to 11/20/24 indicate Cleanse sacral ulcer with cleanser, pat dry, skin prep to edges, allow to dry, cover with foam dressing, one time per day every other day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/11/24: coccyx/sacrum 5.49 x 5.72 (MASD, progress deteriorating, education explained importance of turning way over on his side off his bottom.) On 11/11/24, the facility ordered a pressure-relieving mattress for R30, with correspondence via fax to the NP (Nurse Practitioner) stating, Area on bottom looking worse. Skin prep to edges and foam dressing is what we are doing. We are ordering an air mattress for him. Non-compliant with turning off/staying off bottom. Of note: there is no evidence that the facility completed risk vs benefits with R30 despite knowing that R30 was non-compliant with turning and/or staying off his bottom. The facility did not proactively implement an air mattress until R30's wound deteriorated to an unstageable Pressure injury despite R30 having multiple fractures and needing substantial assistance with cares. On 11/12/24, the facility documented this coccyx/sacrum wound as unstageable, noting the wound was 5.64 cm x 5.81 cm, Type pressure. Stage unstageable due to slough and/or eschar. Acquired present on admission. Wound bed with 70% slough. Treatment soap & water, primary dressing foam, no secondary dressing. Additional care: cushion; incontinence management; mattress with pump; moisture control; repositioning device(s); turning/repositioning program. Progress: deteriorating. 11/13/24: 3.9 x 4.69 (Coccyx, Unstageable, 70% slough) 11/19/24: 2.27 x 3.33 x 0.1 (Sacrum, Unstageable, 100% slough, in house acquired) It should be noted that the facility documented that R30's wound was on his coccyx until 11/19/24 at which time this same area was referred to as the sacrum. The coccyx wound is labeled as upon admission, however, once the wound is assessed as a sacrum wound, it is documented as in-house acquired. Physician orders from 11/20/24 to 1/9/25 indicate 1. Cleanse with cleanser, pat dry 2. Skin prep to edges and allow to dry 3. Cut to fit wound base Hydrofera Blue Transfer 4. Cover with foam dressing, one time per day every other day. 11/26/24: 2.94 x 6.18 x 0.1 (Sacrum Unstageable, 60% slough, 40% epithelial) Of note R30's wound has almost doubled in width. 12/9/24: 1.02 x 1.13 (Sacrum Unstageable, 70% slough, 30% epithelial) education: resident educated on continuing to offload pressure to the sacral area and to alert staff with urge to void or BM. Of note, there are 12 days between 11/26/24 and 12/9/24 measurement/assessment. 12/19/24: 1.79 x 1.05 (sacrum, Stage 2, 100% epithelial) (Of note, the standard of practice, does not allow for the down staging of pressure injuries. There is 10 days between this measurement and R30's last measurement on 12/9/24.) 12/30/24: sacrum 0.87 x 0.73 (Unstageable, 100% epithelial) Of note: there are 11 days between this measurement and R30's last measurement on 12/30/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/6/25: sacrum 1.75 x 1.1 (Healed) Of note: the facility measured this area as 1.75x1.1, but the facility is calling it healed. The facility was unable to provide any documentation that R30's coccyx/sacrum wound was assessed between 11/26/24 and 12/9/24 and between 12/19/24 and 12/30/24. Additionally, on 11/22/24 R30 developed what the facility called MASD, IAD (Incontinence Associated Dermatitis) on his right gluteal fold (Right ischial tuberosity). The initial assessment of the wound was 4.24 x 3.86 with light sanguineous/bloody exudate. Additional documentation shows (L x W in centimeters with facility-documented type of wound): 11/27/24: 5.14 x 4.13 (MASD-IAD, 10% granulation, 90% slough) Location ischial tuberosity. 12/9/24: Right ischial tuberosity 3.73 x 2.2 (MASD-IAD, 100% slough) Of note: there are 11 days since R30's last measurement on 11/27/24. Additionally, R30 required transfer to the hospital on 12/14/24 due to a UTI (Urinary Tract Infection) and returned to the facility on [DATE]. Upon return from the hospital, R30 was put on Juven powder twice daily and house supplement three times daily between meals. The coccyx/sacrum and gluteal wound were not reassessed upon returning to the facility on [DATE] until 12/19/24. 12/19/24: Right ischial tuberosity 2.75 x 2.7 (MASD-IAD, 100% slough) 1/6/25: Right ischial tuberosity 3.4 x 2.49 (MASD-IAD, 20% granulation, 80% slough). Of note, there are 18 days between R30s last assessment on 12/19/24. R30's physician orders 1/9/25 to 2/1/25: Bilateral buttocks wound care: 1. Cleanse with cleanser, pat dry 2. Skin prep edges and allow to dry 3. Cut to fit wound base Puracol Ag 4. Cover with foam dressing, one time per day every other day and as needed. (It is important to note, that the physician orders indicate bilateral buttock wound care meaning there are wounds to both of R30's buttocks.) 1/13/25: Right ischial tuberosity 2.15 x 2.22 with 0.1 depth (MASD-IAD, 90% slough, 10% epithelial) 1/20/25: Right ischial tuberosity 1.96 x 1.92 (MASD-IAD, 20% granulation, 80% slough) 1/31/25: Right ischial tuberosity 3.09 x 2.61 (MASD-IAD, 100% slough) This is 11 days after the last assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R30's Physician orders: 2/1/25 to 2/7/25: Bilateral buttocks wound care: 1. Cleanse with cleanser, pat dry 2. Skin prep edges and allow to dry 3. Apply Medi-honey 4. Cover with foam dressing, one time a day every other day for wound care and as needed. 2/6/25: Right ischial tuberosity 1.94 x 2.13 (MASD-IAD, 50% granulation, 50% slough) R30's Physician order: 2/8/25 to 2/20/25: Bilateral buttocks wound care: 1. Cleanse with cleanser, pat dry 2. Skin prep edges and allow to dry 3. Apply zinc barrier cream to bases 4. Cover with foam dressing, one time per day every other day and as needed. 2/12/25: Right ischial tuberosity 2.38 x 2 with 0.1 depth (MASD-IAD, 100% slough) 2/18/25: Right ischial tuberosity 2.92 x 2.25 with 0.1 depth (Stage 3, 100% slough) education: educated resident to alert staff when having urge to void or defecate and also on the importance of offloading pressure to area. R30's Physician orders: 2/20/25 to present: Bilateral buttocks wound care: 1. Cleanse with cleanser, pat dry 2. Skin prep edges and allow to dry 3. Pack lateral wound bases with collagen powder when available 4. Cover with foam dressing, one time per day every other day and as needed. 