STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676275	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Healthcare and Rehabilitation Center	561 E Ridgecrest Rd Forney, TX 75126

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury for 1 of 3 (Resident #1) residents reviewed for abuse and neglect. The facility staff did not report to the state agency Resident #1's bruising to left brow, temple, and behind right knee on 9/22/24. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings Include: Record review of the face sheet dated 10/3/24 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including anxiety, hypertension (elevated blood pressure), traumatic brain injury (a brain injury caused by an outside force, usually a violent blow to the head), dementia, and heart failure (a chronic condition in which the heart does not pump blood as good as it should). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact . The MDS indicated Resident #1 required substantial/maximum assistance with transfers from sitting to lying, lying to sitting on the side of the bed, and chair/bed to chair. The MDS indicated Resident #1 was dependent on staff for rolling left and right and sitting to standing. Record review of the care plan revised on 9/29/24 indicated Resident #1 had impaired cognitive function/dementia or impaired thought processes. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an incident report regarding Resident #1 dated 9/22/24 at 9:34 a.m. written by LVN B indicated, During routine round, CNA notified this nurse about bruises to the right leg behind the knee and left side of brow. The incident report indicated an immediate skin assessment was complete with bruise noted to right leg behind the knew and the left side of the brow. The incident report indicated LVN B notified the Weekend RN Supervisor of the bruising. The incident report indicated the DON, physician and Resident #1's responsible party were notified of the bruising. The incident report indicated Resident #1 was not able to give facility staff a description of how the bruising occurred. The incident report indicated Resident #1's responsible party was spoke to about the bruised areas and the responsible party said Resident #1 bumped it on the assist bar. Record review of a nursing progress note dated 9/22/24 at 1:19 p.m. written by LVN B indicated Resident #1's responsible party was notified of the bruising to her left brow and behind her right knee. The progress note indicated the responsible party was pleased with the phone call and had no other concerns. During an observation and interview attempted on 10/1/24 at 12:32 p.m. Resident #1 was unable to be interviewed. Resident #1 was unable to form words or answer the surveyor's questions. Resident #1 was observed with Black/Purple bruising to left brow and temple area. During an interview on 10/3/24 at 10:53 a.m. LVN B said she worked weekend doubles at the facility. LVN B said she had been working on 9/22/24. LVN B said a CNA reported to her bruising on Resident #1's face. LVN B said she reported the bruising to the RN Supervisor. LVN B said she and the RN Supervisor went and completed an assessment on Resident #1. LVN B said the DON was notified and Resident #1's responsible party was notified. LVN B said Resident #1's responsible party said the bruising was possibly from her neck pillow. LVN B said she had speculated the bruising was from the neck pillow due to the way Resident #1 laid and the neck pillow pushed against her face. LVN B said Resident #1 had poor skin integrity. LVN B said she completed an incident report on Resident #1 related to the bruising. During an interview on 10/3/24 at 1:20 p.m. the DON said she was notified by the RN Supervisor on 9/22/24 regarding Resident #1's bruising to her face and back of legs. The DON said she could not remember when she notified the Administrator of the bruising. The DON said LVN B had contacted the family and was told by the family when they rolled Resident #1, she would sometimes prop her head on the assist bar. The DON said the family had also been placing a positioning device under her legs. The DON said staff did not witness the resident hitting her head and the resident was unable to explain where the bruising originated from. The DON said she sent the weekend RN Supervisor to investigate the bruising. The DON said the bruising to the Resident #1's brow and temple area lined up with the resident's use of a neck pillow and propping head against assist bar when rolled. The DON said the bruising to Resident #1's leg lined up with the positioning device. The DON said the family was not concerned with how the bruising occurred. The DON said she did not consider the bruising an injury of unknown