STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676222	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bastrop Lost Pines Nursing and Rehabilitation Cent	430 Old Austin Hwy Bastrop, TX 78602

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176 Based on interview and record review the facility failed to ensure the residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research and to formulate an advance directive for 1 of 5 residents (Resident #80) reviewed for advanced directives. The facility failed to ensure Resident #80's out of hospital do-not-resuscitate (OOH-DNR) form included all required signatures which included a signature from the physician. This failure could place residents at risk of having their wishes dishonored, and of having CPR (cardiopulmonary resuscitation) performed against their wishes. Findings include: Record review of Resident #80's face sheet, dated [DATE], reflected Resident #80 was admitted to the facility on [DATE]. Resident #80 had diagnoses which included severe chronic kidney disease and displaced fracture of the base of the neck of the left femur (broken leg). The advance directive listed was DNR . Record review of Resident #80's care plan, dated [DATE], reflected the resident selected a DNR code status. Interventions included to ensure the signed DNR was in the medical record. Record review of Resident #80's quarterly MDS, dated [DATE], reflected a BIMS score of 09, which indicated moderate cognitive impairment. Record review of Resident #80's physician orders reflected DNR/Do Not Attempt Resuscitation order dated of [DATE]. Record review of Resident #80's clinical record reflected an OOH-DNR form, dated [DATE]. Further review revealed under the section all persons who have signed above must sign below, acknowledging that this document has been properly completed there were no signatures from the resident, witnesses/notary, or physician. A second OOH-DNR form dated [DATE] revealed under the section Physician's Statement, there was no physician's signature. Also, under the section all persons who have signed above must sign below, acknowledging that this document has been properly completed there were no signature from the physician . (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:03 AM with Social Worker C, she stated typically, upon admission, the DNR or advance directive was included in the admissions paperwork. Social Worker C looked at both DNRs in the file for Resident #80 and stated both DNRs were not valid because they were missing signatures. The DNR, dated [DATE], was not valid due to no signatures at the bottom, which was why she had a new DNR created in [DATE]. Social Worker C reviewed the new DNR, dated [DATE], and stated it was not valid because it did not have the doctor's signature. Social Worker C stated she wrote the doctor's name on the form, but it was not signed by the doctor. Social Worker C stated she emailed the doctor three times for signature ([DATE], [DATE] and [DATE]) and stated the DNR was not valid and needed the doctor's signature. She stated she failed to follow up after that. Social Worker C stated she put a temporary DNR in the file while they were waiting for the doctor's signature. Social Worker C stated she was not aware of any timeframe for the doctor's signature to be completed on the form, but waiting six months for a signature, would not meet her expectation. She stated the potential negative outcome for the resident with a DNR that was not valid or signed was their choice would not be honored, and they would be resuscitated against their wishes. She stated she thought she could use a temporary DNR without the doctor's signature. During an interview on [DATE] at 11:57 AM with Resident #80, she appeared confused and was not able to understand questions regarding her advance directors or DNR . During an interview on [DATE] at 12:41 PM, the ADM stated he would honor a DNR without a doctor's signature and was not sure if paramedics would honor the DNR without a doctor's signature. The ADM's expectation was a doctor would sign the DNR timely, and the facility did not have a policy regarding specific timeframes for a doctor's signature. If a resident had a DNR and coded, it would be a dignity issue of not honoring the resident's wishes if CPR was performed. During an interview on [DATE] at 01:22 PM, the DON, stated a temporarily DNR was valid if the DNR was only missing the doctor's signature. It would be her expectation to have the doctor sign as soon as possible, but there was no policy that discussed timeframes or deadlines for a doctor's signature on a DNR. During an interview on [DATE] at 01:36 PM, the Regional RN, stated when a new resident was admitted to the facility, the Social Worker would talk to the resident or family member within the 48-hour care plan timeframe about advance directives. When the DNR form was filled out correctly, the facility would call the doctor to inform him or her about the DNR and request a doctor's order for the DNR. The temporary DNR would be put in the resident's record pending the doctor's signature on the form. Her expectation was the doctor's signature would be prompt and waiting six months for a signature, would not meet her expectation. She stated the facility did not have a policy regarding timeframes for signatures on a DNR form. The Regional RN stated a DNR was not valid unless all signatures were on the form. The potential harm to a resident was not having their wishes honored. On [DATE], a signed DNR was provided to the State Surveyor. Record review of the facility's policy titled Residents' Rights Regarding Treatment and Advanced Directives, dated [DATE], reflected it is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive .On admission, the facility will determine if the resident has executed an advance directive . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's manual, revised [DATE], under section titled Advance Directives reflected, This topic and the related information, will be reviewed and discussed with the resident, surrogate decision maker, or legal representative within 14 days of admission and annually Record review of the Health and Safety Code 166.083(7)(13) reflected an OOH-DNR must contain a statement at the bottom of the document, with places for the signature of each person executing the document, that the document had been properly completed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176 comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for five of sixteen (room [ROOM NUMBER], 307, 313, 315, and 316) rooms reviewed for environmental conditions. 1) The facility failed to securely attach a sink basin to the wall, which ensured that the sink did not move or fall off in room [ROOM NUMBER]. 2) The facility failed to ensure the wall in room [ROOM NUMBER] was free from black scuff marks and large patches of peeling paint. 3) The facility failed to ensure the bed in room [ROOM NUMBER] had a footboard to prevent the mattress from sliding down and off the bed. 4) The facility failed to ensure the window in room [ROOM NUMBER] and room [ROOM NUMBER] closed properly without a gap to the outside to ensure proper room temperature could be held and to protect the residents from potential of vandalism or break-in. These failures could place residents at risk of living in an unsafe, unhomelike, and uncomfortable environment. Findings included: 1. Observation and interview on 12/03/2024 at 10:35 AM, revealed room [ROOM NUMBER]'s bathroom sink basin was detached from the wall and there was approximately a 1-inch gap from the basin to the wall on the top and sides of the sink. The sink moved when the sink was pressed down. Resident #55 stated the sink had been like that for months and she called the maintenance director several times and never got a response. Resident #55 did not use the sink as she was dependent on staff for all her activities of daily living. Resident #67 stated she stopped using the sink for fear of getting hurt because the sink was detached from the wall . She did not like the condition of the sink and wanted it repaired. Observation and interview on 12/04/2024 at 8:16 AM, revealed room [ROOM NUMBER]'s bathroom sink basin was detached from the wall and there was approximately a 1-inch gap from the basin to the wall on the top and sides of the sink. Resident #55 stated the Maintenance Director came to work on the sink on 12/03/2024 but told the resident he did not have a sink to replace it and would return later to repair it. Resident #55 stated the Maintenance Director told her to be careful when using the sink . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/04/2024 at 03:12 PM, the Maintenance Director stated he repaired the sink in room [ROOM NUMBER] this morning after the ADM told him about it on 12/02/2024. room [ROOM NUMBER]'s bathroom sink was observed to be fully attached to the wall with new caulking around the basin. The Maintenance Director stated the sink would be considered a critical task that would be repaired immediately because of the safety concern. If the resident applied too much pressure, the sink could fall and cause bodily injury. He stated Resident #67 was in a wheelchair and the sink could fall and break a toe. The Maintenance Director stated he did rounds in residents' rooms often as part of his daily work but would not say how often that was. The Maintenance Director was new to his position and only been at the facility for a couple of months . He relied on staff to put in work orders. He stated residents could make maintenance requests for repairs by telling a staff member, who then created a work order using a Kiosk system that went to the Maintenance Director's phone and computer as work orders . He would review the work orders and prioritize the work and did the work per hallway. Time for repairs varied depending on how critical the task was. During an interview on 12/05/2024 at 10:05 AM, CNA J stated she was not aware of the sink in room [ROOM NUMBER]. She assisted Resident #67 to the bathroom. CNA stated that the sink coming away from the wall would be a safety concern if either resident put any weight on the sink because it could fall and hurt the resident. If she had noticed it, she would have reported it to the nurse. Record review of open and closed work orders provided by the ADM showed no order history for the sink repair. Record review of the work order for the sink repair in room [ROOM NUMBER], provided by the Maintenance Director on 12/04/2024 at 04:00 PM, reflected it was created on 12/04/2024 at 3:49 PM by the Maintenance Director with a due date of 12/02/2024 . 2. Observation on 12/03/2024 at 09:53 AM, revealed room [ROOM NUMBER]'s left side of the wall between bed A and bed B had several black scuff marks which extended along the entire bottom of the wall in the middle of the room above the baseboard. Several areas of paint were peeled off the wall which exposed the white sheetrock. Resident #26 was observed asleep in wheelchair in room and unavailable for interview. The other resident in the room was in the hospital and was not available for interview. During a telephone interview on 12/04/2024 at 01:16 PM, Resident #26's family member stated she had seen the scuff marks and missing paint and thought that was due to the roommate's wheelchair. She stated she had not reported it to staff, but wanted it repaired. She stated Resident #26's vision was poor and probably hasn't noticed the scuff marks and missing pain. She stated Resident #26 currently had an urinary tract infection and was confused and would not be able to answer questions. During an interview on 12/04/2024 at 03:12 PM, the State Surveyor showed the Maintenance Director room [ROOM NUMBER]. The Maintenance Director stated he was not aware of the wall issue with the scruff marks and peeling paint. He stated it was probably due to the roommate's wheelchair and had been like that for a while. He stated the paint was peeling off and he would not consider that a homelike environment. He would not want his mother or grandmother in a room like that. He checked the computer system and did not find a work order . During an interview on 12/05/2024 at 10:05 AM, CNA J stated she had had not noticed the scuff marks and peeling paint but said that was not homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation and interview on 12/03/2024 at 11:51 AM, revealed room [ROOM NUMBER] had a mechanical bed without a footboard. Resident #43 stated it took the facility weeks to respond to a maintenance request . She stated the mattress slides off the bed. Observation and interview on 12/05/2024 at 09:36 AM, revealed Room#315's bed had a footboard . Resident #43 stated her bed had been missing the footboard for approximately 3 to 4 weeks. She reported it to the Administrator and to several unnamed staff members that she could not identify. Resident #46 stated the mattress would slide around while she was lying in the bed, and she was afraid of falling off the bed . She had never fallen off the bed due to not having a footboard. She stated she received a new bed with a footboard on 12/03/2024 and she felt safe . Record review of closed work orders revealed there was no specific order for a footboard. During an interview on 12/04/2024 at 03:12 PM, the Maintenance Director stated he was aware of several concerns regarding the beds on hall 300. There had been a delay in maintenance repairs because he was recently hired and getting caught up on all the repairs. Interview on 12/05/2024 at 12:41 PM, the ADM stated Resident #43 complained about a lot of things in her room and can get fixated on her concerns. The ADM stated any staff members could report a maintenance repair concern. The ADM stated that they did not have a Maintenance Director for about two weeks and had to hire a new one and this created a delay in some maintenance requests being completed. 4. Observation and interview on 12/03/2024 at 12:47 PM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The window had a small gap appropriately 1/2 inch on the left side of the window and would not close completely. Resident #72's AR stated the window did not close all the way and the room got cold due to the gap in the window. The AR reported it to the Maintenance Director at the end of September 2024, but it had not been repaired . The ambient temperature in the room felt comfortable to the State surveyor and Resident #72 was observed to be appropriately dressed. Resident #72 was not interviewable. Observation and interview on 12/03/2024 at 03:31 PM, Resident #84 was observed lying in bed wearing a t-shirt and brief. Resident #84 was non-verbal but could nod in response to yes and no questions. He nodded yes that he was aware of the window problem, and it bothered him. He wanted it repaired. Resident #84 nodded no when asked if he or the room was cold. Observation on 12/04/2024 at 08:11 AM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The window had a small gap appropriately 1/2 inch on the left side of the window and would not close completely. A cold draft could be felt by the window. The outside temperature was appropriately 53 degrees Fahrenheit according to a weather app, but the inside of the room felt comfortable. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/24 at 03:23 PM the State Surveyor showed the Maintenance Director room [ROOM NUMBER]'s window. The Maintenance Director stated he was not aware of any problem with the window. He looked at the window and said there was a small piece of plastic and a string in the bottom left corner of the window that was preventing the window from closing all the way. He stated he checked all the windows two weeks ago and had not noticed it. The Maintenance Director stated the concern would be the draft/weather could cause temperature changes in the room, and someone might try to vandalize or break into the room. He checked the computer system and did not find a work order . Observation and interview on 12/05/2024 at 11:56 AM, revealed room [ROOM NUMBER]'s windowsill had a rolled towel along the base of the window. The towel was dirty with what appeared to be dirt and was slightly damp. The window had a small gap appropriately 1/2 inch that a pen would fit in along the entire window and would not close completely. A cold draft could be felt coming in from the window. The outside temperature was appropriately 55 degrees Fahrenheit according to the weather app on the surveyor's state issued cell phone . Resident #80 was observed wearing gloves. She stated she did not put the towel there and did not know how long it had been there . Resident #80 appeared confused and was not able to answer specific questions about the window. Interview on 12/05/2024 at 08:20 AM and 12:41 PM, the ADM stated he was aware of the delays in maintenance repairs due to problems with the prior Maintenance Director not completing repairs timely. The facility had a mock survey that brought this concern to their attention, and they had an Ad Hoc QAPI meeting on 11/05/2024 to discuss the maintenance repair concerns. Due to these concerns, the previous Maintenance Director was asked to leave, and the facility hired a new Maintenance Director because it was taking a long time to do any repairs. Due to the Ad Hoc QAPI meeting, the new Maintenance Director went through the entire building using a systematic approach to identify maintenance concerns. When asked if the ADM identified priority items that needed to be repaired that would impact a resident's safety, the ADM stated no, they used the systematic approach. The ADM stated there was no formal policy on how soon to respond to work orders and there was no policy on maintenance repairs. The ADM stated he utilized a preventative maintenance program. The ADM stated critical items would be repaired that could possibly harm a resident and should be addressed as soon as possible, such as the sink in room [ROOM NUMBER]. High priority repairs could cause harm and should be handled quickly, such as next day if possible. The delay in maintenance repairs would not be homelike. The ADM stated the concern with the windows in room [ROOM NUMBER] and #316 could affect the room temperature, especially since it was cold outside. The ADM stated during their transition when hiring a new Maintenance Director, they did not have a Maintenance Director for about two weeks and that caused a delay in repairs. Record review of grievances for the last three months did not show any maintenance delay grievances related to these specific concerns. Record review of the facility manual, revised 07/14/2020, under section titled Statement of Resident Rights reflected, the residents have a right to: all care necessary for you to have the highest possible level of health; live in a safe, decent, and clean conditions; be treated with dignity, courtesy, consideration, and respect.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interview and record review, the facility failed to ensure a residents who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident # 5, and Resident #79) reviewed ADL care. 1. The facility failed to ensure Resident #5 and Resident #79 nails were cleaned, trimmed, and did not have any rough edges on 12/03/2024. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings include: 1. Record review of Resident # 5's face sheet, dated, 12/05/2024 , reflected an [AGE] year-old male who was admitted to the facility on [DATE] . Resident #5 had diagnoses which included unspecified dementia , unspecified severity without disturbance, psychotic disturbance, mood disturbance, and anxiety (the loss of cognitive functioning such as: thinking, remembering, and reasoning to the extent that it interferes with a person's daily life and activities without any behavior or mood disturbances), type 2 diabetes mellitus without complications (a long-term medical condition in which your body doesn't use insulin properly, resulting in unusual blood sugar levels), and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). Record review of Resident #5's Quarterly MDS Assessment, dated 10/29/2024, reflected the resident had a BIMS score of 8, which indicated his cognition was moderately impaired. Resident #5 required partial/moderate assistance- staff did less than half the effort with personal hygiene, lower body dressing, toileting, putting on/taking off footwear and transfers. Record review of Resident #5's Comprehensive Care Plan, started on 11/01/2024 and completed on 11/08/2024, reflected Resident #5 had an ADL self-care performance deficit related to dementia, adult failure to thrive, and diabetes mellitus 2. Interventions: Check nail cleanliness, length and trim as needed on bath day and as needed. Report any changes in nail care to nurse. Observation on 12/03/24 at 10:07 AM revealed. Resident #5 was in his room lying on his bed. He had a blackish/ brownish substance underneath the middle and ring finger on his right hand. Resident #5's nails were long and uneven around the edges on all fingernails on his right hand. Interview on 12/03/2024 at 10:09 AM, Resident #5 stated his nails needed to be cleaned and cut. Resident #5 stated he asked a staff to clean and trim his nails. He stated he did not know the staff name. Resident #5 stated the staff did not clean or trim his nails. He stated he asked staff within the past 3 days and the staff said he would get his nails cleaned and trimmed sometime this week or next week . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #79's face sheet, dated 12/04/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #79 needed assistance with personal care (someone required assistance with basic daily living activities such as: bathing, dressing, eating, toileting, grooming due to physical, mental, or cognitive limitations that prevent them from preforming these tasks independently), dementia in other diseases classified elsewhere, moderate, with psychotic disturbance (the loss of cognitive functioning such as: thinking, remembering, and reasoning to the extent that it interferes with a person's daily life and activities and a set of symptoms that indicate a person has lost touch with reality), and generalized muscle weakness (a decrease in muscle strength throughout the body) Record review of Resident #79's Quarterly MDS Assessment, dated 09/30/2024, reflected Resident #79 had a BIMS score of 2, which indicated her cognition was severely impaired. Resident #79 required substantial/maximal assistance (helper does more than half the work) with personal hygiene, upper body dressing, showers, oral hygiene, and eating. She was total dependent on staff for transfers, lower body dressing, and toileting hygiene. Record review of Resident #79's Comprehensive Care Plan, with a start date of 10/03/024 and completed on 10/16/2024, reflected Resident #79 had an ADL self-care performance deficit related to dementia. Interventions: Check nail length, trim, and clean on bath day and as needed. Report any changes to the nurse. Observation and interview on 12/03/2024 at 10:37 AM revealed Resident #79 were lying in bed. Her nails on her right hand were not smooth around the edges. She had a blackish brownish substance underneath her middle and ring fingernails on her right hand. Resident #79 was not interview able. Interview on 12/03/2024 at 10: 44 AM, CNA G stated Resident #79's nails on her right hand were rough around the edges and needed to be filed. She stated there was a blackish substance underneath Resident #79's middle and ring fingernails on her right hand. CNA G stated she was not aware of Resident #79 or Resident #5 refusing nail care. She stated she had given care to these two residents numerous times per month. CNA G stated a resident may scratch themselves or someone else. She stated it was a possibility a resident may develop a skin tear if their nails were not correctly filed such as having rough nails . She stated it was CNAs responsibility to clean and trim all residents' fingernails except resident with diagnosis of diabetes. She stated nurses trimmed and cleaned residents with diabetes fingernails. In an interview on 12/05/24 at 08:36 AM, the Director of Nurses stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria. She