STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525567	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lights Hcc	706 Bratley Dr Washburn, WI 54891

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interview and record review, the facility failed to ensure that written bed hold notice and reason for transfer required for facility-initiated transfers was provided to the residents or resident representatives at time of hospital transfer or within 24 hours of transfer for 2 of 2 residents (R19 and R33) reviewed for hospitalization . This is evidenced by: The facility policy, entitled Bedhold with effective date of December 28, 2016, states: In the event a resident is temporarily absent from Northern Lights for hospitalization or therapeutic leave you will be offered the opportunity to reserve your residency this action is known as a bed hold.Northern Lights prior to or at time of temporary discharge will provide the resident or the representative a written notice specific to behold to include duration and financial obligation as well as the readmission process. Example 1 R33 was admitted on [DATE] to facility and at that time had signed and dated a Notice of Bedhold Agreement indicating, No, I do not wish my bed reserved during any absence of one day or more. I realize that if I wish to return I will be put on a waiting list for readmission according to Northern Lights policy. On 05/20/24 at 2:04 PM, Surveyor reviewed R33's medical record which indicated R33 was transferred and admitted to the hospital on 02/20/24 due to an unresponsive episode and was unable to find a written notice of bed hold and reason for transfer issued to the resident or resident's representative at time of transfer. Example 2 R19 was admitted to facility on 05/03/24 and due to change in condition was transferred and admitted to hospital on 05/12/24. On 05/21/24 at 7:11 AM, Surveyor reviewed R19's medical record and was unable to find a written notice of bed hold and reason for transfer issued to the resident or resident's representative at time of transfer. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 4:49 PM, Surveyor interviewed Director of Nursing (DON) B who stated that residents sign an agreement upon admission to facility indicating whether they request or decline a bedhold. DON B stated the facility has always done it this way and the facility did not provide a bedhold when change of condition required a transfer to hospital nor documentation supporting reason for transfer for R19 and R33. DON B also indicated that R19 does not have a signed bedhold agreement signed upon admission nor received a bedhold and documentation to support reason for hospital transfer on 05/12/24.

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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 17661

30570

Based on observation, record review and interview, the facility did not provide assistance with activities of daily living (ADL) for residents who are dependent on staff. The facility practice affected 3 of 4 residents observed for ADLs (R5, R29, R16).

This is evidenced by:

Example 1:

R5's most recent comprehensive annual Minimum Data Set (MDS) completed 4/25/24 notes:

Dependent on staff for hygiene

Range of Motion (ROM) 1/2 Indicating impairment of 1 side upper extremities and 2 sides lower extremities.

R5's care plan included the following:

Focus: Actual/At risk and/or potential for complications with deficits with ADL's (Activities of Daily Living) related to current medical/physical status

Goal:

Will have needs anticipated and met through review date Initiated: 3/22/24 with target date of 7/26/24

Will be clean, dry and dressed appropriately and maintain ability to participate in ADL's through next review date. Initiated 3/22/24 with target date 7/26/24

Will remain clean, dry and skin intact through review date, Initiated: 3/22/24 with target date: 7/26/24

Hygiene: 1-2 assist

R5's record included Certified Nursing Assistant (CNA) Tasks:

Apply palm guard in left hand; on AM and off HS (hour of sleep): wash hand and in between fingers before putting on and after removing; dry thoroughly: Days and Evenings

On 5/21/24 at 9:15 AM, Surveyor observed CNA E and CNA F provide morning care for R5. CNA E and F provided R5 peri-care and washing under her arms. CNA E and F transferred R5 to her wheelchair and combed her hair and provided oral care. R5 was transported to the front lobby after cares were completed. CNA E or CNA F did not wash R5's face or hands or provide her with her left hand palm guard.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 11:03 AM, Surveyor spoke with CNA E about the observation. CNA F had concluded her shift and was no longer in the building. CNA E expressed morning care should include resident hand washing and face washing. CNA E further expressed she has been a CNA since January 2024 and is aware of the expectation. CNA E indicated R5 depends on staff for hygiene and cannot do it for herself thus she should have. On 5/21/24 at 4:07 PM, Surveyor interviewed Director of Nursing (DON) B about the facility expectation and policy of CNAs washing residents' face and hands during morning care. DON B explained the facility does not have a policy directing staff to wash residents' face and hands during morning care. It is a basic expectation of Certified Nursing Assistants to wash resident face and hands during morning cares and she would expect it to be done. The CNA skills checklist guides CNAs in expected hygiene for dependent residents. CNA training/basic care expectations directs CNAs to do so. It is important for skin integrity and resident hygiene. 47657 Example 2 The facility policy entitled, Protocol for Turning and Repositioning, states, Residents who are unable to change their position in bed or chair by themselves must be assisted to change positions at least every two hours. The facility policy entitled, Perineal Care, states, It is the policy of [Northern Light Services] to provide perennial cleaning with AM (morning) and PM (evening) cares to those residents who are unable to provide the care for themselves and with every change of incontinence product or incontinence soiled clothing. R29 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease with late onset, unspecified dementia, other specified disorders of brain, and other specified problems related to psychosocial circumstances. R29's annual minimum data set (MDS) assessment, completed on 04/24/24, indicates R29 is rarely or never understood, has a short term and long-term memory problem. R29 is always incontinent of urine and bowel. R29 is dependent on staff for personal hygiene, requires substantial to maximal assist for all transfers and requires supervision or touching assistance with eating. R29's current care plan problems dated 03/26/24 included the following: Skin integrity: At risk for skin breakdown r/t reduced mobility and bowel/bladder incontinence. Bowel/Bladder: incontinent of bowel and bladder related to reduced mobility and need for assistance with toileting. ADLs: Requires assistance with Activities of Daily Living (ADL) due to current medical conditions and cognitive deficits. Nutrition and hydration dietary needs related to Alzheimer's dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's care plan interventions include: Bowel and Bladders: Check and change every 2 hours and as needed d/t dementia and reduced ability to communicate need to use the bathroom. Anticipate needs. Eating: Up in wheelchair all meals supervised, and document amount eaten Hygiene: Assist of 1-2 for peri care Transfers: Assist of 1-2 stand and pivot R29's current orders include close supervision for meals. Staff to assist with set up and encourage resident to eat. three times a day with meals On 05/20/24 at 12:20 PM, Surveyor observed staff bring R29 out to Cafe dining area off the hallway corridor, provided lunch tray and attempted to assist R29 to eat. R29 would not open mouth so staff member left R29 alone with meal tray. No other staff within visual sight of resident On 05/20/24 at 12:35 PM, Surveyor observed R29 pick up fork in right hand then put fork down on tray without attempting to eat. On 05/20/24 at 12:44 PM, Surveyor observed R29 pick up an unopened butter pat container and placed in mouth. A staff member walking past removed butter pat container out of R29's mouth then handed R29 a covered drinking cup with straw and walked away. R29 immediately put cup down on to tray. On 05/20/24 at 12:49 PM, Surveyor observed 2 staff members stop at med cart across hall from Cafe dining area and R29 to converse. Surveyor observed R29 pick up a fork in right hand and put empty fork into mouth. No staff assistance offered and both staff members left area. On 05/20/24 at 12:57 PM, Surveyor observed a staff member walk by and place fork in R29's right hand and encouraged R29 to eat, then walked away. R29 took a drink of fluids from a cup and placed cup down. On 05/20/24 at 1:06 PM, Surveyor continued to observe no staff around, resident picked up paper from straw and began tearing apart straw paper and rolling it between fingers. On 05/20/24 at 1:12 PM, Surveyor observed 2 nurses walk by and stand at Med cart with backs to R29 without observing, encouraging or offering assistance to eat. R29 noted to be making chewing motions, but no observation of R29 placing food into mouth. On 05/20/24 at 1:29 PM, Surveyor observed R29 place a piece of straw paper into mouth and making chewing motions. Surveyor flagged a staff member who alerted nursing staff. On 05/20/24 at 1:34 PM, Surveyor observed RN encourage R29 to open mouth. R29 was not cooperative with opening mouth. RN stated, If [R29] did have something in mouth, it was swallowed. On 05/20/24 at 2:11 PM, Surveyor observed R29 still sitting in small dining area with uneaten meal tray; no staff supervision or assistance to eat was provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3 On 05/21/24, Surveyor conducted continued observation of R29 for 5.5 hours from 8:31AM until 2:01 PM. On 05/21/24 at 8:31 AM, Surveyor observed CNA C and CNA D transfer R29 to wheelchair from bed after receiving morning cares. On 05/21/24 at 8:52 AM, Surveyor observed staff bring R29 out to Cafe dining area and assisted to eat. On 05/21/24 following breakfast, R29 sat at dining table until staff brought R29 down to exercise group, immediately placed in front of the bird cage after exercise group and then immediately brought to cafe dining area for lunch. On 05/21/24 at 2:01 PM, Surveyor observed CNA D take R29 to room from dining table to lay down for nap after conducting incontinence care. Surveyor observed R29's buttocks to be reddened and with indentions from urine-soaked incontinent product. CNA D confirmed redness and indentions indicating did extra cleansing with wipes and checked pants to ensure urine did not leak through incontinence product. On 05/21/24 at 2:01 PM, Surveyor interviewed CNA D, who confirmed R29 was not repositioned or checked and changed since getting up in wheelchair at 8:31 AM. On 05/21/24 at 2:03 PM, Surveyor interviewed CNA C, who confirmed R29 was not repositioned or checked and changed since getting up into wheelchair at 8:31 AM. On 05/21/24 at 4:49 PM, Surveyor interviewed DON B regarding observation of R29 not being toileted, repositioned, or offered assistance to eat. DON B stated the expectation would be that staff follow individual plan of care and facility policies. Example 3 R16 has medical diagnoses that include, but are not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy, diabetes mellitus type 2 with polyneuropathy, extended spectrum beta lactimase resistance, urosepsis, obstructive and reflux uropathy, benign prostatic hyperplasia and muscle weakness. R16 also has an above knee left leg amputation and was hospitalized [DATE]- 8/31/23 for urosepsis and cardiac issues. The most recent Minimum Data Set Assessment (MDSA) was a quarterly assessment with an Assessment Reference Date of 4/25/24. According to this assessment, R16 has a Brief Interview of Mental Status (BIMS) of 3, indicating severe cognitive deficit. R16 is dependent on staff for toileting and transfers with the use of a full body mechanical lift. R16 requires maximum assistance of staff for bed mobility and personal hygiene and is incontinent of bladder and bowel. Included in the Comprehensive Care Plan developed for R16, Surveyor noted the following: (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Requires assistance with ADL (Activities of Daily Living) tasks d/t (due to) current medical conditions and/or cognitive deficits. Date Initiated: 03/31/2024 GOALS: a. Will have needs anticipated and met through next review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024 b. Will be clean, dry, dressed appropriately and maintain ability to participate in ADL's through next review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024 c. Will remain clean, dry and skin intact through next review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024 Interventions for this plan include: - Bed Mobility: Assist 1-2. Bilateral grab bars for positioning and transfers. Date Initiated: 03/31/2024 - Hygiene: Assist 1- Date Initiated: 03/31/2024 - Toilet Use: Assist 1-2 -Date Initiated: 03/31/2024 - Transfers: Assist 2 with Hoyer- Date Initiated: 03/31/2024 2. Incontinent of bowel and bladder r/t reduced mobility, use of diuretics and need for assistance with toileting . Date Initiated: 03/31/2024 Interventions for this plan include: - Incontinence cares with incontinent episodes. Date Initiated: 03/31/2024 - Incontinence supplies include: briefs to prevent clothing from getting soiled. - Check and change every 2 hours at night and as needed. Date Initiated: 3/31/24 There are no directives given to staff on repositioning or toileting throughout the daytime. On 5/20/24: Observation 1 - 9:36 AM, R16 was sitting in wheelchair in front of the television in his room. R16 remained in front of the television until 11:30 AM. - 11:30 AM, R16 propelled self to the Main Dining Room (MDR) in preparation for the meal. There was an activity being conducted in the MDR, but R16 did not participate. Staff gave R16 a cup of coffee to sip on until the meal arrived. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12:00 PM, R16's spouse arrived to visit and began to eat a sandwich prepared at home, giving R16 1/2 of this to eat. - 12:20 PM - 1:10 PM, R16 was at the noon meal and taken to his room at 1:10 PM by spouse. - 1:55 PM R16 continued to converse with spouse in room; spouse activated the call light as R16 wanted to see a nurse. - At 2:22 PM, Certified Nursing Assistant (CNA) R responded to the call light. R16 was requesting to lay down. CNA R then left the room to acquire the mechanical lift and a second staff person to assist. - 2:26 PM, CNA R and CNA S entered R16's room with a full body mechanical lift and assisted R16 to bed. R16 was incontinent of a large amount of urine and a moderate amount of feces. This was an observation of 4 hours and 50 minutes in which no staff approached R16 to offer or encourage toileting and perineal cleansing. At 3:32 PM, Surveyor interviewed CNA R regarding R16's care needs related to repositioning. CNA R stated R16 should be repositioned and toileted every two hours. 5/21/24: Observation 2 At 6:46 AM, Surveyor observed morning cares for R16 provided by CNA C. Once cares were completed, R16 was assisted to the wheelchair with the full body mechanical lift by CNA C and CNA F. This was at 7:09 AM. CNA C then propelled R16 to the MDR, upon the resident's request. CNA C placed R16 at the table in preparation for the morning meal. - From 7:10 AM - 8:26 AM, R16 was in the MDR eating the morning meal. At 8:26 AM, CNA E assisted R16 back to his room. There were no toileting or position changes offered at this time. R16 went to the television and turned it on and began to watch programming. From 8:26 AM - 11:20 AM, no staff entered R16's room to offer or encourage toileting or a position change. - At 11:20 AM, Registered Nurse (RN) U approached R16 to greet resident. R16 indicated to RN U that he wished to go to the kitchen area, or the MDR. RN U propelled R16 to the MDR and placed at the table in preparation for the noon meal. At 11:22 AM, Surveyor approached CNA C, R16's primary caregiver on this day, and interviewed regarding R16's needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA C stated that R16's cognitive abilities vary from day to day, sometimes is able to assist in the bathing with cues. CNA C stated R16 was to be repositioned and a check and change completed every two hours. Surveyor asked CNA C why R16 was not yet offered repositioning or toileting with personal hygiene since her assisting up in the wheelchair at 7:09 AM. CNA C stated, Honestly, I have been focusing on getting residents up because I don't know when nights last did their rounds. I did not go back and check on him, I should have. We had one aide that didn't come in until 7:30 and one that left at 10:00, and I have North and South halls with the exception of my parents that live down there. I have been busy. Even with the knowledge that R16 had not been repositioned or toileted for this length of time, CNA C did not approach R16 to offer this. Surveyor continued to observe R16. - At 1:06 PM, CNA C and CNA D assisted R16 to bed and provided incontinent cares, for which he was incontinent of both bladder and bowel. This was an observation of 5 hours 57 minutes in which offers or encouragement were not attempted by staff for R16 to have assist with mobility or personal hygiene after being incontinent. On 5/21/24 at 2:58 PM, Surveyor interviewed Director of Nursing (DON) B on the expectations of repositioning and toileting R16. DON B stated R16 should be repositioned and brief changed with incontinence cleansing . every 2 hours, it's the standard.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 17661 Based on observations, interviews and record reviews, the facility did not ensure 1 of 2 residents reviewed for wounds (R16) received the necessary treatment and services to promote healing of existing skin integrity impairment according to current standards of practice when not repositioned and nursing staff did not follow infection control practices during wound care. This is evidenced by: The Wound Care Education Institute (WCEI), 2018, directs the caregiver for Non-Sterile dressing changes in the following manner: The purpose of non-sterile dressings is to protect open wounds from contamination and absorb drainage . 5. wash hands and apply gloves .9. Remove soiled dressing .10. Remove gloves, wash hands, apply new gloves .12. Clean wound with normal saline or prescribed cleanser. 13. Pat tissue surrounding the wound with dry 4 x 4 gauze .16. Remove gloves, wash hands, apply new gloves . 18. Apply prescribed topical agent to wound. 19. Apply wound dressing . 23. Discard gloves . 24. Wash hands . The facility Protocol for Turing and Repositioning was reviewed. This protocol was not dated. According to this protocol, .Residents who are unable to change their position in bed or chair by themselves must be assisted to change positions at least every two hours . R16 has medical diagnoses that include, but are not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy, diabetes mellitus type 2 with polyneuropathy, hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure, atherosclerotic heart disease of native artery, ventricular tachycardia, venous insufficiency-chronic peripheral, hypotension and muscle weakness. R16 also has an above knee left leg amputation. The most recent Minimum Data Set Assessment (MDSA) was a quarterly assessment with an Assessment Reference Date of 4/25/24. According to this assessment, R16 has a Brief Interview of Mental Status (BIMS) of 3, indicating severe cognitive deficit. R16 is dependent on staff for toileting and transfers with the use of a full body mechanical lift. R16 requires maximum assistance of staff for bed mobility and personal hygiene and is incontinent of bladder and bowel. Included in the Comprehensive Care Plan developed for R16, Surveyor noted the following: 1. Impairment of abscess on left buttock and excoriation to right buttock. At risk for skin breakdown r/t (related to) decreased mobility secondary to amputation and dx (Diagnosis) of Type II DM (diabetes mellitus) Date Initiated: 03/31/2024 GOALS: a. Will have clean, dry, intact skin through next review date. Date Initiated: 03/31/2024 Revision on: 04/30/2024 Target Date: 07/26/2024 Interventions for this problem include: (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- Assist / Encourage Pressure Relief as needed / accepted. Date Initiated: 03/31/2024

