STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555566	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corona Post Acute Center	2600 South Main Street Corona, CA 92882

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 52067 Based on observation, interview, record review, and facility policy review, the facility failed to provide equipment in good condition for 1 (Resident #125) of 5 residents reviewed for environmental hazards. Findings included: An undated facility policy titled, Wheelchair Maintenance Policy, indicated, Policy: It is the policy of this facility that wheelchairs be maintained in good working order. The policy revealed, Inspection includes: b. Checking that removable leg/arm rests are in place, upholstery in good repair and not posing a safety hazard, i.e. [id est, that is], might cause skin injuries if torn etc. [et cetera; and so forth]. The policy revealed, 3. In addition, any staff member aware of a wheelchair needing repairs should give written notice to the maintenance department. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024 revealed the facility admitted Resident #125 on 12/13/2024. According to the MDS, the resident had diagnoses that included hemiplegia (partial paralysis) following cerebral infarction (stroke) affecting the left nondominant side, muscle wasting and atrophy, and other abnormities of gait and mobility. The MDS revealed Resident #125 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS revealed the resident used a wheelchair. The MDS revealed the resident was dependent on staff for chair/bed-to-chair transfers. Resident #125's care plan included a focus area dated 12/14/2024, that indicated the resident had a decline in overall mobility. During an observation and interview on 01/06/2025 at 11:35 AM, Resident #125 was observed lying in bed with their eyes open. When approached Resident #125's eyes closed, and they did not verbally respond. A wheelchair was positioned by the resident's bed. The seat of the chair revealed multiple circular sized burn holes. Resident #125 Family Member was present and stated the wheelchair was provided by the facility. Resident #125 Family Member denied that Resident #125 was a smoker. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/09/2025 at 9:24 AM, Resident #125 was receiving services in the therapy department. The wheelchair sat next to Resident #125 and therapy personnel. The wheelchair seat remained with multiple burn holes. The wheelchair left arm was torn with exposed foam. Physical Therapist (PT) #5 stated when they received a chair maintenance and housekeeping cleaned it. PT #5 stated the therapy department then determined if the chair was appropriate. PT #5 stated that the supply of wheelchairs was in the back third building and someone from their team would retrieve a wheelchair. PT #5 stated they would check the functioning and make repairs to the chair if needed. PT #5 stated that maintenance would fix the breaks and hardware but not cosmetics. PT #5 confirmed they were aware of the condition of Resident #125's wheelchair and stated that it was old. PT #5 stated that they did not complete cosmetic fixing of the wheelchair. During an interview on 01/09/2025 at 9:37 AM, the Director of Maintenance (DOM) stated when new residents were admitted to the facility they provided them with a wheelchair. The DOM stated that when he provided a wheelchair to a resident, he would look at the breaks and check if the wheelchair was in good condition. The DOM stated that there were a few new wheelchairs in stock. The DOM stated that if therapy staff took a chair from the third building it needed to be checked. The DOM stated that they should not have taken a wheelchair from the third back building because those chairs were in storage for repair and were waiting for parts. During an observation and interview on 01/09/2025 at 09:47 AM, Resident #125 was sitting up in bed and smiled when approached and confirmed the wheelchair in their room was provided by the facility. Resident #125 denied that they smoked. The DOM observed the wheelchair. The DOM stated that somebody must have left the wheelchair at the facility, and they used it because it was not one of the facility wheelchairs. The DOM stated that if he had seen the wheelchair, he would have replaced the arm and seat. The DOM stated that the wheels on the wheelchair were worn. The DOM pointed to the side of the wheelchair and stated that the wheelchair was not the name brand that the facility ordered. The DOM confirmed that the wheelchair was not acceptable for use. The Administrator was interviewed on 01/09/2025 at 11:37 AM. The Administrator stated when expecting a new admission and if there is a need for a wheelchair after hours, staff can obtain a wheelchair from the rehab gym. The Administrator stated that maintenance had wheelchairs in their office and that the facility had a process in place. The