origin due to the most probable cause of the bruising was the assist bars, neck pillow, and positioning device. The DON said she decided the bruising was not reportable. The DON said the importance of reporting injuries of unknown origin was possible abuse. During an interview on 10/3/24 at 1:45 p.m. the Administrator said he did not remember when he was notified of the bruising on Resident #1's head and leg or if it was reported and why or why not. The Administrator said he would find out this information and then tell the surveyor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 2:17 p.m. the Administrator said he was notified in the morning clinical meeting on 9/23/24 of the bruising to Resident #1's face and leg. The Administrator said when the bruising was discussed in the clinical meeting the DON said she had completed the investigation. The Administrator said he did not report the bruising to the state agency due to the incident report indicating, [Resident #1's] responsible party stated she bumped it on the assist bar and the assist bars were removed due to non-use. The Administrator was unable to say what it was. The Administrator said he assumed it was Resident #1's head. The Administrator said during an investigation the facility generally checked areas in the resident's room for possible causes. The Administrator said he generally does not take the family's word for something happening. The Administrator said every situation was different. The Administrator said the DON performed the clinical investigations and then they discuss the findings. The Administrator said the importance of reporting injuries of unknown origin was to ensure the incident was investigated allowing the facility to make better decisions and implement changes from incidents happening again. Record review of the facility's Abuse Prohibition policy last revised 5/17/24 indicated, The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation. The facility will report the results of the investigation to the enforcement agency in accordance with state law, including the state survey and certification agency . Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 2 (Resident #1) residents reviewed for quality of care. The facility failed to ensure Resident #1's right heel arterial wound treatment orders were updated in the electronic medical records. This failure could result in residents with wounds of not having their treatments performed as ordered, wounds becoming infected wounds, and decreased wound healing. Findings Included: Record review of the face sheet dated 10/3/24 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including anxiety, hypertension (elevated blood pressure), traumatic brain injury (a brain injury caused by an outside force, usually a violent blow to the head), dementia, and heart failure (a chronic condition in which the heart does not pump blood as good as it should). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with transfers from sitting to lying, lying to sitting on the side of the bed, and chair/bed to chair. The MDS indicated Resident #1 was dependent on staff for rolling left and right and sitting to standing. The MDS indicated Resident #1 had 2 venous and arterial wounds. Record review of the care plan revised on 9/29/24 indicated Resident #1 had an arterial/ischemic ulcer of the right heel with interventions including cleanse wound to right heel with normal apply, pat dry apply Xeroform (a gauze dressing that contains petrolatum and bismuth tribromophenate used to treat a variety of wounds) and cover with bordered gauze (flexible, adhesive, non-woven cloth border secures the dressing in place and is water resistant to help protect the wound from contaminants) every day shift every on Tuesday, Thursday, Saturday, and as needed. Record review of the wound care note dated 9/19/24 indicated Resident #1 had an arterial wound to her right heel measuring 0.5 cm X 0.5 cm X UTD. The wound care note indicated the dressing used to the right heel was xeroform. Record review of the wound care note dated 9/27/24 indicated Resident #1 had an arterial wound to the right heel measuring 1 cm X 0.5 cm X UTD. The wound care note indicated the treatment used to the right heel was betadine. Record review of the skilled wound care communication log dated 9/27/24 indicated the arterial wound to Resident #1's right heel's current treatment was betadine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the physician orders dated 10/1/24 indicated Resident #1 had an order to cleanse wound to right heel with normal saline, apply Xeroform, and cover with bordered gauze every day shift every Tuesday, Thursday, Saturday, and as needed for wound care starting 9/3/24. Record review