- Pressure reduction cushion in W/C (wheel chair) Roho. Date Initiated: 03/31/2024

- Pressure reduction mattress on bed. Date Initiated: 03/31/2024

2. Requires assistance with ADL (Activities of Daily Living) tasks d/t (due to) current medical conditions and/or cognitive deficits. Date Initiated: 03/31/2024

GOALS:

b. Will be clean, dry, dressed appropriately and maintain ability to participate in ADL's through next review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024

c. Will remain clean, dry and skin intact through next review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024

Interventions for this plan include:

- Non-ambulatory r/t below the knee amputation -Date Initiated: 03/31/2024

- Bed Mobility: Assist 1-2. Bilateral grab bars for positioning and transfers. Date Initiated: 03/31/2024

- Hygiene: Assist 1- Date Initiated: 03/31/2024

- Toilet Use: Assist 1-2 -Date Initiated: 03/31/2024

- Transfers: Assist 2 with Hoyer- Date Initiated: 03/31/2024

3. Incontinent of bowel and bladder r/t reduced mobility, use of diuretics and need for assistance with toileting . Date Initiated: 03/31/2024

Interventions for this plan include:

- Incontinence cares with incontinent episodes. Date Initiated: 03/31/2024

- Incontinence supplies include: briefs to prevent clothing from getting soiled.

- Check and change every 2 hours at night and as needed. Date Initiated: 3/31/24

There are no directives given to staff on repositioning or toileting throughout the daytime.

R16 has an abscess on the left buttock region that goes back as far as 2019, that started as a small pimple-like growth with a pinpoint open area and progressed to tracking between two open areas. These areas have opened and healed numerous times over the past few years. However, there is substantial scarring of R16's buttocks and coccygeal region as a result of this opening and closure, making the entire area fragile and prone to reopening.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16 was observed to lay on a Proactive Protekt Aire 1500 adjustable alternating Pressure Overlay mattress. According to the manufacturer's manual, this overlay . provides non-powered pressure redistribution and is appropriate for all stages of wound prevention when used in conjunction with a comprehensive wound prevention management plan . The most recent diagnosis was made on 1/4/24 when R16 was seen at the local hospital and diagnosed with Hidradenitis suppurativa of the buttock region. This is a chronic inflammatory skin condition of follicular occlusion with lesions, including deep-seated nodules and abscesses, draining skin tunnels (also called sinus tracts or fistulae), and fibrotic scars. These lesions most commonly occur in skin folds or in regions anywhere where there is skin to skin contact, such as the axillary, groin, perianal, perineal, and breast regions. Orders at that time included an antibiotic cleanser as well as to keep the area clean and minimize pressure to the buttocks. The most recent treatment orders were dated 2/9/24, Clean wounds on coccyx with wound cleanser, apply Santyl and small foam dressing. The most recent assessment of the wound was completed on 5/20/24 by Registered Nurse (RN) N. The assessment was as follows: Wound #1: Located on the left inner buttock/groin region nearest the anus (Perianal region). This area measured 2.0 cm (centimeters) L (length) x 0.5 cm W (width) x 0.2 cm D (deep). Wound #2: Left inner buttock/groin region slightly above wound #1: measured 0.2 cm L x 0.2 cm W x 0.1 cm D. Wound #4 right inner buttocks/groin region (Perianal) that measured 0.2 cm L x 0.2 cm W x 0.1 cm D. Note: Wound #3 was located on the right buttocks/groin region and had healed over on 4/23/24. Observation 1 On 5/20/24: - 9:36 AM, R16 was sitting in wheelchair in front of the television in his room. R16 remained in front of the television until 11:30 AM. - 11:30 AM, R16 propelled self to the Main Dining Room (MDR) in preparation for the meal. There was an activity being conducted in the MDR, but R16 did not participate. Staff gave R16 a cup of coffee to sip on until the meal arrived. - 12:00 PM, R16's spouse arrived to visit and began to eat a sandwich prepared at home, giving R16 1/2 of this to eat. - 12:20 PM, beverages were passed by dietary staff and R16 was given a small can of Shasta root beer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Lights Hcc	706 Bratley Dr Washburn, WI 54891

