STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675939	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Health Care Center	205 N Bonnie Brae Denton, TX 76201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative where there was a significant change in the resident's physical, mental, or psychosocial status and when there was a need to alter treatment significantly for one of two (Resident #99) post operative surgical residents reviewed for notification of changes related to post operative care. The facility failed to notify Resident #99's attending physician or surgeon after changes to her surgical incision site were repeatedly observed resulting a subsequent infection that required hospitalization and surgical intervention. An Immediate Jeopardy (IJ) situation was identified on 11/08/2024 at 12:35 PM. The IJ was removed on 11/27/2024 at 3:15 PM the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of a delay in medical intervention, decline in health, serious injury, harm, impairment or death. Findings include: Record review of Resident #99's face sheet, dated 11/07/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #99 had relevant diagnoses which included metabolic encephalopathy (alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism,) subluxation of lumbar vertebra (misalignment of spine,) wedge compression fracture of thoracic vertebrae (one or more back bones collapse,) protein-calorie malnutrition, anxiety (persistent nervousness, anxiety, and/or restlessness) and major depressive disorder (persistent low mood.) Record review of Resident #99's MDS dated [DATE], reflected she was cognitively intact with a BIMS score of 15. She required a wheelchair for mobility and required substantial/maximal assistance with toileting and shower/baths which included transfers. Record review of Resident #99's Baseline Care Plan dated 09/26/2024 at 2:30 PM revealed no evidence of surgical site assessment, treatment, or care documentation. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #99's Comprehensive Care Plan was not available for review due to the resident's short-term stay at the facility. Record review of Resident #99's Physician Orders reflected her attending physician as Dr N, Admit to Skilled Services Under The Care of [Dr N] effective 09/20/2024. No orders stated monitoring of surgical site and/or treatment and care from Dr N were observed. Record review of Resident #99's Physician Orders from Dr L stated Clean surgical site on lower back with normal saline, pat dry and apply dry dressing one time a day for wound care start date 10/05/2024. An order to monitor surgical site stated, Monitor surgical site for infection one time a day for wound care start date 10/05/2024. Record review of Resident #99's Physician Orders on 11/27/2024 at 9:30 AM revealed no evidence of physician orders for monitoring of surgical site and/or treatment and care for Resident #99's surgical incision site for the month of September. Record review of Resident #99's Discharge Instructions, from [Hospital] prior to Resident #99's admission at [Facility,] dated 09/20/2024, reflected Resident #99 had back and pelvis surgery on 09/15/2024. Procedures/Surgeries . L4-L5 Laminectomy, L3 to Pelvis Posterior Instrumentation Fusion . Notify PCP of these signs and symptoms . increased redness, increased swelling, increased tenderness/pain . bleeding . pus-like discharge .Dispo: SNF on discharge. S/p L3-S2 instrumentation with pelvic fixation and L4-L5 laminectomy Record review of Resident #99's Progress Notes, dated 10/04/2024, completed by the facility's Treatment Nurse reflected, Noticed resident surgical site was draining, wound DR was informed to see her next visit to the facility, but she stated she cannot see resident unless the surgeon request for her to see patient because patient is still under the care of the surgeon for 3 months. Order to clean surgical site with normal saline and apply dry dressing and order to monitor the surgical site are both in place. Record review of Provider Notes authored by NP L with an encounter date 10/07/2024, reflected Patient lethargic today, she awakens to tactile stimuli and drifts off quickly. Nurse reports surgeon appointment tomorrow Record review of the document reflected no evidence of surgical site observation, assessment, and/or intervention. Record review of Resident #99's Weekly Skin Assessment - V 5 history reflected four assessments on 09/30/2024, two on 10/07/2024, and 10/08/2024 completed by facility's Treatment Nurse. No evidence of Resident #99's incision site was documented by any staff member nor the facility's Treatment Nurse. An additional record review of Resident #99's on 11/27/2024 of Weekly Skin Assessment - V 5 revealed no evidence of Resident #99's incision site documentation by any staff member nor the facility's Treatment Nurse. Record review of Resident #99's Progress Notes, with a look-back period between 10/04/2024 - 10/08/2024, reflected no documentation related to a completed assessment or notification to a provider of Resident #99's incision site drainage nor any other surgical concerns. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An additional record review of Resident #99 on 11/27/2024 of Progress Notes, with a look-back period between 10/04/2024 - 10/08/2024, reflected no documentation related to a completed assessment or notification to a provider of Resident #99's incision site drainage nor any other surgical concerns. In interview with the facility's Wound Physician, Dr L, on 11/06/2024 at 7:16 AM, she stated she never saw or treated Resident #99 as a patient. She stated she never intended to see her at the facility as she did not see post operative neurological or orthopedic patients unless specifically requested by the surgeon. She stated she directed the Treatment Nurse to report her concerns to Resident #99's surgeon. She stated the appropriate monitoring and timely reporting of any surgical site concerns to Resident #99's surgeon was important for infection control purposes. Interview attempts with Resident #99's Surgeon, Dr B, on 11/07/2024 at 11:11 AM and 11/08/2024 at 11:32 AM were unsuccessful. In interview with CNA G on 11/08/2024 at 8:32 AM, she stated she recalled observing and immediately reporting to Treatment Nurse that Resident #99's dressing on her back was soiled with drainage, but she did not recall the specific date this occurred. In interview with the Treatment Nurse on 11/07/2024 at 2:08 PM, she stated CNA G reported Resident #99's surgical incision site on her back was draining on 10/04/2024. She stated she called the facility's wound care doctor, Dr L, for advice but stated Dr L was not Resident #99's provider at this time. She stated Dr L gave her a verbal order to change Resident #99's dressing, to monitor incision site for infection, and to notify her surgeon immediately for further instruction. The Treatment nurse stated she delegated Resident #99's nurse for that day, RN K, to notify the surgeon the incision site had drainage. In follow-up interview with facility's Treatment Nurse on 11/27/2024 at 11:50 AM, she stated she did not notify Resident #99's physician of a change in condition because she delegated that to RN K. She stated she did not document an incision site assessment because there was no physician order that came with [Resident #99's] incision when [Resident #99] was admitted . She stated she did not document any skin assessments of Resident #99's incision site because physician orders dictate her assessment documentation and treatment requirements. In interview with RN K on 11/07/2024 at 12:29 PM, he stated he did not recall any significant events of 10/04/2024 nor the facility's Treatment Nurse asking him to notify Resident #99's surgeon that day. He stated he was not sure if he was allowed to call Resident #99's surgeon directly. RN K referred to his cell phone and stated he was Resident #99 nurse on 10/04/2024, 10/06/2024, 10/07/2024 and 10/08/2024. He stated he did not notice any incision site changes on Resident #99 until just prior to the end of his shift on 10/07/2024. He stated he observed a little bit of pink drainage and the incision looked open on 10/07/2024. He stated he reported to Dr N that I think we need labs on this lady [Resident #99,] but he did not report to Dr N any concerns related to her incision site. He stated he did not report his observations to Resident #99's surgeon either. He stated it slipped his mind and he got busy and did not document it. He stated it was important to report any changes to a resident's surgical incision to a provider because it's an infection risk, a lot of things can happen . which can lead to sepsis. He stated he told the night shift nurse, LVN J, to watch out for this lady, but did not recall if he reported to her about Resident #99's incision site changes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with LVN J on 11/07/2024 at 2:20 PM, she stated she did not recall any specifics as it's been a long time. She stated as far as she knew, when she took care of Resident #99 her incision site was intact during night shift. She stated it was important to report any changes in status of the resident to the doctor immediately for the safety of the resident. In interview with LVN Y on 11/07/2024 at 1:09 PM, she stated her first day of employment at the facility was 10/03/2024. She stated she worked with RN K under his supervision in orientation on 10/06/2024. She stated on 10/06/2024 she stated she observed Resident #99's incision dehisced (to come apart) and observed serosanguinous drainage (thin, watery, pink discharge containing serous fluid and blood) on Resident #99's back incision dressing. LVN Y stated she showed RN K the