Administrator stated a resident's personal wheelchair should be removed after discharge. The Administrator stated that someone grabbed the wheelchair from the third building that belonged to a previous resident, and it made it to a resident's room on accident. The Administrator stated the wheelchair should not have been given to Resident #125 because it was not a facility wheelchair. The Administrator stated that it was her expectation that a wheelchair be maintained without rips and holes. During an interview on 01/09/2025 at 4:58 PM, the Director of Nursing (DON) stated that it was his expectation that the facility provided residents with clean, well maintained, and functional equipment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35314 Based on the interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #72) of 4 residents reviewed for Preadmission Screening and Resident Review (PASRR) was referred for a Level II screening. Specifically, Resident #72 was admitted to the facility with a negative Level I screening; however, the resident had a diagnosis of bipolar disorder, a serious mental illness (SMI). The facility failed to identify the SMI and subsequently failed to refer the resident for a Level II PASRR screening. Findings included: A facility policy titled, PASRR, dated 09/26/2023, revealed, 2. If the resident is admitting from the hospital, the hospital discharge planner will complete the Level I PASRR screen prior to admission to the facility and will provide a copy of the Level I to the facility. The policy revealed, Following Admission: Admission of a resident with a primary major mental illness or developmental disability diagnosis: a. The Social Service Director or designee is responsible for notifying the local mental health authority (OBRA [Omnibus Budget Reconciliation Act] Coordinator and/or developmental disability agency for implementation of new or continuation of existing services. The policy revealed, If a resident's psychiatric status changes after admission, the Social Services Staff are responsible for contacting OBRA Coordinator via completion and submission of a PASRR Level I Screen and indicate the Reason for Referral as a change in mental health status of psychiatric diagnosis. Notification of changes are to be made within 10 business days of identifying the change. An Admission Record revealed the facility originally admitted Resident #72 on 12/11/2021 and readmitted the resident on 11/15/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar disorder. Resident #72's hospital Internal Medicine Progress Note, dated 12/09/2021, revealed the resident had a diagnosis of bipolar disorder and would continue topiramate (medication used to treat bipolar disorder). Resident #72's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 12/13/2021, revealed the resident did not have a serious mental illness, which included a mood disorder. The screening revealed the Level I was negative and a Level II was not required. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/30/2024, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. According to the MDS, Resident #72 had not been considered by the state Level II PASRR to have a serious mental illness. However, the MDS indicated Resident #72 had an active diagnosis of bipolar disorder. Resident #72's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 03/12/2024, revealed the resident did not have a serious mental illness. The screening revealed the Level I was negative and a Level II was not required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2025 at 7:34 AM, the MDS Coordinator stated that she checked to ensure each resident had a PASRR upon admission. She stated she checked Level I PASRRs to ensure the resident had matching diagnoses. She stated if they did not match, they completed a record review or a new PASRR. She stated that they looked at progress notes, hospital records and psychiatric notes to determine if the Level I PASRR was accurate. The MDS Coordinator stated when she reviewed Resident #72's Level I PASRR, the resident did not have a SMI. The MDS Coordinator stated that according to the hospital record and progress notes, Resident #72 had a history of bipolar disorder since 2021. She stated she was not aware the resident's Level I PASRR was not accurate, and the diagnosis of bipolar disorder should have been on the Level I PASRR. During an interview on 01/09/2025 at 11:22 AM, the Director of Nursing (DON) stated he was not involved in the PASRR screening process at facility. The DON stated that the MDS office ensured PASRR screenings were accurate, and he expected them to be accurate. During an interview on 01/09/2025 at 1:32 PM, the Administrator stated the Admission Director was responsible for ensuring PASRR screenings were accurate. The Administrator stated that the MDS Coordinator also reviewed PASRRs for accuracy and would resubmit if needed.