2/25/25: Right ischial tuberosity 2.17 x 9.03 (Stage 3, tissue type unknown/not assessed) The facility did not have any documentation that R30's right gluteal/ischial tuberosity pressure injury was assessed between 11/27/24 and 12/9/24 or 1/20/25 and 1/31/25. Of note, it was identified by the facility that R30 had developed a pressure injury on his left gluteal. This was evident in pictures that accompany facility wound assessments and confirmed on 3/3/25 at 10:40 AM in an interview with RN D (Registered Nurse), who conducts most of the wound care at the facility and is also a nurse manager. At this time, RN D stated that although the facility was aware of the left gluteal pressure injury, they did not assess or measure this wound until today (3/3/25) and assessed it to be a stage 3 pressure injury. Of note, this is the third facility acquired pressure injury for R30. On 2/25/25, R30 would not allow surveyors to observe his pressure injuries when approached. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 2:01 PM, Surveyor interviewed RN D who stated that it was her interpretation that when a wound has slough, it is now a stage 3. When asked about the inconsistencies with the assessments for R30's coccyx/sacrum wound (unstageable to stage 2) and left heel (diabetic to unstageable pressure), RN D indicated that the facility did not have a wound certified nurse and those that were at the facility did the best that they could with their judgement. RN D also indicated that R30's gluteal fold wound went from MASD-IAD to a stage 3 pressure injury due to noticing the way he sat in his chair and seeing where the injuries on his bottom were in line with boney prominences. Additionally, RN D stated that she believed the 10/15/24 skin assessment referring to the 0.5 cm open area on the intergluteal cleft was most likely the start of the coccyx/sacrum wound but there was not any follow up with the physician or NP and there was no further assessment. RN D indicated the NP should have been updated on 10/15/24 regarding this open area. RN D also indicated that the facility generally implements air mattresses as a reactive measure rather than a proactive measure, even though R30 was immobile in his bed and relied on staff for mobility and transfers. On 2/26/25, Surveyor gathered additional interviews: *At 2:31 PM, CNA U (Certified Nursing Assistant) stated that R30 is completely dependent on staff and needs help to reposition when in bed. CNA U stated that R30 should be repositioned every 2-3 hours but is not sure if this is documented anywhere. CNA U indicated that she would tell the nurse if R30 refused repositioning. *At 2:38 PM, CNA T stated that R30 requires 2 people to get in and out of bed. CNA T stated that R30 can roll himself in bed, but sometimes needs help and definitely needs 1 person on the night shift. CNA T stated that they try to reposition R30 4 times per shift (on an 8-hour shift). CNA T indicated that she would tell the nurse if R30 refused to be repositioned but wasn't sure if repositioning gets documented anywhere. *At 2:51 PM, CNA I stated that R30 needs 2 people to get in and out of bed and needs staff assistance to reposition in bed. CNA I stated that when R30 is out of bed, they will lay him down after meals. Additionally, CNA I indicated that R30 should be repositioned every 2 hours and she would tell the nurse if he refused but was unaware if this gets documented or if the repositioning is being done consistently. On 2/26/25 at 1:31 PM, Surveyor interviewed DON B (Director of Nursing) and NHA A (Nursing Home Administrator). Both DON B and NHA A indicated that air mattresses are put into place as a reactive measure, rather than a proactive measure. DON B indicated that there were other measures in place before the air mattress such as repositioning. Additionally, DON B stated that it was her expectation that staff be repositioning R30 every 2 hours. When asked if repositioning was being documented and tracked to ensure that it was being completed, DON B indicated that they would not have documentation on that as it was an as needed intervention. Also, DON B indicated that it is her expectation that any open area on a resident be assessed at least once every 7 days. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/7/25 at 10:42 AM, Surveyor interviewed NP V (Nurse Practitioner) via phone regarding R30's wounds. NP V indicated that R30 is a complicated case and is high risk for skin conditions due to being diabetic, with neuropathy, spinal stenosis and polyneuropathy. NP V indicated R30 is significantly impaired due to limited mobility and being a very high risk for skin breakdown. NP V indicated she sees R30 weekly. NP V indicated she saw R30 today (3/7/25). NP V indicated R30 has a pressure injury on both ischial tuberosities, and that R30 has two total wounds. NP V indicated she visited R30 on 10/18/24 related to his significant injuries after his accident and was having a difficult time with pain management. NP V indicated on 11/1/24, R30 was seen again for pain management due to being in pain in certain positions and he was leaning due to the pain. NP V indicated she saw R30 on 11/12 and noted that staff made multiple attempts with interventions, and he frequently refused and would remove his boot. NP V indicated that R30 understood that his wound was getting worse. NP V indicate R30's wound was worsening due to noncompliance and he was educated on following interventions. NP V indicated on 11/19/24, R30 had a sacral ulcer and R30 was difficult with repositioning and refused. NP V indicated she discussed the importance of repositioning with R30. NP V indicated on 11/26/24, R30's pain was improving and continued to have the sacral area. NP V indicated R30's groin was mentioned, but gluteal fold would be a better location. Surveyor asked NP V if she observed this area, NP V indicated she viewed the area through nursing photos with wound rounds. NP V indicated is unable to describe what the areas looked like due to not seeing the wound. Surveyor asked NP V about when R30's wounds changed from MASD to a pressure injury. NP V indicated the left groin was actually the left ischial tuberosity and the right gluteal was the ischial tuberosity as well. NP V indicated it is difficult to say when it changed to pressure due to R30 being so