of the TAR dated 9/1/24 through 9/30/24 indicated Resident #1's treatment to her right heel was with normal saline, apply Xeroform, and cover with bordered gauze and was provided every scheduled shift without a missing treatment. Record review of the TAR dated 10/1/24 indicated Resident #1's treatment to her right heel was to with normal saline, apply Xeroform, and cover with bordered gauze and was provided every scheduled shift without a missing treatment. During an interview on 10/2/24 at 10:40 a.m. the Treatment Nurse said she received written orders from the Wound Care Physician via email or text. The Treatment Nurse said when she received the orders, she entered them into the electronic medical record. During an interview on 10/2/24 at 10:45 a.m. the Treatment Nurse said the wound care physician came to the facility weekly. The Treatment Nurse said the wound to Resident #1's right heel was healed, and she still need to resolve or heal it out in the electronic medical records. During an observation on 10/2/24 at 10:47 a.m. the Treatment Nurse cleansed the wound to Resident #1's right heel with normal saline then applied betadine. During an interview on 10/2/24 at 3:08 pm the Wound Care Physician said he made rounds at the facility on 9/27/24. The Wound Care Physician said he saw Resident #1. The Wound Care Physician said he made rounds with the Treatment Nurse on 9/27/24. The Wound Care Physician said he had ordered betadine as treatment to Resident #1's arterial wound to her right heel. The Wound Care Physician said he would expect the facility to follow the orders he gave until another physician made rounds and changes to the orders. The Wound Care Physician said he expected orders to be implement within 24 hours. During an interview on 10/3/24 at 9:50 am the Treatment Nurse said she worked Monday through Friday from 8:30 am to 5:00 pm. The Treatment Nurse said on the weekends and when she was off during the week the charge nurses or float nurse performed wound care. The Treatment Nurse said she always made rounds with the Wound care physicians. The Treatment Nurse said she made rounds with the Wound Care Physician on 9/27/24. The Wound Care Physician provided verbal orders for wound care while making rounds. The Treatment Nurse said if the wound care physician saw a wound there would be a treatment in place for the wound. The Treatment Nurse said she did not document the verbal orders. Treatment Nurse the order for Resident #1's treatment to her right heel in the electronic medical records was incorrect and it was her fault. The Treatment Nurse said staff performing wound care in her absence would follow the orders in the electronic medical records and be performing incorrect treatments to Resident #1. The Treatment Nurse said the importance of ensuring wound care orders were followed accurately was for wound healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 1:20 p.m. the DON said if a nurse received a verbal order from a physician, it should be input into the electronic medical records and documented in the progress notes. The DON said nurses have 24 hours to document late entries in the progress notes and then they are unable to document a late entry. The DON she expected the wound care physician orders to be followed. The DON said if a verbal order was received by the wound care physician it should be implement immediately and if the order was received on paper or in a report it should be implemented by the end of the day it was received. The DON said if a wound care order was received, and the current treatment was blank she expected the nurse to verify and clarify the treatment order. The DON said if there was a change in the treatment orders, she expected the change to be entered into the electronic medical records. The DON said the importance of following the wound care physician's orders was to promote wound healing. During an interview on 10/3/24 at 1:45 p.m. the Administrator said he expected staff to follow physician's orders. The Administrator said if a nurse received a verbal order, he expected it to be entered into the electronic medical records and documented in the progress notes. The Administrator said if a nurse received a wound care order with the current treatment being blank, he would expect the nurse to obtain clarification for the order. The Administrator said the importance of inputting orders and following physician orders was so a resident did not receive the wrong treatment. Record review of the facility's Skin Integrity Prevention and Treatment Program policy revised 1/2003 indicated, . if non-pressure area-complete new wound evaluation / assessment; c. Notify MD-obtain treatment orders; .e. Update care plan; f. Note on 24 hour report; .

