STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. Building B. Wing	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Guy Gorman Sr Care Home	Highway 191 & Hospital Road Chinle, AZ 86503

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 - Some	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** 29087 Based on interview and record review the facility failed to report an allegation of abuse for Resident (R22), failed to report injuries of unknown origin for R22 and R252, and did not report timely for injury of unknown origin for R103. Failure to report may lead to failure to identify, prevent, and correct resident abuse. Resident R22 Record review: Progress note dated [DATE]: Incident Note: note text-- resident crying in dining room and complaining of right arm pain. I asked a fell ow employee to help translate for me because resident is Navajo speaking. resident is stating the staff is too rough with me, pulling me and ripping off my clothes for the passed 3 days assessed resident and administered prn (as needed) pain medication. I also informed social services of the incident. will continue to monitor resident. Interview: [DATE] at 2:10 PM, with social services staff (SS1): . When asked about the progress note dated [DATE] indicating social services was informed of the allegation of abuse of staff being rough with R22 and pulling off her clothes. SS1 stated she was the social service staff assigned to the women's Household and said she was the social worker that would have been notified. SS1 said she did not recall any such notice. SS1 reviewed the grievance log and records in her office and stated she was not notified of this allegation and consequently she did not report this allegation to the state or to CMS (Centers for Medicare and Medicaid Services). SS1 said rough handling was possible abuse and required reporting to CMS. SS1 said QA (Quality Assurance) nurse was responsible for investigations of allegations of abuse. In a later interview the QA nurse and SS1 confirmed they were unaware of the allegation of rough handling so no report was made to CMS. Cross reference F610. injury unknown origin Record Review: progress note dated [DATE]: In R22's EHR (electronic health record) that noted a large bruise 20 cm by 12 cm (approximately 8 inches by 5 inches) on the breast, dark purplish in color. The Electronic Health Record (EHR) indicated the physician and family were notified of the bruise. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The breast is a vulnerable area not generally exposed to bumps and bruises due to day-to-day activities. The breast area is an area that raises suspicion for potential sexual abuse. Documentation of reporting to CMS was requested regarding the bruise on the breast. The facility did not provide documentation of reporting or of an investigation. On [DATE] at 3:30 PM, the DON (Director of Nursing) stated the bruise on the breast was noted on the CNA (certified nursing assistant) check off sheet, however the nurse failed to complete a facility incident report . No incident report was generated by the nurse and consequently no reporting to the state or to CMS of potential abuse occurred. Both the QA nurse and DON stated reporting was required and reporting should have been done. The DON said it got hung up at the nurse. The nurse was a temporary nurse and was not available for interview. The QA nurse described the facility expectation: 1. The CNA reported to the nurse. 2. The nurse should have assessed the resident and then complete an incident report and forward the original to QA nurse. With the information in the incident report; QA nurse would ensure appropriate reporting to the state and to CMS. The QA nurse confirmed the bruise was in a vulnerable location and the abuse policy should have been followed. The QA nurse and DON stated the facility policy regarding reporting of abuse/potential abuse was not followed. Cross reference F 610 40844 R103: Review of the e-HR revealed R103's most recent admission was on [DATE]. Diagnoses included dementia, depression, age related osteoporosis (gradual and progressive bone loss), and failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed R103 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of ,d+[DATE]), and required two-person extensive assistance for transfers. Review of facility's Allegation/Incident report sent to CMS on [DATE] at 3:18 PM, revealed an injury of unknow origin occurred at an 'unknown' time, and was reported on [DATE]. Under the timeline of events it described a CNA (certified nursing assistant) reported multiple bruises to hand, arms/lt. outer foot to nursing on [DATE]. R103 expressed reports of pain and was sent to the emergency roiagnom on [DATE] where she was diagnosed with an Impacted fracture through the left humeral surgical neck. The part of the upper arm bone near the shoulder is the is the surgical neck of the humerus. The Emergency Medicine visit [DATE] report read under assessment and plan, I advised [LN2], charge nurse . of pt's fracture. She will notify pt's family as well as her supervisor to investigate further as no apparent witnessed fall reported. During an interview on [DATE] at 8:57 AM, nurse QA confirmed she completed facility investigations of all allegations of abuse and other unusual occurrences. When asked if R103's injury of unknow origin was reported within 2 hours she stated, I thought it was 5 days. R52: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the e-HR revealed R52 was admitted on [DATE]. Diagnoses included dementia with behavioral disturbances, obesity, osteoarthritis (osteoarthritis occurs when the smooth cartilage joint surface wears out), cardiomegaly (an enlarged heart), presence of pacemaker, pulmonary hypertension, asthma, hearing loss, and cataracts. The annual MDS dated [DATE] revealed R52 was rarely/never understood and an interview or assessment of cognitive patterns was not done. Under the Functional status section (G) it read R52 was totally dependent of staff for all ADLs excepts eating. R52 expired on [DATE] in the facility and was reviewed as a closed record. Additional record review revealed R52 was sent to the emergency roiagnom on [DATE]. A nursing progress note dated [DATE] 3:28 PM read, Writer enter resident room to given her medications. Writer began to sit her up in bed which resident scream out with facial pain expression and stated: My leg hurts. Writer assessed right leg and seen swelling, pain with touch or movement, and slight discoloration. The physician's routine 60-day evaluation note, dated [DATE], read, Nursing reports no falls, or additional concerns, stable behaviors. - right knee pain: see in ED [emergency department] yesterday . no known falls or other trauma. xrays w/o [without] obvious fracture of xray of the knee showed lipohemarthrosis [floating fat in the joint cavity] suggestive of fracture . reviewed imaging w/ [with]radiology and consistent w/ my exam, most likely does have a fracture of the rle [right lower extremity] suspect either distal femur or prox. tibia [lower leg bones]. During an interview with nurse QA on [DATE] at 8:57 AM she confirmed R52 had dementia and was cognitively impaired; was sent to the emergency roiagnom on [DATE]; and the primary physician's note dated [DATE] indicated he was suspicious of fracture. When asked if this injury of unknown origin was reported to CMS she stated, Not this one. Facility policy titled Abuse Policy dated Under types of abuse it included Neglect/Mistreatment which included an example which read, mishandle or rough handling of individual. Under the Components of Abuse Prevention it indicated injuries of unknown source would be investigated and that all alleged violations were to be reported to the administrator and to other officials in accordance with state law through established procedures.