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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. 35314 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to provide residents with activities of daily living that included fingernail care for 1 (Resident #69) of 3 residents reviewed for activities of daily living. Findings included: An undated facility policy titled, Fingernails/Toenail, Care of, revealed, 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. An Admission Record revealed the facility admitted Resident #69 on 03/21/2021. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia (paralysis) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (stroke) affecting the left nondominant side, left hand muscle wasting and atrophy, and age-related physical debility. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/2024, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #69 did not have behaviors of rejection of care. According to the MDS, Resident #69 required substantial/maximal assistance from staff with personal hygiene. Resident #69's care plan included a focus area initiated 03/21/2023, the indicated the resident had an impaired ability to perform activities of daily living and required assistance from others to perform tasks related to a diagnosis of cerebrovascular accident (CVA) with hemiplegia/hemiparesis and gout. Interventions directed staff to check the resident's body during care and each shift and to report any findings to the licensed nurse and for the licensed nurse to report the findings to the physician. During an observation and interview on 01/06/2025 at 2:24 PM, Resident #69 had long dirty fingernails on both hands. Resident #69 stated the facility staff did not trim their nails. Resident #69 stated the facility staff had told them that the facility did not have fingernail trimmers. Resident #69 stated that they had purchased nail trimmers previously and staff took them and never trimmed their nails. During an observation on 01/07/2025 at 3:38 PM, Resident #69's fingernails on both hands were long and had not been trimmed. During an interview on 01/08/2025 at 10:12 AM, Certified Nurse Aide (CNA) #2 revealed the aides were allowed to complete fingernail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2025 at 11:18 AM, CNA #1, who was Resident #69's assigned aide, stated while working with Resident #69 last week, Resident #69 requested to have their fingernails trimmed. CNA #1 stated she looked for nail trimmers throughout the facility and was unable to locate nail trimmers. She stated that Resident #69's fingernails were not trimmed. CNA #1 stated while working with Resident #69 on the present day, the resident continued to need their fingernails trimmed because their fingernails were long. During an interview on 01/08/2025 at 11:30 AM, Licensed Vocational Nurse (LVN) #3 revealed she was the assigned nurse for Resident #69. She stated that as the charge nurse, she had not been informed that any residents wanted their nails trimmed including Resident #69. LVN #3 stated she had not seen Resident #69 fingernails and did not know if the resident needed their nails trimmed. During an interview on 01/08/2025 at 12:00 PM, Registered Nurse (RN) #4, who was also a supervisor, stated that the aides or the nurses were able to trim the residents' fingernails if needed. RN #4 stated the facility had nail trimmers in the clean utility room or medication room. During the interview, RN #4 looked inside the utility room and presented nail trimmers and nail filers. During an interview on 01/09/2025 at 11:01 AM, the Director of Nursing (DON) stated if residents need their fingernails trimmed, the facility staff should be able to trim the residents' nails. The DON stated that the facility had nail trimmers and filers in the utility room. The DON stated that if the resident asked for nail trimming, the staff should complete the nail trimming. The DON stated the facility always had nail trimmers available. He stated that he was not made aware of the nail trimmers not being located to trim Resident #69's nails. He stated that he expected the staff to trim the resident's nails. During an interview on 01/09/2025 at 1:19 PM, the Administrator stated that the residents should receive nail care from the facility staff. The Administrator stated that staff should complete nail care during shower days. The Administrator stated that aides or nurses could trim the residents' fingernails.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure pressure ulcer treatment was provided as ordered by the physician for 3 (Resident #57, #63, and #160) of 5 residents reviewed for pressure ulcers. Findings included: A facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered in accordance with prescriber orders, including any required time frames. 1. An Admission Record revealed the facility admitted Resident #57 on 10/11/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of Stage 4 pressure ulcer of the sacral region. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/14/2024, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one Stage 4 pressure ulcer that was present upon admission/entry or reentry. Resident #57's care plan included a focus area initiated 10/12/2023, that indicated the resident had a Stage 4 pressure ulcer to the sacrum. The focus area revealed a goal was for the area to be free from signs/symptoms of infection. Interventions initiated 10/12/2023, directed staff to provide wound care as ordered by the physician, consult with the wound physician as needed, and monitor the effectiveness and response to treatments as ordered. Resident #57's Order Recap [Recapitulation] Report revealed an order dated 01/07/2025, to cleanse the wound to the sacrum with normal saline, pat the area dry, pack the wound bed with Medi honey and calcium alginate and cover the area with a foam dressing every day shift. The report revealed an order dated 11/13/2024 that indicated staff were to replace the foam dressing as needed if it became soiled, dislodged, or damaged. Resident #57's January 2025, Treatment Administration Record [TAR] revealed Treatment Nurse (TN) #11 signed the TAR indicating the treatment to the sacrum was provided on 01/08/2025. Observations of wound care for Resident #57 on 01/09/2025 at 9:22 AM, with TN #8 and Certified Nurse Aide (CNA) #9, revealed when staff removed the resident's incontinence brief there was no dressing in place to the wound on the sacrum. During a concurrent interview CNA #9 stated she had not provided any personal care for Resident #57 since starting her shift at 6:30 AM. She stated the resident went to breakfast, then to activities, and returned to their room for wound care. During an interview on 01/09/2025 at 2:19 PM, TN #8 stated Resident #57's dressing often came off due to frequent bowel movements, but it should be replaced, which was the reason for as needed orders. She stated treatments should be documented. She stated the CNAs usually notified a nurse when a dressing was not in place. According to TN #8, she was frustrated when she went in to complete Resident #57's wound care and there was no dressing in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 01/09/2025 at 4:14 PM, TN #11 stated she was a treatment nurse for the hall where Resident #57 resided on 01/08/2025 and provided wound care for the resident. She stated if the dressing came off, there were orders to provide treatment as needed. She stated the nurse should check to ensure the dressing was in place and the CNAs should also watch and notify the nurse if the dressing needed to be replaced. During a phone interview on 01/09/2025 at 2:10 PM, CNA #10 stated she cared for Resident #57 during the night shift on 01/08/2025 through 01/09/2025. She stated the resident had a small bowel movement and she changed the resident's brief, but she could not recall whether the resident had a dressing in place. She stated if she saw that the wound was without a dressing or if the dressing was coming off, she would let the nurse know. During an interview on 01/09/2025 at 2:32 PM, LVN #12 stated she worked with Resident #57 during the night on 01/08/2025 through 01/09/2025. She stated she did not provide wound care, or a dressing change for Resident #57 and the CNA did not tell her that a dressing was not in place. During an interview on 01/09/2025 at 1:40 PM, LVN #13 stated wound care was provided according to the physician orders. She stated if the dressing came off when the treatment nurse was not at the facility and the CNA notified them, any nurse could replace the dressing. During an interview on 01/09/2025 at 4:31 PM, the Director of Nursing (DON) stated wound care should be provided according to physician orders. He stated if the dressing fell off or was soiled, the charge nurse should provide a treatment. He stated every staff was responsible to ensure the dressing was in place. During an interview on 01/09/2025 at 5:04 PM, the Administrator stated wound care was provided according to the physician order and should include an as needed order. She stated the nurse, and the CNA were responsible to ensure the dressing was in place. She stated the staff should be providing care and the wound should be covered. The Administrator stated that the CNA should have reported that the dressing was missing, and the nurse should have reapplied it according to the orders. 2. An Admission Record indicated the facility admitted Resident #63 on 12/20/2017. According to the Admission Record, the resident had a medical history that included a diagnosis of a Stage 4 pressure ulcer of the sacral region. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one Stage 4 pressure ulcer. Resident #63's care plan included a focus area initiated 10/26/2022, that indicated the resident was at risk for skin breakdown. Interventions directed staff to report skin abnormalities to the licensed nurse when showering/bathing the resident and to provide medications if ordered (initiated 10/30/2020). Resident #63's Order Summary Report revealed an order dated 01/02/2025, to cleanse the sacro-coccyx (sacrum) area with normal saline, pat the area dry, apply Medi honey, and cover with a dry dressing every day shift and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63's January 2025 Treatment Administration Record [TAR], revealed Treatment Nurse (TN) #11 documented that the treatment to the sacro-coccyx was completed on 01/08/2025. Observations of wound care for Resident #63 on 01/09/2025 at 9:22 AM with TN #8 and Certified Nurse Aide (CNA) #14, revealed when staff removed the resident's incontinence brief there was no dressing in place to the wound on the sacrum. During a concurrent interview CNA #14 stated she had provided personal care to the resident that morning and did not remember a dressing being in place or soiled in the brief. CNA #14 stated usually when she completed a brief change and the dressing was soiled, she removed the dressing and told a nurse. She stated she did not think about telling the nurse that there was no dressing in place. During an interview on 01/09/2025 at 1:38 PM, Licensed Vocational Nurse (LVN) #13 stated she worked with Resident #63 the evening of 01/08/2025. She stated she assisted to reposition the resident in the bed, but she did not provide any wound care and was not told that the dressing was not in place during her shift. She stated if the dressing came off when the treatment nurse was not at the facility, any nurse could replace the dressing if the CNA told them. During