high risk for pressure injuries. NP V indicated once they started R30 on prednisone his wounds started changing weekly and his risk was extremely high this whole time. Surveyor asked NP V what her expectations are for how often to reposition R30. NP V indicated repositioning and pressure have been an issue this whole time due to R30 being so neuropathic and having no sensation but pain. NP V indicated R30 was not worried about wounds he couldn't feel. Surveyor asked if an air mattress should have been in place since admission given his high risk for PIs. NP V indicated No, as R30 is up and out of bed and would encourage him to lay down, he wants to be up in his chair. Surveyor asked NP V if she had access to the facility wound assessments, NP V replied yes. Surveyor asked NP V to review the 12/19/24 wound assessment photo. NP V reviewed the photo. Surveyor asked NP V if she could tell Surveyor what she sees in the photo. NP V indicated slough tissue with granular tissue. Unable to say percentage due to photo. Surveyor asked NP V if she could see two wounds in the photo. NP V replied, yes. Surveyor asked the location, NP V replied ischial tuberosities. Surveyor asked what type of wounds they were. NP V indicated it was hard to say pressure due to him having incontinence. Surveyor asked if the wounds are circular in shape. NP V indicated yes, circular in shape is a characteristic of pressure. NP V indicated in previous photos, R30 has scar tissue present on the left ischial area and that R30 is at high risk for pressure. Surveyor asked about having slough with MASD, NP V replied yes, as it's dead tissue sloughing off. Surveyor asked how often R30 should be repositioned, NP V replied the facility expectation is every 2 hours. Surveyor asked what R30's left ischial wound looked like today. NP V indicated today (3/7/25), R30's left ischial wound was initially largely slough covered, so it was an unstageable and now it's 90% granulation and 10 % slough with 3cm of scar tissue around it in a week. NP V wanted Surveyor to note that R30 was incontinent of stool three times during wound care today. Surveyor asked NP V about the area measuring 0.5cm on admission. NP V indicated she would expect the hospitalist to address the open area on admit. NP V indicated expected wounds to be measured at least weekly. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure that residents who are continent of bladder and bowel, on admission, receive services and assistance to maintain continence, unless his or her clinical condition is or becomes such that continence is not possible to maintain for 1 of 1 resident's (R25) reviewed for bowel and bladder. The facility did not develop a toileting plan for R25 after they assessed and concluded that R25 would be a candidate for retraining. This is evidenced by: The facility's policy and procedure entitled Urinary Incontinence - Clinical Protocol/Guidelines, with an effective date of 10/2024, states, in part: Assessment and Recognition 1. As part of the initial assessment, the nursing staff will attempt to identify individuals with impaired urinary continence, i.e., reduced ability to maintain urine in a socially appropriate manner .3. For incontinent individuals, the nursing staff will identify, and document circumstances related to the incontinence; for example, frequency, nocturia, dysuria, or relationship to coughing or sneezing .Treatment/Management .2. Assess for environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) that facilitate toileting. 3. As appropriate, based on assessment of the category and causes of incontinence, provide a scheduled toileting, prompted voiding, or other interventions to try to improve the individuals' continence status . R25 was admitted to the facility on [DATE], with diagnoses that include, in part: polyosteoarthritis, atherosclerotic heart disease, type 2 diabetes, hypertension, and muscle weakness (generalized). R25's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 2/12/25 states that R25 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R25 is cognitively intact. Section GG states R25 requires partial/moderate assistance for toilet transfers and requires partial/moderate assistance for walking 10 feet. Section H states R25 does not use any bladder and bowel appliances, has not had a trial of toileting program attempted since admission to the facility, and that R25 is frequently incontinent, which is defined as 7 or more episodes of urinary incontinence, but a least one episode of continent voiding). R25's Physician Orders state, in part: Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for edema (swelling). Order status: Active. Start Date: 5/7/24. (Of note: Furosemide is a diuretic and often causes the need to urinate more frequently) (continued on next page)

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Columbus Health and Rehab	825 Western Ave Columbus, WI 53925

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's evaluation titled, Bladder Incontinence Evaluation- V2, indicates it is unknown if R25's incontinence has a recent onset, R25 currently uses disposable continence products, specifically adult briefs at night only and adult underwear during the day only (Pull Ups). This document also indicates R25 is taking a diuretic, has decreased manual dexterity, requires physical assistance to access commode/urinal, and has decreased muscle strength in his lower extremities. Environmental factors identified include distance to toilet and requires grab bars for support. Type of incontinence is identified as Functional (Normal function affected by environment or disease). A question that states, Irreversible but there is a potential for continence to be maintained or improved by reducing incontinent episodes through a bladder program is marked yes. The Approaches/Plan section has Habit Training/Scheduled Toileting and Incontinence Products/Garments both checked. R25's Comprehensive Care Plan, states, in part: Focus: [Resident Name] is incontinent at times of urine. Date initiated: 5/9/24. Interventions: BRIEF USE: [Resident Name] uses disposable briefs. Change daily and PRN (as needed). Date initiated: 5/9/24. Ensure unobstructed path to the bathroom. Date initiated: 5/9/24. INCONTINENT: Wash, rinse, and dry perineum. Change clothing PRN after incontinent episodes. Date initiated: 5/9/24. Monitor/document