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12:42 PM, R16 was served the meal of pork, baked potato and asparagus. R16's spouse remained during the meal, giving assistance as needed. - 1:10 PM, R16 was taken out of the MDR by spouse and taken to his room, where they continued to visit. - 1:55 PM, R16 continued to converse with spouse in room; spouse activated the call light as R16 wanted to see a nurse. - At 2:22 PM, Certified Nursing Assistant (CNA) R responded to the call light. R16 was requesting to lie down. CNA R then left the room to acquire the mechanical lift and a second staff person to assist. - 2:26 PM, CNA R and CNA S entered R16's room with a full body mechanical lift and assisted R16 to bed. R16 was incontinent of both bladder and bowel. This was an observation of 4 hours and 50 minutes in which no staff approached R16 to offer or encourage a position change off of the open sores. At 3:32 PM, Surveyor interviewed CNA R regarding R16's care needs related to repositioning. CNA R stated that R16's sores on his buttocks are long-standing and come and go. CNA R stated R16 should be repositioned and toileted every two hours. Observation 2 5/21/24: At 6:46 AM, Surveyor observed morning cares for R16 provided by CNA C. Once cares were completed, R16 was assisted to the wheelchair with the full body mechanical lift by CNA C and CNA F. This was at 7:09 AM. CNA C then propelled R16 to the MDR, upon the resident's request. CNA C placed R16 at the table in preparation for the morning meal. - 7:30 AM R16 was given a cup of coffee by dietary staff. - 7:59 AM, Dietary staff passed out beverages to the residents in the MDR. R16 was served the meal, consisting of 8 ounces milk, two 4 ounce glasses of orange juice, coffee, a breakfast sandwich (Fried egg, sausage and cheese in an English muffin) and a bowl of hot cereal. R16 shook some pepper on the egg and began to eat. - 8:23 AM, R16 ate 100% and drank 100% without any issues. - 8:26 CNA E assisted R16 back to his room. There were no toileting or position changes offered at this time. R16 went to the television and turned it on and began to watch programming. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 8:26 AM - 11:20 AM, no staff entered R16's room to offer or encourage toileting or a position change. - At 11:20 AM, RN U approached R16 to greet resident. R16 indicated to RN U that he wished to go to the kitchen area, or the MDR. RN U propelled R16 to the MDR and placed at the table in preparation for the noon meal. At 11:22 AM, Surveyor approached CNA C, R16's primary caregiver on this day, and interviewed regarding R16's needs. CNA C stated that R16's cognitive abilities vary from day to day, sometimes is able to assist in the bathing with cues. CNA C stated R16 was to be repositioned every two hours. Surveyor asked CNA C why R16 was not yet offered repositioning since assisting R16 up in the wheelchair at 7:09 AM. CNA C stated, Honestly, I have been focusing on getting residents up because I don't know when nights last did their rounds. I did not go back and check on him, I should have. We had one aide that didn't come in until 7:30 and one that left at 10:00, and I have North and South halls with the exception of my parents that live down there. I have been busy. Even with the knowledge that R16 had not been repositioned for this length of time, CNA C did not approach R16 to offer repositioning. Surveyor continued to observe R16. - At 1:06 PM, CNA C and CNA D assisted R16 to bed and provided incontinent cares, for which he was incontinent of both bladder and bowel. This was an observation of 5 hours 57 minutes in which offers or encouragement were not attempted by staff for R16 to reposition. Immediately following staff providing incontinent cares, Licensed Practical Nurse (LPN) O entered the room to complete the treatment to R16's wounds. The following was observed: - LPN O washed her hands and donned a pair of gloves. LPN O then removed the old dressing. LPN O did not remove her soiled gloves and wash or sanitize her hands. With the same gloves on from removing the old dressing, LPN O picked up the bottle of SeaClens wound cleanser and sprayed the wounds. LPN O then took clean 4x4 gauze pads and patted the wounds dry. R16 had extensive scarring encompassing the left groin and inner buttocks regions. There were two slitted areas on the inner left buttock/cleft region, near the anus and one additional slit on the right side of this area. There was a red/purple discoloration that extended from the anal region up into the left gluteus/coccyx region that measured approximately 5 centimeters (cm) wide x 3 cm length. Within this area, there is old scarring from previously healed wounds. Below the redness in the cleft and just above the coccyx is a slit or divot area approximately. 2 cm L x .5 cm w open area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- After cleansing the wounds, LPN O did not remove the gloves and sanitize or wash her hands. Instead, LPN O applied Santyl ointment to the center of a Mepilex gauze dressing and then applied this dressing to the red/purple discolored area. LPN O then removed her gloves and covered R16, attached the call light to the sheet and washed her hands. Immediately following at 1:24 PM, Surveyor asked LPN O what directive she was given for the application of the Santyl ointment as it wasn't applied in the wounds but over an area of intact skin. Surveyor explained that Santyl ointment is a chemical debridement and should be placed into the wounds to remove slough and bioburden. LPN O stated, The wound nurse wants us to place the dressing on the gluteal or red areas. I don't know. That's what we are supposed to do. Surveyor then asked LPN O what education she has had related to hand hygiene during a treatment of wounds. LPN O stated, I wash before doing anything and remove the old dressing. Then I should change my gloves and wash the wound. Then I should apply the new dressing and remove my gloves and wash or sanitize my hands. On 5/21/24 at 2:58 PM, Surveyor interviewed Director of Nursing (DON) B on the expectations of repositioning R16. DON B stated R16 should be repositioned . every 2 hours, it's the standard. Surveyor then asked DON B the expectations of hand hygiene during a treatment. DON B stated, The nurse should wash and don gloves upon entering the room and remove the old dressing, then remove the gloves and wash or sanitize and don new gloves. Then the nurse should cleanse the wound and take off gloves and sanitize or wash again and put on new gloves. Then put on the new dressing. Once finished, they should remove the gloves and wash or sanitize again. Every time they switch gloves, they should wash or sanitize their hands. On 05/22/24 at 9:00 AM, Surveyor interviewed RN N via telephone. RN N stated R16 has had the abscess for a long time and it repeatedly opens and closes. RN N stated, at one point the wound tunneled and is considered a full thickness wound. The observations made above were explained to RN N and asked if her directive was to place the Santyl on the discolored area on the buttocks. RN N stated, No, it should always go into the wound itself. It doesn't do anything on intact skin. That would explain why it isn't healing. When asked what the risks are for R16 with no repositioning, RN N stated, Well, the wounds will get worse or new ones could develop.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews and record reviews, the facility did not ensure 1 of 2 residents reviewed for wounds (R89) received the necessary treatment and services to promote healing of existing Stage IV pressure injuries (PIs), according to current standards of practice. - R89 has three Stage IV and two Stage II PI's. Two continuous observations were conducted by the surveyors in which R89 was not offered or encouraged to reposition or offload the buttocks in order to redistribute pressure over the area to allow for healing; - A new wound developed and was given an incorrect anatomical location; - The wound nurse inaccurately staged the wounds; and - Registered Nurse (RN) P completed dressing changes on the wound and did not practice appropriate hand hygiene and completed the treatment inaccurately. This is evidenced by: R89 has medical diagnoses that include but are not limited to paraplegia at thoracic 7-10, hypertensive heart disease, depression, neuromuscular dysfunction of the bladder, neurogenic bowel, chronic pain, acquired absence of the right leg above the knee, carrier of Methicillin Resistance Staphylococcus Aureus and Cauda Equina Syndrome, which occurs when the nerve roots in the lumbar spine are compressed, cutting off sensation and movement. R89's admission Minimum Data Set Assessment (MDSA) was dated 4/9/24. According to this MDSA, R89 has a Brief Interview of Mental Status of 15, indicating full cognitive function. R89 has no behavior or mood indices. This assessment also indicates that R89 requires partial to moderate assistance of staff for toileting and substantial to maximum assistance with dressing upper and lower body and rolling left to right in bed. R89 is totally dependent on staff for transfers with the use of a full body mechanical lift. Included in the care plan developed for R89 were the following: 1. SKIN INTEGRITY: Actual/At Risk and/or Potential for Complications with impaired skin integrity including skin tears, bruising AND/OR pressure R/T (related to) current medical/physical status. Has medications/dx (diagnoses) that can/may affect skin integrity. Resident was admitted with an open groin wound. Date initiated: 04/09/2024; Revision on: 04/13/2024 The goals written for this problem were: Will be free of serious complications r/t (related to) current skin status through next review date. Date initiated: 04/09/2024; Revision on: 04/13/2024 Will have improvement in current pressure injury through next review date. Date initiated: 04/09/2024; Revision on: 04/13/2024 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions to assist R89 to meet the above goals included: - Provide wound care as ordered. Monitor wound weekly and as needed. Update physician if wound is not healing or worsening. Monitor for pain r/t wound and wound care. Date initiated: 04/13/2024 - Medications, Labs and Treatments as ordered. Date initiated: 04/07/2024 - Assist / Encourage Pressure Relief as needed / accepted. Date initiated: 04/07/2024 - Float heel Date initiated: 04/09/2024; Revision on: 05/20/2024 - Observe skin with morning and evening cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Review skin concerns with MD. Date initiated: 04/07/2024 - Follow community skin protocol. Date initiated: 04/07/2024 - Incontinence care with incontinent brief changes. Date initiated: 04/09/2024 - Pressure reduction mattress on bed. Date initiated: 04/09/2024 - Reposition in bed every two hours and as needed. Date initiated: 5/20/24 2. ADL: Actual/At Risk and/or Potential for Complications with Deficit's with ADL's R/T current medical / physical status. Has meds/dx that can/may affect ADL's. Date Initiated: 04/07/2024; Revision on: 04/12/2024 Interventions for this problem included: - Bed mobility: 1-assist Date Initiated: 04/07/2024; Revision on: 04/12/2024 - Transfers: Hoyer with 2-assist Date Initiated: 04/07/2024; Revision on: 04/12/2024 R89 slept on a low air loss mattress, Group 2 (Drive Med Aire variable pressure.) The manufacturer's instructions indicate this overlay is appropriate for all stages of PIs. The most recent Braden Scale Screening Tools, which evaluates an individual's risk for the development of PIs, was dated 5/14/24 and scored R89 a 16. Scores of 15-18 indicates a mild risk for the development of PIs. R89's wounds were then reviewed. According to the Medical Record, R89 admitted to the facility on [DATE] from home with these wounds, but the first assessment was completed on 4/9/24, or one week after admission. The wounds were identified as follows: - Wound #1: Located to the perianal region and identified as R89's groin. This open wound measured 3.0 cm (centimeters) L (length) x 6.2 cm W (width) x 1.5 cm D (depth); There was no stage given; wound base was noted as having 75% granulation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wound #2: Open area on right buttock, body chart also identifies this area to the groin; date of onset 4/3/24 listed as other not PI; 2.0 cm L x 2.8 cm w x 0.6 cm D;' 50% granulation tissue with minimum serous drainage; surrounding tissue intact; undermining/tunneling is present and unable to visualize extent. - Wound #3: identified this wound on the body diagram as the left lower front leg, or upper shin. 2.0 cm L x 2.0 cm W x >0.1 cm D; 75% granulation and 25% slough. On 4/16/24 a new wound appeared: Wound #4: Wound to right side posterior scrotum Area appears red with open tears is in line with the edges of brief that is altered by spouse, recommended using a different brief, same was refused. 2.5 cm L x 3.2 cm W x 0.1 cm D R89 was hospitalized from 5/8/24 - 5/13/24 for fever and nausea and was diagnosed with a urinary tract infection. Of note: R89 sees the wound clinic for the wounds. The most recent assessment by the wound clinic was dated 5/14/24 and the wounds were staged as follows: - Right Ischium: Stage IV - Scrotum: Stage IV - Left malleolus: Stage IV - Midline scrotum: Stage II - Posterior left thigh: Stage II The most recent assessments were dated 5/20/24 and revealed the following: - Wound #1 (Perianal): 2.0 cm L x 3.0 cm W x 4.0 cm D with 75% granulation and minimum Serosanguineous (Thin, Watery, Pale, Red/Pink) drainage. The wound nurse identified this as a Stage II PI. - Wound #2 (Right buttock): 2.0 cm L x 1.5 cm W x 0.8 cm D, with 50% granulation and minimum serosanguineous drainage. The wound nurse identified this as a Stage II PI. - Wound #3 (Left shin): 0.8 cm L x 0.8 cm W x 0.3 cm D Stage II with 100% granulation and minimum serosanguineous drainage. The wound nurse identified this wound as a Stage II. - Wound #4 (Right posterior scrotum): 1.0 cm L x 1.0 cm W x 0.1 cm D with 75% granulation and minimum serosanguineous drainage surrounding tissue intact. Per wound clinic to continue with the Calazime generously On 5/20/24 another new wound developed (#5) to the right upper posterior thigh. The assessment stated, Wound is in line with wound tape that is manipulated daily during dressing changes for another wound in close proximity. This wound was described as excoriation and measured 1.0 cm L x 1.5 cm W x 0.1 cm D with 100 % granulation and minimum serosanguineous drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	OBSERVATIONS/INTERVIEWS: OBSERVATION 1 On 5/21/24 at 6:40 AM, R89 was noted to be in bed with the room dark. R89 was asleep and lying on his back. R89 remained this way until 7:58 AM, when the morning meal was delivered by Certified Nursing Assistant (CNA) C. There was no repositioning completed at that time. CNA C placed the meal tray on R89's table, elevated the head of the bed and adjusted the pillow behind R89's head. At that time, Surveyor interviewed R89 on repositioning. R89 stated that staff come in the room . about once a night and roll me. Other than that, I lay on my back the majority of the night . Also noted with the interview, R89's left foot was resting on a foam cushion, with the outer ankle against the foam. This is an area of breakdown and was not floating, as directed in the plan of care. - From 7:58 AM - 8:59 AM, no staff entered the room to remove the meal tray or offer to reposition him. R89's spouse arrived for a visit. - At 9:13 AM, RN Registered Nurse (RN) P entered R89's room to complete the treatments to the PIs. The following was observed: RN P washed her hands and placed paper toweling on the over bed table and a basket of supplies, including Vashe wound cleanser. RN P then donned a pair of gloves. - RN P then uncovered R89 and removed the foam pad under the left foot and repositioned the left leg to reveal a wound to the left outer ankle bone (malleolus). This wound was lying directly against the foam pad and was not floating. Note: This wound was not identified in any of the weekly assessments. There also was no wound on the left shin, as previously identified in the 5/20/24 assessment. - RN P removed the dressing from the outer ankle bone to reveal a wound approximately 0.5 cm diameter. RN P then removed the soiled gloves, and without sanitizing or washing her hands, donned a fresh pair. RN P then proceeded to apply skin prep solution around the wound. Without removing the now soiled gloves, RN P proceeded to apply Omnicide antimicrobial gel to the PI. RN N removed her gloves and again, without sanitizing or washing her hands, donned a new pair. - RN P then cut a piece of Conva foam to fit the area and placed this over the top of the wound, then initialed and dated a piece of tape and placed this over the foam. RN P removed these gloves and without sanitizing or washing her hands, donned a fresh pair. RN P opened the top drawer of R89's dresser and pulled out a heel protector and a protective leg sleeve and placed these on R89's left foot and leg. RN P then removed the gloves and sanitized her hands. RN P then cleansed R89's front perineum with wet wipes and removed the brief from under the resident. RN P then removed the gloves, sanitized her hands and donned a fresh pair of gloves. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:27 AM, RN P rolled R89 onto the left side in order to complete the dressing changes to the posterior wounds. Note this was 2 hours 47 minutes (6:40 AM - 9:27 AM) of R89 lying on his back with pressure applied directly to these PIs. Surveyor observed R89 to have a large abdominal pad dressing on the right gluteus which contained a moderate amount of shadowing of blood. RN P cleansed R89's buttocks with wet wipes prior to removing the dressing. RN P removed the soiled dressing to reveal four wounds: R89 had one large dark pink to red shiny area, containing scar tissue and excoriation on the left gluteus that extends down into the groin and contains four open areas: 1. posterior thigh 2. Inner perianal area (Stage IV) linear wound 3. Slightly inferior to #2 was another smaller linear wound, stage IV 4. base of the scrotum red and beefy stage II RN P washed off old white cream remnants from the posterior thigh wound. RN P removed her gloves and sanitized her hands. - RN P then removed packing from the two perianal wounds. Without removing gloves and sanitizing or washing hands, RN P sprayed the wounds with Vashe (acetic acid) wound cleanser and gently patted dry. RN P then removed the gloves and sanitized her hands and donned a fresh pair of gloves. - RN P then applied skin prep to the closed skin surrounding the PIs. RN P removed her gloves and donned a clean pair without first sanitizing or washing her hands. - RN P then cut two pieces of Iodoform and placed one piece into each PI (Wound 2 and wound 3), noted above. - Without removing the gloves, RN P picked up the tube of Calazime cream and applied to skin surrounding the PI and the posterior scrotum. RN P then removed the gloves and donned a fresh pair of gloves and covered the PIs with an abdominal pad and taped into place. RN P then removed her gloves and sanitized her hands. Note: Per orders dated 4/18/24: These are for the two open wounds in the perianal region: - One wound was Cleanser: Acetic Acid. Use prior to each dressing change. Peri-wound care: Adapt no sting protective wipe/Apply protective wipe to peri-wound skin. Primary dressing: Ioplex Iodophor foam dressing 6x9 inches/ Cut a tongue of the Ioplex and have it lay flat on the bottom of the wound bed in the pocket. It is to cover the whole base of the wound but not to fill the cavity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The second groin/Perianal wound which was inferior to the one above was Cleanser: Acetic Acid. Use prior to each dressing change. Peri-wound care: Adapt no sting protective wipe/Apply protective wipe to peri-wound skin. Topical: Omnicide Antimicrobial gel/Apply a thin layer to the wound bed. Primary dressing: Aquacel foam non-adhesive dressing. This observation indicated the wrong treatment was given to the inferior PI. At 9:48 AM, RN P removed her gloves and placed a clean brief under R89. RN P then positioned the resident onto the back and washed her hands. OBSERVATION 2 At 11:18 AM, R89 was assisted into the motorized wheelchair by CNA C. Surveyor continued to observe R89 for repositioning offers by staff. At 1:34 PM, Surveyor approached RN P and interviewed her regarding her knowledge of hand hygiene with dressing changes. RN P stated, The basics, I guess. Wash hands with entering the room, place sanitizer on the table, sanitize in between, I mean, exchange gloves in between and wash when all finished. At 2:58 PM, Surveyor interviewed Director of Nursing (DON) B and asked what R89's repositioning needs were. DON B stated, [R89's] repositioning is very specific every two hours, nurses are to document on him that they have seen in different position or they repositioned him themselves. Surveyor asked DON B what the expectation of hand hygiene during a dressing change was. DON B replied, Staff enter the room and wash their hands and wash or sanitize. Switching of gloves and sanitizing should be done after removing the old dressing, when they wash the wound, when they do the treatment and again when applying the new dressing. At 5:50 PM, R89 was still up in his wheelchair. Surveyor entered the room to interview R89, who also had his spouse visiting at that time (Family V). Note: This was 6 hours 30 minutes from when R89 was placed into the chair. R89 was asked if staff offered him a position change since he was assisted to the wheelchair at 11:18 AM. R89 stated, Nobody. No, nobody has come in. R89 was asked if he was able to activate the call light to ask for help. R89 stated, No. I didn't. I have done so in the past and still had to wait up from anywhere to 45 minutes to an hour for them to answer the light. I have just given up asking. Family V was present in the room and stated, I had his wounds nearly healed up when I took care of him at home . I am a retired nurse and know the dangers of not repositioning off the wounds . R89 stated, I am concerned. The sores were getting better, then I had to go to the hospital and they got worse and a new one appeared. I am concerned about them not healing. I have heard of people getting bedsores and infection going to their blood. I don't want that happening to me. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was encouraged to activate his call light to be repositioned and/or laid down and positioned off the pressure injuries. R89 stated, They don't reposition me. I am lucky if they come in once during the night and lay me on the side. I don't have any feeling down there, so I lose track of time. At 6:10 PM, Surveyor approached DON B once again and explained the situation of being up 6 hours and 30 minutes in the chair. DON B immediately called staff and ordered R89 be repositioned. On 5/22/24 at 9:00 AM, Surveyor interviewed RN N (Wound Nurse) via telephone as she was unavailable in-person during the survey, regarding her assessments of R89's wounds. Surveyor asked RN N what she would stage a wound if tunneling was present, as in R89's two groin wounds. RN N stated, That is a IV, I agree with you. Initially upon admission, it looked like a Stage II, then he went to the wound clinic and they did debridement on it and when he came back, it was worse. The reason I put it as a Stage II was because he had it for years, and that is what it looked like to me. I put what I saw as opposed to what the wound clinic had on paper. Surveyor then asked if an assessment was completed of the left outer ankle or malleolus wound. RN N indicated that she had been assessing the outer ankle. Surveyor informed RN N that an assessment of the left shin was done but was unable to locate an ankle wound assessment. RN N stated, No, that should be the ankle not the shin. I will correct that when I come back. I must have put the wrong location on the body diagram assessment. He has no wounds on the shin. Surveyor then asked what the risks are for extensive time periods of no repositioning. RN N replied, Well the pressure injuries will get worse and new ones could develop. Surveyor then explained the observations made with no repositioning R89. RN N stated, Well, that would explain no healing.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30570