an interview on 01/09/2025 at 2:19 PM, TN #8 stated Resident #63's dressing often came off due to frequent bowel movements, but it should be replaced, which was the reason for as needed orders. She stated treatments should be documented. She stated the CNAs usually notified a nurse when a dressing was not in place. According to TN #8, she was frustrated when she went in to do Resident #63's wound care and there was no dressing in place. During an interview on 01/09/2025 at 1:40 PM, LVN #13 stated wound care was provided according to the physician orders. She stated if the dressing came off when the treatment nurse was not at the facility and the CNA notified them, any nurse could replace the dressing. During an interview on 01/09/2025 at 4:31 PM, the Director of Nursing (DON) stated wound care should be provided according to physician orders. He stated if the dressing fell off or was soiled, the charge nurse should provide a treatment. He stated every staff was responsible to ensure the dressing was in place. During an interview on 01/09/2025 at 5:04 PM, the Administrator stated wound care was provided according to the physician order and should include an as needed order. She stated the nurse, and the CNA were responsible to ensure the dressing was in place. She stated the staff should be providing care and the wound should be covered. The Administrator stated that the CNA should have reported that the dressing was missing, and the nurse should have reapplied it according to the orders. 52067 3. An Admission Record revealed the facility admitted Resident #160 on 12/18/2024. According to the Admission Record, the resident had a medical history that included diagnoses of sepsis, chronic systolic (congestive) heart failure, type 2 diabetes mellitus with unspecified complications, weakness, and anemia. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/2024, revealed Resident #160 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had no pressure ulcers during the assessment look-back period but was at risk of developing pressure ulcers/injuries. Resident #160's care plan included a focus area dated 12/18/2024, that indicated the resident was at risk and/or had the potential for skin breakdown due to fragile skin, poor mobility, and a diagnosis of anemia. Interventions directed staff, specifically certified nurse aides (CNA) to report any skin abnormalities to a nurse when showering/bathing the resident, and for the charge nurse to complete a weekly skin assessment. Resident #160's care plan included a focus area dated 12/18/2024, that indicated the resident was at risk for further impairment to skin integrity related to the presence of rashes, fragile skin, and a diagnosis of anemia. An intervention directed staff to follow facility protocols for treatment of injury (initiated 12/19/2024). An SBAR [Situation-Background-Appearance-Review and Notify] Communication form dated 01/03/2025 at 10:30 PM and completed by Licensed Vocational Nurse (LVN) #16 revealed a CNA noticed redness to the resident's heels after providing a shower. Resident #160's January 2025, Treatment Administration Record [TAR], revealed a transcription of an order dated 01/04/2025, for the left lateral heel to be painted with betadine, covered with an abdominal pad, and wrapped with rolled gauze every day shift. Further review revealed an order dated 01/04/2025, for the left lateral foot to be painted with betadine, covered with an abdominal pad, and wrapped with rolled gauze every day shift. The TAR revealed LVN #17 documented that the treatment to the left heel and left lateral foot was provided on 01/06/2025, 01/07/2025, and 01/08/2025. During an observation of Resident #160's left foot on 01/08/2025 at 10:17 AM, CNA #15 removed a blanket from the resident's lower extremities and a piece of tape on a gauze dressing to the resident's left foot was dated 01/05 (no year). During an interview on 01/08/2025 at 10:55 AM, LVN #17 stated she did not provide Resident #160's treatment on Monday (01/06/2025) or Tuesday (01/07/2025). She stated that she asked the next shift to provide the treatments. During an observation on 01/08/2025 at 11:27 AM, LVN #17 removed the gauze dressing from Resident #160's left foot and confirmed the dressing was dated 01/05 (no year) and that she had written the date on the dressing. LVN #17 stated that she provided the resident's treatment on Monday (01/06/2025) because she was not at the facility on Sunday (01/05/2025). LVN #17 stated the treatment for Tuesday (01/07/2025) was missed. She stated when she got ready to provide the treatment, she signed the TAR. LVN #17 revealed she signed Resident #160's TAR for Tuesday (01/07/2025) indicating the treatment was provided; however, when she went to the resident's room, other staff were busy with the resident. She stated she planned to go back to provide the resident's treatment but did not. LVN #17 stated that the same thing happened today (01/08/2025), she had signed Resident #160's TAR indicating the treatment was provided; however, she did not provide the resident's treatment. During an interview on 01/08/2025 at 3:39 PM, the Director of Nursing (DON) stated he had been telling the nurses to read the order, gather materials, check yes in the TAR, and once the treatment was provided, they should check save. The DON stated he expected staff to follow treatment orders. (continued on next page)