stated there was a possibility a resident may develop vomiting or diarrhea. She stated all residents were expected to receive nail care during showers and as needed. The Director of Nurses stated the CNAs completed nail care on all residents except for the residents with diagnosis of diabetes. She stated all residents with a diagnosis of diabetes, the nurse was responsible for their nail care. The Director of Nurses stated she expected the CNAs to report any changes in all residents' nails to the nurse supervisor. She stated if a resident had rough nails, there was a potential a resident may scratch themselves or someone else and cause a skin tear. She stated it was the nurse supervisor's responsibility to monitor ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/05/2024 at 9:14 AM , CNA H stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA H stated the residents nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. She stated a resident may cause a skin tear if their fingernails were not smooth. CNA H stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she had given care to Resident # 79 and Resident #5 and she was not aware of these residents refusing nail care . In an interview on 12/05/24 at 09:25 AM, LVN D stated the nurses, and the CNAs were responsible for nail care. He stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. LVN D stated it was the CNAs responsibility to clean and trim all other residents' nails during showers or as needed. He stated if there was a blackish substance underneath the resident's nails, there was a possibility the substance had bacteria. LVN D a stated if a resident swallowed the bacteria there was a possibility a resident may become ill with stomach problems and may develop a stomach infection. LVN D stated he was not aware of Resident # 5 or Resident # 79 refusing nail care. monitoring nail care. LVN D stated he was in-serviced on nail care; however, he did not recall the date. Record review of the facility's policy on Activities of Daily Living, dated 05/26/2023, reflected a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176 Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 7 residents (Resident #84) reviewed for limited range of motion. The facility failed to ensure Resident #84 was evaluated, treated, and had interventions in place for hand contractures (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in range of motion) . This deficient practice could place at risk for decrease in mobility, range of motion, further decline, future injuries, pain and contribute to worsening of contractures. Findings include: Record review of Resident #84's face sheet, dated 12/04/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #84 had diagnoses which included quadriplegia (a form of paralysis that affects all four limbs and the torso), contractures of both hands, dysphagia (difficulty swallowing), aphasia (a disorder that affects how you communicate), pain, history of traumatic brain injury, and acquired absence of unspecified leg above the knee (amputation of leg). Record review of Resident #84's Quarterly MDS assessment, dated 10/02/2024, reflected Resident #84 was assessed to have a BIMS score of 99, which indicated the resident was unable to complete the interview. Resident #84 was assessed to have functional limitations in range of motion for both upper extremities. Resident #84 was assessed to be dependent on staff for toileting, showering, footwear, and transfers and was assessed to be incontinent of bowel and bladder. He required maximum assistance with eating, oral and personal hygiene and dressing. The resident required partial/moderate assistance with rolling from side to side, sit to lying, and lying to sitting on side of bed. No occupational or physical therapy nor restorative programs had not been performed. Record review of Resident #84's comprehensive care plan under ADL self-care, revised on 10/25/2024, reflected the resident had contractures to bilateral hands, impaired cognition, seizures, quadriplegia, and history of a traumatic brain injury. Interventions reflected the resident was extensive to total assist times 1-2 staff for repositioning and turning in bed and eating. Interventions included PT/OT evaluation and treatment per as MD (medical doctor) orders. Under limited mobility due to contractures to bilateral hands and quadriplegia, interventions included monitor, document and report any symptoms of immobility or contractures forming or worsening, and PT, OT referrals as ordered or PRN. Resident was at risk for falls and interventions included, PT evaluate and treat as ordered or PRN. Record review of Resident #84's consolidated physician orders, dated 09/26/2024, reflected an order for PT and OT to evaluate and treat. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's progress note, dated 10/09/2024, signed by the treating family nurse practitioner, reflected the resident had no pain upon exam. Progress note, dated 11/18/2024, signed by the treating family nurse practitioner, reflected the resident had pain greater than five. Resident #84 was diagnosed with chronic pain from contracture of limbs with probable spasms of muscles. The resident's pain medications were changed due to pain not controlled by oxycodone twice a day and as needed medications. Oxycodone was changed to three times a day. Observation and interview on 12/03/2024 at 03:31 PM, revealed Resident #84 had contractures to both hands. His fingers were flat and bent toward his palms. There were no splints or palm guards observed, but there were photos on the wall of wrist/hand guards. The resident was non-verbal. He could nod in response to yes or no questions and used a communication board to communicate his needs. The resident expressed he was not receiving therapy services and wanted therapy services. Observation on 12/04/2024 at 12:00 PM, revealed Resident #84 was in the dining room in his wheelchair. Resident #84's bilateral hands remained without splints or palm guards. Observation on 12/04/2024 at 04:35 PM, revealed Resident #84 was lying in bed without any splints or palm guards. During an interview on 12/04/2024 at 03:57 PM, ST A and OT B stated Resident #84 had not been evaluated for therapy services yet, but there was an order in the resident's file . During an interview on 12/04/2024 at 04:02 PM, the PT Regional Rehabilitation Director stated Resident #84 had not been evaluated or treated for therapy services. She was not aware of an order to evaluate the resident. She stated the therapy teams usually responded to orders to evaluate a resident within 48-hours and because it had been over two months since the order was written, that meant the therapy department staff missed the order and it was not communicated with them. The PT Regional Rehabilitation Director stated usually, the person who made the order will inform the therapy team of the new order during morning meetings. This order was put in by the resident's nurse practitioner and it was not communicated to them during the morning meeting. She stated it was important to evaluate quickly to determine a resident's eligibility for services to avoid a decline in function. During an interview on 12/04/2024 at 04:40 PM, the DON stated all residents received a standing order to screen for therapy services as indicated but did not mean all residents needed therapy. The DON stated Resident #84 would be a good candidate for therapy services . The DON did not give a reason why Resident #84 was not evaluated. During an interview on 12/05/2024 at 10:52 AM, the PT Regional Rehabilitation Director stated Resident #84 was evaluated on 12/04/2024 and was eligible for receiving services. The short-term goal was improving function and ability and the long-term goal was restorative care. Resident #84 was a really good candidate for occupational therapy and the delay in completing the therapy evaluation and services could have caused the contractures and pain to worsen and decreased the resident's the quality of life . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's Occupational therapy evaluation and plan of treatment, dated 12/05/2024, revealed the resident qualified for OT services 5 times a week for 8 weeks. Resident #84 was prescribed a resting hand splint and elbow extension splint on the left fingers, left hand, left wrist, and left elbow. A carrot or [NAME] guard for the right hand and right elbow protector. The Clinical impressions included high pain levels impacting his safety with ADLs and increasing risks of secondary complications from immobility. During an interview on 12/05/2024 at 12:03 PM, LVN D stated he saw Resident #84 wearing hand braces sometimes, but it was the therapy staff who were responsible for putting the braces on the resident. LVN D stated it was important for the resident to wear hand braces due to the resident's contractures; otherwise, the contractures could get worse. LVN D was not aware of any doctor's orders regarding therapy services. During an interview on 12/05/2024 at 12:09 PM, CNA J stated she had never seen Resident #84 wear hand/arm braces, but the resident was evaluated by therapy on 12/05/2024. CNA J stated it was important to treat the contractures in the resident's arms and hands because she saw the resident was in pain . CNA J stated she told the charge nurse , and no one did anything about it. During an interview on 12/05/2024 at 12:15 PM, CNA I stated she saw Resident #84 wear hand/arm braces sometimes and it was important to treat the contractures in the resident's hands so the contracture would not get worse. During an interview on 12/05/2024 at 12:23 PM, ADON N stated she thought Resident #84 was receiving therapy services, but the resident did not like to wear the hand/arm braces because he would rub his hands/wrists together when he had them on. ADON N stated the nurse on the hall or CNAs would be responsible for putting on the braces. ADON N stated Resident #84 needed to wear the hand braces to prevent further contractures, further decline in the hand function, and possible comfortable measures to reduce pain. During an interview on 12/05/2024 at 12:41 PM, the ADM stated the facility did not have a policy about contractures or range of motion. The ADM's expectation was the facility would take care of the resident's needs and regarding Resident #84's order for therapy evaluation, they missed it. The ADM stated when a resident had an order to screen or evaluate for therapy, the Director of Rehabilitation, Case management nurses, and other nurse management staff would be responsible for notifying the therapy team of the order. The delay in therapy evaluation could have caused the resident to decline in functionable ability and have increased pain. This would not meet his expectation. During an interview on 12/05/2024 at 01:22 PM, the DON stated the facility had batch orders for therapy if residents needed to be seen. It was not a specific order to be evaluated that day. The DON stated she realized they had a problem with the way the batch orders were sent, and she had stopped that practice due to Resident #84's order being overlooked. The DON stated Resident #84 would was a good candidate for therapy services due to prevent the worsening of contractures, loss of function, pain, and possible skin breakdown . On 12/05/2024 at 11:47 AM, State Surveyor requested a copy of the facility's policy for Contracture Management and ADM stated in an email that they had no policy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on interview and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 8 residents (Resident #78) reviewed for unnecessary drugs. The facility failed to monitor Resident #78 for adverse effects of prophylactic antibiotic use. This failure could place residents at risk of nausea, diarrhea, and secondary infection. Findings include: Record review of Resident #78's admission record, dated 12/3/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #78 had diagnoses which included but not limited to encephalopathy (a group of disorders that affect the brain and cause altered mental state), Urinary tract infection, dysphagia (difficulty swallowing), and need for assistance with personal care. Record review of Resident #78's admission MDS reflected a BIMS score of 0, which indicated severe cognitive impairment. Record review of Resident #78's care plan, dated 11/6/2024 and revised on 11/14/24, reflected the resident had bladder incontinence r/t weakness, advanced age, dementia with interventions which included: Monitor/document for signs and symptoms of UTI. No other care plan related to antibiotics. Record review of Resident #78's antibiotic clinical review, dated 11/26/24, reflected signs/symptoms observed including McGeer's Criteria (these criteria are used to make an empiric diagnosis of UTI in a nursing home resident): Frequent UTIs Under the section UTI without indwelling catheter the form reflected 6. Must fulfill at least three of the following signs or symptoms No listed symptoms were indicated for Resident #78 at that time. Under the section Infection outcome reflected Did the resident meet McGeer's Criteria for Infection? with a response of no. Record review of Resident #78's physician order summary, dated 12/3/24, reflected an order for Bactrim Oral Tablet 400-80 MG, Give 1 tablet by mouth one time a day for prophylaxis with a start date of 11/26/24. There were no orders for tracking side effects of an antibiotic. Interview on 12/5/24 at 10:31 AM with ADON ICP N revealed she oversaw the infection control program. She stated when a practitioner ordered antibiotics or a resident was admitted from the hospital with orders for antibiotics, they were started or continued and not questioned. She stated it was her responsibility to review orders for antibiotics and review the first section of the antibiotic clinical review and complete the last part of the review. The ADON ICP N stated she reviewed the antibiotic clinical review but just went with the orders from the nurse practitioner instead of questioning the order. ADON ICP N stated she didn't know residents were not supposed to take antibiotic prophylactically per the CDC guidelines. She stated this was a learning experience for her. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/5/24 at 1:15 PM with the DON revealed she was aware Resident #78 was on prophylactic antibiotics. She stated Resident #78's family contacted the nurse practitioner because the resident was taking an antibiotic prophylactically at home due to chronic recurring urinary tract infections. The DON stated there was no indication that was approved to take antibiotic prophylactically. She stated her expectations of the nurses was to question the provider if they received an order for prophylactic antibiotics. She expected the nurses to complete the first part of the antibiotic clinical review and the infection control prevention nurse to finish the form. The DON stated she didn't think there were any potential effects to residents on long term antibiotics but stated a resistance to the antibiotic could happen. Record review of the facility's policy titled Antibiotic Stewardship Program, dated 10/24/22, reflected: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines . 4. The program includes antibiotic use protocols and a system to monitor antibiotic use . a. Antibiotic use protocols: iii. The facility uses the updated McGeer's criteria to define infections . v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use . b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50872 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were were stored and labeled in accordance with currently accepted professional principles for 1 of 4 medication carts (100 hall Nurses' Medication Cart). The facility failed to ensure expired supplies were removed from 100 Nurses' Medication Cart including 7 Disposable syringes with expiration date of [DATE]. This failure could place residents at risk of contamination which could cause infection or injury. Findings include: Observation on [DATE] at 9:32 AM of the top drawer on the 100 hall Nurses' Medication cart revealed 7 Disposable syringes with needles that had an expiration date of [DATE]. Interview on [DATE] at 9:35 AM with LVN E revealed all floor nurses were to check expiration dates on the supplies as they go. He stated using expired supplies could lead to contamination. Interview on [DATE] at 1:15 PM with the DON revealed the staff should be checking for expiration dates in their carts every day. She stated using the expired supplies could vary depending on what the supplies were but using expired syringes or needles could lead to infection at the site of injection or weakness in the supplies being used. Interview on [DATE] at 2:20 PM with the ADM revealed his expected was for staff to check for expired supplies at least weekly. He stated using the expired supplies could result in infection. There was no specific policy for expired supplies.