Based on observation, record review and interview, the facility did not implement restorative and Functional Maintenance Programs (FMP) in attempt to improve or maintain residents' functional abilities. The facility practice has the potential to affect 13 of 39 sampled and supplemental sampled residents (R5, R21, R12, R25, R15, R22, R9, R28, R30, R32, R17, R27 and R16).

This is evidenced by:

The facility restorative program was reviewed. According to this program, The goal of a Restorative Nursing Program is to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable .

Example 1

Surveyor observed R5 throughout survey in various locations including in bed in her room, in the front lobby and in the dining room for meals. At no time did Surveyor observe a palm protector device in her left hand that was contracted.

On 5/21/24 at 9:15 AM, Surveyor observed Certified Nursing Assistants (CNA)s E and F assist R5 with morning care with R5 in bed. CNA E and F performed peri care, washed under R5's arms and dressed her in bed before transferring her to her wheelchair. CNA E or F did not perform range of motion exercise of R5's upper extremities or place a palm protector in R5's left hand. R5 was transported to the front lobby. Subsequently Surveyor observed R5 in the lobby and in the dining room with no palm protector in place.

On 5/21/24 at 11:03 AM, Surveyor spoke with CNA E about R5's joint limitations and any devices R5 may have to aid her with her limitations. CNA E expressed she has been a CNA since January and was not aware of any devices R5 has that staff should be applying. Surveyor asked CNA E if R5 has a palm protector that should be applied by staff. CNA E expressed she was not aware of any palm protector staff should apply. CNA E and Surveyor went to R5's room, and CNA E attempted to locate a palm protector that could not be located in R5's room.