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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** 44637 Based on observation, interview and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 3 (Resident #1) residents reviewed for pressure injuries. The facility failed to ensure Resident #1's pressure wounds to her sacrum (a triangular bone at the base of the spine) and left calf were treated as ordered by the Wound Care Physician. These failures could place residents at risk for worsening of existing pressure injuries, infection, pain, and decreased quality of life. Findings included: Record review of the face sheet dated 10/3/24 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including anxiety, hypertension (elevated blood pressure), traumatic brain injury (a brain injury caused by an outside force, usually a violent blow to the head), dementia, and heart failure (a chronic condition in which the heart does not pump blood as good as it should). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with transfers from sitting to lying, lying to sitting on the side of the bed, and chair/bed to chair. The MDS indicated Resident #1 was dependent on staff for rolling left and right and sitting to standing. The MDS indicated Resident #1 was at risk for pressure ulcers. The MDS indicated Resident #1 did not have an unhealed pressure ulcer/injury. Record review of the care plan revised on 9/29/24 indicated Resident #1 had the potential to develop a pressure ulcer/injury related to frequent urinary and/or bowel incontinence, history of pressure injuries, immobility, poor nutritional status/malnutrition: Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough (yellow/white material in the wound bed) or bruising) to sacrum-healed 9/19/24 with interventions including monitor right buttock wound every shift for signs and symptoms of infection, monitor wound to sacrum every shift for signs and symptoms of infection, apply z-guard (zinc oxide) to right buttock ulcer every shift for wound care, and apply z-guard to sacrum every shift for wound care. Record review of the wound care note dated 9/19/24 indicated Resident #1 did not have a pressure wound to her sacrum or left calf. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the wound care note dated 9/27/24 indicated Resident #1 had a pressure ulcer to her sacrum measuring 3.2 cm X 2.2 cm X UTD. The wound care note indicated the dressing used to the sacrum was calcium alginate (highly absorptive, non-occlusive dressings made of soft, non-woven calcium alginate fibers) and bordered gauze (flexible, adhesive, non-woven cloth border secures the dressing in place and is water resistant to help protect the wound from contaminants). The wound care note indicated Resident #1 had a pressure ulcer to her left posterior calf measuring 4 cm X 2.2 cm X UTD. The wound care note indicated the dressing used to the left calf was calcium alginate and bordered dressing. Record review of the skilled wound care communication log dated 9/27/24 for Resident #1 indicated the pressure ulcer to the sacrum's current treatment was blank (without a treatment listed). The skilled wound care communication log indicated the pressure ulcer to the left calf's current treatment was alginate and dry dressing. Record review of the hospice physician's order dated 10/1/24 indicated Resident #1's left calf was to cleanse with normal saline, pat dry, apply xeroform (a gauze dressing that contains petrolatum and bismuth tribromophenate and is used to treat a variety of wounds) with calcium alginate, and cover with bordered gauze 3 times a week and as needed for saturation. Record review of the physician orders dated 10/1/24 indicated Resident #1 had an order to apply z-guard to sacrum every shift for wound care starting 9/2/24. The physician orders did not indicate Resident #1 had a treatment for the pressure wound on her left calf. Record review of the TAR dated 9/1/24 through 9/30/24 indicated Resident #1's treatment to her sacrum was provided every shift without a missing treatment. The TAR indicated Resident #1 did not have a treatment to her left calf. Record review of the TAR dated 10/1/24 indicated Resident #1's treatment to her sacrum was provided every shift without missing a treatment. The TAR indicated Resident #1 did not have a treatment to her left calf. During an interview on 10/2/24 at 10:40 a.m. the Treatment Nurse said she received written orders from the Wound Care Physician via email or text. The Treatment Nurse said when she received the orders, she entered them into the electronic medical record. During an interview on 10/2/24 at 10:45 a.m. the Treatment Nurse said 10/1/24 was the first time she had seen the wound to Resident #1's left calf. The Treatment Nurse said the wound care orders for Resident #1's left calf was not in the electronic medical record. The Treatment Nurse said she performed wound care to Resident #1's left calf on 10/1/24. The Treatment Nurse said the date on the dressing to Resident #1's left calf would be proof of her performing wound care 10/1/24. The Treatment Nurse said the wound care physician came to the facility weekly. During an observation on 10/2/24 at 10:47 a.m. the Treatment Nurse removed the dressing dated 10/1/24 to Resident #1's left calf, cleansed the wound with normal saline, and applied xeroform, calcium alginate, and a bordered dressing. The Treatment Nurse cleansed Resident #1's sacral wound with normal saline and applied zinc oxide. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24 at 3:08 p.m. the Wound Care Physician said he made rounds at the facility on 9/27/24 with the treatment nurse. The Wound Care Physician said he saw Resident #1. The Wound Care Physician said he had ordered calcium alginate and bordered dressing as the treatment for Resident #1's unstageable pressure injury to her left calf and stage III pressure sore to her sacrum. The Wound Care Physician said zinc oxide can heal a pressure sore, but calcium alginate speeds up the healing process. The Wound Care Physician said he would expect the facility to follow the orders he gave until another physician made rounds and changes to the orders. The Wound Care Physician said he expected orders to be implement within 24 hours. During an interview on 10/3/24 at 9:50 a.m. the Treatment Nurse said she worked Monday through Friday from 8:30 a.m. to 5:00 p.m. The Treatment Nurse said on the weekends and when she was off during the week the charge nurses or float nurse performed wound care. The Treatment Nurse said she always made rounds with the wound care physicians. The Treatment Nurse said she made rounds with the Wound Care Physician on 9/27/24. The Treatment Nurse said she did not remember seeing Resident #1's wound to her left calf on 9/27/24. The Treatment Nurse said the Wound Care Physician provided verbal orders for wound care while making rounds. The Treatment Nurse said if the wound care physician saw a wound there would be a treatment in place for the wound. The Treatment Nurse said she could not prove there was a treatment in place for Resident #1's wound to her left calf from 9/27/24 through 10/1/14. The Treatment Nurse said when she saw the wound on Resident #1's left calf on 10/1/24 she did not contact the Wound Care Physician or consult the orders he had sent over. The Treatment Nurse said she had contact Resident #1's hospice company to obtain treatment orders on 10/1/24. The Treatment Nurse said the Wound Care Physician gave her verbal orders to continue treatment of z-guard to Resident #1's sacrum. The Treatment Nurse said she did not document the verbal order and did not clarify the order when the treatment section was blank on the written orders for Resident #1's sacrum. The Treatment Nurse said she would not make up her own orders. The Treatment Nurse said staff performing wound care in her absence would follow the orders in the electronic medical records and be performing incorrect treatments to Resident #1. The Treatment Nurse said the importance of ensuring wound care orders were followed accurately was for wound healing. During an interview on 10/3/24 at 1:20 p.m. the DON said if a nurse receives a verbal order from a physician, it should be input into the electronic medical records and documented in the progress notes. The DON said nurses have 24 hours to document late entries in the progress notes and then they are unable to document a late entry. The DON she expected the wound care physician orders to be followed. The DON said if a verbal order was received by the wound care physician it should be implement immediately and if the order was received on paper or in a report it should be implemented by the end of the day it was received. The DON said if a wound care order was received, and the current treatment was blank she expected the nurse to verify and clarify the treatment order. The DON said if there was a change in the treatment orders, she expected the change to be entered into the electronic medical records. The DON said the importance of following the wound care physician's orders was to promote wound healing. During an interview on 10/3/24 at 1:45 p.m. the Administrator said he expected staff to follow physician's orders. The Administrator said if a nurse received a verbal order, he expected it to be entered into the electronic medical records and documented in the progress notes. The Administrator said if a nurse received a wound care order with the current treatment being blank, he would expect the nurse to obtain clarification for the order. The Administrator said the importance of inputting orders and following physician orders was so a resident did not receive the wrong treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Skin Integrity Prevention and Treatment Program policy revised 1/2003 indicated, .Weekly Skin Integrity Checks [included]: a. Weekly assessment looking for new wounds-completed by a licensed nurse; b. Documented on/in Treatment Record If new; c. area found- if pressure injury- complete new wound evaluation / assessment [or] if non-pressure area-complete new wound evaluation / assessment; c. Notify MD-obtain treatment orders; d. Notify RP/ or family if they are RP or Resident has directed family to be updated; e. Update care plan; f. Note on 24 hour report; g. Referrals to therapy, dietician or other consultant as deemed necessary; h. Monitor weekly via weekly wound reporting and skin integrity quality assurance processes .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676275	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Healthcare and Rehabilitation Center	561 E Ridgecrest Rd Forney, TX 75126