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	555566	A. Building B. Wing	01/09/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 11:37 AM, the Administrator stated he expected physician orders to be followed. The Administrator stated he expected staff to sign after they provided the treatment, which was the standard of practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory breathing treatments as ordered by the physician for 1 (Resident #15) of 2 residents reviewed for respiratory services. Findings included: A facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, specified, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The policy revealed, Preparation included 2. Review the resident's care plan, current orders and diagnoses to determine resident needs. 3. Check the treatment record. 4. Assemble the equipment and supplies as needed. An Admission Record indicated the facility admitted Resident #15 on 04/29/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #15's care plan included a focus area initiated 05/05/2023, that indicated the resident was at risk for shortness of breath and difficulty breathing related to COPD, asthma, and cough. Interventions directed staff to provide medication/puffers (inhalers) as ordered and monitor/document side effects and effectiveness (initiated 02/02/2024). During an observation and interview on 01/06/2025 at 12:44 PM, Resident #15 stated they were supposed to get breathing treatments, but the staff only came once. A nebulizer machine was observed under several personal items next to the nightstand. During an observation and interview on 01/07/2025 at 1:47 PM, Resident #15's nebulizer machine was inside a wagon next to their nightstand with personal items covering the machine. The medication cannister and tubing were in a bag that was dated 12/30/2024. Resident #15 again stated they only received a treatment once since the treatments were started in December 2024. A handwritten Physician and Telephone Order dated 12/16/2024 for Resident #15 revealed an order for DuoNeb (ipratropium-albuterol; medications delivered via a nebulizer machine to open the airways to help an individual breath) one vial every six hours routinely for seven days. Resident #15's Order Recap [Recapitulation] Report revealed the order for the ipratropium-albuterol was transcribed into the electronic health record incorrectly. The report indicated the order was entered as ipratropium-albuterol solution one vial every six hours every seven days, instead of every day for seven days as documented on the written physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's December 2024 Respiratory Therapy treatment administration record (TAR) revealed the transcription of the ipratropium-albuterol order that also indicated the medication should be administered every six hours, every seven days and was scheduled to be administered once on 12/16/2024, then again on 12/23/2024 and 12/30/2024 at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM (every six hours). Resident #15's Progress Notes dated 01/02/2025 at 11/17/2025, revealed Respiratory Therapist (RT) #19 documented that the resident stated they had shortness of breath, cough, and congestion. The notes indicated a breathing treatment was given for 15 minutes and was well tolerated. The notes indicated the physician was notified and ordered a chest x-ray and reordered breathing treatments for seven more days. A review of Resident #15's Order Recap Report revealed the order for ipratropium-albuterol was renewed on 01/02/2025 and continued to be ordered every six hours, every seven days. Resident #15's January 2025, Respiratory Therapy TAR revealed staff had documented that ipratropium-albuterol was administered once on 01/02/2025 at 12:00 PM. The TAR revealed the ipratropium-albuterol was scheduled to be administered at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM (every six hours) one day per week on 01/09/2025, 01/16/2025, 01/23/2025, and 01/30/2025. During an interview on 01/07/2025 at 3:22 PM, Licensed Vocational Nurse (LVN) #18 revealed that the handwritten order in the chart for Resident #15's ipratropium-albuterol did not match the order in the electronic health record (Order Recap Report). LVN #18 also revealed that the nebulizer machine was under several items in a wagon next to the resident's nightstand, and the date on the nebulizer tubing and plastic bag was 12/30/2024. During an interview on 01/09/2025 at 12:46 PM, RT #19 stated she did not put the original order in for Resident #15's ipratropium-albuterol but did renew the order when the resident was having increased congestion and cough (on 01/02/2025). She stated the order was supposed to be for every six hours for seven days. RT #19 stated she only changed the dates on the order in the computer and did not ensure the order or scheduling was accurate. She stated it was an oversight. During an interview on 01/09/2025 at 1:40 PM, LVN #13 stated that upon receiving an order, she entered it into the electronic system and scheduled when it should be completed. She stated that staff saw the orders every shift, and that nursing and medical records staff should be checking orders. During an interview on 01/09/2025 at 4:31 PM, the Director of Nursing (DON) stated when a new physician's order was received, staff should enter the order into the electronic health record and staff should also complete a clinical note. The DON stated the clinical team should review clinical notes during a morning meeting and should check to ensure that orders were entered into the electronic health record correctly. The DON stated when renewing an order, they should change the stop date. During an interview on 01/09/2025 at 5:04 PM, the Administrator stated that when receiving a new order, the nurse should carry out the order by verifying it, transcribe the order to the treatment administration record and care plan, and notify the resident and responsible party of the new order. She stated the nebulizer order for Resident #15 should have been checked and verified that it was put in correctly then double checked by another nurse.