Surveyor reviewed R5's medical recorded and noted the following:

R5's most recent annual comprehensive MDS (Minimum Data Set) dated 4/25/24 was compared to her previous comprehensive Annual MDS completed 5/28/23. Surveyor noted:

R5 understands and is understood. R5 is cognitively intact as compared to her previous MDS which noted mild impairment. R5 experiences hallucinations and has behavioral indicators. R5 Is dependent on staff for bed mobility, transfer, hygiene and bathing. She has range of motion (ROM) impairment on 1 upper extremity and both lower extremities as compared to 1 upper and lower extremity. R5 is always incontinent.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's care plan does not address FMPs or palm protector device for her left hand. R5's CNA care card does not address her palm protector or FMP for ROM. The CNA Care tasks indicated: Apply palm guard in left hand; ON AM, OFF HS; wash hand and in between fingers before putting on and after removing; dry thoroughly. R5's physician orders included: 3/26/24: OT eval related to use of hand brace 4/12/24: Palm Guard to be placed on left hand AM, off at HS (hour of sleep) daily. Nurse to ensure this is being done. Two times a day R5's most recent Occupational Therapy/ OT Evaluation dated 4/09/24 noted: Diagnosis: Hemiplegia and hemiparesis following unspecified cardiovascular disease affecting left non-dominant side, weakness, pain in left arm. Current referral: .referred to OT services following a nursing report of worsening left wrist and elbow tone Medical Hx (history) hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, personal history of Covid 19, unilateral osteoarthritis of right knee Contracture: functional limitations requiring orthotic Intervention: Pt (Patient) presenting with a flexed elbow, wrist and digits. Location: left hand and wrist. Reason for skilled service: Nursing staff reeducated on FMP and following through, evaluation only due to PROM and splinting, FMP already in place for pt for this issue. PROM (passive range of motion) completed on left elbow, wrist and digits, severe tone present in elbow and wrist. Pt unable to tolerate supination, presenting in guarded flexed position. Elbow extended in 90 degrees. Palm guard placed in pt's hand, FMP reviewed for pt to wear daily, nursing staff not following through with previous FMP. R5's FMP read: I have FMPs in place for left hand skin check/hygiene r/t contracture and BLE (both lower extremities), BUE (both upper extremities) PROM (passive range of motion). Goal: I will participate in my FMP's as recommended by nursing and/or therapy . Approach: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing staff will be monitoring my FMPs for effectiveness and will alter as needed for best results Staff will encourage me to participate in my BUE and BLE PROM FMP, which will help increase my strength and prevent contractures. 4/09/24: Please place white palm guard in left hand during the day. Perform gentle finger, wrist and elbow PROM as patient can tolerate. Surveyor requested data collection showing R5's FMP programs were completed for the past 6 months as none could be located in her medical record. Surveyor was provided Point of Care History dated 2/01/24-2/29/24. The data collection shows R5 refused her FMP on 4 of 29 days and 25 of 29 days there is no data. No other data was provided by the facility showing R5 had been offered her FMPs. On 05/21/24 at 4:37 PM, Surveyor spoke with Director of Nursing (DON) B about R5's lack of data collection showing R5 had been provided her FMPs. DON B expressed the facility has no formal restorative program in place. The facility is aware of concerns related to FMPs not being implemented but no formal quality improvement plan has yet been developed. R5 had FMP in place for a splint or brace much longer than the dated program of 4/09/24. Staff were reeducated after her OT evaluation on R5's FMPs including the palm protector. R5's FMPs were not on her care plan or care card to prompt staff to complete the programs. On 05/22/24 at 10:59 AM, Surveyor interviewed Occupational Therapist (OTR) G about R5's therapy evaluations, R5's FMPs and whether or not R5 had experienced any decline in her joints due to her programs not being completed. OTR G indicated she is a contracted employee and has been working at the facility since June 2023. OTR G expressed R5 has been dependent on staff for care and a hoyer lift transfer since she has been on staff. OTR further expressed R5 has done some basic therapy in past and her left upper extremity does not tolerate passive range of motion well due to her impairments and type of impairment of cognition. R5 was not fond of therapy. R5 FMPs carry over with nursing staff to complete. The last OT evaluation on 4/09/24 OTR G chose to put a palm protector in place versus her splint that was discontinued from nursing due to complaints from resident. The palm guard is to keep R5's left hand in a neutral state to prevent further decline. There is no restorative program here and there is a nursing shortage thus no restorative programs are being done by staff. ROM programs are not being completed. The programs were not added to resident care plans as the facility transitioned to point click care electronic medical record. Staff would not know residents have FMPs if not in their plan of care. Therapy communicated the 4/09/24 update to the cart nurse and 2 CNAs but are now doing electronic submission of programs in attempt to make sure the programs are getting on residents' care plans. Surveyor asked OTR G how the lack of implementation of FMP affected R5. OTR G responded R5 could potentially continue to have decline if her FMPs are not carried through. OTR G confirmed R5 is to have PROM of her upper and lower extremities and a palm guard in place. The palm protector is more of a comfort measure as R5 has no functional movement in her left arm. OTR G expressed many residents are affected by lack of implementation of their FMPs; it has been a chronic subject. The facility is so short staffed there is no restorative aide option. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 11:39 AM, Surveyor interviewed Assistant Director of Nursing (ADON) W who is a Registered Nurse and oversees the restorative programs about repeat deficiency from last year related to lack of restorative and FMPs not being done at the facility. ADON W explained after last year a full sweep was done in house of residents and their programs. When residents came off therapy, programs were discussed and were put in Matrix electronic record. When the facility changed to Point Click Care medical record not all residents' programs were transcribed and transferred from Matrix to Point Click Care. ADON W further expressed she investigated last night and discovered 16 residents had their programs carried over from Matrix to Point Click Care when they transferred electronic record at the end of March. The facility identified 12 residents that their programs were not migrated from electronic medical record system Matrix to Point Click Care when the facility changed programs. The programs were not added to care plans. The certified nursing assistants staff would not know these residents have programs to implement them. Example 2 R21 has FMP in place as follows: Problem: I have FMPS in place for upper body dressing and hygiene, LUE (left upper extremity) ROM (range of motion) . Goal: I will participate in my FMP's as recommended by nursing and/or therapy through my review date. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results Staff will encourage me to participate in the exercise class provided by the facility which includes ROM exercises. This will help increase my strength and flexibility as well as provide social interaction. Staff will encourage me to participate in my left upper extremity ROM FMP which will help increase my strength and prevent contracture's. It may also help reduce my falls and/or complications related to immobility. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R21's care plan did not include her FMPs until brought to the attention of the facility by Surveyor on 5/21/24, at which time ADON W updated R21's care plan. Example 3 R12 has FMP in place as follows: Problem: I have FMP in place for ROM (range of motion) and ambulation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: I will participate in my FMP's as recommended by nursing and/or therapy through my review date. Approach: Nursing staff will monitor distance ambulated for FMP Staff will encourage me to participate in my ambulation FMP, which will help me increase my strength and endurance. It may also help reduce my falls and/or complications related to immobility. Ambulate with resident as tolerated, increasing distance as tolerated. Staff will encourage me to participate in my ROM FMP which will help increase my strength and prevent contracture's. It may also help reduce my falls and/or complications related to immobility. AROM (active range of motion): ankle pumps, seated hip flexion, knee extension, seated hip abduction with thera band. Nursing staff will be monitoring my FMP for effectiveness and will alter as needed for best results. R12's care plan did not include her FMPs until brought to the attention of the facility on 5/21/24, at which time ADON W updated R12's care plan. Example 4 R25 has FMP in place that read: Goal: I will participate in my FMP as recommended by nursing and/or therapy through review date. Target date: 6/08/24 Approaches: When repositioning resident encourage resident to utilize assist rails for self repositioning. Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in my FMP to sit on edge of bed for core strength (be flat do not raise hob (head of bed) This will help increase strength and flexibility. Staff will encourage me to participate in my ROM FMP which will help increase my strength and prevent contracture's. It may also help reduce falls and/or complications related to immobility. R25's care plan did not include his FMPs until brought to the attention of the facility on 5/21/24, at which time ADON W updated R25's care plan. Example 5 R15 has FMP in place that read: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my my FMP. This will help me to increase or maintain some independence with ADL's. R15's care plan did not include his FMP. Example 6 R22's FMP read: Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in my BLE ROM FMP, which will help increase my strength and prevent contracture's. It may also help reduce falls and/or complications related to immobility. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R22's care plan did not include his FMP. Example 7 R9's FMP read: Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in my BLE ROM FMP, which will help increase my strength and prevent contracture's. It may also help reduce falls and/or complications related to immobility. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's care plan did not include his FMP. Example 8 R28's FMP read: Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Resident should be encouraged to sit up in WC (wheel chair) with goal of at least 2 hours at a time Vision: Impaired vision, wears glasses. Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will be encouraging to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R28's care plan did not include his FMP. Example 9 R30's FMP indicated: I have an FMP in place for upper body dressing and AROM (active range of motion) of BLE Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in my AROM FMP, which will help increase my strength and prevent contracture's. It may also help reduce falls and/or complications related to immobility. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R30's care plan did not include his FMP. Example 10 R32 FMP read: I have FMP's in place for ambulation and upper body dressing. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Bilateral upper extremity AROM, progress as tolerated in relation to strengthening. Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in my BLE AROM FMP, which will help increase my strength and prevent contracture's. It may also help reduce falls and/or complications related to immobility. I will remain free from falls or injury during my ambulation FMP Staff will encourage me to participate in my ambulation FMP, which will help increase my strength and endurance. It may also help me reduce falls and/or complications related to immobility. R32's care plan did not include his FMP. Example 11 R17's FMP read: I have FMP's in place for upper body dressing and hygiene and ambulation. Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. I will remain free from falls or injury during my ambulation FMP Staff will encourage me to participate in my ambulation FMP, which will help increase my strength and endurance. It may also help me reduce falls and/or complications related to immobility. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R17's care plan did not include his FMP. Example 12 R27's FMP read: I have FMP's in place for upper body dressing and hygiene, ambulation and up in wheelchair for lunch. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: I will participate in my FMP as recommended by nursing and/or therapy. Approach: Nursing staff will be monitoring my FMP's for effectiveness and will alter as needed for best results. Staff will encourage me to participate in the exercise class provided by the facility which includes ROM exercises. This will help increase my strength and flexibility as well as provide social interaction. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's. R27's care plan did not include his FMP. 17661 Example 13 R16 has medical diagnoses that include, but are not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy, diabetes mellitus type 2 with polyneuropathy, hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure, atherosclerotic heart disease of native artery, ventricular tachycardia, venous insufficiency-chronic peripheral, hypotension and muscle weakness. R16 also has an above knee left leg amputation. The most recent Minimum Data Set Assessment (MDSA) was a quarterly assessment with an Assessment Reference Date of 4/25/24. According to this assessment, R16 has a Brief Interview of Mental Status (BIMS) of 3, indicating severe cognitive deficit. R16 is dependent on staff for toileting and transfers with the use of a full body mechanical lift. R16 requires maximum assistance of staff for bed mobility and personal hygiene and is incontinent of bladder and bowel. Included in the Comprehensive Care plan for R16 were the following: 1. ADL (Activities of Daily Living): Requires assistance with ADL tasks d/t (due to) current medical conditions and/or cognitive deficits. Date Initiated: 03/31/2024 Interventions include: - OT (Occupational Therapy) as ordered. Follow OT Recommendations as able / accepted. Date Initiated: 03/31/2024 - PT (Physical Therapy) as ordered. Follow PT Recommendations as able / accepted. Date Initiated: 03/31/2024 2. RESTORATIVE / FUNCTIONAL PROGRAM: Communication, Upper body Dressing /Grooming, PROM (Passive Range of Motion) Date Initiated: 03/31/2024; Revision on: 03/31/2024 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals include: - Will maintain current functional level through next review. Date Initiated: 03/31/2024 Revision on: 04/30/2024 - Will participate in FMPs (Functional Maintenance Plans) as recommended by nursing and/or therapy through the review date. Date Initiated: 03/31/2024; Revision on: 04/30/2024 Interventions for this plan include: - Restorative / Functional Program: Encourage / Assist / Document - Communication. Encourage resident to use verbal communication, speak slowly and minimize frustration r/t communication difficulties Date Initiated: 03/31/2024; Revision on: 03/31/2024 - Restorative / Functional Program: Encourage / Assist / Document - Encourage resident to assist in upper body Dressing / Grooming to the maximum of potential Date Initiated: 03/31/2024; Revision on: 03/31/2024 - Restorative / Functional Program: Encourage / Assist / Document - PROM (Passive Range of Motion). Encourage elevation of right leg above level of heart for 30 minutes, 6 times daily, pumping right ankle several times. Date Initiated: 03/31/2024; Revision on: 03/31/2024 - Encourage participation in program - notify nurse unit manager and/or therapy of any barriers r/t program. - Notify PT/OT/ST (Speech Therapy) if noted increase / decrease in functional level as needed. Date Initiated: 05/21/2024 R16 also has a separate restorative plan of care dated 5/25/23, and last reviewed on 2/3/24, which states, I have FMP's (Functional Maintenance Program) in place for upper body dressing and hygiene and ROM (Range of Motion). The goals written for this plan included: 1. I will participate in my FMPs as recommended by nursing and/or therapy through the review date. The target date for this goal was 5/3/24. Approaches for this plan include: 1. Staff will encourage me to participate in [NAME] RLE (Right lower extremity) ROM FMP of elevating right leg ABOVE level of heart for 30 minutes, 5-6 times daily and pump right ankle several times when sitting upright. It will help increase strength and prevent contractures. Start date 5/25/23. Frequency in which staff were to implement is written as Twice a day; Days 0600 AM - 0200 PM and Evenings 0200 PM - 10:00 PM 2. Nursing staff will be monitoring my FMPs for effectiveness and will alter as needed for best results. Start date 5/25/23. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Staff will be encouraging me to participate in performing upper body dressing and hygiene per my FMP. This will help me to increase or maintain some independence with ADL's (Activities of daily living.) Start date 5/25/23. The frequency for this approach was twice a day, day shift and evening shift. Surveyor reviewed documentation for the past nearly four months completed by staff, related to the implementation of R16's restorative plan and noted the following: February 2024: to be done twice daily, 15-30 minutes - Number of minutes for dressing and grooming: received once on day shift and received 20 times on evening shift, or a total of 21 times out of 58 opportunities. - Number of minutes for passive range of motion: received 6 times on day shift and 20 times on evening shift, for a total of 26 times out of 58 opportunities; day shift documented not observed 6 times - Number of minutes for active range of motion: documented as being give 6 times on day shift and 22 times on evening shift, for a total of 28 times out of 58 opportunities. Day shift documented not observed 6 times. March 2024: to be done twice daily, 15-30 minutes - Number of minutes for dressing and grooming: received 2 times on day shift and 14 times on evening shift or a total of 16 times out of 62 opportunities. - Number of minutes for passive range of motion: Received 4 times on day shift and 21 times on evening shift with 1 refusal for a total of 26 opportunities out of 62. - Number of minutes for active range of motion: Received 4 times on day shift and 17 times on evening shift with one evening shift noted as resident refused for a total of 22 opportunities out of 62. April 2024: to be done twice daily, 15-30 minutes - Number of minutes for dressing and grooming: did not receive on either shift or 60 opportunities not completed. - Number of minutes for passive range of motion: 0 times on both shifts for a total of 60 opportunities in which it was not completed - Number of minutes for active range of motion: not given on either shift for a total of 60 missed opportunities May 1-22: (22 days or 44 opportunities) to be done twice daily, 15-30 minutes (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Number of minutes for dressing and grooming: did not receive on either shift or 44 opportunities in which it was not completed. - Number of minutes for passive range of motion: did not receive on either shift for a total of 44 opportunities in which it was not completed. - Number of minutes for active range of motion: not given on either shift for a total of 44 opportunities missed. On 5/20/24: Observation 1 Surveyor completed a continuous observation for R16 from 9:36 AM - 2:26 PM. During this continuous observation, R16 was not encouraged nor attempts made to engage in any aspect of the restorative program. At 2:26 PM, R16 was assisted to bed for incontinence care. R16 was then assisted back into the wheelchair. Again, there were no attempts made by staff to encourage or engage R16 in the restorative program. 5/21/24: Observation 2 At 6:46 AM, Surveyor observed morning cares for R16 provided by CNA C. Once cares were completed, R16 was assisted to the wheelchair with the full body mechanical lift by CNA C and CNA F. This was at 7:09 AM. CNA C then propelled R16 to the MDR (Main Dining Room), upon the resident's request. CNA C placed R16 at the table in preparation for the morning meal. R16 remained in the MDR until meal was completed at 8:26 AM, when R16 was assisted back to his room. R16 remained in his room without any staff engagement until 11:20 AM, when he was taken to the MDR for the noon meal. R16 remained in the MDR until meal completion at 12:24 PM, when R16 was taken back to his room. At 1:06 PM, R16 was assisted to bed to receive incontinence care. During this entire day shift, no staff approached to encourage or attempt to engage R16 in the restorative program. On 5/22/24 at 8:15 AM, Surveyor approached CNA Q and asked what her knowledge of R16's restorative plan was. CNA Q stated, Sometimes the one leg, I move it up and down and left to right, arms he works on with propelling his wheelchair. If he looks like he needs it I will do his arms, but I try to do his leg each time I take care of him . I try to do it in the morning with ADLs but sometimes when he lays down, I will do some. At 8:30 AM on this same date, Surveyor interviewed CNA C and asked what her knowledge of R16's restorative program was. CNA C stated, I do his lower right leg. He has free range of the upper extremities. I do hip flexion and extension, raise the right leg 3-4 times as I am getting dressed. I work on flexing and extending knee and do ankle pumps. CNA C was asked why it was not observed when Surveyor observed cares that morning given by her. CNA C stated, All I can say is that I try to do a little as I am dressing him. He doesn't have an FMP to follow. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor then pointed out that R16 actually does have an FMP to follow and showed it to her. CNA C stated, Oh, I guess I wasn't aware he had one. At 8:38 AM, Surveyor interviewed DON B regarding the restorative program. DON B stated the facility was cited heavy on the previous recertification survey and the plan was to initiate a restorative program; however, the facility never did get the program initiated. DON B stated, We are in process of developing one. We have an experienced CNA starting next week, she will go through the training with therapies and be responsible to do the restorative programs. DON B further indicated that the facility has no performance improvement plan in place at the current time. On 5/22/24 at 1:18 PM, Surveyor interviewed ADON W, who oversees the restorative programming and asked her to explain the documentation. ADON W stated, If it was documented as not observed it wasn't completed. A check mark indicates that the task was completed by the certified nursing assistants (CNAs). We had issues when we first transferred over from Matrix care electronic records to the Point Click Care system about a month or two ago. Many residents' restorative programs didn't transfer over, but [R16's] did. The blanks indicate they just didn't do it. I guess I need to do some training with the CNAs.