soiled dressing and reported her observation to him. She stated she did not notify any physicians. She stated she did not recall if any doctors were notified that day and she was on orientation and assumed [RN K] reported it to the doctor. In a follow up interview with RN K on 11/07/2024 at 2:50 PM, he stated he trained LVN Y on 10/06/2024. He stated he did not recall observing Resident #99's incision site that day but he should have. He stated LVN Y did show him Resident #99's soiled dressing with light drainage present, but he did not conduct any follow up assessments on Resident #99's incision site and could not specify why. He stated he should have because LVN Y was his trainee, and that it was his responsibility to assess Resident #99's incision site because something negative can occur. RN K stated he should have notified Resident #99's surgeon but stated he did not and could not specify why. In interview with Resident #99's attending doctor, Dr N, she stated she was not informed of any incision site physician orders, incision site changes, or concerns. She stated her expectations were, at a minimum, for the facility staff to notify her of any resident condition changes so follow up with the surgeon could be facilitated. She stated this was important for infection purposes, especially surgical cases. In interview with Dr N's Nurse Practitioner, NP L, on 11/08/2024 at 8:12 AM, she stated he was not informed of any incision site changes or concerns. She stated she saw Resident #99 at the facility on 10/07/2024 but was not informed of any incision site changes or concerns and did not assess the incision site. She stated if I had known, I would have taken a look at it [incision site] and assessed as it was important for infection purposes. She stated she expected the facility to ultimately report any incision site changes to the surgeon for further advisement. In interview with Resident #99's family member on 11/05/2024 at 11:33 AM and 11/07/2024 at 1:34 PM, he stated Resident #99 had to go back into the hospital for another surgery after her admission at [Facility.] He stated he believed the incision came apart on 10/06/2024. He further stated on 10/07/2024 I noticed her acting strange, like the infection had returned. On 10/08/2024, Resident #99 had a follow up appointment with her surgeon where it was found the infection had indeed returned and she was readmitted to the hospital where she had to have another surgery to clean out their [the facility's] mistake. He stated Resident #99 has experienced a lot of pain and suffering due to the facility's negligence. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow up interview with Resident #99's family member on 11/13/2024 at 9:11 AM, he stated Resident #99's current condition was she has pretty much [gone] out of her mind, she stays very confused, and she does not know where she is and is still having [cognitive] problems. He stated he was hopeful that her course of Intravenous (IV) antibiotics would help her get back to normal but it hasn't happened yet . Attempts to interview Resident #99 on 11/08/2024 at 2:00 PM and 11/13/2024 9:11 AM were unsuccessful due to her cognitive limitations. In interview with DON on 11/08/2024 at 9:14 AM, she stated it was her expectation for Resident #99's surgeon to be called immediately if there were any incision site changes. She stated this was not done and it was a failure on the facility's part. The DON stated no documentation was able to be provided to reflect that any provider of Resident #99 was notified about her incision site changes. She stated prompt notification to a provider about a decline in condition and/or incision site changes was important for infection control purposes. In interview with the Administrator on 11/08/2024 at 11:35 AM, he stated his expectations were for the nurse to have reported it [incision site changes] to the doctor. He stated it was important for facility nursing staff to notify the doctor of any changes a resident may have to prevent any decline. In interview with the facility's ADO on 11/08/2024 at 12:35 PM, she stated she did not expect the surgeon to be called by facility per their [facility] policy. She provided the State Surveyor with facility policy, Notifying the physician of Change in Status and stated facility nurses see incisions as wounds and she felt the facility notified the appropriate provider [Dr L.] She further stated it was then Dr L's responsibility to follow up with the surgeon and not the facility staff. Record review of the facility's staffing schedule, provided by the DON, via email on 11/07/2024 reflected: RN K worked day shift on 10/04/2024, 10/06/2024, 10/07/2024, and 10/08/2024. LVN J worked night shift 10/06/2024 and 10/07/2024. LVN Y worked day shift and was in orientation 10/05/2024 and 10/06/2024. On 10/06/2024, RN K oriented LVN Y on day shift. The following documents reviewed state Resident #99's status and condition immediately after her admission at [Facility] and after her 10/08/2024 surgical appointment that necessitated her subsequent re-admission to [Hospital] on 10/08/2024: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #99's Discharge Summary dated 10/30/2024, from Resident #99's hospital admission after her admission at [Facility] revealed Discharge diagnosis . lumbar incisional wound dehiscence with possible infection . Hospital course . recent L4/L5 laminectomy and L3 to pelvis posterior instrumentation done 09/15/2024 and discharged to SNF. She presented to outpatient neurosurgery clinic from SNF for evaluation of lower back wound with discharge. She was seen at outpatient clinic and sent to ER from neurosurgery clinic for evaluation of lumbar wound dehiscence and yellow-colored drainage . continue wound vac . intraoperative culture results and UTI culture results, both growing E. coli (bacteria) . ID recommend to continue 6 week of antibiotics, Rocephin 2 g daily through a PICC line, right upper extremity PICC line in place . Followed by plastic surgery . Procedures: 1. Excisional debridement of skin, subcutaneous tissue, muscle and bone, lumbar wound 120 square cm. 2. Drainage of deep lumbar abscess. 3. Application of a drug-eluting antibiotics beads deep in lumbar wound over lumbosacral area. 4. Application of VAC dressing, negative pressure dressing lumbar wound 80 square cm . Long-term wound VAC . Acute UTI . Anemia; uncertain etiology. May be related to postop blood loss versus infection . transfuse 1 PRBC 10/20 . Follow up with [ID Doctor] in 2-3 weeks after discharge. Patient will likely need oral suppressive antibiotic after finishing the IV as she does have infected hardware . wound vac in place on low back . Continue wound vac with MWF changes . Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Brief Operative Report, dated 10/22/2024, reflected Pre-operative diagnosis . Lumbar Spine Dehiscence . Name of Procedure: 1. Excisional debridement of skin, subcutaneous tissue, and bone of the lumbar spine 2. Placement of deep antibiotic beads 3. Placement of negative pressure wound vac . Findings: 1. Open lumbar spine wound 2. Necrotic tissue wound bed . Assessment/Plan . Plastic surgery was consulted for wound closure. Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Hospitalist Progress Note, dated 10/28/2024 revealed status post I&D by neurology on 10/09. Disposition . patient will need rehab secondary to multiple needs starting from deconditioning wound vac to IV antibiotics. Personally messaged plastic surgery . Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Wound Progress Note, dated 10/29/2024 revealed Wound Diagnosis: S/p excisional debridement of lumbar wound . location low back, midline . type open surgical or dehisce . drain wound vac/neg pressure . dressing drainage amount copious . serosanguineous . length/width/depth 8.8 x 3.5 x 5.9 cm . percent necrotic tissue 5%. Facility policy review: Record review of the facility policy, Notifying the Physician of Change in Status, dated 03/11/2013, reflected The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention . 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record . 3 . The nurse is responsible . for responding to a change in condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record. 4 . The nurse will document all attempts to contact the physician in the resident's clinical record . Physicians should develop a working diagnosis and guide nursing staff in what to monitor, and when to notify the physician if the resident's condition does not improve. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility policy, Skin Integrity Management, undated/provided by the facility's CCD via email on 11/08/2024 at 3:27 PM did not specifically address surgical/incisional site care. In interview with facility's CCD via email at 11/27/2024 at 10:35 AM revealed the facility did not have a policy specific to surgical care, incision site care, or quality of care. This was determined to be an Immediate Jeopardy (IJ) on 11/08/2024 at 12:35 PM. The Administrator, Director of Nursing, Area Director of Operations, and Clinical Compliance Director were notified. The Administrator, DON, ADO, and the CCD as provided with the IJ template on 11/08/2024 at 12:35 PM and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 11/27/2024 at 3:15 PM. [Facility] 11/8/2024 [rev. 11/27/2024] Plan of Removal F580 Notify Change of Condition Interventions: 100% skin sweep of all residents completed on 11/8/24 by the DON, ADON, and Charge Nurses. All residents with wounds including surgical wounds were assessed on 11/8/24 by the DON for potential decline in wound status. No acute changes noted. The Administrator and DON were in-serviced 1:1 on the following by the Regional Compliance Nurse on 11/8/24. Notification of Change in Condition Policy- Reporting changes in condition involving wounds to the physician, nurse practitioner, or surgeon - i.e., new wound or decline of a current wound. If the change in condition involves a surgical wound, the surgeon will also be notified immediately for any additional orders. If a LVN or RN Charge Nurse does not assess or notify the physician timely, the DON or Administrator will be notified. -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -All surgical wounds/incisions changes or decline in condition will be reported to the surgeon of the incision site and attending physician. This will start 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. Abuse and Neglect Policy to include failure to assess a wound and/or notify a physician for a change in condition on a wound including surgical wounds, could be considered neglect. The DON or Designee will review the clinical dashboard daily for any documentation that notes a change in condition in wounds including surgical wounds. The DON or Designee will ensure that the wound was assess and notification to the Attending MD as well as the Surgeon was completed timely. This will begin 11/8/24 and continue indefinitely. -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -All surgical wounds/incisions changes or decline in condition will be reported to the surgeon of the incision site and attending physician. This will start 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. The medical director was notified of the immediate jeopardy situation on 11/8/24 by the Administrator. An ADHOC QAPI meeting was completed on 11/8/24 to include the IDT team and Medical Director. The following in-services were initiated by the DON, ADON and regional nurse on 11/8/24. Any staff member not present or in-serviced on 11/8/24, will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation prior to taking an assignment. All agency staff will in serviced prior to their scheduled shift. All Charge Nurses: -Notification of Change in Condition Policy- Reporting changes in condition involving wounds to the physician, nurse practitioner, or surgeon - i.e. new wound or decline of a current wound. If the change in condition involves a surgical wound, the surgeon will also be notified immediately for any additional orders. If a LVN or RN Charge Nurse does not assess or notify the physician timely, the DON or Administrator will be notified. -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-All surgical wounds/incisions changes or decline in condition will be reported to the surgeon of the incision site and attending physician. This will start 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. Abuse and Neglect Policy to include failure to assess a wound and/or notify a physician for a change in condition on a wound including surgical wounds, could be considered neglect. Non-licensed nursing staff -Abuse and Neglect Policy- failure report a change a change in condition on a resident such as a new or worsening wound, could be considered neglect. -Notification of Change in Condition Policy- Reporting negative changes in condition involving wounds to the charge nurse immediately. Changes include a soiled dressing, foul odor, redness, or complaints of pain to the wound. If the charge nurse is not available, the DON or ADON will be notified. Monitoring of the POR Included the following: Record review of the facility's Skin Sweep Documentation on 11/08/2024 at 4:58 PM reflected no other post operative residents at the facility. In interview with facility's CCD on 11/08/2024 at 1:00 PM she stated there were no post-operative surgical residents currently at the facility. In follow-up interview with facility's CCD on 11/27/2024 at 11:40 AM she stated there were no post-operative surgical residents currently at the facility. Record review on 11/08/2024 of facility's AD HOC QUAPI meeting minutes and sign in sheet, titled OFF CYCLE (AD HOC) QA MEETING DOCUMENT, content included facility failures related to physician notification, assessment, and abuse/and or neglect. Facility CCD, DON, Administrator, Medical Director, and ADO signatures were included. Record review on 11/08/2024 of In-service, Notification of Change in Condition, conducted by CCD, included facility definition, purpose, process for provider notification as it related to all surgical wounds/incisions changes or decline in condition are required to be reported to the surgeon and attending physician by utilizing the facility sanctioned communication documents. Facility Administrator and DON's signatures were included. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on 11/08/2024 of In-service, Notifying the Physician of Change in Status, conducted by the Administrator and the DON, included facility definition, purpose, process for provider notification as it related to all surgical wounds/incisions changes or decline in condition are required to be reported to the surgeon and attending physician by utilizing the facility sanctioned communication documents. Multiple staff RN and LVN signatures were included. Record review on 11/08/2024 of In-service, Abuse and Neglect, conducted by CCD, included facility definition of abuse/neglect, identification of abuse/neglect, and facility specific policy, protocol, and procedure for reporting abuse/neglect at the facility. Facility Administrator and DON's signatures were included. Record review on 11/08/2024 of In-service, Abuse and Neglect, conducted by DON, included facility definition of abuse/neglect, identification of abuse/neglect, and facility specific policy, protocol, and procedure for reporting abuse/neglect at the facility. Multiple staff signatures included department leadership, rehabilitation department, nurses, nursing aides, social services, dietary department, housekeeping, and the maintenance department. In interview with facility's CCD via email on 12/06/2024 at 12:32 PM, she clarified that the facility's Abuse and Neglect policy was not revised; but the facility in-serviced on the current policy. This includes a clarification that neglect could include failure to notify would be considered neglectful. Record review on 11/27/2024 of In-service titled, SBAR, conducted by CCD, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Facility Administrator and DON's signatures were included. Record review on 11/27/2024 of In-service titled, SBAR for Surgical Incisions, conducted by DON, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Multiple facility nursing staff signatures were included. In interview with the facility Administrator and DON on 11/08/2024 at 6:10 PM and 6:02 PM respectively, they stated the clinical dashboard was reviewed for compliance as per the POR. In follow up interview with the Administrator and DON on 11/27/2024 at 1:50 PM, they stated the clinical dashboard was reviewed for compliance which included action items added by the facility on 11/27/2024 per the POR. (continued on next page)

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	675939	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with the facility Administrator on 11/08/2024 at 6:10 PM, he stated failure to report a change a change in condition to the resident's nurse could be considered neglect. Immediate notification to a provider for any resident change in condition was important. He sufficiently explained what would constitute a change in condition and the signs and symptoms his staff should be monitoring for infection. He further stated what and where his staff should be documenting any change in condition in the electronic medical record (EMR) and the other parties that should be notified in addition to the provider. He sufficiently defined abuse, neglect, and/or exploitation and the expectations of his staff to report any observed, reported, or suspected abuse, neglect, and/or exploitation to him immediately. In follow up interview with facility's Administrator on 11/27/2024 at 2:30 PM he stated facility's DON, or a designee were responsible for daily monitoring of new surgical incision resident orders and will present this information to leadership during the daily stand-up meeting to ensure treatment orders are in place and admission assessments included surgical incision sites. He stated the DON was responsible to ensure resident surgical contact information was updated in resident EMRs upon admission and was responsible for monitoring weekly for compliance. He stated he will ensure the DON will complete weekly audits to ensure that all surgical wounds were to monitored daily by nurses, any changes or decline were reported to attending physician and surgeon of incision site, to ensure all surgical wounds have treatment orders upon admission, all surgical wounds/incisions changes or decline in condition were reported to the surgeon and attending physician, and all skin assessments upon admission reflect any surgical incisions a resident may have. He stated the DON will complete an audit weekly to ensure charge nurses included surgical incision sites on baseline care plans upon admission and the DON included any updates in resident care plans when any change in condition or surgical incision site changes occur. He further stated all nurses were in-serviced by the DON and CCD and were expected to be knowledgeable on facility's SBAR document and his expectations were for facility nurses to utilize this document for any change in condition and/or changes to a resident's surgical incision site. In interview with the facility DON on 11/08/2024 at 6:02 PM, she stated failure to report a change a change in condition to the resident's nurse could be considered neglect. Immediate notification to a provider for any resident change in condition was important. She sufficiently explained