s/sx (signs and symptoms) of UTI (urinary tract infection). Date initiated: 5/9/24. (Of note: R25's Comprehensive Care Plan does not note any type of habit training or scheduled toileting program). On 2/26/25 at 4:53 PM, Surveyor interviewed RN L (Registered Nurse). Surveyor asked RN L who completes the resident comprehensive care plans. RN L indicates that DON B (Director of Nursing) was, but recently RN L has taken over this responsibility. Surveyor asked RN L who is responsible for setting up the bladder and bowel programs. RN L indicates all she does is set up the care plan and she does not do anything with the bowel and bladder program or management diaries. On 2/26/25 at 5:06 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B who is responsible for completing the resident comprehensive care plans. DON B indicates it is a shared responsibility between herself and RN L; however, RN L completes the bulk of initiating care plans and each specialty, such as dietary or therapy, works on their own section. Surveyor asked DON B who is responsible for completing bladder and bowel diaries or managing the bowel and bladder program. DON B indicates she is unsure if the facility has been doing formal bladder and bowel diaries. Surveyor advised DON B that R25's Bladder Incontinence Evaluation indicates the facility had a plan to conduct habit training or scheduled toileting to improve or maintain R25's urinary continence. Surveyor asked DON B if those interventions should have been conducted. DON B indicates that if the facility said they were going to do those interventions, they should have done them and documented it.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 49434 Based on observation, interview, and record review, the facility did not ensure nursing staff followed professional standards of practice when flushing a peripherally inserted central catheter (PICC) for 1 of 1 residents reviewed (R237). Staff did not check blood return prior to flushing R237's PICC. Evidenced By: The Facility follows their Pharmacies Policy and Procedure entitled Central Vascular Access Device (CVAD) Flushing and Locking dated 6/1/24, it documents the following in part: .Considerations: 1. Central vascular access devices (CVADs) include: 1.1 Peripherally inserted central catheter (PICC) .4. Flushing/locking is performed to ensure and maintain catheter patency and to prevent the mixing of incompatible medications/solutions. 5. Needless connectors require vigorous cleansing with alcohol prior to accessing to reduce the risk of catheter related bloodstream infection .Guidance .5. Catheter patency must be verified prior to each medication administration. To assess patency, aspirate the catheter to obtain positive blood return. The aspirated blood should be the color and consistency of whole blood .Procedure: 1. Verify prescriber order. 2. Identify patient using appropriate identifiers. 3. Explain procedure to patient/significant other. 4. Perform hand hygiene. 5. Assemble equipment and supplies on clean work surface. 6. [NAME] gloves. 7. Vigorously cleanse needleless connector with alcohol. Allow to air dry .9. Attach syringe filled with prescribed flushing agent to needleless connector. Aspirate the catheter to obtain positive blood return to verify vascular access patency. 10. Flush while observing for signs and symptoms of complication/infiltration. 11. Disconnect syringe .12. Dispose of used supplies per facility policy. 13. Remove gloves. 14. Perform hand hygiene. 15. Documentation in the medical record . R237 is a recent short-term admission to the facility. R237 has the following diagnoses: sepsis due to methicillin resistant staphylococcus aureus, infection following procedure deep incisional surgical site, type 2 diabetes mellitus, and morbid obesity due to excess calories. R237's Progress Note dated 2/15/24 at 21:50 (9:51 PM) documents: PICC flushed with NS and blood return noted. Wound vac and dressing in place. Ice for R (right) hand. On 2/26/25 at 6:56 AM, Surveyor observed RN/MDS L (Registered Nurse/Minimum Data Set) perform R237's PICC line medication initiation. RN/MDS L performed hand hygiene, donned appropriate personal protective equipment (PPE), knocked on R237's door, announced herself and Surveyor, explained what she was there to do, and set up her supplies. RN/MDS L hung IV (intravenous- into or within a vein) medication bag on the IV pole, primed the IV tubing, and removed air bubbles. RN/MDS L cleaned the hub (end) of the PICC line with alcohol, removed NS (normal saline- solution) syringe from package and removed cap, attached NS syringe to hub of PICC line, she unclamped PICC line port and began flushing line with a pulsating (push/stop) motion until syringe was empty. RN/MDS L then took the end of the IV medication bag tubing and removed cap, she cleaned the PICC line hub with alcohol again, attached the IV medication bag tubing to the PICC line hub, set the pump to the correct setting, unclamped IV tubing and PICC line clamps, and monitored for medication to run appropriately. Once that was noted, RN/MDS L doffed PPE, performed hand hygiene, and exited room. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is important to note that RN/MDS L never aspirated (pulled back) to obtain blood return prior to administering medication per their policy and procedure. On 2/26/25 at 4:26 PM, Surveyor interviewed RN/MDS L. Surveyor asked RN/MDS L to explain the flushing protocol for a PICC line, RN/MDS L said complete hand hygiene, alcohol cap, attach syringe, flush line in pulsating motion, remove syringe, and re-apply clamp. Surveyor asked RN/MDS L should blood be aspirated during flush prior to medication administration, RN/MDS L stated I was never taught that, I would for a peripheral line, I was not taught that with PICC line, not even when administering chemotherapy medication. Surveyor asked RN/MDS L if she had had any IV/PICC line training or education here at this facility, RN/MDS L replied skill checks annually but I just started in June, I had one of the nurses go through this with me so I would know how. On 2/26/25 at 10:09 AM, Surveyor interviewed RN M. Surveyor asked RN M to explain the flushing protocol for a PICC line, RN M stated, Clean the hub for 30 seconds with alcohol, attach syringe, unclamp line, push a little NS in, pull back for blood return, finish