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

17661

Based on observation, interview and record review, the facility did not provide sufficient staffing to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. This has the potential to affect 14 of 39 residents (R5, R21, R12, R25, R15, R22, R9, R28, R30, R32, R17, R27, R16, and R89) that reside in the facility.

Findings:

The Facility Assessment read in part .Average daily census is 44-50. Based on the facility's resident population and their needs for care and support, the Director of Nursing (DON) is responsible for ensuring appropriate numbers of clinical staff to effectively meet the needs of residents. Nursing staff is evaluated at the beginning of each shift and adjusted as needed to meet the care needs and acuity of the resident population. Number of staff to meet resident needs: licensed nurses to provide direct care, 5-6 total average per day. Nurse aides, 12-15 average per day.

On 05/22/24, Surveyor reviewed nurse staff schedules and daily posting data for the survey period. The schedule for nursing staff included many partial shifts. Surveyor converted the total average staff per day to average hours per day to ensure accuracy. Based on the facility's assessment, licensed nurses to provide direct care converted to 40-48 hours per day and nurse aides converted to 96-120 hours per day.

On 05/20/24, the facility scheduled 66.5 hours/day of nurse aide staff. This is 29.5 hours less than what the facility assessment has determined is needed to meet resident needs.

On 05/21/24, the facility scheduled 94 hours/day of nurse aide staff. This is 2 hours less than what the facility determined is needed.

30570

Example 1

Restorative Services

R5's Functional Maintenance Programs (FMP) for range of motion and placing a palm protector in her left hand during waking hours was not implemented by staff. Occupational Therapist (OTR) G indicated there are not enough certified nursing staff for resident FMPs to be implemented. The facility identified FMPs were not being implemented by staff for R5, R21, R12, R25, R15, R22, R9, R28, R30, R32, R17, and R27.