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29087 The facility did not thoroughly investigate an allegation of abuse for resident-R-22 and injuries of unknown origin for R22, R52, and R103. A lack of thorough investigations may result in failure of the facility to identify and prevent abuse. Resident #22 Alleged abuse Interview: [DATE], 10:47 AM: Interviewed R22 with staff interpreting the Navajo language. Per staff interpreting, R22 did not report any concerns related to abuse or mistreatment. Record review: Progress note dated [DATE]: Incident Note--Note Text: resident crying in dining room and complaining of right arm pain. I asked a fell ow employee to help translate for me because resident is Navajo speaking. resident is stating the staff is too rough with me, pulling me and ripping off my clothes for the past 3 days assessed resident and administered prn [as needed] pain medication. I also informed social services of the incident. will continue to monitor resident.-- Interview [DATE] 2:10 PM: Interview social service staff (SS1). Interview about the progress note dated [DATE], regarding an allegation of abuse of staff being rough and pulling off R22's clothes. SS1 stated she was the designated social services staff for the womens Household. SS1 said she did not recall any notice as stated in the progress note. SS1 said she was the social worker who should be notified about incidents involving the women residents but she was not informed of the above allegation. Documentation of investigation about this allegation was requested. SS1 said she would look into this and provide the documentation of follow up and investigation of this allegation. On [DATE] at 2:44 PM: SS1 again confirmed nether she nor the QA (quality assurance) nurse who is responsible for conducting the abuse investigations (QA nurse) received notice about the allegation. (see above). QA nurse confirmed this constituted an allegation of abuse and required a full investigation to rule out abuse. QA nurse stated the facility did not investigate this allegation that was documented in the record by the nurse. Cross reference F609 injury of unknown origin Record Review: A progress note dated [DATE] noted R22 had a large bruise 20 cm by 12 cm (approximately 8 inches by 5 inches) on the breast, dark purplish in color. The physician and family were notified of the bruise. The breast is a vulnerable area not generally exposed to bumps and bruises from activities of daily living. Injuries to the breast area raise suspicion for sexual abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Investigation documents were requested regarding the bruise on the breast. The facility did not provide documentation of an investigation. On [DATE] at 3:30 PM the DON (Director of Nursing) and the QA nurse confirmed no incident report was generated by the nurse and consequently no investigation was conducted. It was noted on the Certified Nursing Assistant (CNA) check off sheet however the nurse failed to complete an incident report to forward to QA nurse, therefore the facility did not conduct an investigation to rule out abuse. Both QA nurse and DON stated an investigation should have been done. DON said it got hung up at the nurse. The nurse was a temporary nurse and was not available to interview. The QA nurse described the facility expectation: 1. The CNA reported to the nurse. 2. The nurse should have assessed the resident and then should have completed an incident report and forwarded the original to QA nurse. The DON stated the bruise was in a vulnerable location and the abuse policy should have been followed to ensure a thorough investigation to rule out abuse. Both concurred the facility policy was not followed. Cross reference F609 40844 R103: Review of the e-HR (electronic health record) revealed R103's most recent admission was on [DATE]. Diagnoses included dementia, depression, age related osteoporosis (gradual and progressive bone loss), and failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R103 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of ,d+[DATE]), and required two-person extensive assistance for transfers. Review of facility's Allegation/Incident report sent to CMS (Centers for Medicare and Medicaid Services) on [DATE] at 3:18 PM revealed an injury of unknow origin occurred at an 'unknown' time, and was reported on [DATE]. Under the timeline of events it described a CNA (certified nursing assistant) reported multiple bruises to hand, arms/lt. [left]outer foot to nursing on [DATE]. R103 expressed reports of pain and was sent to the emergency roiagnom on [DATE] where she was diagnosed with an Impacted fracture through the left humeral surgical neck. An impacted fracture refers to a fracture in which bone fragments have been driven into each other. The end of the arm bone near the shoulder is referred to as the surgical neck of the humerus bone. Further review of the facility's investigation revealed a time line starting with the report of the incident on [DATE] day shift by CNA3, through the emergency room visit on [DATE]. It also included CNA checks lists and skin monitoring documents between [DATE] and [DATE]. It did not include a review of resident care before the reporting of the bruising on [DATE]. Statements and incident reports from the following staff were included. Statement from CNA4 dated [DATE] which indicated she worked with the resident on [DATE] from 7:15 PM to 7:30 AM the next morning. Incident report for [DATE] by CNA5 dated [DATE] which indicated she worked with the resident on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Incident report for [DATE] by CNA3 dated [DATE] which indicated she worked with the resident on [DATE]. Incident report for [DATE] by Unidentified staff member dated [DATE] which indicated she worked with the resident on [DATE]. Incident report for [DATE] by CNA6 dated [DATE] which indicated she was working with the resident on [DATE] and that R108 did not complain of any pain or yelling out. The investigation did not include interviews or statements from staff which worked with the resident before the bruising was reported. There were no interviews with alert and oriented residents who may have received care from the same providers. The Emergency Medicine visit [DATE] report read under assessment and plan, I advised [LN2], charge nurse . of pt's [patient's] fracture. She will notify pt's family as well as her supervisor to investigate further as no apparent witnessed fall reported. Additional review of the e-HR revealed a lack of notes and vital signs recorded between [DATE] and [DATE]. Review of the Medication Administration record reveals LN2, LN3, and LN4 worked with the resident on [DATE] and [DATE]. During an interview on [DATE] at 8:57 AM nurse QA 9quality assurance) confirmed she completed facility investigations of all allegations of abuse and other unusual occurrences. When asked if she included the time frame before the initial report of bruising in her investigation she stated, I did look back to see the notes as far back the 28th of June, and the check off sheets. She confirmed she did not include that in her report and confirmed there was a lack of documentation in the medical record. She explained that before the bruising the resident was not on alert charting and documentation would not be required. When asked if she had interviewed any nurses that took care of R103 before the bruising was noted, she stated she did interview LN2, though did not include that in the investigation. The facility investigation identified the root cause as Unsafe handling and transferring of resident - being too rough with transfers and assistance. QA Nurse confirmed during the interview It could have been the lifters [a mechanical device used to lift and transfer residents] however they were unable to identify who or exactly when it occurred. Facility policy titled Abuse Policy, Under types of abuse it included Neglect/Mistreatment which included an example which read, mishandle or rough handling of individual. Under the Components of Abuse Prevention it indicated injuries of unknown source would be investigated and that all alleged violations were to be reported to the administrator and to other officials in accordance with state law through established procedures. R52: Review of the e-HR revealed R52 was admitted on [DATE]. Diagnoses included dementia with behavioral disturbances, obesity, osteoarthritis (osteoarthritis occurs when the smooth cartilage joint (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surface wears out), cardiomegaly (an enlarged heart), presence of pacemaker, pulmonary hypertension, asthma, hearing loss, and cataracts. The annual MDS dated [DATE] revealed R52 was rarely/never understood and an interview or assessment of cognitive patterns was not done. Under the Functional status section (G) it read R52 was totally dependent of staff for all ADLs excepts eating. R52 expired on [DATE] in the facility and was reviewed as a closed record. During an interview with LN2 on [DATE] at 10:25 AM, she described R52 as requiring assistance with transfers, stating she was a 'total assist, not able to stand and bear weight. She confirmed the resident was transferred with a mechanical lift. During the interview she also stated that R52 had a leg immobilizer for a fractured leg. She did not recall how the fracture occurred. Additional record review revealed R52 was sent to the emergency roiagnom on [DATE]. A nursing progress note dated [DATE] at 3:28 PM read, Writer enter resident room to given her medications. Writer began to sit her up in bed which resident scream out with facial pain expression and stated: My leg hurts. Writer assessed right leg and seen swelling, pain with touch or movement, and slight discoloration. The physician's routine 60-day evaluation note dated [DATE] read, Nursing reports no falls, or additional concerns, stable behaviors. -right knee pain: see in ED [emergency department] yesterday . no known falls or other trauma. xrays w/o [without] obvious fracture of xray of the knee showed lipohemarthrosis [floating fat in the joint cavity] suggestive of fracture . reviewed imaging w/ [with]radiology and consistent w/ my exam, most likely does have a fracture of the rle [right lower extremity] suspect either distal femur or prox. tibia [lower leg bones]. During an interview on [DATE] at 9:23 AM the DON (director of nursing) described R52 had been sent for knee x-rays which did not initially show a fracture. When asked how R52 got the leg fracture, she indicated she understood it had something to do with the demineralization of the bones. She agreed to review to chart. On the same day the DON provided an Incident report, and a death certificate. The death certificate did not indicate the cause of death was related to the fracture. The Incident report was dated [DATE] and signed by NA7. It revealed that on [DATE] she and another staff transferred R52 to a wheel chair at 5:00 PM uneventful and the resident did not express pain or combative behaviors. The next day the resident did express pain by screaming and touching her leg. The report was stamped Received on [DATE] by the ADON (assistant director of nursing). During an interview with nurse QA on [DATE] at 08:57 AM she confirmed R52 had dementia and was cognitively impaired; was sent to the emergency roiagnom on [DATE]; and the primary physician's note dated [DATE] indicated he was suspicious of fracture. When asked if this injury of unknown origin was reported to CMS she stated, Not this one. Cross reference F609. When asked if the facility investigated the circumstances surrounding the injury QA nurse stated, We did do one, and talked about it in stand up. When asked for the investigation she stated they did not do a formal investigation and added, We weren't able to pinpoint a cause. When asked about the conclusion to the 'informal' investigation she stated, It may be from the sling [of a mechanical lifter]. We didn't think it was fracture . It was after the ER [emergency room] visit that the doctor felt it was a fracture. Cross reference F689.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44720 Based on observation, interview and record review, one resident (R-28) sampled for change of condition had loose bowels and the physician was not notified. This failure had the potential to affect R28's health and well-being. Findings included: R28 was admitted to the facility on [DATE], with diagnoses which included Olgilvie Syndrome (the intestine is unable to contract and push food, stool, and air through the digestive tract. The disorder most often affects the small intestine, but can also occur in the large intestine. Symptoms include abdominal pain, constipation, abdominal distension and diarrhea) per the facility's Census and Diagnoses tabs, located in the Electronic Health Record (EHR). R28's EHR was reviewed on 8/23/22 at 2:03 PM. Per the facility Tasks, R28 had one episode of loose stools/diarrhea on 7/28/22 and 7/30/22. R28 had two episodes of loose stools/diarrhea on 8/1/22, and one episode on 8/2/22. On 8/3/22, R28 had five episodes of loose stools/diarrhea and four more episodes on 8/4/22. There were no progress notes found between 7/28/22 and 8/5/22, which indicated the nurses had notified the physician R28 had loose stools/diarrhea, or that the nurses were made aware of the loose stools/diarrhea. Per the Progress Notes, on 8/5/22 at 5:50 AM, R28 was sent to the