flush of NS, detach the syringe, and re-clamp line. Surveyor asked RN M how she knew to pull back for blood return, RN M stated that's the way she was taught in the hospital. Surveyor asked RN M if she had, had any IV/PICC line training or education here at this facility, RN M stated, No not since I've been here. On 2/26/25 at 11:51 AM, Surveyor interviewed RN D. Surveyor asked RN D to explain the flushing protocol for a PICC line, RN D replied take the cap off, clean the hub with alcohol, unclamp. flush with NS, re-clamp, and put the cap back on. Surveyor asked RN D if she would aspirate blood, RN D said I don't. Surveyor asked RN D if she had had any IV/PICC line training or education here at this facility, RN D said the pharmacy has come out in the past but not recently. Surveyor asked RN D if LPN's (Licensed Practical Nurses) do IV therapy, RN D said no they do not. On 2/26/25 at 4:55 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B what standard of practice you use for PICC line flushing and maintenance, DON/IP B said the pharmacy guideline. Surveyor asked DON/IP B how you expect a PICC line to be flushed, DON/IP B explained they'd clean the hub with alcohol, flush out air bubbles from syringe, attach to needless connector, flush in pulsation motion until gone, and disconnect. Surveyor asked DON/IP B would you expect blood to be aspirated prior to medication administration, DON/IP B stated, No. On 2/26/25 at 5:44 PM, Surveyor interviewed DON/IP B. Surveyor asked DON/IP B how you ensure nurses are competent when using a PICC line, DON/IP B said there is a list of tasks that need to be signed off within 30 days of hire. Surveyor asked DON/IP B who signs off the nurses, DON/IP B said DON/IP B. Surveyor asked DON/IP B how frequently competency is reviewed, DON/IP B said annually. Surveyor asked DON/IP B how competency is completed for PICC line care, DON/IP B replied I watch them do the task. Surveyor asked DON/IP B if that is documented, DON/IP B stated no. Surveyor asked DON/IP B would you expect staff to be able to perform PICC line skills competently, DON/IP B stated yes. According to <https://www.ncbi.nlm.nih.gov/books/NBK594495/> Before flushing the lumen with 0.9% sodium chloride, aspiration of blood should be attempted to ensure patency. The volume of fluid used for flushing should be twice the volume of the lumen. RN/MDS L was observed not following the policy and procedure for IV medications and does not have a competency check for administering IV 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. 36253 Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the ability to affect all 38 residents. Food items were observed to be spoiled. Scoops were found in containers of sugar. Nutritional supplements were found without use by dates. Four Sysco Imperial Strawberry Shakes were found in the medication room refrigerator with no use by date. Findings include Example 1 On 2/24/25 at 9:24 AM, Surveyor observed in the facility kitchen's refrigerator, along with DM C (Dietary Manager), an unoppened and unchopped bag of fresh parsley with a received date of 1/21/25. Portions of the parsely were visbly brown and slimey. Additionally, Surveyor observed a bag of unopened lettuce with a received date of 2/11/25 that appeared to be slimey and discolored. DM C stated at this time that the lettuce and parsley should be thrown away. Example 2 On 2/24/25 at 9:42 AM, Surveyor observed in the facility kitchen, along with DM C, 3 containers, 1 each of flour, brown sugar and sugar with scoops in each container. DM C indicated to Surveyor at this time that the scoops should not be in the containers as it could be a cross contamination issue. 50228 Example 3 On 2/25/25 at 1:31 PM, Surveyor observed four Sysco Imperial Strawberry Shakes (nutritional supplement) in the medication room refrigerator with no use by date. Surveyor interviewed RN E (Registered Nurse) and asked when the shakes expire / when the shakes should be disposed of. RN E stated unable to tell as the shakes don't have labels. On 2/26/25 at 10:09 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked if there is no label on a supplemental shake, would the staff be able to accurately determine when it needs to be used by / disposed of. NHA A and DON B stated no. Surveyor asked if there should be a use by date on supplemental shakes. NHA A and DON B stated yes.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 49434 Based on interview and record review, the facility did not ensure the facility wide assessment developed by the facility included all relevant details to ensure the facility provided care and services to residents to meet their individual needs within the facility's identified resources. This has the potential to affect all 38 residents residing in the facility. The Facility Assessment did not indicate: -the facility's resident capacity -the care required by the resident population considering the types of disease, conditions, physical and cognitive disabilities, overall acuity -Staff competencies that are necessary to provide the level and types of care needed for the resident population -Physical environment, equipment services, and physical plant considerations that are necessary for care of the population -Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services -The facilities resources, including but not limited to, all buildings and/or other physical structures and vehicles, equipment (medical and non-medical) -Services provided, such as therapy, pharmacy, and specific rehabilitation therapies -All personnel, including managers, staff (both employees and contracted employees), and volunteers as well as their education and/or training and competencies to provide resident care -Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during normal operations -Health information technology resources such as systems for electronically managing patient records and electronically sharing information with other organizations This is evidenced by: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled, Facility Assessment F 838, dated 10/2024, states, in part: Policy Statement: The community will conduct a facility wide assessment, review it periodically and update it annually. Policy Interpretation and Implementation: 1. Purpose - to determine what resources are necessary to care for our residents during both day-to-day operations and emergencies. 2. Updates occur periodically and at least annually. 3. Include: a. The number of residents and the facility's resident capacity; b. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that apply to the current population, c. The staff competencies that are necessary to provide the level and types of care needed for the resident population, d. The physical environment, equipment, services and other physical plan consideration that are necessary for this population, and e. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to activities and food and nutrition services. 4. List, at a minimum the following resources: a. All buildings and/or other physical structures and vehicles; b. Equipment (medical and non-medical); c. Services provided; d. Staff and their associated competencies required; e. Contracts for normal and emergent services; and f. Health information services . Surveyor reviewed the facility document titled Facility Assessment, dated January 2025. Surveyor noted the document contained several categories, the first being Resident Population Profile, dated 12/21/23-12/20/24 that includes sections labeled number of admission/stays, % of admissions/stays, frequency relative to benchmark. The actual benchmark is not listed for any category. Other categories included are Diseases, Conditions & Treatments, Acuity-Frequency of Potentially High-Risk Treatments, Acuity-Care Requirements, Cognitive, Mental & Behavioral Status, Cultural, Ethnic, & Religious Factors. None of these categories had a listed benchmark which the facility had assessed their facility to be capable of accepting. Additionally, the staffing section is titled Staffing, Training, Services & Personnel, containing categories titled Overall Staffing, Staff/Training/Competencies, and Services. All categories are marked Evaluated with no additional information or other staffing needs quantified. Finally, the sections marked Physical Environment, Technology, Equipment have the same categories marked Physical Environment, Technology, and Equipment, and all sections are marked Evaluated with no actual benchmark or quantity of equipment or technology listed. (Of note: Quite often the Frequency Relative to Benchmark is indicated as High or Very High without any reference to the actual benchmark) On 2/26/25 at 11:15 AM, Surveyor asked NHA A (Nursing Home Administrator) for any additional information or documentation related to the facility assessment. NHA A indicated there was none, and that all information was provided. On 2/26/25 at 11:30 AM, Surveyor advised NHA A that Surveyors were looking for documentation stating specific numbers of residents that can be accepted with different conditions, therapies such as IVs, and equipment needs. NHA A indicated she would look for additional documentation. On 2/26/25 at 12:01 PM, NHA A provided Surveyor with the same documentation that was previously described and advised that the information Surveyor was looking for was contained in a paragraph within the previously provided documentation. Surveyor reviewed the paragraph again and could find no additional information specifying the quantity of assessed resident population, staffing, or physical environment needs. Another Surveyor also reviewed the documentation looking for the required information to ensure nothing was missed. Another Surveyor confirmed the required information was not contained within the documents provided. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No additional information was provided as to why the facility did not conduct and document a complete facility-wide assessment to determine what resources are necessary for the care of its residents. The facility assessment must reflect the resident population, and the resources needed to care for this population.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 of 1 resident (R7) reviewed for hospice. R7's current hospice plan of care and visit notes were not available to facility staff. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. This is evidenced by: The facility's Hospice Program policy, dated 10/2024, states, in part: .7. Identify a member of the IDT (interdisciplinary team) who is responsible for working with the hospice representative.This person's responsibilities include: .d. Ensuring the appropriate documents are readily available.If the hospice does not document in PCC (Point Click Care-the facility electronic health record), community may include selecting one personal to scan and upload hospice documents to the resident's electronic medical record no more than 5 days after documents are received as outlined below, to include: i. most recent hospice plan of care. viii. Visit notes from all hospice disciplines, nurse, chaplain, social services, and volunteer.9. The community retains the ultimate responsibility for the care plan. Coordinate the plan of care with the hospice provider, community staff and resident/family. 10. To promote continuity of care, collaborate with the hospice, nursing home and resident/representative on a coordinated care plan noted in the medical record . 14. Designate a member of the community staff to coordinate the plan of care with the hospice provider, specifically to ensure coordination, continuity of care and to resolve differences. Each provider should know how to review the other's care plan. R7 was admitted to the facility on [DATE] and has diagnoses that include, in part: encounter for palliative care (care specializing in managing symptoms and improving quality of life); dementia with agitation (a condition characterized by impairment of brain function, such as memory loss and impaired judgement along with a state of restlessness, anxiety, or distress); diastolic heart failure (a condition where the heart muscle is unable to function properly resulting in reduced blood flow to the body). R7's physician orders include, in part: (provider name) Hospice services related to terminal prognosis. Order date: 3/15/24. On 2/25/25 at 4:08 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) and asked how the facility communicates with hospice. LPN F stated resident's receiving hospice services have a hospice binder for information to be kept. LPN F stated that there is not a facility contact person for hospice; all the nurses communicate with hospice as