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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. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff performed hand hygiene and glove changes during wound and peri-care for 2 (Resident #57 and Resident #63) of 5 residents reviewed for pressure ulcers. Findings included: An undated facility policy titled, Wound Care, indicated, Steps in the Procedure included 2. Wash and dry your hand thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves. Further review revealed, 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. The policy revealed, 12. Apply treatments as indicated. 13. Dress wound. The policy revealed, 15. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. The Centers for Disease Control and Prevention (CDC) publication titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/2024 revealed the CDCs recommendations for cleaning hands included, - Immediately before touching a patient [resident]. - Before moving from work on a soiled body site to a clean body site on the same patient. - After touching a patient or patient's surroundings. - After contact with blood, body fluids, or contaminated surfaces. - Immediately after glove removal. Per the publication, Gloves are not a substitute for hand hygiene and recommendations included, - If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. - Always clean your hands after removing gloves. The publication revealed recommendations for changing gloves and cleaning hands included, - If gloves become soiled with blood or body fluids after a task. - If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs. 1. An Admission Record revealed the facility admitted Resident #57 on 10/11/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of Stage 4 pressure ulcer of the sacral region. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/14/2024, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one Stage 4 pressure ulcer that was present upon admission/entry or reentry. Resident #57's care plan included a focus area initiated 10/12/2023, that indicated the resident had a Stage 4 pressure ulcer to the sacrum. The focus area revealed a goal was for the area to be free from signs/symptoms of infection. Interventions initiated 10/12/2023, directed staff to provide wound care as ordered by the physician, consult with the wound physician as needed, and monitor the effectiveness and response to treatments as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57's care plan included a focus area, initiated 04/18/2024, that indicated the resident required enhanced barrier precautions and was at risk for infection related to an indwelling urinary catheter and wounds. Interventions initiated 04/18/2024 emphasized the importance of frequent and thorough handwashing with soap and water and utilizing alcohol-based hand sanitizer and educating the resident, family, and healthcare providers on proper hand hygiene. Resident #57's Order Recap [Recapitulation] Report revealed an order dated 01/07/2025, to cleanse the wound to the sacrum with normal saline, pat the area dry, pack the wound bed with Medi honey and calcium alginate and cover the area with a foam dressing every day shift. During observations on 01/09/2025 at 9:22 AM, Treatment Nurse (TN) #8 and Certified Nurse Aide (CNA) #9 entered Resident #57's room, washed their hands, and donned a gown and gloves. They removed Resident #57's adult brief and feces was noted. CNA #9 provided incontinence care and without changing her gloves, touched the resident's linens, pillows, and bed control. The observation revealed TN #8 assisted CNA #9 by holding the resident on their side during incontinence care and was observed touching the resident's linens and pillows. TN #8 did not change her gloves or perform hand hygiene prior to cleaning the pressure ulcer to Resident #57's coccyx. TN #8 cleansed the pressure ulcer with normal saline and patted the area dry. With the same gloved hands, TN #8 applied Medi honey to the wound bed with a tongue depressor and then covered the pressure ulcer with calcium alginate and a foam dressing. During an interview on 01/09/2025 at 2:08 PM, CNA #9 stated hand hygiene should occur before and after providing care and between each resident. She stated she had not considered that if she touched items with the gloves, the items were dirty and needed to be changed. During an interview on 01/09/2025 at 2:19 PM, TN #8 stated when providing wound care, hand hygiene should occur before the treatment, between glove changes and after care was provided. She stated hand hygiene should also be done before and after incontinence care was provided. 2. An Admission Record indicated the facility admitted Resident #63 on 12/20/2017. According to the Admission Record, the resident had a medical history that included a diagnosis of a Stage 4 pressure ulcer of the sacral region. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one Stage 4 pressure ulcer. Resident #63's care plan included a focus area initiated 04/16/2024, that indicated the resident required enhanced barrier precautions and was at risk for infection related to a feeding tube, indwelling urinary catheter, and wounds. Interventions initiated 04/16/2024, emphasized the importance of frequent and thorough handwashing with soap and water and utilizing alcohol-based hand sanitizer, and educating the resident, family, and healthcare providers on proper hand hygiene. Resident #63's Order Summary Report revealed an order dated 01/02/2025, to cleanse the sacro-coccyx (sacrum) area with normal saline, pat the area dry, apply Medi honey, and cover with a dry dressing every day shift and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 01/09/2025 at 9:37 AM, Treatment Nurse (TN) #8 and Certified Nurse Aide (CNA) #14 entered Resident #63's room, washed their hands, and donned a gown and gloves. They removed Resident #63's adult brief and loose feces was noted. CNA #14 provided incontinence care but did not change her gloves or perform hand hygiene after cleaning the resident. With the same gloves, CNA #14 touched Resident #63's pillows and bed control, put on clean linen, and applied a clean brief before assisting to hold the resident in position for wound care. TN #8 cleansed Resident #63's sacral wound with normal saline then removed her gloves but did not perform hand hygiene before putting on new gloves. The observation revealed TN #8 patted the wound dry, applied Medi honey with a tongue depressor, and covered the area with a foam dressing. Without changing her gloves, TN #8 cleaned an open area noted to scar tissue to the middle of the resident's back and covered the area with a dry dressing. During an interview on 01/09/2025 at 1:53 PM, CNA #14 stated that prior to providing incontinence care, she washed and dried her hands and put on gloves. CNA #14 stated that after providing care, she removed the gloves and sanitized her hands. She stated if feces got on the gloves, she would remove them and put on a new pair; however, she stated she could not leave the resident to wash her hands. During an interview on 01/09/2025 at 2:19 PM, TN #8 stated when providing wound care, hand hygiene should occur before the treatment, between glove changes, and after care was provided. She stated hand hygiene should also be done before and after incontinence care was provided. During an interview on 01/09/2025 at 1:40 PM, Licensed Vocational Nurse (LVN) #13 stated when providing wound care or incontinence care hand hygiene should occur before, after, and in between glove changes. She stated gloves would not be clean after multiple surfaces were touched. During an interview on 01/09/2025 at 2:15 PM, TN #11 stated while providing wound care, hand hygiene should be done throughout the process. She stated at the beginning of the treatment, she washed her hands and applied gloves, prepared the area, removed the dirty dressing and then removed her gloves. She stated then she performed hand hygiene, applied gloves, provided the treatment, removed the gloves and performed hand hygiene. She stated if there was more than one wound, they had to change gloves and perform hand hygiene for each wound. During an interview on 01/09/2025 at 2:32 PM, LVN #12 stated hand hygiene should be done before providing care, after glove changes, and after providing care. She stated surfaces would no longer be clean after touching them with gloves. During an interview on 01/09/2025 at 4:31 PM, the Director of Nursing (DON) stated when providing wound or incontinence care, gloves should be changed with every step and hand hygiene be done in between glove changes. He stated gloves were not clean after touching multiple items. During an interview on 01/09/2025 at 5:04 PM, the Administrator stated hand hygiene should be done before putting on gloves and between glove changes. He stated if they touched anything that would contaminate the gloves, then they should be changed.