hospital due to abdominal distension and abdominal pain. Per the hospital discharge record, R28 was hospitalized with a bowel obstruction caused by Olgilvie's Syndrome. R28 returned to the facility on [DATE]. On 8/26/2022 at 10:12 AM, a concurrent record review and interview was conducted with the Assistant Director of Nursing (ADON). The ADON reviewed R28's Tasks and stated the EHR would alert the nurses if a resident had no bowel movement for 3 days, however it would not alert a nurse if a resident had loose stools or diarrhea. The ADON stated it was the responsibility of the nursing assistants to notify the nurse, the nurse would assess the resident and notify the physician. The ADON stated R28 began having loose stools or diarrhea from 7/28/22 through 8/4/22, and stated there were no progress notes which indicated the physician had been notified. The ADON stated symptoms of a bowel obstruction included episodes of loose or watery stools. On 8/26/22 at 10:45 AM, R28's hospital Discharge Summary was reviewed which indicated due to Olgilvie's syndrome, R28 would continue to have repeat bowel obstructions and bowel obstructions had occurred twice during his hospitalization . The facility did not provide a policy which indicated who was responsible to report loose stools/diarrhea to the nurse or guidance which indicated when the physician should be notified.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29087 Based on observation, interview, record review, and policy review the facility failed to provide supervision to prevent resident injury during assisted transfers utilizing a mechanical lift. The facility failed to develop and implement policies for safe use of mechanical lifts and failed to ensure staff were trained and competent prior to using the mechanical lifts. Three residents (R22, R32 and R34) who required mechanical lift transfer were at risk for serious injury or death during transfers. Direct observation identified unsafe practice when R32 was left unattended while suspended in the lift sling during mechanical lift transfer that placed R32 in immediate jeopardy for severe injury or death. R22 experienced minor injury to lower leg and R34 fell and hit his head with development of a hematoma during mechanical lift transfers. Findings include: Mechanical patient lifts are named after one of the first companies to manufacture them-Hoyer. The mechanical lifts used in the facility were battery powered Invacare Reliant 450. The facility referred to the Invacare lifts as Hoyer lifts. FDA (Food and Drug Administration), NIOSH (National Institute for Occupational Safety and health) and Hoyer manufacturers provide written protocols for operation of mechanical lifts. Sample protocols direct two persons to perform mechanical lift transfer; one person required to operate the lift and the other person assists and guards the patient/resident against injury. The second person can seek needed supplies/equipment such as replacement battery leaving one person with the patient so they are never left unattended. FDA patient Lift Safety Guide at https://www.fda/gov/media/88149/download. page 2; Know your lift. Receive training and practice before operating a lift. !ALERT-Patient falls from lifts may cause injuries including head trauma and death. Page 10: Lift the patient. !DO NOT leave patient unattended while in lift. Never keep patient suspended in sling for more than a few minutes. Slowly lift patient only as high as necessary to complete transfer. Resident R32 Record review: The Plan of Care last reviewed 8/5/22 indicated R32 admitted to the facility with diagnoses that included but not limited to Diabetes, Dementia, Parkinson's disease and age-related osteoporosis. Taber's medical dictionary; osteoporosis means porous bones, a disease that weakens bones making bones more susceptible to fractures. The care plan indicated; [Activities of daily living] ADL self-care performance deficit r/t [related to] Dementia, Impaired balance, Limited Mobility, Neuralgia (nerve pain) and Neuritis (inflamed nerves) Date Initiated: 5/16/2019 TRANSFER: per 1/10/2022: PT [physical therapy] recommends a mechanical liftfor transfer. The care plan indicated R32 was at high risk for falls and had acute and chronic pain r/t Neuralgia and neuritis, bilateral knee pain, and history of pelvic fracture. R32 had Sensor chair and Bed alarms in use for fall prevention purposes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing progress notes dated 8/6/22 at 12:55 PM noted sensor alarm alerted staff and R32 was found sitting on the wheelchair footrests between the bed and the locked wheelchair with no apparent injury. A nursing progress note dated 7/15/22 at 7:00 PM noted R32 was sitting on the floor with her back against the wheelchair seat cushion and her legs spread out in front of her. R32 stated I slid off the chair. Observation: 8/23/22 11:06 AM: R32 lay in bed. A transfer/bed mobility rail was raised on the left side of bed and a fall mat was on the floor on the left side, the bed was in lowest position (at floor). When asked the purpose of the low bed and floor mat, Nursing Assistant (NA) 8 said R32 was impulsive and a high fall risk and recently had a fall. NA8 provided incontinent care for R32. At 11:19 AM, NA8 wheeled R32 out of the room in a high back reclining wheelchair, the Hoyer lift was at the bedside with no other staff in the area. When asked if she transferred R32 with the Hoyer lift by herself, NA8 said yes. Asked about process for Hoyer lift for R32 and her risk for falls. NA8 said she was able to do it [Hoyer transfer] by herself because R32 was cooperative with her. Observation: 8/25/22 10:01 AM. R32 lay in bed as Certified Nursing Assistant (CNA) 10 and CNA11 prepared to use a Hoyer lift to transfer R32 from bed to chair. CNA10 wheeled the Hoyer lift into the room. CNA11 cued resident to roll to her side. CNA10 and CNA11 each stood on a side of the bed. CNA11 verbalized the process as they worked together adjusting the lift sling under the resident. CNA11 said a blue sling was used due to R32's size. Once the sling was attached to the sling bar on the lift, CNA10 stood behind the high-back reclining wheelchair. CNA11 used the lift controls and raised R32 up off the bed. With R32 suspended over the bed, CNA11 went around to the front of the lift and held R32's lower legs to rotate and swing her body off the bed, CNA11 used R32's legs to push the lift back away from the side of the bed. CNA11 then went to the back of the lift and used the controls to raise R32 higher. R32's feet and lower legs dangled. CNA11 pushed the lift toward the wheelchair, R32's right foot was up on the lift frame and the left ankle and foot twisted and nearly became entrapped between the wheelchair and the lift mast. CNA10 saw the foot turn and exclaimed Oh. CNA10 was not in a position to protect the legs and feet and was not in a position to support the resident if she started to slip from the sling or if the sling failed. CNA10 remained behind the wheelchair during the entire Hoyer transfer process. CNA11 reached underneath R32's suspended body and adjusted her feet. Interview followed observation: CNA10 and CNA11 said they were trained on the use of the lift in their nurse aide training program and during facility orientation. CNA10 stated they also had the training in Relias. (Relias is a proprietary online program for health care worker training). When asked their understanding for one or two staff to perform Hoyer transfers CNA11 said the facility preferred two staff for the Hoyer lift. CNA10 said it required two staff and that is what the facility said. When asked what the Relias training taught; CNA11 said the Relias training showed to use two people but it also gave another choice to use one person. When asked how did they know when to use one or two. CNA10 said; the facility says two. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/24/22 at 9:14 AM the assistant to the CEO stated the facility did not have a policy on the lifter [referring to mechanical lift]. On 8/25/22 at 9:14 AM an undated document marked Draft, and titled; Resident Lifting/Assisting Transfers was presented. The QA nurse said the lift policy was in process but it was not yet submitted for approval so it was not implemented. When asked the facility expectation regarding one or two staff to perform Hoyer lift transfers. QA nurse said two people were required to use the Hoyer lift in the facility and she was not aware of any exceptions for one-person Hoyer lift. QA nurse said Relias was used for training and she provided staff a list of all required trainings. QA nurse said Relias had a program on mechanical lifts and it was mandatory for all nursing assistants. QA nurse 'ran a print-out' that showed CNA10 and CNA11 completed the Relias training in April 2022. The training was assigned to NA8 however the training was not completed. The printed Relias lesson: Section 1: Transfers: Mechanical Lift directed: Before you start transferring someone with a mechanical lift, you first need to *Check individual's plan of care, your organization's policies and procedures, and the manufacturer's instructions on proper lift use. *Determine if another person is needed to assist with the lift. Most lifts require two people -one to operate the lift and one to guide the sling. ---Only lift the individual as high as needed to clear the transfer surfaces. -pull the lift backwards so the legs are clear of the bed or chair. Interview 8/25/22 at 11:20 AM with QA nurse: Reported observation of NA8 using the Hoyer lift without assistance. QA nurse said the described practice was not consistent with the facility expectation. Reported findings of the mechanical lift transfer observation with CNA10 and CNA11. QA nurse pulled up the Relias training video. The video showed the second staff supporting the legs and standing directly at the side of the suspended resident with hands in contact with the sling as it was maneuvered over the wheelchair and then the second person was shown behind the wheelchair to guide the lowering of the sling into the chair. The User Manual for Invacare 450 obtained on the internet directed; This manual must be given to the user of the product. BEFORE using this product, read the manual and save for future reference. Warnings Signal words are used in this manual and apply to hazards or unsafe practices which could result in personal injury or property damage. Definitions of the signal words included: Signal DANGER Danger indicates an imminently hazardous situation which, if not avoided, will result in death or serious injury. WARNING Warning indicates a potentially hazardous situation which, if not avoided, could result in death or serious injury. Page 7 WARNING! DO NOT attempt any transfer without approval of the patient's physician, nurse or medical assistant. Thoroughly read the instructions in this Owner's Manual, observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted. WARNING! Although Invacare recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pages 30-31: * When the resident is clear of the bed, swing their feet off the bed (Detail B). *Use the steering handles, move the lift away from the bed. Detail B is an illustration that shows 2-persons using the lift. One person with hands-on support of the legs and the other person using the steering handles to pull the lift away from the bed. Observation: 8/26/22 10:51 AM: NA8 prepared to assist R32 from bed to wheelchair. R32 reported knee pain, and stated they hurt all the time. NA8 worked alone and placed the lift sling under R32 while she lay in bed. NA8 attached the sling straps to the lift bar and raised R32 very high up off the bed surface. NA8 then held R32's legs, rotated her body off the bed, then pulled on her legs to move the lift away from the bed. NA8 moved the lift into the roommate's area of the room. R32 was suspended in the sling very high off the floor at the level of NA8's chest. NA8 left R32 unattended while suspended in the air. NA8 walked across the room and around the bed to the alcove by the window to retrieve the wheelchair. NA8 placed the wheelchair in the middle of the room, then pushed the lift near the wheelchair. While R32 was still suspended in the sling, NA8 pushed on R32s upper leg moving the sling to the left to clear the wheelchair armrest and used the other hand to manipulate the lift controller to lower R32 into the wheelchair. Lastly, NA8 went behind the wheelchair and pulled on the sling to straighten R32 in the chair. While unattended and suspended in the air in the lift sling, R32 was in immediate jeopardy and at risk for serious injury including head trauma, fractures, and death in the event of a fall from the lift. The facility was informed of IJ on 8/26/22 at 1:14 PM. IJ template presented to the facility DON, Assistant to the CEO, and QA nurse. The facility presented a removal plan that included immediate notification to all staff on duty that residents were not to be left unattended during use of the Invacare Reliant 450 mechanical lift. In-service training to begin immediately with the day shift and continue with the start of each shift until all direct care employees were provided the in-service. The removal plan was accepted on 8/26/22 at 4:05 PM. Observation: 8/26/22 at 4:30 PM: A large group of staff were assembled in the living room of Household 1. QA nurse, DON, and assistant to the CEO led a discussion and in-service regarding use of the Invacare mechanical lift. The in-service was repeated on Household 2. Interviews: On 8/26/22 at 4:55 PM interview with CNA13 confirmed she attended the Hoyer lift in-services. CNA13 stated two staff were needed to transfer-one to operate the lift, and one to manage the resident. CNA13 was able to describe activities for 'managing the resident'. Interview with (training Nursing Assistant) TNA1 conducted 8/26/22 at 4:59 PM; TNA1 described the Hoyer lift training she received that same day and stated she understood two staff were required to transfer residents with the Hoyer lift. Interview conducted 8/26/22 at 5:02 PM; CNA5 confirmed she was trained today on the use of the Hoyer lift. CNA5 stated two staff were needed, one to assist the resident and one to use the lift. CNA5 confirmed that the resident should not be left unattended at any time while in the lift. The IJ was removed on 8/26/22 at 5:03 PM after onsite verification of implementation of the removal plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A pattern of deficient practice remained at level two no actual harm but potential for more than minimal harm. Resident R22 Record review: R22 admitted to the facility on [DATE] with diagnoses that included Dementia, COPD (chronic obstructive pulmonary [lung] disease), osteoarthritis of the right knee and adult failure to thrive. A Physical Therapy assessment conducted on 3/14/22 noted R22 reported pain in her right knee for one year and did not walk because of her knees. The PT noted R22 was dependent to move from sit to stand and was unable to achieve standing position due to significantly limited knee extension. R22 was dependent in all ADLs including transfers. A mechanical lift was used for all transfers. Record review: Progress notes dated 3/21/22 4:00 PM: CNA reported R22 had a skin tear on her left lateral lower leg that occurred during a transfer. Assessment showed a 2.0 cm length skin tear. Active bleeding was stopped and a dressing was applied. The facility documented an investigation on a QAQI [Quality Assurance] Incident/Complaint Report. The report dated 3/22/22 indicated CNA14 was transferring R22 from bed to wheelchair and foot rests got in the way and caused a skin tear to left lower leg. CNA14 did not notice the skin tear until she was putting booties on the resident. The CNA14 wrote; Next time I will remove the leg rests before transferring. The investigation concluded; as a result of not removing the foot rest on the wheelchair before patient transferring, the foot rest caused a 2.0 cm skin tear on the left lower lateral leg. The report: Describe the corrective measure taken to address immediate hazards related to incident. Written response; Employee review regarding *proper positioning during transfers *Follow resident care plans regarding transfers: >Requires Hoyer lift for all transfers with 2 staff assistance > review Kardex >requires total assistance by 2 staff. *Call for assistance from fell ow CNA if help is needed. *Plan to start skills competency for transfers, mechanical lifts, vital signs, etc. TBD. The QAQI report was signed by QA nurse 3/22/22 Interview: 8/26/22 11:06 AM with QA nurse; When asked how the facility ensured competency to use the Hoyer lift; QA nurse said the facility did not currently have anyone who tracked skills checks. QA nurse said newly hired nurse assistants participated in an 8-hour orientation day that covered a brief presentation by each department head. Once CNAs were on the floor, they worked with a senior CNA and they did hands on training with the equipment such as lifts. When asked about the plan to start skills competency for transfers and mechanical lifts as stated in the 3/22/22 QAQI report, QA nurse said it did not happen yet. Interview: 8/26/22 11:26 AM with ADON (assistant DON). ADON said she supervised the CNAs. ADON said she did not have checklists for skills or competencies. ADON said It is up to the assigned CNA to go over things when they orient new CNAs. ADON referred to the lead CNA. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview: 8/26/22 11:45 AM with lead CNA (CNA15): CNA15 said newly hired CNAs start with one 8-hour day of general orientation and then shadow a CNA. CNA15 said she paired new hires with senior CNAs for 4 night shifts and 3 day shifts to show them the tasks and how to care for the residents. CNA15 said the CNAs had a checklist with the things like the forms they have to complete and the day to day tasks. CNA15 said there was no skills check. When asked how she determined when a CNA was ready to work independently, CNA15 said she knows they are ready when they say I am ready to work alone. 40844 Resident 34: Review of medical record revealed the facility admitted R34 on 6/16/22 with an admitting diagnosis of Diabetes. Additional diagnoses included rheumatoid arthritis, osteoarthritis, atrial fibrillation (abnormal heart rhythm), spinal stenosis, history of transit ischemic attacks (TIA), and repeated falls. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R34 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15. The Functional Status section revealed R34 required extensive assistance for transfers, bed mobility, dressing and toiletings. Physician's Orders revealed the following orders with revision date 3/16/22: ASSISTANCE: Total care w/ ADL's REFERRAL: PT/OT eval on admission. An intervention for the ADLs care plan read. TRANSFER: [R34] requires Hoyer Lift with (2) staff assistance for transfers. PT evaluation/recommendations: she requires a Hoyer lift for all transfers. Date Initiated: 3/22/2022 . Revision on: 7/18/2022 Review of the progress notes revealed an incident note dated 8/11/22 4:35 PM. It read, Note Text: 1635 pm [4:35 PM] staff reported to writer that resident was on the floor. Witnessed Fall during transfer and slip out of w/c [wheel chair] and bump head. Head to Toe assessment completed. Alert and oriented x 2 (name/situation) and stated headache. [vital signs]: 185/85, 65 (pulse), 22 (respiratory rate), 97.8, 91% RA (oxygen saturation on room air) and glucose 98. Transfer resident from floor to bed with (3) staffs. 1645 [4:45 PM] writer contacted EMS for transfer to ER department for witnessed fall and hematoma on right side head . Review of the ER clinic notes revealed radiological imaging of head, neck and chest revealed no acute injuries and R34 was discharged back to the facility. Review of the POC Response History (CNA documentation of care provided) revealed the Question TRANSFER: SUPPORT PROVIDED - How resident moves between surfaces to or from: bed, chair, wheelchair, standing position. CNA responses read, One person physical assist 12 out 20 times (60%) between 8/16/22 and 8/22/22. An additional review of the responses recorded during the look back period for the 6/29/22 MDS assessment revealed a similar pattern of one person assistance for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/29/22 at 3:47 PM the QA Nurse was asked how R34 slipped out of chair. She stated that a nursing assistant was transferring R34 from the bed to the chair by herself with a mechanical lifter and slid out of the chair. She confirmed the care plan called for 2 staff to perform transfers.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44720 Based on observation, interview and record review, the facility failed to ensure two residents (R- R16 and R45) sampled for medication administration received the correct amount of fluid with their medication. This failure had the potential to affect the residents' health and well-being. There were 23 medication administration opportunities observed and there were two medication errors. The facility medication error rate was 8.7%. Findings included: R45 On 8/25/2022 at 11:39 AM, an interview and observation were conducted with the Assistant Director of Nursing (ADON) during the lunch-time medication pass. The ADON stated she was preparing medication for R45. The ADON removed a bottle of laxative powder (a powder used to treat and prevent constipation), poured a capful into a blue plastic cup, poured water into the same cup and stirred. The ADON stated she added 120 milliliters (4 ounces) of water. The ADON then brought the medication to R45 and he drank it. On 08/26/2022 at 10:12 AM, a concurrent record review and interview was conducted with the ADON. The ADON reviewed R45's physician's order for the powdered laxative and stated the physician had ordered it be given in 8 ounces of water. The ADON stated it was not an issue to give in less water as long as the medication was fully dissolved. On 08/26/22 at 2:40 PM, the Food and Drug Administration prescriber data for the powdered laxative was reviewed (https://www.accessdata.fda.gov/drugsatfda_docs/label/1999/20698pi.pdf). Per the prescriber data, the powdered laxative must always be given with 8 ounces of water. 40844 R16: During a medication administration observation on 8/26/22 at 8:29 AM, the Director of Nursing (DON) prepared a laxative for R16. She mixed 1 scoop of polyethylene glycol in a blue plastic cup and administered it to R16. During an interview with the DON following the administration a concurrent observation of the cup and the medication label revealed the cup was a 5 oz. (ounce) cup and the label read to mix the medication in at least 8 oz. The DON described the cups on the medication cart had recently changed and she had not realized they were too small. Review of physician orders revealed the following order: MiraLax Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 1 scoop by mouth one time a day for constipation 1 capful daily MAY hold for loose stool

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40844 The facility failed to follow their menu when they provided a sliced bread slurry instead of a cornbread slurry on 8/23/22, and kitchen staff did not use the correct size portions of mashed potatoes for a consistent carbohydrate diet, and gravy during tray line on 8/25/22. This had the potential to not meet nutritional needs of residents and affect palatability of the the food. Findings: 1) Bread Slurry A bread product slurry is made from liquid and a commercial thickener. It is used to soak a bread product (such as bread, cookies, muffins, or pancakes) to help soften the food to the right texture. Bread product slurries feel like pudding in the mouth. The survey team observed the lunch meal on 8/23/22 at 11:30 AM. During the meal Resident (R) 26 was served a pureed meal with a sliced bread slurry. R26 was assisted with feeding by Nursing Assistant (NA) NA8. At the end of the meal R26 had not eaten the bread slurry. NA8 stated She did not eat the bread. She said it was soggy. During the same meal R32 was also served a pureed diet with a sliced bread slurry. R32 indicated to staff that she did not like the bread slurry. A review of the 8/23/22 lunch menu revealed the recipe for the Dysphagia Mechanical Altered, and the Pureed diets called for a Cornbread Slurry. During an interview on 8/25/22 at 12:00 PM, Cook1 was asked about the bread slurry served on 8/23/22. She stated that a dietitian about 8-9 years ago recommended all slurry be made with sliced bread. After a concurrent review of the 8/23/22 menu Cook1 confirmed a cornbread slurry was not provided, and the facility generally provided a bread slurry, which did not follow the menu. The Dietary Manager (DM) was interviewed on the same day at 12:10 PM. When asked about the slurry she stated 'They should follow the recipe. She added she had not received any complaints from residents about the bread slurry. The Registered Dietitian stated during a phone interview, on 8/26/22 at 1:49 PM, I wouldn't say lets do a bread slurry every day. I would want them to follow the cornbread slurry. 2) Menu Portions During a kitchen observation on 8/25/22 at 11:15 AM, observed Cook1 place portion sized serving scoops on the tray line in preparation. Cook1 stated the grey handled scoop was an 8, the green handled scoop was a 12, the small gravy ladle was 1 ounce. The menu was posted above the steam table at eye level. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The follow observations were made during the plating of lunch meal on 8/25/22: Residents R27, R51, and R34 had meal cards which read CCHO (a carbohydrate diet that is consistent, constant, or controlled). Cook1 used the grey handled #8 scoop to serve the mashed potatoes for CCHO meals as well as regular diet meals. Kitchen staff RNA9 was assisting Cook1 with plating meals and when applying the gravy on top of the potatoes she applied 2 scoops of gravy. Interviewed Cook1 and RNA9 following the tray line at 12:00 PM. A concurrent review of the menu revealed the #12 scoop should be used to serve mashed potatoes for the CCHO meals. When asked if she used the #12 scoop, Cook1 confirmed she did not, and stated she Should have. When asked RNA9 about using the 2 scoops of gravy she stated It didn't look like enough. The menu indicated that 1 oz. of gravy should be served on all meals except the large portions and the Dysphagia Mechanically Altered Level 2 diets. They both confirmed they did not refer to the menu while plating the meals. During the interview with the DM on 8/25/22 at 12:10 PM, the observations were described. The DM stated, They should follow the recipe. The RD was asked about the portion observations during a phone interview on 8/26/22 at 1:49 PM. She confirmed she was aware of the observations and stated From a dietitian stand point I encourage them to follow the menu. She added that the difference in carbohydrates was not likely to affect diabetic control, however she would have concern and do training.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 29087 One resident (R32) was served slurry bread which she indicated to staff she did not want, it was too soggy, no alternative was offered. Failure to serve foods that are palatable to the resident may negatively impact food intake and enjoyment of meals. Findings include; Observation of lunch meal on 8/23/22 at 12:29 PM : R32 was fed/assisted by staff in the main dining room. R32 stated she did not like the bread and would not eat it. She said it was too soggy. R32 said they keep giving it to her every day and she never eats it. The bread served was a slice of bread saturated with a thick liquid and was obviously soggy with a glue or paste-like texture. The staff in the dining room did not offer an alternative when R32 stated she did not like and would not eat the bread. Cross reference: F803.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 The facility failed to store food in accordance with professional standards when items in the unit refrigerator of Household 1 were expired and not removed. This had the potential for residents to be served expired food. Findings: Observed Household 1 unit refrigerator contents on [DATE] at 3:24 PM, accompanied by Unit Aide (UA1). Observed four individually unopened packaged cups of prune juice. The use by date read [DATE]. UA1 confirmed the juice should have been discarded. When asked who's responsibility it was to monitor and remove expired foods she stated It is supposed to be all of us. She further explained the refrigerator was used to store resident food and snacks. Requested policy addressing the unit refrigerators on [DATE]. The Quality Assurance Nurse (QA), informed the survey team on [DATE] there was not a specific policy or procedure for the unit refrigerators. The refrigerators would fall under the kitchen's policy on food storage. The food storage chart provided by the Dietary Manager read, Follow is a recommended outline of proper storage ties for opened and unopened . items. Where different, follow manufacturer's recommendations and expiration dates. The policy titled Record of Refrigeration Temperatures, undated, read in pertinent part, Nursing unit refrigerators must be clean, have dated food products (not outdated) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. Building B. Wing	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Guy Gorman Sr Care Home	Highway 191 & Hospital Road Chinle, AZ 86503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44720 Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene while assisting three resident's (R-2, 13, and 42) during lunch. This failure had the potential to cause the spread of infections. Findings included: On 08/23/2022 at 11:41 AM, a concurrent observation and interview were conducted. Certified Nursing Assistant (CNA1) was observed assisting three residents with their meals. She touched one resident's food, eating utensils and wiped her hands on a visibly soiled crumpled napkin. CNA1 then touched another resident's shoulder and plate. CNA1 then walked to the tray line (an area where the food is being served) and returned to the three residents. CNA1 touched one resident's spoon and stirred his food, handing him the spoon after. CNA1 did not perform hand hygiene after touching the three resident's eating utensils, visibly soiled napkin or shoulder before assisting another resident. CNA1 stated the three residents were R2, R13 and R42. CNA1 stated the residents needed assistance and encouragement while eating. CNA1 stated she should have performed hand hygiene between residents. On 08/25/22 at 3:02 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated when staff assist residents with meals, it is expected if they came in contact with spit or saliva they were expected to wash their hands. The IP stated the handwashing sink and hand sanitizer were far across the room and difficult for staff to get to during meals. The IP stated staff had been given hand sanitizer to carry, but it may have run out. The facility policy, titled Infection Control, revised 7/26/13, read in pertinent part Standard Precautions. These precautions must be used for all residents, regardless of diagnosis or presumed infection status, when contact is anticipated with blood, all body fluids, secretions, excretions, including feces and urine but excluding sweat, non-intact skin and mucous membranes. Standard precautions consist of the following components: Routine handwashing, using soap, running water and friction must be strictly adhered to. In certain circumstances, hands may be cleaned with an alcohol based waterless hand cleaner . Per the Centers for Disease Control, Hand Guidance, dated 1/30/20, (https://www.cdc.gov/handhygiene/providers/guideline.html, accessed 8/31/22), read in pertinent part The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Before moving from work on a soiled body site to a clean body site on the same patient -After touching a patient or the patient's immediate environment -After contact with blood, body fluids, or contaminated surfaces -Immediately after glove removal Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.

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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. 40844 Based on interview and record review the facility failed to follow their policy when a antibiotic was prescribed outside the normal parameters when the prescriber was not given feedback by either the consulting pharmacist or the medical director. This had the potential for Resident (R) R26 to receive unnecessary antibiotics. Findings: Review of the e-HR revealed the facility admitted R26 on 05/24/22. Diagnoses included Dementia, non-pressure chronic ulcers of the left heel, midfoot and left foot, and cellulitis of the left lower leg. The wounds were present upon admission. Review of antibiotic orders since admission read as follows: Clindamycin HCl Capsule 300 MG Give 1 capsule by mouth every 6 hours for infection for 5 Days (6/2/22 - 6/7/22) Clindamycin HCl Capsule 300 MG Give 1 capsule by mouth four times a day related to OPEN WOUND, LEFT FOOT (6/15/22 - 6/20/22) Clindamycin HCl Capsule 300 MG Give 1 capsule by mouth three times a day for Cellulitis of Left Foot (6/30/22 - 7/1/22) Clindamycin HCl Capsule 300 MG Give 1 capsule by mouth three times a day for treat infection related to CELLULITIS OF LEFTLOWER LIMB . (6/30/22 - 7/5/22) Review of the June 2022 Antibiotic Surveillance report revealed three of R26's antibiotic courses were listed. Under the comment sections one of the three courses indicated sufficient symptoms of infection were not identified. The Concerns read, Symptoms not documented to meet criteria for cellulitis R26 was the only resident treated for cellulitis in the month of June. The facility Infection Preventionist (IP) was interviewed on 8/29/22 at 9:52 AM. When asked to describe how the Antibiotic Stewardship Program functioned she stated, We do tracking and submit to the consulting pharmacist and he sends us the report. We share that with Medical Director. We don't usually meet on it The report is presented in QAPI [The monthly Quality Assurance and Performance Improvement meetings] where we review it and share it with the hospital physicians. She did not recall R26 being discussed or if a question about the number of courses of Clindamycin was reviewed. She also stated that the prescriber was a podiatrist that who prescribed the courses during hospital visits. During a follow up interview with the IP on 8/29/22 at 3:47 PM, the IP reviewed the pharmacist's recommendations and stated there were no recommendations made regarding R26's antibiotics. When asked if the Medical Director provided any feedback to the podiatrist she stated, there was nothing. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy for Antibiotic Stewardship Program dated 6/2019, read in pertinent part, Structured feedback to prescribers and nurses directed towards facilitating transition in thinking would be provided; After tracking and trending was done, the pharmacist will review and report antibiotic usage patterns, most specifically recommendations made to prescribers as follow up to quarterly stewardship protocol reporting. Additionally it read, Feedback will be given by the medical director to prescribers on their individual laboratory ordering practices and prescribing patterns, as indicated.