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review, the facility failed to develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care that was developed within 48 hours of resident's admission for one (Resident #99) of six residents reviewed for baseline care plans. The facility failed to complete a sufficient baseline care plan that identified her surgical incision site care needs for Resident #99 within 48 hours of resident's admission. This failure placed the facility care staff and Resident #99 at risk of not being informed of their initial goals and services, receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Findings included: Record review of Resident #99's face sheet, dated 11/07/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #99 had relevant diagnoses which included metabolic encephalopathy (alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism,) subluxation of lumbar vertebra (misalignment of spine,) wedge compression fracture of thoracic vertebrae (one or more back bones collapse,) protein-calorie malnutrition, anxiety (persistent nervousness, anxiety, and/or restlessness) and major depressive disorder (persistent low mood.) Record review of Resident #99's MDS dated [DATE], reflected she was cognitively intact with a BIMS score of 15. She required a wheelchair for mobility and required substantial/maximal assistance with toileting and shower/baths which included transfers. Record review of Resident #99's Baseline Care Plan Acknowledgement dated 09/20/2024 at 10:30 PM revealed A copy of the baseline care plan was provided to the resident . Date and Time Provided 09/20/2024 at [8:00 PM.] Record review of email documentation from Administrator at 11/08/2024 at 2:47 PM, he provided Resident #99's Baseline Care Plan dated 09/26/2024 at 2:30 PM for review. The document provided revealed no evidence of surgical site assessment, treatment, or care documentation. In a follow up email from Administrator at 11/08/2024 at 3:01 PM, he stated this is all I have [to provide for review,] when asked for any supplementary documentation related to Resident #99's Baseline Care Plan documentation. Record review of what the facility presented as Resident #99's Care Plan Conference documentation dated 9/26/2024 at 2:30 PM revealed no evidence of surgical site assessment, treatment, or care documentation. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #99's Comprehensive Care Plan was not available for review due to the resident's short-term stay at the facility. In interview with facility's Administrator on 11/27/2024 at 2:30 PM he stated expected the facility's DON, or a designee to ensure resident baseline care plans were completed per facility policy. He stated, going forward, she will be responsible for the completion of weekly audits to ensure charge nurses included surgical incision sites on all new admission baseline care plans if appropriate the DON is to include any updates in resident care plans if any change in condition or surgical incision site changes occur. In interview with facility DON on 11/27/2024 at 2:00 PM, she stated when Resident #99 was admitted , she just started her role as the DON at the facility. She stated going forward, she stated she will ensure via a weekly audit that charge nurses included surgical incision sites on baseline care plans upon admission and she was ultimately responsible for including any updates in resident care plans when any change in condition or surgical incision site changes occur. In interview with facility's CCD on 11/27/2024 12:56 PM revealed her expectation were for resident baseline care plans to be initiated within 48 hours of admission and reflect a resident-centered plan of care that addresses the current needs of the resident. She stated it was ultimately the DON's responsibility to ensure this task was completed. Review of facility policy, Skin Integrity Management, undated/provided by the facility's CCD via email on 11/08/2024 at 3:27 PM did not specifically address surgical/incisional site care or how it related to resident baseline care plan needs. In interview with facility's CCD via email at 11/27/2024 at 10:35 AM revealed the facility did not have a policy specific to surgical care, incision site care, or quality of care. Review of facility policy, Base Line Care Plans, undated provided by facility CCD via email on 11/27/2024 at 11:51 AM revealed Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission . The baseline care plan will . Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- Initial goals based on admission orders, physician orders . The baseline care plan will reflect the resident's stated goals and objectives and include interventions that address his or her current needs. It will be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan. Facility staff will implement the interventions to assist the resident to achieve care plan goals and objectives .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan for one (Resident #99) of two residents reviewed for quality of care. 1. The facility failed to ensure physician orders for treatment, care, and monitoring of Resident #99's surgical site incision was obtained upon admission resulting a subsequent infection that required hospitalization and surgical intervention. 2. The facility failed to complete and document any skin/incision/wound assessments of Resident #99's surgical incision site resulting a subsequent infection that required hospitalization and surgical intervention. 3. The facility failed to develop a baseline care plan that addressed Resident #99's surgical care needs. An Immediate Jeopardy (IJ) situation was identified on 11/08/2024 at 12:35 PM. The IJ was removed on 11/27/2024 at 3:15 PM the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed Resident #99 at risk of not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which resulted in a delay in medical intervention and decline in health for Resident #99. As a result of these failures, Resident #99 was readmitted to the hospital on 11/08/2024 and required further treatment, surgeries, IV antibiotics, and medical devices. Findings include: Record review of Resident #99's Face Sheet, dated 11/07/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #99 had relevant diagnoses which included metabolic encephalopathy (alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism,) subluxation of lumbar vertebra (misalignment of spine,) wedge compression fracture of thoracic vertebrae (one or more back bones collapse,) protein-calorie malnutrition, anxiety (persistent nervousness, anxiety, and/or restlessness) and major depressive disorder (persistent low mood.) Record review of Resident #99's MDS dated [DATE], reflected she was cognitively intact with a BIMS score of 15. She required a wheelchair for mobility and required substantial/maximal assistance with toileting and shower/baths which included transfers. Record review of Resident #99's Baseline Care Plan dated 09/26/2024 at 2:30 PM revealed no evidence of surgical site assessment, treatment, or care documentation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #99's Comprehensive Care Plan was not available for review due to the resident's short-term stay at the facility. Record review of Resident #99's Physician Orders reflected her attending physician as Dr N, Admit to Skilled Services Under The Care of [Dr N] effective 09/20/2024. No orders stated monitoring of surgical site and/or treatment and care from Dr N were observed. Record review of Resident #99's Physician Orders from Dr L stated Clean surgical site on lower back with normal saline, pat dry and apply dry dressing one time a day for wound care start date 10/05/2024. An order to monitor surgical site stated, Monitor surgical site for infection one time a day for wound care start date 10/05/2024. Record review of Resident #99's Physician Orders on 11/27/2024 at 9:30 AM revealed no evidence of physician orders for monitoring of surgical site and/or treatment and care for Resident #99's surgical incision site for the month of September. Record review of Resident #99's Discharge Instructions, from [Hospital] prior to Resident #99's admission at [Facility,] dated 09/20/2024, reflected Resident #99 had back and pelvis surgery on 09/15/2024. Procedures/Surgeries . L4-L5 Laminectomy, L3 to Pelvis Posterior Instrumentation Fusion . Notify PCP of these signs and symptoms . increased redness, increased swelling, increased tenderness/pain . bleeding . pus-like discharge .Dispo: SNF on discharge. S/p L3-S2 instrumentation with pelvic fixation and L4-L5 laminectomy Record review of Resident #99's Progress Notes, dated 10/04/2024, completed by the facility's Treatment Nurse stated she reported Resident #99's incision site drainage to Dr L, Noticed resident surgical site was draining, wound DR was informed to see her next visit to the facility, but she stated she cannot see resident unless the surgeon request for her to see patient because patient is still under the care of the surgeon for 3 months. Order to clean surgical site with normal saline and apply dry dressing and order to monitor the surgical site are both in place. Record review of Provider Notes authored by Dr N's Nurse Practitioner, NP L with an encounter date 10/07/2024, reflected Patient lethargic today, she awakens to tactile stimuli and drifts off quickly. Nurse reports surgeon appointment tomorrow Record review of the document reflected no evidence of surgical site observation, assessment, and/or intervention. Record review of Resident #99's Weekly Skin Assessment - V 5 history reflected four assessments on 09/30/2024, two on 10/07/2024, and 10/08/2024 completed by facility's Treatment Nurse. No evidence of Resident #99's incision site was documented by any staff member nor the facility's Treatment Nurse. An additional record review of Resident #99's on 11/27/2024 of Weekly Skin Assessment - V 5 revealed no evidence of Resident #99's incision site documentation by any staff member nor the facility's Treatment Nurse. Record review of Resident #99's Progress Notes, with a look-back period between 10/04/2024 - 10/08/2024, reflected no documentation related to a completed assessment or notification to a provider of Resident #99's incision site drainage nor any other surgical concerns. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An additional record review of Resident #99 on 11/27/2024 of Progress Notes, with a look-back period between 10/04/2024 - 10/08/2024, reflected no documentation related to a completed assessment or notification to a provider of Resident #99's incision site drainage nor any other surgical concerns. In interview with the facility's Wound Physician, Dr L, on 11/06/2024 at 7:16 AM, she stated she never saw or treated Resident #99 as a patient. She stated she never intended to see her at the facility as she did not see post operative neurological or orthopedic patients unless specifically requested by the surgeon. She stated she directed the Treatment Nurse to report her concerns to Resident #99's surgeon. She stated the appropriate monitoring and timely reporting of any surgical site concerns to Resident #99's surgeon was important for infection control purposes. Interview attempts with Resident #99's Surgeon, Dr B, on 11/07/2024 at 11:11 AM and 11/08/2024 at 11:32 AM were unsuccessful. In interview with CNA G on 11/08/2024 at 8:32 AM, she stated she recalled observing and immediately reporting to Treatment Nurse that Resident #99's dressing on her back was soiled with drainage, but she did not recall the specific date this occurred. In interview with the Treatment Nurse on 11/07/2024 at 2:08 PM, she stated CNA G reported Resident #99's surgical incision site on her back was draining on 10/04/2024. She stated she called the facility's wound care doctor, Dr L, for advice but stated Dr L was not Resident #99's provider at this time. She stated Dr L gave her a verbal order to change Resident #99's dressing, to monitor incision site for infection, and to notify her surgeon immediately for further instruction. The Treatment nurse stated she delegated Resident #99's nurse for that day, RN K, to notify the surgeon the incision site had drainage. In follow-up interview with facility's Treatment Nurse on 11/27/2024 at 11:50 AM, she stated she did not notify Resident #99's physician of a change in condition because she delegated that to RN K. She stated she did not document an incision site assessment because there was no physician order that came with [Resident #99's] incision when [Resident #99] was admitted . She stated she did not document any skin assessments of Resident #99's incision site because physician orders dictate her assessment documentation and treatment requirements. In interview with RN K on 11/07/2024 at 12:29 PM, he stated he did not recall any significant events of 10/04/2024 nor the facility's Treatment Nurse asking him to notify Resident #99's surgeon that day. He stated he was not sure if he was allowed to call Resident #99's surgeon directly. RN K referred to his cell phone and stated he was Resident #99 nurse on 10/04/2024, 10/06/2024, 10/07/2024 and 10/08/2024. He stated he did not notice any incision site changes on Resident #99 until just prior to the end of his shift on 10/07/2024. He stated he observed a little bit of pink drainage and the incision looked open on 10/07/2024. He stated he reported to Dr N that I think we need labs on this lady [Resident #99,] but he did not report to Dr N any concerns related to her incision site. He stated he did not report his observations to Resident #99's surgeon either. He stated it slipped his mind and he got busy and did not document it. He stated it was important to report any changes to a resident's surgical incision to a provider because it's an infection risk, a lot of things can happen . which can lead to sepsis. He stated he told the night shift nurse, LVN J, to watch out for this lady, but did not recall if he reported to her about Resident #99's incision site changes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with LVN J on 11/07/2024 at 2:20 PM, she stated she did not recall any specifics as it's been a long time. She stated as far as she knew, when she took care of Resident #99 her incision site was intact during night shift. She stated it was important to report any changes in status of the resident to the doctor immediately for the safety of the resident. In interview with LVN Y on 11/07/2024 at 1:09 PM, she stated her first day of employment at the facility was 10/03/2024. She stated she worked with RN K under his supervision in orientation on 10/06/2024. She stated on 10/06/2024 she stated she observed Resident #99's incision dehisced (to come apart) and observed serosanguinous drainage (thin, watery, pink discharge containing serous fluid and blood) on Resident #99's back incision dressing. LVN Y stated she showed RN K the soiled dressing and reported her observation to him. She stated she did not notify any physicians. She stated she did not recall if any doctors were notified that day and she was on orientation and assumed [RN K] reported it to the doctor. In a follow up interview with RN K on 11/07/2024 at 2:50 PM, he stated he trained LVN Y on 10/06/2024. He stated he did not recall observing Resident #99's incision site that day but he should have. He stated LVN Y did show him Resident #99's soiled dressing with light drainage present, but he did not conduct any follow up assessments on Resident #99's incision site and could not specify why. He stated he should have because LVN Y was his trainee, and that it was his responsibility to assess Resident #99's incision site because something negative can occur. RN K stated he should have notified Resident #99's surgeon but stated he did not and could not specify why. In interview with Resident #99's attending doctor, Dr N, she stated she was not informed of any incision site physician orders, incision site changes, or concerns. She stated her expectations were, at a minimum, for the facility staff to notify her of any resident condition changes so follow up with the surgeon could be facilitated. She stated this was important for infection purposes, especially surgical cases. In interview with Dr N's Nurse Practitioner, NP L, on 11/08/2024 at 8:12 AM, she stated he was not informed of any incision site changes or concerns. She stated she saw Resident #99 at the facility on 10/07/2024 but was not informed of any incision site changes or concerns and did not assess the incision site. She stated if I had known, I would have taken a look at it [incision site] and assessed as it was important for infection purposes. She stated she expected the facility to ultimately report any incision site changes to the surgeon for further advisement. In interview with Resident #99's family member on 11/05/2024 at 11:33 AM and 11/07/2024 at 1:34 PM, he stated Resident #99 had to go back into the hospital for another surgery after her admission at [Facility.] He stated he believed the incision came apart on 10/06/2024. He further stated on 10/07/2024 I noticed her acting strange, like the infection had returned. On 10/08/2024, Resident #99 had a follow up appointment with her surgeon where it was found the infection had indeed returned and she was readmitted to the hospital where she had to have another surgery to clean out their [the facility's] mistake. He stated Resident #99 has experienced a lot of pain and suffering due to the facility's negligence. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow up interview with Resident #99's family member on 11/13/2024 at 9:11 AM, he stated Resident #99's current condition was she has pretty much [gone] out of her mind, she stays very confused, and she does not know where she is and is still having [cognitive] problems. He stated he was hopeful that her course of Intravenous (IV) antibiotics would help her get back to normal but it hasn't happened yet . Attempts to interview Resident #99 on 11/08/2024 at 2:00 PM and 11/13/2024 9:11 AM were unsuccessful due to her cognitive limitations. In interview with DON on 11/08/2024 at 9:14 AM, she stated it was her expectation for Resident #99's surgeon to be called immediately if there were any incision site changes. She stated this was not done and it was a failure on the facility's part. The DON stated no documentation was able to be provided to reflect that any provider of Resident #99 was notified about her incision site changes. She stated prompt notification to a provider about a decline in condition and/or incision site changes was important for infection control purposes. In interview with the Administrator on 11/08/2024 at 11:35 AM, he stated his expectations were for the nurse to have reported it [incision site changes] to the doctor. He stated it was important for facility nursing staff to notify the doctor of any changes a resident may have to prevent any decline. In interview with the facility's ADO on 11/08/2024 at 12:35 PM, she stated she did not expect the surgeon to be called by facility per their [facility] policy. She provided the State Surveyor with facility policy, Notifying the physician of Change in Status and stated facility nurses see incisions as wounds and she felt the facility notified the appropriate provider [Dr L.] She further stated it was then Dr L's responsibility to follow up with the surgeon and not the facility staff. Record review of the facility's staffing schedule, provided by the DON, via email on 11/07/2024 reflected: RN K worked day shift on 10/04/2024, 10/06/2024, 10/07/2024, and 10/08/2024. LVN J worked night shift 10/06/2024 and 10/07/2024. LVN Y worked day shift and was in orientation 10/05/2024 and 10/06/2024. On 10/06/2024, RN K oriented LVN Y on day shift. The following documents reviewed state Resident #99's status and condition immediately after her admission at [Facility] and after her 10/08/2024 surgical appointment that necessitated her subsequent re-admission to [Hospital] on 10/08/2024: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #99's Discharge Summary dated 10/30/2024, from Resident #99's hospital admission after her admission at [Facility] revealed Discharge diagnosis . lumbar incisional wound dehiscence with possible infection . Hospital course . recent L4/L5 laminectomy and L3 to pelvis posterior instrumentation done 09/15/2024 and discharged to SNF. She presented to outpatient neurosurgery clinic from SNF for evaluation of lower back wound with discharge. She was seen at outpatient clinic and sent to ER from neurosurgery clinic for evaluation of lumbar wound dehiscence and yellow-colored drainage . continue wound vac . intraoperative culture results and UTI culture results, both growing E. coli (bacteria) . ID recommend to continue 6 week of antibiotics, Rocephin 2 g daily through a PICC line, right upper extremity PICC line in place . Followed by plastic surgery . Procedures: 1. Excisional debridement of skin, subcutaneous tissue, muscle and bone, lumbar wound 120 square cm. 2. Drainage of deep lumbar abscess. 3. Application of a drug-eluting antibiotics beads deep in lumbar wound over lumbosacral area. 4. Application of VAC dressing, negative pressure dressing lumbar wound 80 square cm . Long-term wound VAC . Acute UTI . Anemia; uncertain etiology. May be related to postop blood loss versus infection . transfuse 1 PRBC 10/20 . Follow up with [ID Doctor] in 2-3 weeks after discharge. Patient will likely need oral suppressive antibiotic after finishing the IV as she does have infected hardware . wound vac in place on low back . Continue wound vac with MWF changes . Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Brief Operative Report, dated 10/22/2024, reflected Pre-operative diagnosis . Lumbar Spine Dehiscence . Name of Procedure: 1. Excisional debridement of skin, subcutaneous tissue, and bone of the lumbar spine 2. Placement of deep antibiotic beads 3. Placement of negative pressure wound vac . Findings: 1. Open lumbar spine wound 2. Necrotic tissue wound bed . Assessment/Plan . Plastic surgery was consulted for wound closure. Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Hospitalist Progress Note, dated 10/28/2024 revealed status post I&D by neurology on 10/09. Disposition . patient will need rehab secondary to multiple needs starting from deconditioning wound vac to IV antibiotics. Personally messaged plastic surgery . Record review from Resident #99's hospital admission after her admission at [Facility,] titled [Hospital] Wound Progress Note, dated 10/29/2024 revealed Wound Diagnosis: S/p excisional debridement of lumbar wound . location low back, midline . type open surgical or dehisce . drain wound vac/neg pressure . dressing drainage amount copious . serosanguineous . length/width/depth 8.8 x 3.5 x 5.9 cm . percent necrotic tissue 5%. Facility policy review: Record review of the facility policy, Notifying the Physician of Change in Status, dated 03/11/2013, reflected The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention . 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record . 3 . The nurse is responsible . for responding to a change in condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record. 4 . The nurse will document all attempts to contact the physician in the resident's clinical record . Physicians should develop a working diagnosis and guide nursing staff in what to monitor, and when to notify the physician if the resident's condition does not improve. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility policy, Skin Integrity Management, undated, provided by the facility's CCD via email on 11/08/2024 at 3:27 PM did not specifically address surgical/incisional site care. In interview with facility's CCD via email at 11/27/2024 at 10:35 AM revealed the facility did not have a policy specific to surgical care, incision site care, or quality of care. Review of facility policy, Base Line Care Plans, undated provided by facility CCD via email on 11/27/2024 at 11:51 AM revealed Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission . The baseline care plan will . Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- Initial goals based on admission orders, physician orders . The baseline care plan will reflect the resident's stated goals and objectives and include interventions that address his or her current needs. It will be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable. Because the baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care would dictate that it must also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan. Facility staff will implement the interventions to assist the resident to achieve care plan goals and objectives . This was determined to be an Immediate Jeopardy (IJ) on 11/08/2024 at 12:35 PM. The Administrator, Director of Nursing, Area Director of Operations, and Clinical Compliance Director were notified. The Administrator, DON, ADO, and the CCD as provided with the IJ template on 11/08/2024 at 12:35 PM and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 11/27/2024 at 3:15 PM. [Facility] 11/8/2024 [rev. 11/27/2024] Plan of Removal F684 Quality of Care Interventions: 100% skin sweep of all residents completed on 11/8/24 by the DON, ADON, and Charge Nurses. All residents with wounds including surgical wounds were assessed on 11/8/24 by the DON for potential decline in wound status. No acute changes noted. The Administrator and DON were in-serviced 1:1 on the following by the Regional Compliance Nurse on 11/8/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Notification of Change in Condition Policy- Reporting changes in condition involving wounds to the physician, nurse practitioner, or surgeon - i.e., new wound or decline of a current wound. If the change in condition involves a surgical wound, the surgeon will also be notified immediately for any additional orders. If a LVN or RN Charge Nurse does not assess or notify the physician timely, the DON or Administrator will be notified. -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -All surgical wounds have treatment orders, upon admission, as of 11/27/24. DON/designee to monitor weekly for compliance. -All skin assessments, upon admission and weekly reflect any surgical incision, as of 11/27/24. DON/designee to monitor initial skin assessments weekly for compliance. -DON/designee to monitor new surgical incision resident orders during daily stand up to ensure treatment orders are in place and admission assessment includes surgical incisions, starting 11/27/24. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. Abuse and Neglect Policy to include failure to assess a wound and/or notify a physician for a change in condition on a wound including surgical wounds, could be considered neglect. The DON or Designee will review the clinical dashboard daily for any documentation that notes a change in condition in wounds including surgical wounds. The DON or Designee will ensure that the wound was assess and notification to the Attending MD as well as the Surgeon was completed timely. This will begin 11/8/24 and continue indefinitely. -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -All surgical wounds have treatment orders, upon admission, as of 11/27/24. DON/designee to monitor weekly for compliance. -All skin assessments, upon admission and weekly reflect any surgical incision, as of 11/27/24. DON/designee to monitor initial skin assessments weekly for compliance. -DON/designee to monitor new surgical incision resident orders during daily stand up to ensure treatment orders are in place and admission assessment includes surgical incisions, starting 11/27/24. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. The medical director was notified of the immediate jeopardy situation on 11/8/24 by the Administrator. An ADHOC QAPI meeting was completed on 11/8/24 to include the IDT team and Medical Director. The following in-services were initiated by the DON, ADON and regional nurse on 11/8/24. Any staff member not present or in-serviced on 11/8/24, will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation prior to taking an assignment. All agency staff will in serviced prior to their scheduled shift. All Charge Nurses: -All surgical wounds are to be monitored daily by nurse, any changes or decline will be reported to attending physician and surgeon of incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -All surgical wounds have treatment orders, upon admission, as of 11/27/24. DON/designee to monitor weekly for compliance. -All skin assessments, upon admission and weekly reflect any surgical incision, as of 11/27/24. DON/designee to monitor initial skin assessments weekly for compliance. -The Charge nurse or designee will include surgical incision sites on the baseline care plan upon admission, as of 11/27/24. Charge nurse or designee will update the baseline care plan for changes in surgical incision site, as of 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee to monitor new surgical incision resident orders during daily stand up to ensure treatment orders are in place and admission assessment includes surgical incisions, starting 11/27/24. -DON/designee to ensure surgeon contact information is available in resident's EMR upon admission, starting 11/27/24. DON/designee to monitor weekly for compliance. -DON/designee completed in-service of all nurses on SBAR change of condition for surgical wounds, as of 11/27/24. DON/designee to monitor weekly for compliance. Abuse and Neglect Policy to include failure to assess a wound and/or notify a physician for a change in condition on a wound including surgical wounds, could be considered neglect. Non-licensed nursing staff -Abuse and Neglect Policy- failure report a change a change in condition on a resident such as a new or worsening wound, could be considered neglect. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Notification of Change in Condition Policy- Reporting negative changes in condition involving wounds to the charge nurse immediately. Changes include a soiled dressing, foul odor, redness, or complaints of pain to the wound. If the charge nurse is not available, the DON or ADON will be notified. Monitoring of the POR Included the following: Record review of the facility's Skin Sweep Documentation on 11/08/2024 at 4:58 PM reflected no other post operative residents at the facility. Record review of 5 recent admissions at [Facility] on 11/27/2024 at approximately 3:00 PM revealed compliance with admission physician orders, baseline care plans, skin assessments, and clinical dashboard information. Record review on 11/08/2024 of facility's AD HOC QUAPI meeting minutes and sign in sheet, titled OFF CYCLE (AD HOC) QA MEETING DOCUMENT, content included facility failures related to physician notification, assessment, and abuse/and or neglect. Facility CCD, DON, Administrator, Medical Director, and ADO signatures were included. Record review on 11/08/2024 of In-service, Notification of Change in Condition, conducted by CCD, included facility definition, purpose, process for provider notification as it related to all surgical wounds/incisions changes or decline in condition are required to be reported to the surgeon and attending physician by utilizing the facility sanctioned communication documents. Facility Administrator and DON's signatures were included. Record review on 11/08/2024 of In-service, Notifying the Physician of Change in Status, conducted by the Administrator and the DON, included facility definition, purpose, process for provider notification as it related to all surgical wounds/incisions changes or decline in condition are required to be reported to the surgeon and attending physician by utilizing the facility sanctioned communication documents. Multiple staff RN and LVN signatures were included. Record review on 11/08/2024 of In-service, Abuse and Neglect, conducted by CCD, included facility definition of abuse/neglect, identification of abuse/neglect, and facility specific policy, protocol, and procedure for reporting abuse/neglect at the facility. Facility Administrator and DON's signatures were included. Record review on 11/08/2024 of In-service, Abuse and Neglect, conducted by DON, included facility definition of abuse/neglect, identification of abuse/neglect, and facility specific policy, protocol, and procedure for reporting abuse/neglect at the facility. Multiple staff signatures included department leadership, rehabilitation department, nurses, nursing aides, social services, dietary department, housekeeping, and the maintenance department. Record review on 11/27/2024 of In-service titled, SBAR, conducted by CCD, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Facility Administrator and DON's signatures were included. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on 11/27/2024 of In-service titled, SBAR for Surgical Incisions, conducted by DON, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Multiple facility nursing staff signatures were included. In interview with the facility Administrator and DON on 11/08/2024 at 6:10 PM and 6:02 PM respectively, they stated the clinical dashboard was reviewed for compliance as per the POR. In follow up interview with the Administrator and DON on 11/27/2024 at 1:50 PM, they stated the clinical dashboard was reviewed for compliance as per the POR. In interview with facility's CCD on 11/08/2024 at 1:00 PM she stated there were no post-operative surgical residents currently at the facility. In follow-up interview with facility's CCD on 11/27/2024 at 11:40 AM she stated there were no post-operative surgical residents currently at the facility. In follow up interview with facility's Administrator on 11/27/2024 at 2:30 PM he stated facility's DON, or a designee were responsible for daily monitoring of new surgical incision resident orders and will present this information to leader [TRUNCATED]

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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** 42824 Based on observation, interview, and record review the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers for one (Resident #44) of five residents reviewed for wound care treatment and services. The facility failed to ensure Resident #44 wore her heel protector on 11/05/2024 per physician order to prevent the re-development of a previous pressure ulcer. This failure could place the residents at risk for the development, re-development, or worsening of pressure wounds . Findings included: Review of Resident #44's Face Sheet on 11/05/2024 revealed a [AGE] year-old resident admitted on [DATE] from an acute care hospital. She was admitted on hospice. Relevant diagnoses included dementia, anxiety disorder, pain, and pressure ulcer of the right heel. Review of Resident #44's Comprehensive Care Plan, dated 09/09/2024, revealed she had impaired visual function and had a communication problem related to her dementia. Resident #44 was at risk for falls related to her dementia, poor balance, weakness and interventions included the need for a safe environment, quarter positioning rails, proper inflation of resident's mattress, proper footwear, and fall mat on floor next to bed. She was incontinent of bladder and had other self-care performance deficits that required one to two staff assistance for bathing, bed mobility, dressing, eating, toilet use, and eating. No evidence of non-compliance related to pressure off-loading boot was documented. Review of Resident #44's MDS assessment dated [DATE] revealed she was severely cognitively impaired with BIMS score of 06 and was incontinent of bowel and bladder. Resident #44's MDS stated she was at risk for developing pressure ulcers/injuries and had a stage four (full thickness tissue loss with exposed bone, tendon, or muscle .) unhealed pressure ulcer/injuries at the time of assessment. Review of Resident #44's physician orders on 11/05/2024 revealed: Off-load wound: Float heels in bed: Pressure Off-Loading Boot every shift for Wound Care . with a start date of 10/30/2024. Stage 4 Pressure Wound of the Right Heel Full Thickness . Apply Skin Prep [per] Q shift . every shift for wound treatment . with a start date of 10/30/2024. In observation of Resident #44 on 11/05/2024 at 1:23 PM revealed her resting in bed without any heel protectors on her feet. Resident #44 was not interview-able due to her cognitive status. On a table in front the foot of her bed were heel protectors. Located on the bulletin board above the heel protectors was a color photo in a sheet protector that depicted someone wearing a right heel protector. Written on the picture in red marker was instructions that stated pt [patient] positioning in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Resident #44's nurse aide for that day, CNA O, at 11/05/2024 at 1:28 PM she stated she was not sure about her heel protector and stated she would go ask the resident's nurse, LVN Z. In observation and interview with LVN Z on 11/05/2024 at 1:37 PM she stated Resident #44 was compliant with cares and kept her heel protector on when applied. She stated Resident #44's heel protector should be on now and if it was not, it should be because she is prone to pressure wounds. When LVN Z went into Resident #44's room to assess the resident, she stated the heel protector was not on and that she would get an aide to apply it. In observation of LVN Z and CNA O on 11/05/2024 at 1:47 PM, they both went into Resident #44's room and applied the heel protector to Resident #44's right heel. In interview with facility's Treatment Nurse on 11/07/2024 at 2:02 PM she stated Resident #44 had a pressure wound to the right heel. She stated when she was admitted it was a stage four but she has been working on [improving] it. She stated right now the wound was closed up and her wound care consists of skin prep and heel protection as a preventative. She stated it was very important for Resident #44 to wear the heel protector because we don't want it to open up again. She stated the bedside nurse was responsible to ensure Resident #44 had her heel protector on all the time to prevent a re-occurrence of her pressure injury. In interview with DON on 11/07/2024 at 2:29 PM she stated Resident #44 should have her heel protector on per physician orders. She stated it was her expectation for resident's nurses to ensure resident's pressure relieving devices were on each resident per physician orders. She stated if Resident #44 does not have her heel protector on, her wound can worsen, [which is] the opposite of what we are trying to do. Review of facility policy, Skin Integrity Management, rev . 10/05/2016, revealed 5. Use . foam to keep bony prominences from direct contact . 11. The Treatment Nurse/designee and the DON should add a written plan for the use of positioning devices to the care plan . 