needed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25, at 9:00 AM, Surveyor asked LPN F for R7's hospice plan of care. LPN F stated she was unable to locate R7's binder in the nurse's station cupboard and stated that each hospice patient is handled differently. On 2/26/25 at 9:02 AM, Surveyor asked RN D (Registered Nurse) for R7's hospice plan of care. RN D stated that RN D was unable to locate R7's binder in the nurse's station cupboard. Surveyor asked RN D how the facility gets information from hospice. RN D stated R7's provider faxes new orders to the facility. Surveyor asked how the facility receives visit notes. RN D stated R7's hospice provider doesn't necessarily send visit notes to the facility. Surveyor asked if there is a facility contact person for hospice coordination. RN D said there is no one person; all the nurses contact hospice as needed. RN D requested assist from DON B (Director of Nursing) with locating the binder. DON B was able to locate the binder in the nurse's station cupboard and provide to surveyor. Binder included information for multiple residents receiving services from (provider name) hospice. R7's information included a plan of care for benefit period 11/9/24 through 1/7/25 and a skilled nursing visit summary dated 12/17/24. On 2/26/25 at 9:33 AM, Surveyor interviewed RN D and asked how often there is facility collaboration with hospice. RN D stated one to two times weekly; more as needed. Surveyor asked where this is documented. RN D stated there is mostly verbal discussion that is not documented. Surveyor asked if the resident's most recent hospice documentation should be in the hospice binder. RN D stated yes. Surveyor asked RN D to review the information in the hospice binder for R7. RN D stated that the date of the most recent plan of care was 12/19/24 and the date of the most recent visit note was 12/17/24. Surveyor asked if there should be a current plan of care and visit notes for staff to reference. RN D stated yes, there is nothing here from 2025. Surveyor asked how the facility ensures that the facility plan of care and the hospice plan of care match. RN D stated if we don't have a current plan of care, we can't. On 2/26/25 at 10:21 AM, Surveyor interviewed DON B (Director of Nursing) and asked if there is a facility staff member who coordinates hospice. DON B stated their nurses handle communication with hospice on their own; there is no coordinator in house. Surveyor asked if there should be a current hospice plan of care and visit notes in the hospice binder for staff to reference. DON B stated yes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 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 infection. This has the potential to affect the census (38). The facility is not monitoring the temperature of 3 of their 5 water heaters as part of their control measures for Water Management Program. The facility's policy and procedure for Pneumococcal Vaccine is not up to date. A breach in infection control was observed with R236, R16, R7, and R22. This is evidenced by: Example 1 Per Centers for Disease Control and Prevention (CDC), 3/15/24 documents, in part: .Cold water guidance: Store and circulate cold water at temperatures below 77 F, although Legionella may grow at temperatures as low as 68 F (20 C). Hot water guidance: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation doesn't fall below 120 F (49 C) and recirculate hot water continuously, if possible . The Facilities Water Management Program dated as reviewed 1/21/25 documents in part: Description of Building Water System .Cold water is heated to 140 degrees by two joined 120-gallon water heaters in the water heater utility room that serves shower and faucet fixtures in room on all three wings. Cold water is also delivered to a 120-gallon water heater in the water heater utility room that serves the kitchen. Cold water is also delivered to an 80-gallon water heater in the 300-wing janitor closet that serves the 300-wing spa. Cold water is also delivered to an 80-gallon water heater in the laundry room that serves the laundry room . Logbook Documentation from 2025 includes the following, in part: 1/9/25- Laundry= 155.1 degrees, Kitchen= 147.1 degrees, 300 Spa= out of order, mixing valve temp= 132 degrees 1/15/25- Laundry= 155 degrees, Kitchen= 147.7 degrees, 300 Spa= closed for repairs, mixing valve temp= 131 degrees 1/24/25- Laundry= 150 degrees, Kitchen= 147.2 degrees, 300 Spa= out of order, mixing valve temp= 132 degrees 1/29/25- Laundry= 151 degrees, Kitchen= 146.2 degrees, 300 Spa= out of order, mixing valve temp= 131 degrees (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525445	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Health and Rehab	825 Western Ave Columbus, WI 53925

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 - Many	2/6/25- Laundry= 155 degrees, Kitchen= 145 degrees, 300 Spa= 112.1, mixing valve temp= 130 degrees 2/13/25- Laundry= 150 degrees, Kitchen= 147.5 degrees, 300 Spa= 113.1, mixing valve temp= 133 degrees 2/20/25- Laundry= 155 degrees, Kitchen= 146 degrees, 300 Spa= 113.2, mixing valve temp= 131 degrees On 2/26/25 at 10:19 AM, Surveyor interviewed Maintenance K. Surveyor asked Maintenance K what control measures are being monitoring routinely to prevent Legionella, Maintenance K said weekly water temperatures. Surveyor asked Maintenance K are the temperatures of the water heaters being check regularly, Maintenance K stated yes technically, the laundry and kitchen each have their own and the rest of the building runs off of 3 other water heaters. Surveyor asked Maintenance K what those water heaters would be labeled on the temperature documentation received, Maintenance K said kitchen, laundry, mixing valve (has 2 water heaters) and the 300 spa (has 1 water heater). Surveyor asked Maintenance K if the temperatures recorded for the mixing valve and the 300 spa were at the water heaters themselves, Maintenance K replied no, those are not, the kitchen and laundry are. Surveyor asked Maintenance K what temperature water must heat to in order to prevent Legionella, Maintenance K stated, Minimum 130 degrees or is it 116 degrees. Of note, 140 degrees is the temperature required to prevent Legionella. On 2/26/25 at 3:28 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A would you expect the control measures for your Water Management Program