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided such care, consistent with professional standards of practices for 1 of 4 residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1 had orders for oxygen therapy. This failure could place residents at risk of not receiving a therapeutic level of oxygen therapy . Findings include: Record review of the face sheet dated 10/3/24 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including anxiety, hypertension (elevated blood pressure), traumatic brain injury (a brain injury caused by an outside force, usually a violent blow to the head), dementia, COPD and heart failure (a chronic condition in which the heart does not pump blood as good as it should). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS did not indicate Resident #1 was receiving oxygen therapy. Record review of the care plan revised on 9/29/24 indicated Resident #1 had impaired cognitive function/dementia or impaired thought processes. Record review of the hospice comprehensive assessment dated [DATE] indicated Resident #1 had an order for oxygen 2-4 l/min as needed for shortness of breath. Record review of the physician orders dated 10/1/24 did not indicated Resident #1 had an order for oxygen therapy, oxygen monitoring, or the oxygen tubing to be changed. During an observation on 10/1/24 at 2:32 p.m. Resident #1 was observed with oxygen in place via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) at 2 l/min. The oxygen tube was observed to be undated. During an observation on 10/3/24 at 9:45 a.m. Resident #1 was observed with oxygen in place via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) at 2 l/min. The oxygen tube was observed to be undated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 11:05 a.m. RN A said residents would require oxygen if they were short of breath or had a decreased oxygen saturation (the percentage of oxygen saturated hemoglobin in the blood compared to the total hemoglobin). RN A said if a resident was short of breath or required oxygen the nurse should contact the doctor to obtain an order for oxygen. RN A said the order for oxygen should be entered into the electronic medical records. RN A said the order should contain whether the oxygen was continuous or as needed, to monitor oxygen saturation every shift, how much oxygen should be administered in l/min, what the delivery method should be, and for the oxygen tubing to be changed and dated weekly. RN A said oxygen tubing should have the nurse's initials and the date it was put in use on it. RN A said if she entered a room, and the oxygen tubing was not dated she would remove the current tubing and replace it with tubing dated for the day she discovered the undated tubing. RN A said without a dated you could not tell how long the oxygen tubing had been in use. RN A said the importance of ensuring the oxygen orders were in the electronic medical record was so the nurses and other staff knew how much oxygen a resident was supposed to be receiving. RN A said the importance of changing the oxygen tubing weekly was to give better oxygen administration and aide in breathing better. During an interview on 10/3/24 at 1:20 p.m. the DON said nurses would know if a resident was receiving oxygen by checking in the electronic medical records. The DON said if a resident was short of breath or had decreased oxygen saturation, she expected the nurses to place oxygen on the resident as not to delay treatment and then notify the physician and obtain an order for oxygen. The DON said the oxygen orders should include the frequency, rate, monitoring oxygen saturation, changing oxygen tubing as needed when visibly soiled or broken. The DON said the importance of oxygen orders was so the nurses knew the needs of the resident and residents with certain respiratory conditions were not over oxygenated. The DON said all hospice orders should be entered into the electronic medical records. Record review of the facility's Oxygen Administration policy revised 5/2024 indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify there is a physician's order for the procedure. Review the physician's orders or the facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident .General Guidelines: 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter . Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs and symptoms of cyanosis (blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs and symptoms of oxygen toxicity (tracheal irritation, difficulty breathing, or slow, shallow rate of breathing; 4. Vital signs; 5. Lung sounds .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on 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 1 of 3 staff (Treatment Nurse), and 2 of 2 residents (Resident #1 and Resident #2) reviewed for infection control. The facility failed to ensure the Treatment Nurse changed gloves and performed hand hygiene while performing wound care on Resident #1 and Resident #2 These failures could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include: 1. Record review of the face sheet dated 10/3/24 indcated Resident #2 was an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including diabetes, muscle weakness, lack of coordinations, and chronic kidney disease. Record review of the MDS dated [DATE] indicated Resident #2 was understood by others and usually understood others. The MDS indicated Resident #2 had a BIMS of 05 and was severely cognitively impaired. The MDS indicated Resident #2 was at risk for developing pressure ulcers. The MDS indicated Resident #2 did not any unhealed pressure ulcers/injuries. Record review of the care plan last reviewed 8/6/24 indicated Resident #2 resident had actual impairment to his skin integrity related to MASD (moisture associated skin disorder) of the left buttock. During an observation on 10/2/24 at 10:24 a.m. the Treatment Nurse performed wound care on Resident #2. The Treatment Nurse applied gloves and removed the dressing to Resident #2's arm. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse cleansed the wound to Resident #2's arm with normal saline and patted dry. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse applied xeroform (a gauze dressing that contains petrolatum and bismuth tribromophenate and is used to treat a variety of wounds), calcium alginate (highly absorptive, non-occlusive dressings made of soft, non-woven calcium alginate fibers), and bordered dressing (flexible, adhesive, non-woven cloth border secures the dressing in place and is water resistant to help protect the wound from contaminants) to the wound. The Treatment Nurse removed her gloves and performed hand hygiene. Resident #2 rolled to his left side with assistance from a CNA. There was not a dressing on Resident #2's sacrum. The Treatment nurse changed gloves and performed hand hygiene. The Treatment Nurse cleansed wound with normal saline. The Treatment Nurse did not change her gloves. The treatment Nurse applied Medi-honey and calcium alginate to the wound. The Treatment Nurse changed her gloves and did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of the face sheet dated 10/3/24 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including anxiety, hypertension (elevated blood pressure), traumatic brain injury (a brain injury caused by an outside force, usually a violent blow to the head), dementia, and heart failure (a chronic condition in which the heart does not pump blood as good as it should). Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with transfers from sitting to lying, lying to sitting on the side of the bed, and chair/bed to chair. The MDS indicated Resident #1 was dependent on staff for rolling left and right and sitting to standing. The MDS indicated Resident #1 was at risk for pressure ulcers. The MDS indicated Resident #1 did not have an unhealed pressure ulcer/injury. Record review of the care plan revised on 9/29/24 indicated Resident #1 had the potential to develop a pressure ulcer/injury related to frequent urinary and/or bowel incontinence, history of pressure injuries, immobility, poor nutritional status/malnutrition: Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough (yellow/white material in the wound bed) or bruising) to sacrum-healed 9/19/24 with interventions including monitor right buttock wound every shift for signs and symptoms of infection, monitor wound to sacrum every shift for signs and symptoms of infection, apply z-guard (zinc oxide) to right buttock ulcer every shift for wound care, and apply z-guard to sacrum every shift for wound care. During an observation on 10/2/24 at 10:47 a.m. the Treatment Nurse applied gloves, entered Resident #1's room to set-up her supplies, exited the room, and changed gloves without performing hand hygiene. The Treatment Nurse entered Resident #1's room changed gloves and performed hand hygiene. The Treatment Nurse removed the dressing to Resident #1's left calf. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse cleansed the wound to Resident #1's left calf with normal saline. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse applied xeroform, calcium alginate, and a bordered dressing to the wound on Resident #1's left calf. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse cleansed Resident #1's sacral wound with normal saline. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse applied zinc oxide (a medicated cream, ointment, or paste that treats or prevents skin irritation) to Resident #1's sacral wound. The Treatment Nurse changed gloves and did not perform hand hygiene. The Treatment Nurse exited to the room to obtain betadine and normal saline from her treatment cart. The Treatment Nurse cleansed the wound to Resident #1's right heel with normal saline then applied betadine. The Treatment Nurse removed her gloves and performed hand hygiene. During an interview on 10/3/24 at 9:50 a.m. the Treatment Nurse said she had been nervous when performing wound care observed by the surveyor. The Treatment Nurse said she did not realize she had not performed hand hygiene between glove changes. The Treatment Nurse said hand hygiene should be performed when walking into a resident room, after removing a wound dressing, and when changing gloves. The Treatment Nurse said the importance of proper hand hygiene was for infection control. During an interview on 10/3/24 at 1:20 p.m. the DON said she expected staff to perform hand hygiene when they entered or exited a room, when visibly soiled, and between glove changes. The DON said the importance of hand hygiene was infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 1:45 p.m. the Administrator said he expected staff to perform hand hygiene as needed, before and after providing care, in-between care, and between glove changes. The Administrator said the importance of hand hygiene was infection prevention and to prevent cross contamination. Record review of the facility's Handwashing-Hand Hygiene policy revised 3/2020 indicated, This facility considers hand hygiene the primary means to prevent the spread of infections . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub containing at least 62:5 alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water in the following situations .g. Before handling clean or soiled dressing, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care .k. After handling used dressings, contaminated equipment, etc.m. After removing gloves .