Two days of observations were made in which staff did not encourage or attempt to engage R16 in his written restorative program.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 10:59 AM, Surveyor interviewed OTR G about R5's therapy evaluations, her FMPs and whether or not R5 had experienced any decline in her joints due to her programs not being completed. OTR G indicated ROM programs are not being completed. OTR G expressed many residents are affected by lack of implementation of their FMP's; it has been a chronic subject. The facility is so short staffed there is no restorative aide option. On 05/21/24 at 4:37 PM, Surveyor interviewed Director of Nursing (DON) B about R5's FMPs and the overall lack of a restorative program. DON B expressed the facility has no formal restorative program in place. There are not enough staff to dedicate a staff for restoratives. The facility is aware of the concern, but no formal quality improvement plan has yet been developed. Refer to F688 for more detail 47657 Example 2 Meal Assistance R29 is dependent on staff for assistance with meals. On 05/20/24 at 12:20 PM, Surveyor observed staff bring R29 out to Cafe dining area off the hallway corridor, provided lunch tray and attempted to assist R29 to eat. R29 would not open mouth so staff member left R29 alone with meal tray. No other staff within visual sight of resident On 05/20/24 at 12:35 PM, Surveyor observed R29 pick up fork in right hand then put fork down on tray without attempting to eat. On 05/20/24 at 12:44 PM, Surveyor observed R29 pick up an unopened butter pat container and placed in mouth. A staff member walking past removed butter pat container out of R29's mouth then handed R29 a covered drinking cup with straw and walked away. R29 immediately put cup down on tray. On 05/20/24 at 12:49 PM, Surveyor observed 2 staff members stop at med cart across hall from Cafe dining area and R29 to converse. Surveyor observed R29 pick up a fork in right hand and put empty fork into mouth. No staff assistance offered and both staff members left area. On 05/20/24 at12:57 PM, Surveyor observed a staff member walked by and place fork in R29's right hand and encouraged R29 to eat then walked away. R29 took a drink of fluids from a cup and placed cup down. On 05/20/24 at 1:06 PM, Surveyor continued to observe no staff around. Resident picked up paper from straw and began tearing apart straw paper and rolling it between fingers. On 05/20/24 at 1:12 PM, Surveyor observed 2 nurses walk by and stand at med cart with backs to R29 without observing, encouraging or offering assistance to eat. R29 noted to be making chewing motions, but no observation of R29 placing food into mouth. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 at 1:29 PM, Surveyor observed R29 place a piece of straw paper into mouth and making chewing motions. Surveyor flagged a staff member who alerted nursing staff. On 05/20/24 at 1:34 PM, Surveyor observed RN encourage R29 to open mouth. R29 was not cooperative with opening mouth. RN stated If R29 did have something in mouth, it was swallowed. On 05/20/24 at 2:11 PM, Surveyor observed R29 still sitting in small dining area with uneaten meal tray; no staff supervision or assistance to eat was provided. Example 3 Repositioning/personal hygiene On 05/21/24, Surveyor conducted continued observation of R29 for 5.5 hours from 8:31 AM until 2:01 PM. On 05/21/24 at 2:01 PM, Surveyor interviewed CNA D, who confirmed R29 was not repositioned nor checked and changed since getting up in wheelchair at 8:31 AM. On 05/21/24 at 2:03 PM, Surveyor interviewed CNA C, who confirmed R29 was not repositioned nor checked and changed since getting up into wheelchair at 8:31 AM. Of note, one CNA didn't come in until 7:30 a.m. on day shift today and one that left at 10:00 a.m., leaving the facility short staffed. Refer to F677 for more detail Example 4 R89 has three Stage IV and two Stage II PI's. Two continuous observations were conducted by the surveyors in which R89 was not offered or encouraged to reposition or offload the buttocks in order to redistribute pressure over the area to allow for healing. These observations were as follows (Refer to F686 for details): 1. On 5/21/24 at 6:40 AM, R89 was noted to be in bed with the room dark. R89 was asleep and lying on his back. R89 remained this way until 7:58 AM, when the morning meal was delivered by Certified Nursing Assistant (CNA) C. There was no repositioning completed at that time. CNA C placed the meal tray on R89's table, elevated the head of the bed and adjusted the pillow behind R89's head. At that time, Surveyor interviewed R89 on repositioning. R89 stated that staff come in the room . about once a night and roll me. Other than that, I lay on my back the majority of the night . - From 7:58 AM - 8:59 AM, no staff entered the room to remove the meal tray or offer to reposition him. R89's spouse arrived for a visit. - At 9:13 AM, Registered Nurse (RN) P entered R89's room to complete the treatments to the wounds. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN P first completed a treatment to R89's left outer ankle and then rolled R89 off the back and onto the left side at 9:27 AM. This was a time period of 2 hours 47 minutes in which R89 laid directly on three Stage IV Pressure Injuries without attempts made by staff to change the resident's position. 2. On 5/21/24 at 11:18 AM, R89 was assisted into the motorized wheelchair by CNA C. Surveyor continued to observe R89 for repositioning offers by staff. At 2:58 PM, Surveyor approached Director of Nursing (DON) B and asked what R89's repositioning needs were. DON B stated, [R89's] repositioning is very specific every two hours, nurses are to document on him that they have seen in different position or they repositioned him themselves. At 5:50 PM, R89 was still up in his wheelchair. Surveyor entered the room to interview R89, who also had his spouse visiting at that time (Family V). Note: This was 6 hours 30 minutes from when R89 was placed into the chair. R89 was asked if staff offered him a position change since he was assisted to the wheelchair at 11:18 AM. R89 stated, Nobody. No, nobody has come in. R89 was asked if he was able to activate the call light to ask for help. R89 stated, No. I didn't. I have done so in the past and still had to wait up from anywhere to 45 minutes to an hour for them to answer the light. I have just given up asking. Family V was present in the room and stated, I had his wounds nearly healed up when I took care of him at home . I am a retired nurse and know the dangers of not repositioning off the wounds . R89 was encouraged to activate his call light and insist he be repositioned and/or laid down and positioned off the sores. R89 stated, They don't reposition me. I am lucky if they come in once during the night and lay me on the side. I don't have any feeling down there, so I lose track of time. Refer to F686 for more detail Example 5 R16 has a perianal abscess with three open areas extending from the abscess. Two continuous observations were conducted by the surveyors in which R16 was not offered or encouraged to reposition or offload the buttocks in order to redistribute pressure over the area to allow for healing or provide toileting/incontinence care. (Refer to F684 and F690 for details) The observations were: 1. 5/20/24 from 9:36 AM - 2:26 PM (4 hours 50 minutes) 2. 5/21/24 from 7:09 AM when R16 was assisted to the wheelchair - 1:06 PM (5 hours 57 minutes) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 11:22 AM, Surveyor approached CNA C, R16's primary caregiver on this day, and interviewed regarding R16's needs. CNA C stated that R16's cognitive abilities vary from day to day, sometimes is able to assist in the bathing with cues. CNA C stated R16 was to be repositioned and he is to be checked and changed every two hours. Surveyor asked CNA C why R16 was not yet offered repositioning since her assisting up in the wheelchair at 7:09 AM. CNA C stated, Honestly, I have been focusing on getting residents up because I don't know when nights last did their rounds. I did not go back and check on him, I should have. We had one aide that didn't come in until 7:30 and one that left at 10:00, and I have North and South halls with the exception of my parents that live down there. I have been busy. Even with the knowledge that R16 had not been repositioned for this length of time, CNA C did not approach R16 to offer this until 1:06 PM. Refer to F684 for more detail On 05/21/24 01:42 PM, Surveyor interviewed Licensed Practical Nurse (LPN) O. LPN O stated, Staffing is a problem. I am always helping the certified nursing assistants (CNAs). The staffing is low for CNAs, it has been that way since the last year or so, it has not changed. There is not enough staff to answer lights, toilet residents, reposition residents. Sometimes there will be two nurses and two aides. If the nurses do not help, the aides are on their own. In the morning we can get about 10 people up, and a CNA will come in about 9 or 10, but we need them here early in the morning to help get people up. Those 10 people will be done eating breakfast, by the time more help comes in. There would be more people up and eating in the dining room if we had more staff. I know the facility is trying and they have increased the CNA wage and it is very good, but there are no staff in the community. We don't ask for time off because there is not enough staff. I feel burnt out every day. DON (Director of Nursing) and ADON (Assistant Director of Nursing) help and work on the floor when they can.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on record review and interview, 2 of 5 residents (R11 and R14) reviewed for unnecessary medications were not comprehensively assessed or adequately monitored for sleep disturbance with use of medications to promote sleep This is evidenced by: Surveyor requested and received the facility policy titled Psychotropic Medication Use dated April 28, 2021. The policy in part read: Procedure: ~The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in long term care facility . ~The facility supports the goal of determining the underlying cause of residents having difficulty sleeping so the appropriate treatment of environmental or medical interventions can be utilized prior to psychopharmacological medication use. ~Nursing: Monitors psychotropic drug use daily. Example 1 R11 was admitted [DATE] with diagnosis that includes insomnia, unspecified. R11's admission Minimum Data Set (MDS) dated [DATE] notes resident understands, is understood and is cognitively intact. R11's at risk medications include antidepressant. Surveyor reviewed R11's physician orders and noted the following: ~Trazodone Oral Tablet 100 MG (milligrams) Give 100 mg by mouth at bedtime related to Insomnia, Unspecified Active 5/2/2024 Surveyor reviewed R11's medical record and noted: ~Sleep Assessment none present in record. ~Sleep Monitoring none present in record Surveyor reviewed R11's care plan and noted the following: Focus: Sleep Disturbance: Resident has dx (diagnosis) of insomnia and sleep apnea. Date Initiated: 5/11/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Will be free of pharmacological interventions for sleep disturbance through next review date. Will report feeling well rested upon rising through next review date. Target Date: 8/08/24 Interventions: Med's / Labs / Treatments as ordered / accepted. Observe / Monitor / Document hours of sleep daily or per protocol. Allow to rise naturally in the morning. Avoid excessive food, fluid, or caffeine intake prior to bedtime. Dim the lights and limit extraneous noises at nighttime. Encourage / Assist participation in daytime activities of interest to promote restful sleep at nighttime. Encourage / Assist to maintain a consistent sleep-wake routine. Limit napping during the day to promote restful sleep at nighttime. Update provider for ongoing sleep disturbance(s). R11's care plan was developed for sleep disturbance without proper assessment of resident individual needs or monitoring to evaluate whether the medication was effective. Example 2 Surveyor reviewed R14's record and noted the following: R14's admission MDS dated [DATE] notes she understands, is understood and is cognitively intact. R14's at risk medications included antidepressant. R14's physician orders included: ~Trazodone Oral Tablet 50 MG Give 12.5 mg via PEG-Tube at bedtime related to Insomnia , unspecified: Active: 4/1/2024 A comprehensive sleep assessment was not located in R14's medical record. The medical record did not show any sleep monitoring to determine if the medication was effective. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's care plan read: Problem: I am at risk for sleep disturbance r/t (related to) Insomnia: Edited: 3/21/24 Goal: I will report feeling rested, not show s/s (signs or symptoms) of sleep deprivation and I will remain free of adverse reactions r/t (related to) my use of sleep enhancing medications through review date: Long term goal target date: 6/21/24 Approach: Encourage me to become involved with activities during the day so I am more tired at bedtime I am on a supplement to promote sleep. Monitor for effectiveness and and update my physician as needed I am on an antidepressant medication to promote sleep. Monitor for effectiveness and adverse effects such as increased lethargy. somnolence, depression, nightmares or restlessness and update my physician as needed. Provide me a quiet environment to help avoid sleep interruption. Update my physician if sleep I have sleep complaints such as over-sleeping, difficulty falling asleep R14's care plan was developed for sleep disturbance without proper assessment of resident individual needs or monitoring to evaluate whether the medication was effective. On 5/21/24 at 4:11 PM, Surveyor interviewed Director of Nursing (DON) B regarding the facility process for comprehensively assessing resident sleep disturbance and monitoring for effectiveness of medications used to promote sleep. DON B explained the facility process is to conduct 72 hour sleep monitoring upon a resident admission. If there are noted sleep difficulties a sleep assessment needs to be completed to identify resident specific difficulties. The information gathered is to be forwarded to the Minimum Data Set (MDS) nurse to complete a sleep assessment and put sleep monitoring in place. This was not done for R11 or R14. No sleep assessment was completed thus DON B is not sure how a care plan got written without proper assessment and monitoring being put in place.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, staff interview and record review, the facility did not ensure food was stored and served under sanitary conditions. This practice had the potential to affect all 39 residents (R) residing in the facility. -Chocolate milk expired on [DATE], five days prior to observation. -Dishwasher temperature logs were not completed. -Internal dishwasher temperatures were not routinely checked. -During tray line service in the kitchen, the maintenance director and a roofer carrying a ladder, entered the kitchen without hairnets. The roofer used the ladder to remove a ceiling tile in the kitchen and view the ceiling above, while speaking with the maintenance director. The roofer then replaced the ceiling tile and exited the kitchen. -A dietary aide did not wear hairnet appropriately. -The cook touched ready to eat food with contaminated gloved hands. Findings: Facility policy related to food storage, stated in part .Perishable foods with expiration dates should be used prior to the use by date on the package. Facility policy titled Employee Sanitary Practices, stated in part .Wear hair restraints, hairnet, hat, and/or beard restraint. Facility policy titled Food Safety and Sanitation, stated in part .Hair restraints are required and should cover all hair on head. [NAME] nets are required when facial hair is visible. Facility policy titled Bare Hand Contact with Food and the Use of Plastic Gloves, stated in part .Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task, used for no other purpose, and discarded when damaged or soiled. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: after handling soiled trays or dishes, after handling anything soiled, after handling packages, any time a contaminated surface is touched. On [DATE] at 9:05 AM, Surveyor completed an initial tour of the kitchen. Surveyor observed individual chocolate milk containers in the line cooler. The line cooler is used for tray line service. The expiration date on the chocolate milk containers was [DATE]. Surveyor interviewed Culinary Director H. Culinary Director H stated the chocolate milk should be disposed of and removed the chocolate milk from the cooler. Culinary Director H reported it is the responsibility of all dietary staff to ensure items are disposed of once expired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial tour of the kitchen, Surveyor observed dishwasher temperature logs for hot water sanitizing dishwasher. Surveyor observed temperatures logs were completed through [DATE]. There were no documented temperatures from [DATE]-[DATE]. Surveyor interviewed Culinary Director H. Culinary Director H reported the expectation is dishwasher temperatures are to be taken and logged at each meal. Culinary Director H was not able to state why the logs were not completed, and reported she would be providing education to the dietary staff. On [DATE] at 11:34 AM, Surveyor observed Culinary Aide K complete dishwashing. During observation Surveyor noted a bag of high temperature dish machine test strips pinned to a corkboard in the dish room. Surveyor noted the test strips had an expiration date of 2022. Surveyor interviewed Culinary Aide K. Culinary Aide K had been employed at the facility for three days and was unsure what the strips were used for. Surveyor interviewed Culinary Aide L. Culinary Aide L was also unsure what the test strips were used for, and stated she thought they were for testing the sanitization buckets. Surveyor observed Culinary Aide L wearing a hairnet, with long hair exposed on the sides and the back of the hairnet. Culinary Aide L was assisting with preparation for tray line service. On [DATE] at 11:41 AM, Surveyor observed dietary staff preparing tray line service for lunch meal. The facility's steam table with food items was confined to the kitchen, and dietary staff completed tray line service in the kitchen. Surveyor observed Plant Operations Director (POD) I enter the kitchen without a hairnet or beard net. POD I walked through the kitchen to a back exit/entrance. POD I returned to the kitchen with a roofer (the facility was completing roofing work during the survey) and a ladder. POD I and the roofer set up the ladder approximately 12 feet from the tray line service area and the steam table containing food items. The roofer used the ladder to remove a ceiling tile in the kitchen and observe the ceiling above. Nursing Home Administrator (NHA) A entered the kitchen wearing a hairnet. NHA A observed POD I and the roofer in the kitchen. After obtaining items, NHA A exited the kitchen. Surveyor did not observe NHA A speak with POD I. The roofer then replaced the ceiling tile, removed the ladder, and POD I and roofer exited the kitchen. Surveyor interviewed [NAME] J. [NAME] J stated, This is not routine. On [DATE] at 11:44 AM, Surveyor observed [NAME] J serving items from the steam table. [NAME] J was wearing disposable gloves. Surveyor observed [NAME] J with gloved hands use all utensils on the steam table to serve food, place gloved hands on the steam table counter covered with spilled food, used gloved hands to push food cart to service line, with gloved hands opened a cooler door and obtained a carton of sour cream. Surveyor observed [NAME] J did not remove gloves or wash hands. Surveyor observed [NAME] J hold pork tenderloin with one gloved hand and remove grill pin with utensil. Surveyor observed [NAME] J hold baked potato with gloved hand and cut the potato open with a knife. Surveyor observed [NAME] J serve pork tenderloin and baked potatoes in this same manner for five plates before removing her gloves, washing her hands, and donning a new pair of disposable gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:21 PM, Surveyor interviewed Culinary Director H. Culinary Director H reported internal dish machine temperatures were not being completed, and she would begin staff education and create a weekly temperature log. Culinary Director H stated the expectation is for anyone entering the kitchen to wear a hairnet, and hairnets to be worn appropriately, covering all hair with no hair exposed. Culinary Director H reported she is usually in the kitchen during tray line service but was unavailable on this date. Culinary Director H stated staff should have instructed POD I to complete maintenance work at a different time, and stated had she been present she would have instructed POD I and the roofer to leave the kitchen during tray line service. Culinary Director H reported during food service, staff should be using utensils to serve food and should not be touching ready to eat food items. Culinary Director H stated she would complete staff education regarding this. On [DATE] at 4:03 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported NHA A did witness POD I and the roofer in the kitchen during meal service and acknowledged he did not address POD I during the incident. NHA A confirmed maintenance should not be completed in the kitchen during food service. NHA A stated he would educate POD I regarding wearing hairnet and beard net, and appropriate times to conduct maintenance in the kitchen.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 44863 Based on interview and record review, the facility did not ensure the mandatory staffing data submitted was complete, accurate, and auditable. This has the potential to affect all 39 residents residing in the facility. Findings: Surveyor reviewed the facility's Payroll Based Journal (PBJ) Staffing reports for Quarter 3 2023, Quarter 4 2023, and Quarter 1 2024. On 05/21/24 at 12:15 PM, Surveyor interviewed Human Resources staff (HR) M. HR M reported she could not provide payroll data for Quarter 3 2023, as the facility had switched payroll systems in July 2023, and she no longer had access to the previous system. HR M was able to provide payroll data for Quarter 4 2023 and Quarter 1 2024. Surveyor noted PBJ for Quarter 3 2023, triggered for, Failed to have Licensed Nursing Coverage 24 hours/day. Surveyor reviewed infraction dates for 04/22/23, 04/23/23, 05/06/23, 05/07/23, 05/14/23, 05/20/23, 05/28/23, 06/03/23, 06/04/23, 06/17/23, 06/23/23, and 06/25/23. Surveyor reviewed schedules for Quarter 3 2023 and noted licensed nursing staff was scheduled for all shifts for all infraction dates. Surveyor noted PBJ data for Quarter 4 2023, triggered for, Excessively Low Weekend Staffing, No RN Hours, Failed to have Licensed Nursing Coverage 24 hours/day. Surveyor reviewed infractions dates for 07/01/23, 07/02/23, 07/08/23, 07/15/23, 07/23/23, 07/29/23, 07/30/23, 08/06/23, 08/12/23, 08/13/23, 08/19/23, 08/20/23, 08/26/23, 08/27/23, 09/02/23, 09/03/23, 09/09/23, 09/10/23, 09/17/23, 09/23/23, 09/24/23, and 09/30/23. Surveyor reviewed schedules and payroll data and noted RN hours were appropriate and licensed nursing staff was scheduled for all shifts for all infraction dates. Surveyor reviewed staffing hours and noted hours worked were consistent during the week and weekends. Surveyor noted PBJ data for Quarter 1 2024, triggered for, Excessively Low Weekend Staffing. Surveyor reviewed schedules and payroll data and noted hours worked were consistent during the week and the weekends. This most recent quarter is reported accurately. On 05/22/24 at 1:38 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported the facility was aware of the inaccurate PBJ data submitted. On 04/12/24, the facility implemented a performance improvement plan for PBJ submission as part of Quality Assurance and Performance Improvement (QAPI). DON B confirmed the facility does not use agency staff, but it was identified that existing staff were not being coded correctly when data was submitted. Based on the facility's assessment with an average census of 44-50 residents, licensed nurses to provide direct care are scheduled for 40-48 hours per day, and nurse aides scheduled for 96-120 hours per day. Surveyor reviewed the facility's schedules and daily postings from 04/12/24-05/22/24 and noted the facility is scheduling adequate staff based on census and facility assessment. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility corrected inaccurate PBJ reporting on 04/12/24 and is in compliance with regulatory requirements. This was cited as past non-compliance.

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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** 30570 Based on observation, record review and interview, staff did not perform hand hygiene when warranted when providing care to 1 of 6 residents observed for care (R5). Certified Nursing Assistants (CNA) E and F did not perform hand hygiene when warranted when providing morning care to R5. This is evidenced by: Surveyor requested and received the facility policy tiled Alcohol Based Hand Rub dated most recently as June 23, 2020. The policy in part read: Policy: It is the policy of Northern Lights Health Care to promote and maintain infection control standards to prevent the spread of infection. Procedure: ~Alcohol Based Hand Rub (ABHR) may be used to clean hands in those situations when soap and water is unavailable, with limited resident contact or while performing tasks with a resident and the ability to wash hands at a sink is not possible. ~ABHR significantly reduce the number of microorganisms on skin, are fast acting . ~ABHR should not take the place of handwashing rather they can act as a sensible strategy to reduce the number of microorganisms . Surveyor requested and received the facility policy tiled Handwashing dated most recently as June 23, 2020. The policy in part read: Policy: All personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure, between glove changes . Surveyor reviewed R5's record and noted her most annual comprehensive MDS dated [DATE] notes she is dependent on staff for bed mobility, transfer, hygiene and bathing. R5 is always incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 9:15 AM, Surveyor observed CNA E and F assist R5 with morning care. CNA E pulled R5's privacy curtain and proceeded to the sink to fill a basin with water. CNA E did not perform hand hygiene. CNA F donned gloves without performing hand hygiene. CNA E removed a floor mat in front of R5's bed and brought the basin of water to R5's bedside table. CNA F obtained a brief and shirt for R5. CNA E removed gloves and stepped out of room for washcloths and returned and donned gloves without performing hand hygiene. CNA E performed peri-care for R5 as CNA F assisted with rolling R5 side to side in bed. CNA F removed her gloves and exited the room to obtain garbage bags. CNA F did not perform hand hygiene with removal of gloves. CNA F returned with garbage bags and went to R5's bathroom washing her hands and donning gloves. CNA E and F continued with R5's peri-care rolling her side to side in bed with CNA E washing R5's peri area and buttocks. CNA E informed Surveyor R5's brief was wet with urine. CNA E proceeded to place a clean brief, clean pants and clean socks without removing her gloves, performing hand hygiene or donning clean gloves. CNA E continued with same contaminated gloved hands to remove R5's shirt and wash under her arms. CNA F retrieved the hoyer lift, removed her gloves and performed hand hygiene. CNA E donned a clean shirt on R5 and assisted CNA F to place the hoyer sling under R5. CNA F removed her gloves with no hand hygiene to retrieve a different sling. CNA E and F transferred R5 to her wheelchair with hoyer lift. CNA F removed her gloves and got a brush to brush R5's hair. No hand hygiene was done when CNA F removed her gloves. CNA E spilled water to the floor from basin, wiped the water from floor, wiped R5's bedside table and rinsesd R5's basin. CNA E removed her gloves and tied up the garbage. CNA F washed her hands and proceeded to brush R5's teeth. CNA E brought R5 water in glass without performing hand hygiene. CNA E and F performed hand hygiene and exited the room with R5. On 5/21/24 at 11:02 AM, Surveyor interviewed CNA E about the observation and hand hygiene expectation. CNA E expressed it is expected to wash hands before donning gloves, when removing gloves and after resident peri care, All the time, every time .should have washed my hands. On 5/21/24 at 4:08 PM, Surveyor interviewed Director of Nursing (DON) B about the observation and expectation for hand hygiene. DON B explained it is expected for staff to perform hand hygiene prior to donning gloves, when removing gloves and after peri care. DON B would expect staff to remove gloves, wash hands and don clean gloves before proceeding. Hand hygiene is important to prevent the spread of infection.