to be documented, NHA A stated yes. Example 2 The CDC's Pneumococcal Vaccine Recommendations dated 10/26/24 documents in part: .CDC recommends pneumococcal vaccination for children younger than 5 years and adults [AGE] years or older . The Facilities Policy and Procedure entitled Pneumococcal Vaccine F883 dated 10/24, documents in part: . Pneumococcal Vaccine Schedule for Adults greater than or equal to [AGE] years old . On 2/26/25 at 3:31 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist). Surveyor asked DON/IP B do you know the current guidance for pneumococcal vaccine, DON/IP B stated there's the Prevnar 13, Pneumovax 23, and Pneumococcal conjugate 20 for adults over [AGE] years old. Surveyor asked DON/IP B if she is aware of any new guidance after the new addition of the newest vaccine, DON/IP B said not that I am aware of. 49434 Example 3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/25/25 at 1:27 PM, Surveyor observed CNA J (Certified Nursing Assistant) performing Peri Care for R236. R236 was on a toilet at the start of the process. CNA J performed hand hygiene and donned gloves. CNA J then assisted R236 into a standing position and ensured resident safety while standing. CNA J then wiped the perineal area from front to back with several clean wipes. After CNA J, had finished cleaning the resident, she pulled R236's brief and pants up without cleaning her hands or changing gloves. After the resident's clothes were adjusted, CNA J then removed her gloves and performed hand hygiene. On 2/25/25 at 1:35 PM, Surveyor interviewed CNA J. Surveyor asked CNA J if hand hygiene should be performed before touching the resident's clothes after performing peri-care. CNA J, states yes. 50228 Example 4 On 2/24/25 at 11:21 AM, Surveyor observed CNA G (Certified Nursing Assistant) assisting R16 with pericare. During this observation, CNA G performed pericare for R16's front, turned R16 to the side touching R16's bed linens and clothing, touched the wipes package and obtained more wipes, performed pericare for R16's backside, and applied barrier cream. There was no removal of gloves with hand hygiene after contact with bodily fluids prior to touching bed linens, clothing, wipes package, or barrier cream. Surveyor interviewed CNA G regarding infection control. CNA G stated that gloves are contaminated after performing pericare and should have been removed and hand hygiene performed prior to touching resident items and applying barrier cream. On 2/26/25 at 10:22 AM, Surveyor interviewed DON B (Director of Nursing) and asked about hand hygiene and pericare. DON B stated that hand hygiene is expected prior to task, when changing gloves, when moving from dirty to clean site, and when task is complete. Surveyor asked if resident's clothing, linens and supplies should be touched without hand hygiene. DON B stated no. Example 5 On 2/24/25 at 1:51 PM, Surveyor observed CNA H assisting R7 with pericare. During this observation, CNA H removed a mechanical device transfer sling from under the resident and threw the sling onto the floor. CNA H performed pericare for R7's front, turned the R7 to the side touching R7's bed linens and clothing, touched the wipes package and obtained more wipes, then performed pericare for R7's backside. R7 complained of discomfort to R7's bottom. CNA H took the walkie talkie from CNA H's waistband and called the nurse to the room. CNA H gathered the two packages of wipes from R7's bed, opened R7's bedside cabinet and put the wipes away. There was not removal of gloves with hand hygiene after contact with bodily fluids prior to touching bed linens, clothing, wipes packages, walkie talkie, or bedside cabinet. Surveyor interviewed CNA H regarding infection control. Surveyor asked if the floor is contaminated. CNA H stated yes. Surveyor asked if the mechanical device transfer sling should be on the floor. CNA H stated no. Surveyor asked about infection control with pericare. CNA stated that gloves are contaminated after performing pericare and should have been removed and hand hygiene performed prior to touching resident items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/26/25 at 10:22 AM, Surveyor interviewed DON B and asked about hand hygiene and pericare. DON B stated that hand hygiene is expected prior to task, when changing gloves, when moving from dirty to clean site, and when task is complete. Surveyor asked if resident's clothing, linens, supplies, and walkie talkie should be touched without hand hygiene. DON B stated no. Surveyor asked if the floor is considered contaminated. DON B stated yes. Surveyor asked if a transfer sling should be placed on the floor. DON B stated no. Example 6 On 2/26/25 at 11:37 AM, Surveyor observed CNA I assisting R22 with pericare. During this observation, CNA I performed pericare, then CNA I removed one glove, touched the box of gloves with the gloved hand and removed a new glove with the ungloved hand, then applied the new glove to the gloveless hand with the gloved hand. CNA I then assisted R22 with adjusting clothing and transferred R22 to the wheelchair with use of the mechanical sit to stand device. R22 removed both gloves and attempted to cleanse hands with hand sanitizer mounted to the wall in R22's room. CNA I stated the sanitizer was empty. CNA I opened R22's bedroom door, pushed the mechanical device out of the room, and asked Surveyor if anything else was needed before going on to the next resident. Surveyor interviewed CNA I about infection control. CNA I stated that gloves are contaminated after performing pericare and should be removed and hands cleansed prior to touching resident items. Surveyor asked if hand sanitizer is not available is there another option for hand hygiene. CNA I stated hand hygiene could be performed in the resident room with soap and water at the sink. On 2/26/25 at 10:22 AM, Surveyor interviewed DON B (Director of Nursing) and asked about hand hygiene and pericare. DON B stated that hand hygiene is expected prior to task, when changing gloves, when moving from dirty to clean site, and when task is complete. Surveyor asked if staff should remove one glove, obtain another glove, and apply without performing hand hygiene. DON B stated no. Surveyor asked if resident's clothing, supplies, mechanical transfer device, wheelchair, and door should be touched without hand hygiene. DON B stated no.