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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** 40884 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of eight residents(Resident # 21, Resident #85, and Resident #95) reviewed for infection control. 1. The facility failed to secure the ice chest and prevent Resident # 85 from placing her fingers and hands inside the ice chest . 2. The facility failed to ensure the Wound Care Nurse LVN and CNA K followed Enhanced Barrier Precautions by wearing a gown while performing direct care tasks with Resident #21 and Resident #95. These failures could place residents at risk of transmission of disease and infection. Findings include: 1. Record review of Resident #85's face sheet, dated 12/04/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included vascular dementia, unspecified, without behavioral disturbance, psychotic disturbance, mood disturbance , and anxiety (caused by damage to brain blood vessels- affects a person's thinking and memory functions without noticeable changes in mood or behavior), anemia (a condition in which the blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues), and expressive language disorder (a condition where a person struggles to communicate their thoughts and ideas effectively through speech or writing). Record review of Resident #85's Quarterly MDS, dated [DATE], reflected Resident #85 had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #85 required set up for bathing and was independent with eating, hygiene, transfers, and ambulation. Record review of Resident #85's Comprehensive Care Plan, with a start date of, 10/14/2024 and completion date of 10/22/2024, reflected Resident #85 was a wanderer. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and / or a book. Identify pattern of wandering: is it purposeful, aimless, or escapist? Does Resident #85 indicate the need for more exercise? Intervene as appropriate. Provide Resident #85 structured activities : toileting, walking inside and outside , reorientation strategies including signs, pictures, and memory boxes. Resident #85 had impaired cognitive function/impaired thought processes as evidence by difficulty making decisions and poor judgement. Intervention: communicate with the resident/family regarding residents' capabilities and needs. Keep Resident #85's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Observation on 12/03/2024 at 10:14 AM revealed the ice chest on a rolling cart was located approximately across from the medical record office when entering the 400 hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/03/2024 at 10:14 AM revealed Resident #85 walked from the open area near the nurses' desk onto the 400 hall. She immediately -placed her hands in the ice and placed the ice in a cup. There was a yellowish dried substance on the side of Resident #85's left hand and her small finger. Resident #85 was at the ice chest and placed her right and left hands onto the ice. ADON N Infection Control Preventionist walked by Resident #85 as she placed her hands into the ice chest and looked at Resident #85. ADON N Infection Control Preventionist did not intervene and continued to walk away from Resident #85. Interview on 12/03/2024 at 10:20 AM, ADON N Infection Control Preventionist stated she did see Resident #85 with her hands in the ice chest touching the ice. ADON ICP N stated Resident #85 cross contaminated the ice when she touched the ice with her bare hands, and it was an infection control issue. She stated she did observe Resident #85 place her hands on the ice located in the ice chest and she did not intervene or re-direct Resident #85 . ADON ICP N stated the State Surveyor already made the observation and she knew it would be an infection control issue and she did not see the need to correct it due to it was already going to be an infection control issue. ADON ICP N stated she was expected to stop and re-direct Resident #85 and remove the ice chest from the 400 hall to the kitchen for sanitations. She stated the ice chest was never to be on any halls without supervision from staff . She stated the ice chest was expected to be in the nourishment room near the nurse's desk or in the kitchen. ADON ICP N stated she did not take precautions to prevent infection control or cross contamination with the ice in the ice chest on 400 hall. She stated she was the Infection Control Preventionist and she knew she was to remove the ice chest immediately and she did not do this when she saw Resident #85 place her hands in the ice chest and touched the ice. She stated if a resident ingested contaminated ice there was a potential the resident may become physically ill such as stomach infection. Interview on 12/03/2024 at 10:35 AM, Hospitality Aide M stated she passed out ice approximately 6:00 AM to 7:00 AM on 12/03/2024. She stated she placed the ice chest in the nourishment room when she finished passing out ice. Hospitality Aide M stated the protocol for obtaining the ice chest was either the CNA or Hospitality Aide would go to the kitchen and ask for the ice chest and someone from dietary staff would push the ice chest out into the dining area for the CNA or Hospitality Aide to push the cart to the hall where ice was going to be passed out to the residents. She stated when the staff was finished the ice chest was pushed to the nourishment room. Hospitality Aide M stated the ice chest was not to be left anywhere in the facility unattended which included the halls. She stated if a resident touched the ice with their bare hands this was cross contamination onto the ice. Hospitality Aide M stated if a resident did swallow some bacteria from the ice there was a possibility a resident may become sick such as vomiting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/03/2024 at 10:46 AM, CNA G stated the ice chest was not to be left on the hall unsupervised to prevent residents obtaining their own ice. She stated the CNA or Hospitality Aide was expected to request the ice chest from dietary department and the dietary department would push the ice chest from the kitchen into the dining room and the CNA or hospitality aide would push it onto the hall and pass out the ice to the residents. She stated when the staff was finished passing out the ice the staff was to push it into the nourishment room if there was ice in the ice chest. CNA G stated if the ice chest was empty, the staff was to return the ice chest to the kitchen for them to sanitize it for the next time it was to be used by staff. She stated if a resident placed their bare hands in the ice chest and touched the ice it was considered to be an infection control issue such as cross contamination of germs from the resident's hands onto the ice. CNA G stated she observed the Hospitality Aide pass out ice between 6:00 AM and 7:00 AM on 12/03/2024. She stated she did not observe Hospitality Aide M push the ice chest off the 400 hall. Interview on 12/04/2024 at 9:55 AM, the Dietary Manager stated the ice chest protocol was a CNA or Hospitality Aide would come to the kitchen door and request the ice chest filled with ice. She stated a dietary staff would push the ice chest outside of the kitchen door for the CNA or Hospitality Aide. The Dietary Manger stated the