20. Additional heel protection may be needed .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #44) of five residents reviewed for accidents, hazards, and supervision. The facility failed to ensure Resident #44's fall mat was placed appropriately on the floor by her bed on 11/05/2024. This failure could place residents at risk for serious injury. Findings included: Review of Resident #44's Face Sheet on 11/05/2024 revealed a [AGE] year-old resident admitted on [DATE] from an acute care hospital. She was admitted on hospice. Relevant diagnoses included dementia, anxiety disorder, pain, and pressure ulcer of the right heel. Review of Resident #44's Comprehensive Care Plan, dated 09/09/2024, revealed she had impaired visual function and had a communication problem related to her dementia. Resident #44 was at risk for falls related to her dementia, poor balance, weakness and interventions included the need for a safe environment, quarter positioning rails, proper inflation of resident's mattress, proper footwear, and fall mat on floor next to bed. Review of Resident #44's MDS assessment dated [DATE] revealed she was severely cognitively impaired with a BIMS score of 06 and was incontinent of bowel and bladder. No falls were documented related to falls since admission/entry or reentry. Review of Resident #44's physician orders on 11/05/2024 revealed she May have a fall mat at bedside . with a start date of 07/24/2024. Record review of facility's Incident report during a look-back period from 08/01/2024-11/05/2024 on 11/05/2024 revealed no documented incidents of falls for Resident #44. In observation of Resident #44 on 11/05/2024 at 1:23 PM revealed her resting in bed with her fall mat not located on the floor. The plastic covered foam mat was folded up between her bed and wardrobe/closet. Resident #44 was not interview-able due to her cognitive status. In interview and observation with Resident #44's nurse aide for that day, CNA O, on 11/05/2024 at 1:28 PM she stated she thinks she [Resident #44] is a fall risk. Upon observation of Resident #44 in her room, she located her fall mat folded up between her bed and wardrobe/closet. CNA O then proceeded to unfold the fall mat and then placed it on resident's right side of her bed. CNA O stated her fall mat should be in place on the floor while Resident #44 was in bed. CNA O stated if her fall mat was not in place, she can fall out of bed, break a bone, or hurt herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observation and interview with LVN Z on 11/05/2024 at 1:37 PM she stated Resident #44 is compliant with cares and was stable. LVN Z stated she was moved rooms to be located closer to the nurse's station to keep an eye on her. She stated if Resident #44 was in bed, her fall mat should be down on the floor as it was important to minimize injury. In interview with DON on 11/07/2024 at 2:29 PM she stated Resident #44 should have her fall mat down while resident was in bed. She stated it was her expectation for the nurse aides and nurses to ensure resident's fall precautions were appropriately in place and specifically for Resident #44, her fall mat appropriately placed on the floor per physician orders. She stated if Resident #44 does not have her fall mat down, she can fall down and have an injury, it's not safe. Review of facility policy, Preventative Strategies to Reduce Fall Risk, dated 10/05/2016, revealed 1. After risk is assessed, individualized nursing care plans will be implemented to prevent falls . Review of facility policy, Comprehensive Care Planning, undated, revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #08, Resident #38) of four residents observed for infection control. 1. The facility failed to ensure MA X sanitized the blood pressure device between contact and care of Resident #08 and Resident #38on 11/06/2024. 2. The facility failed to ensure RN K and CNA G sanitized their hands during the distribution of lunch trays on 11/05/2024. These failures could affect resident's health and place them at risk of illness and exposure to diseases. Findings included: 1. Review of Resident #08's Face Sheet, dated 11/06/2024, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included major depressive disorder, type 2 diabetes (insulin resistance,) hypertension (high blood presure,) and hemiplegia and hemiparesis following cerebral infarction affecting his left non-dominant side (partial paralysis following a disruption of oxygen to the brain.) Review of Resident #08's Comprehensive Care Plan, dated 10/10/2024, revealed he had impaired visual function, impaired cognitive function, was at risk for falls, has a potential for uncontrolled pain, and is on diuretic therapy (treatment that uses drugs to help the body get rid of excess salt and fluid.) Review of Resident #38's Face Sheet dated 11/06/2024 revealed she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included dementia, chronic kidney disease, heart disease, major depressive and anxiety disorder. Review of Resident #38's Comprehensive Care Plan dated 10/04/2024 revealed she had impaired visual function, impaired cognitive function, was on pain medication therapy, and is on diuretic therapy. In observation of MA X on 11/06/2024 at 8:05 AM during medication administration for Resident #08, she placed a blood pressure measurement device on the resident's right wrist. MA X obtained a blood pressure reading and placed the device on her medication cart. She then provided medication to the resident. MA X failed to sanitize the blood pressure measurement device before, between, or after resident contact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675939	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Health Care Center	205 N Bonnie Brae Denton, TX 76201

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In observation of MA X on 11/06/2024 at 8:50 AM during medication administration for Resident #38, she placed a blood pressure measurement device on the resident's right wrist. MA X obtained a blood pressure reading and placed the measurement device on her medication cart. She then provided medication to the resident. MA X failed to sanitize the blood pressure measurement device before, between, or after resident contact. In interview with MA X on 11/06/2024 at 9:41 AM she stated she did not sanitize the blood pressure measurement device between Resident #08 and Resident #38 use, but stated she should have because of infection control purposes. In interview with DON on 11/07/2024 at 2:33 PM she stated MA X should sanitize shared use equipment between use with the residents. She stated she expected MA X to sanitize the blood pressure measurement device between use with Resident #08 and Resident #38 to prevent the spread of infection. 2. On 11/05/24 at 12:42 PM, during observation of lunch trays being passed to rooms 1-30 and the dining room on that hall, revealed CNA G and RN K passed multiple trays without using hand sanitizer. RN K was observed placing the trays in front of residents and then getting another tray and placed it in front of another resident without sanitizing. CNA G was observed to have passed three trays before being instructed to sanitize her hands by a corporate staff member between each tray. CNA G was passing trays and was observed setting up the tray for the resident before passing another tray without sanitizing her hands. The corporate staff member who instructed CNA G to sanitize her hands in the dining room could not be located after the observation for interview . During an interview on 11/05/24 at 1:17 PM with RN K, he stated hand sanitizer in the wall dispensers dry his hands out, so he uses his personal one, which was issued to him by another nurse. He stated the purpose for using hand sanitizer before each tray was to prevent cross contamination. Observation of the cart, did not reveal hand sanitizer was on the cart. On 11/06/24 at 12:48 PM, during an interview with C.N.A. G, she stated she knows to use hand sanitizer before serving each tray. She stated there was a lot going on and she was trying to move fast to get the trays out and she forgot. She stated the reason they are to sanitize between trays was to prevent cross contamination. She stated they get a reminder in-service on hand hygiene on their bi-monthly pay-day , she said before they are able to pick up their paychecks, they must read the inservices on hand hygiene and sign that they understand the content. She said they also are educated on hand hygiene whenever something regarding infection control comes up. On 11/06/24 at 02:39 PM, during an interview with the DON, she stated hand sanitizer is to be used before passing each tray. She stated using hand sanitizer is a method to prevent cross-contamination. She stated staff are in-serviced on Hand Hygiene regularly. the DON stated she expected the staff tp use hand sanitizer before and after handling each tray to prevent cross contamination. (continued on next page)

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	675939	A. Building B. Wing	11/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy, Infection Control Plan: Overview, rev. 2022, revealed Process surveillance . minimizes exposure to a potential source of infection . reusable equipment is appropriately cleaned, disinfected . Review of facility policy, Fundamentals of Infection Control Procedures, rev. 03/2022, revealed 1. Hand hygiene continues to be the primary means of preventing transmission of infection. The following is a list of some situations that require hand hygiene . before or after assisting a resident with meals; before [NAME] after assisting a resident with personal care . Upon and or after coming in contact with a resident's intact skin .