only time dietary staff pushed the ice chest on the hall was at night before they went home and they delivered the ice chest to the nourishment room. She stated the dietary staff never pushed the ice chest to the hall or anywhere in the facility except the nourishment room. In an interview on 12/05/2024 at 8:36 AM, the DON stated the CNA or hospitality aide was required to go to the kitchen and request the ice chest filled with ice. She stated the CNA or hospitality aide was expected to push the ice cart to the hall and pass out ice. She stated when the staff completed passing out the ice the staff was to return it to the nourishment room if there was ice in the ice chest. The DON stated if there was not ice in the ice chest the staff was to return it to the kitchen for cleaning. The DON stated ADON ICP N was expected to stop and redirect Resident #85. She stated after ADON ICP N redirected Resident #85 she was expected to push the ice chest to the kitchen and explain to dietary staff the ice chest needed to be cleaned. She stated the staff had been in serviced on infection control. The DON stated she did not recall if there was a discussion about residents touching medical devices, other residents' food and/or ice these items would be considered cross contaminated. 50872 2. Record review of Resident # 21's admission record, dated 12/3/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #21 had diagnoses which included but were not limited to pressure ulcer of sacral region (open area to area just above the buttocks), chronic obstructive pulmonary disease (a progressive disease of the lung affecting the ability to breath), need for assistance with personal care, hypertension (high blood pressure), and low back pain. Record review of Resident #21's annual MDS, dated [DATE], reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #21 had one stage 4 wound and one unstageable-deep tissue injury. Record review of Resident #21's care plan, dated 11/4/24, reflected the resident had an alteration in skin integrity related to a stage 3 pressure ulcer/injury to left shin and a self-care deficit related to a stage 4 pressure ulcer to the sacral region. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's physician order summary, dated 12/3/24, reflected an order which stated, Use gown and gloves for high contact resident care activities for those with known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDRO (residents with wounds or indwelling medical devices) .Stage 3 pressure wound to left shin cleanse with NS, pat dry and apply Betadine and dry dressing q day .Sternum Surgical clean site with NS apply calcium alginate and cover with a dry dressing .Sacro coccyx (area just above and including buttocks) Stage 4 Cleanse with NS pat dry. Apply medihoney and collagen. Cover with calcium alginate and a dry dressing. Record review of Resident #95's admission record, dated 12/4/24, reflected an [AGE] year-old female admitted to the facility on [DATE]. Resident #95 had diagnoses which included but were not limited to atrial fibrillation (an abnormal heart rhythm), pneumonia (an infection in the lungs), muscle wasting, need for assistance with personal care, and dysphagia (difficulty swallowing). Record review of Resident #95's comprehensive MDS, dated [DATE], reflected a BIMS score of 10, which indicated mild cognitive impairment. Record review of Resident #95's care plan, dated 11/6/24, reflected Pressure ulcer/injury: The resident has an alteration in skin integrity r/t the presence of a unstageable pressure ulcer/injury on my Sacro coccyx with a date of origin of 11/6/24. Resident has the need for Enhanced Barrier Precautions due to pressure ulcer. With interventions including, Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures; Gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated. Record review of Resident #95's physician order summary, dated 12/4/24, reflected an order which stated, Use gown and gloves for high contact resident care activities for those with known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR. Wound care: Right Buttock MASD Cleanse with WC/NS. Pat dry with gauze. Apply Medi honey and calcium alginate to wound bed and cover with a dry dressing. Wound care: Sacro coccyx pressure unstageable Cleanse with WC/NS. Pat dry with gauze. Apply Medi honey and calcium alginate to wound bed and cover with a dry dressing. Observation on 12/4/24 at 9:59 AM of wound care for Resident #21 was conducted by Wound care nurse LVN F and CNA K. Orange Enhanced Barrier Precaution caution sign was taped to the room door with a small cart that contained gowns and gloves outside the room. The Wound care nurse LVN F and CNA K did not put on a gown prior to providing resident care. Observation on 12/4/24 at 9:34 AM of wound care for Resident #95 was conducted by Wound care nurse LVN F and CNA K. Orange Enhanced Barrier Precaution caution sign was taped to the room door with a small cart that contained gowns and gloves outside the room. The Wound care nurse LVN F and CNA K did not put on a gown prior to providing resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 1:01 PM with Wound Care Nurse LVN F, she stated she did not wear a gown while performing wound care on Residents #21 and #95. The Wound Care Nurse LVN F stated EBP should be utilized while performing direct patient care to those who are immunocompromised, have foley catheters, chronic wounds, and PEG tubes. Wound Care Nurse LVN F stated that in order to perform direct care to these residents that staff is to wear a gown and gloves then dispose of gown and gloves in box and wash hands before exiting room. She stated not following this procedure could result in cross contamination. During an interview on 12/5/24 at 1:15 PM, the DON stated her expectations for staff are to follow EBP with any residents who have PEG tubes, tracheostomies (a surgically inserted tube into the neck to assist with breathing), foley catheters, or chronic wounds. She stated these residents can be identified by signs on their doors and staff is to wear gown and gloves during direct care. The in-service dated 9/5/24 with the topic EBP revealed For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing She stated not following these precautions could leave the resident at risk for infection. During an interview on 12/5/24 at 2:20 PM with the ADM revealed his expectations for EBP are for staff to follow policy and standard of care He stated that not doing so could put residents and employees at risk of illness. Record review of the facility's policy on Infection Prevention and Control Program, dated 5/13/2023, reflected this facility has established and maintains 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 as per accepted national standards and guidelines. Record review of the facility's policy on Infection Preventionist, dated 10/24/2022, reflected Infection Preventionist was designed as the individual designated by the facility to be responsible for the infection prevention and control program. The IP (Infection Preventionist) will have knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/ state/ local public health authorities. The IP responsibilities include but not limited to: 1. Develop and implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment. 2. Establish facility-wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff, and visitors. 3. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on interview and record review the facility failed to establish an infection prevention and control program (IPCP) that must include, at a minimum, an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 1 of 5 residents (Resident #78) reviewed for infection control. The facility failed to follow antibiotic stewardship policy for Resident #78 by ensuring a duration for medication. This deficient practice could place residents at risk for unnecessary antibiotic use, inappropriate antibiotic use and increased multi drug resistant organisms. Findings include: Record review of Resident #78's admission record, dated 12/3/24, reflected a [AGE] year-old female who was admitted on [DATE]. Resident #78 had diagnoses which but not limited to encephalopathy (a group of disorders that affect the brain and cause altered mental state), Urinary tract infection (an infection in the urine), dysphagia (difficulty swallowing), and need for assistance with personal care. Record review of Resident #78's admission MDS, dated [DATE], reflected a BIMS score of 0, which indicated severe cognitive impairment. Record review of Resident #78's physician order summary, dated 12/3/24, reflected an order for Bactrim Oral Tablet 400-80 MG, Give 1 tablet by mouth one time a day for prophylaxis with a start date of 11/26/24. There were no orders for tracking side effects of an antibiotic. Record review of Resident #78's care plan, dated 11/6/2024 and revised on 11/14/24, reflected the resident has bladder incontinence r/t weakness, advanced age, dementia with interventions which included: Monitor/document for signs and symptoms of UTI. There was no other care plan related to antibiotics. Record review of Resident #78's antibiotic clinical review, dated 11/26/24, reflected signs/symptoms which included McGeer Criteria: Frequent UTIs Under the section UTI without indwelling catheter the form reflected 6. Must fulfill at least three of the following signs or symptoms No listed symptoms were indicated for Resident #78 at that time. Under the section Infection outcome reflected Did the resident meet McGeer Criteria for Infection? with a response of no. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/5/24 at 10:31 AM with ADON ICP N revealed she oversaw the infection control program. She stated when a practitioner ordered antibiotics or a resident was admitted from the hospital with orders for antibiotics, they were started or continued and not questioned. She stated it was her responsibility to review orders for antibiotics and review the first section of the antibiotic clinical review and complete the last part of the review. The ADON ICP N stated she reviewed the antibiotic clinical review but just went with the orders from the nurse practitioner instead of questioning the order. ADON ICP N stated she didn't know residents were not supposed to take antibiotic prophylactically per the CDC guidelines. She stated this was a learning experience for her. Interview on 12/5/24 at 1:15 PM with the DON revealed she was aware Resident #78 was on prophylactic antibiotics. She stated Resident #78's family contacted the nurse practitioner because the resident was taking an antibiotic prophylactically at home due to chronic recurring urinary tract infections. The DON stated there was no indication that was approved to take antibiotic prophylactically. She stated her expectations of the nurses was to question the provider if they received an order for prophylactic antibiotics. She expected the nurses to complete the first part of the antibiotic clinical review and the infection control prevention nurse to finish the form. The DON stated she didn't think there were any potential effects to residents on long term antibiotics but stated a resistance to the antibiotic could happen. Record review of the facility's policy titled Antibiotic Stewardship Program, dated 10/24/22, reflected: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines . 5. The program includes antibiotic use protocols and a system to monitor antibiotic use . b. Antibiotic use protocols: iii. The facility uses the updated McGeer's criteria to define infections . v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use . c. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on interview and record review, the facility failed to develop policies and procedures to ensure each resident was offered an influenza immunization October 1 through March 31 annually, unless the immunization was medically contraindicated or the resident had already been immunized during this time period and before offering the pneumococcal immunization, each resident was offered a pneumococcal immunization, unless the immunization was medically contraindicated or the resident had already been immunized for 1 of 5 residents (Resident #92) reviewed for immunizations . 1. The facility failed to ensure Resident #92 was offered the pneumococcal and influenza vaccinations per her RP wishes. 2. The facility failed to ensure Resident #92's medical record reflected her vaccination history for the pneumonia and influenza vaccinations . 3. The facility failed to ensure the consent form for the pneumonia and influenza vaccinations, dated 09/04/2024, reflected an accurate account of Resident #92's RP wishes. These failures could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes. Findings include: Record review of Resident #92's face sheet, dated 12/05/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #92 had diagnoses which included cerebral infarction due to embolism of left middle cerebral artery (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply [ischemia] and restricted oxygen supply), hemiplegia (a symptom that involves one-sided paralysis), and gastrostomy status (is a surgical procedure for inserting a tube through the abdomen wall and into the stomach). Record review of Resident #92's Quarterly MDS, dated [DATE], reflected she was assessed to have no BIMS score conducted which indicated severe cognitive impairment. Resident #92 was assessed to require substantial to dependent assist with all ADLs. Resident #92 was assessed to not receive the influenza vaccine which indicated it was offered and declined. Resident #92 was assessed to not receive the pneumococcal vaccine which indicated it was offered and declined. Record review of Resident #92's comprehensive care plan reflected no entries related to her immunization status. Record review of Resident #92 EMR reflected no entries for influenza vaccines or PCV20 (pneumococcal conjugate vaccine) or Pneumovax 23 (pneumococcal polysaccharide vaccine) the documentation reflected Resident #92 refused both the pneumococcal and influenza vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #92's pneumonia and influenza consent form, dated 09/04/2024, reflected Resident #92 declined the influenza vaccine; no reason was indicated for decline and no history of previous vaccinations were documented and no teaching was provided. Resident #92' consent form reflected Resident #92 accepted the pneumonia vaccine no history of previous pneumonia vaccinations was documented on the form. In an interview on 12/05/2024 at 10:20 AM, Resident #92's RP stated she wanted Resident #92 to have all immunizations for influenza and pneumonia and did not decline the vaccinations. In an interview on 12/05/2024 the ADON (also the ICP) stated when a resident came into the facility a consent form for immunizations was completed. She stated a vaccination history should be performed. She stated Resident #92 had not gotten her pneumonia vaccination since admission and she was not sure of her history. The ADON stated since Resident #92 was high risk related to her stroke and G-tube, not getting the vaccinations could lead to complications if she developed flu or pneumonia. The ADON stated Resident #92 should have gotten her pneumonia vaccination since she accepted it. The ADON further stated Resident #92's medical record should have reflected an accurate account of her wishes. In an interview on 12/05/2024 at 11:27 AM, the DON stated the ADON was responsible for performing immunizations and conducting immunizations histories when a resident was admitted . She stated it was her expectation that residents received their immunizations as needed and per wishes. Record review of the facility's policy infection prevention and control program, dated 05/13/2023, reflected .7. Influenza and Pneumococcal Immunization: a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. B Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere. c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. d. Residents will have the opportunity to refuse immunizations. e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations .