STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245359	A. Building B. Wing	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43084 Based on observation, interview, and document review, the facility failed to provide personal care assistance to promote dignity for 1 of 2 female residents (R49) who depended on staff for assistance with shaving facial hair. R49's significant change Minimum Date Set (MDS) completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene and grooming. R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's. R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair. On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/14/21, at 8:23 a.m. R49 was seated in her wheelchair in the dining room. R49 had greater than 30 coarse, white hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then brought R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair. On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, Yeah, there's a lot there. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/21, at 8:18 a.m. RN-J confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-J stated she expected residents were assisted with shaving facial hair as needed. RN-J stated, There are a lot who have long chin hairs, we aren't doing it and staff are in a hurry. RN-J indicated she would feel embarrassed and uncomfortable if she was around other residents and had long facial hair. On 9/15/21, at 8:56 a.m. RN-H stated if R49 was able to speak for herself, she would be bothered having long facial hair when around other residents and visitors. On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of on bath days and as needed in between. DON expected female residents received assistance with shaving facial hair for dignity, I would anticipate if they were to see themselves in the mirror, the whiskers would not be acceptable to them. DON compared it to herself walking out of the house without her hair being combed. Facility policy, Dignity revision date 2/2021, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34985 Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident and/or resident's representative who had a facility-initiated transfer 1 of 1 resident (R48) reviewed for hospitalization s. Findings include: R48's progress note dated 8/13/21, at 10:30 a.m. indicated R48 was transferred to the emergency at 10:30 a. m. due to an increase in shortness of breath. R48's medical record lacked evidence of notification and/or reason regarding transfer. During an interview on 9/16/21, at 10:15 a.m. social services designee (SSD), licensed social worker (LSW), and registered nurse (RN)-A, indicated the facility had not been providing residents and/or resident's representatives written hospital transfer notices. During an interview on 9/16/21, at 11:42 a.m. director of nursing (DON) was not aware a written reason for transfer was not being provided, stated nursing should have been providing that information.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on observation, interview, and document review the facility failed to ensure a comprehensive care plan was developed for urinary indwelling catheter for 1 of 1 resident (R61) reviewed for catheters. Findings include: During an observation on 9/13/21, at 2:55 p.m. R61 laid in bed, R61 was observed to have a urine collection bag secured to the right side of his bed. R61 stated he had been recently hospitalized because of a bad urinary tract infection from his catheter being mismanaged at another facility. R61's face sheet dated 9/16/21, identified R61 was admitted to the facility on [DATE], with diagnoses that included urinary tract infection, sepsis, acute renal failure, and urinary retention. R61's hospital discharge summary dated 8/11/21, the section Lines/Drains/Airways/Wounds included Indwelling Urinary Catheter Latex; Coude [curved type] 16 Fr [French]. The summary did not identify the size of the catheter balloon (balloon to hold catheter inside the bladder). R61's admission Minimum Data Set (MDS) dated [DATE], indicated R61 had an indwelling urinary catheter. R61's catheter care plan dated 8/11/21, also did not identify the size and type of catheter R61 required. R61's current physician orders did not identify an order for an indwelling catheter. The physician order dated 8/15/21, directed staff to change R61's catheter every 30 days. R61's treatment administration record indicated R61's catheter was changed on 8/30/21. R61's record did not identify what size or type of catheter was inserted, nor the size of the balloon. During an interview on 9/15/21, at 7:05 a.m. RN-B was asked what size and type of catheter did R61 have, RN-B stated an unawareness of size and type of catheter. RN-B reviewed R61's physician orders and care plan and stated there was not a physician order for the indwelling urinary catheter, nor was the information in the R61's care plan. RN-B stated there had to be a physician order for the catheter that included the size and type of catheter and balloon size. During an interview on 9/15/21, at 10:29 a.m. RN-B indicated he had checked R61's catheter, the size that was printed on the catheter was 16 Fr (French), however, the print did not identify the type. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/21, at 7:52 a.m. licensed practical nurse (LPN)-A reviewed R61's record and confirmed there was not an order for size and type of catheter R61 required. LPN-A stated she would have to call the physician to get an order. At 8:38 a.m. LPN-A observed R61's catheter and stated the print on the catheter indicated the size as 16 Fr, however, did not identify the type or balloon size. LPN-A indicated there was not a way to tell if R61 had the correct catheter in place. During an interview on 9/16/21, at 11:44 a.m. director of nursing (DON) stated a catheter required a physician's order that identified the size and type of catheter and balloon size and there should have been an order obtained prior to changing the catheter. Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a thorough analysis of the information gathered as part of a thorough comprehensive assessment. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Iincorporate identified problem areas, reflect treatment goals, timetables, and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on observation, interview, and document review the facility failed to ensure revision of the care plan for activities of daily living (ADLs) after the completion of significant change Minimum Data Set (MDS) was completed for 1 of 2 (R175) residents reviewed for bowel and bladder. Findings include: R175's Restorative Nursing Screener dated 7/14/21, indicated R175 was independent with bed mobility and required supervision or touching assistance for transfers. R175's care plan for mobility/positioning/locomotion dated 5/11/20, included Transfers/ambulation with FWW [front wheeled walker] and gait belt. Use wheelchair for longer distances outside of room. R175's care plan for transfers dated 5/11/20, indicated R175 required assist of one for use with FWW. R175's dressing care plan dated 4/2/21, indicated assist of one. R175's significant change MDS dated [DATE], indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R175's care plan did not identify the level of assistance in accordance with the MDS. During an observation on 9/14/21, at 12:32 p.m. R175 sat in her wheelchair in front of the nursing station. Nursing assistant (NA)-A asked licensed practical nurse (LPN)-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy; LPN-D called therapy and stated to NA-A, R175 required two assist with a gait belt and a walker. NA-A wheeled R175 into her room, NA-D followed into the room. NA-A put a gait belt around R175, NA-A and NA-B attempted to assist R175 to a standing position, however, R175 was not able to stand up and was not cooperative with the NAs. At 12:38 p.m. LPN-D entered the room to try and assist NAs with transferring R175 to bed. NA-A and LPN-D attempted to assist R175 to a standing position and again R175 was not able to stand up and LPN-D stated he was going to go get a physical therapist to assist. At 12:49 p.m. NA-A pushed in a full body mechanical lift into R175's room, PT-A entered the room. PT attempted to stand R175 up with NA-A and NA-B however, R175 was not able to stand, PT-A then instructed to use the mechanical lift. PT-A and NAs then transferred R175 into bed using the full body mechanical lift. During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) reviewed R175's record, DON indicated R175's mobility had changed within the last month. DON verified the care plan was inconsistent with the significant change MDS and should have been revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Care plans, Comprehensive Person Centered policy dated 12/2016, included, The care plan interventions are derived from a thorough analysis of the information gathered as part of a thorough comprehensive assessment. The comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem areas reflect treatment goals, timetables and objectives in measurable outcomes. The comprehensive, person centered care plan is developed within seven days of the completion of the required MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on observation, interview, and document review the facility failed to follow the care plan for 1 of 2 residents (R175) reviewed for bowel and bladder. In addition, the facility failed to ensure grooming assistance was provided to 2 of 2 residents (R64, R49) who were dependent on staff for shaving. R175 toileting R175's face sheet dated 9/16/21, included diagnosis of dementia with behavioral disturbance and muscle weakness. R175's significant change Minimum Date Set (MDS) dated [DATE], indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for toilet use and personal hygiene. The MDS indicated R175 was occasionally incontinent of urine and bowel. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and unidentified nursing assistant were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors were observed to also be urine soaked. During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been toileted or changed. During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued sit in her wheelchair by the nursing station with her breakfast in front of her. During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her bed by NA-A and NA-B. When NA's exposed R175's incontinent garment it was observed to be heavily saturated with urine. NA-A stated R175 had not been toileted since 6-7:00 a.m. that morning. During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) stated the expectation was residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention. 44645 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64 Shaving R64's admission MDS dated [DATE], indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs), including personal hygiene. R64's face sheet printed 9/16/21, indicated R64's diagnoses included degenerative disease of the nervous system, type 2 diabetes mellitus, and chronic kidney disease. R64's care plan, last review date 8/12/21, indicated R64 required assist of one staff with personal hygiene which included shaving facial hair. Record reviewed for 8/16/21 through 9/14/21, of R64's Point-of-Care (POC) Tasks documentation for section labeled, Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, indicated resident needed extensive assist of one staff. On 9/13/21, at 5:11 p.m. R64 was observed in the hallway as she was escorted in her wheelchair by staff. R64 had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip. During observation and interview on 9/14/21, at 8:31 a.m. R64 was sitting in her bed in her room. R64 acknowledged that she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip, and they were due to her hormone levels. R64 stated that she had always shaved them every other day and she wanted staff to assist her. On 9/15/21, at 7:48 a.m. R64 was sitting in her bed in her room and acknowledged she had black and white hairs that were approximately 1/8 inch in length that thickly covered her chin and upper lip. On 9/16/21, at 1:03 p.m. nursing assistant (NA)-B stated if she had seen too many whiskers on a resident, she would have shaved the resident. NA-B further stated she had not assisted R64 very much and had not noticed any whiskers on R64. On 9/16/21, at 1:35 p.m. NA-I stated shaving is considered a part of daily grooming care. NA-I further stated if a female resident had a lot of whiskers, assistance shaving should have been provided. 43084 R49 Shaving R49's significant change MDS completed 8/6/21, indicated R49's cognition was severely impaired. R49 was dependent on physical assistance from staff for all activities of daily living (ADLs) including personal hygiene. R49's care plan last review date 6/25/21, indicated R49 required total assistance with personal hygiene which included shaving facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R49's face sheet printed on 9/15/21, indicated R49's diagnoses included depression, dementia, and Alzheimer's. On 9/13/21, at 12:25 p.m. R49 was observed seated in her wheelchair in her room. R49 had greater than 30, coarse, white hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/14/21, at 8:23 a.m. R49 was seated in her wheelchair in the dining room. R49 had greater than 30 coarse, while hairs that were approximately 1/4 inch in length on her chin and upper lip. On 9/15/21, at 7:31 a.m. nursing assistant (NA)-D and registered nurse (RN)-H were observed assisting R49 with morning cares. R49 was assisted out of bed, into her wheelchair. RN-H washed R49's face and dried it. NA-D combed R49's hair then pushed R49 to the dining room. Neither NA-D nor RN-H offered to assist R49 with shaving her facial hair. On 9/15/21, at 7:43 a.m. NA-D stated R49 required full physical assistance from staff for personal hygiene and grooming which included shaving facial hair. NA-D stated he had never assisted a female resident with facial hair but would do it if it was needed. NA-D confirmed he did not check R49's face with morning cares and that R49 did have a shaver in her room. NA-D observed R49 in the dining room then confirmed R49 had long, coarse, white hairs on her chin and upper lip, Yeah, there's a lot there. On 9/15/21, at 8:56 a.m. RN-H confirmed R49 had several coarse, long, white hairs on her chin and upper lip. RN-H expected female residents who require physical assist with shaving facial hair, received the assistance as needed. RN-H stated she noticed R49's facial hair when she assisted with morning cares and R49 had a shaver in her room, it was right in front of my eyes. On 9/15/21, at 10:29 a.m. director of nursing (DON) stated she expected facial hair was taken care of bath days and as needed in between. Facility policy, Shaving a Resident revised 2/2018 provided direction for how to assist a resident with shaving but did not address the frequency. According to the policy, the purpose of the procedure was to promote cleanliness and to provide skin care.

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F 0684 Level of Harm - 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** 34985 Based on observation, interview, and document review, the facility failed to ensure appropriate assessment, monitoring and physician notification were completed for 3 of 3 residents (R48, R36, R44). This resulted in actual harm when R48 required re-hospitalization with fluid overload resulting in respiratory failure and acute on chronic congestive heart failure. Findings include: R48's facility face sheet identified R48 was admitted to the facility on [DATE], with diagnoses of heart failure, chronic obstructive pulmonary disease, and hypercapnic respiratory failure. R48's physician visit dated 7/30/21, included R48 had leg swelling and his weight was 333.8 lbs. (pounds). Plan was to continue Lasix 40 milligrams [mg], will adjust if needed, nursing to monitor weight, Check daily weight notify provider if gain 2 lbs. in a day or 5 lb. in a week. R48's physician orders reviewed, included the following -Daily weights, notify physician for weight gain over 2 lbs. (pounds) in a day OR 5 lbs. in a week (start date 8/2/21) -Lasix 40 mg (milligrams) one time a day for congestive heart failure (start date 7/31/21) -Occupational therapy wrap bilateral lower extremities Monday through Friday (start date 8/6/21) R48's Admission assessment dated [DATE], indicated R48 had +3 pitting edema in both lower extremities; location in the lower extremities was not identified. R48's admission Minimum Data Set (MDS) dated [DATE], identified R48 did not have cognitive impairment, required extensive assistance of two or more staff members for activities of daily living that involved mobility and extensive assist of one staff for personal hygiene and dressing. The MDS indicated R48 was administered diuretic medications. R48's care plan dated 8/6/21, indicated R48 had a diagnoses of congestive heart failure with corresponding interventions, compression stockings on in the morning off and night, physician to assess medication program periodically, medications as ordered, staff to observe for signs and symptoms of increased edema, significant weight changes, increase shortness of breath/new shortness of breath, and notify physician as needed, and weight at least weekly, or as ordered by physician, notify physician of significant weight gain. R48's record indicated on 8/6/21, physician ordered a chest X-ray to rule out tuberculosis. R48's chest X-ray results on 8/11/21, indicated R48 had patching opacification (air in lungs replaced with other material such as fluid or bacteria) in the right lower lobe, and small pleural effusion (water on the lungs). The report also included Patchy right lower lobe infiltrate is seen, follow up exam recommended). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R48's weight record identified over 2 lb. weight gain in a day without evidence of physician notification per physician order. -On 8/3/21, weight was 330.4 lbs. -on 8/4/21, weight was 334.2 lbs. -On 8/5/21, weight was 339.0 lbs. -On 8/7/21, weight was 343.0 lbs. -On 8/9/21, weight was 343.0 lbs. R48's record lacked evidence of daily weights on 8/10/21, 8/11/21, 8/12/21, and 8/13/21. R48's progress note dated 8/13/21, at 7:39 a.m. included, Resident had a sudden onset of shortness of breath around 4:00 a.m. Resident appeared pale/cyanotic. Resident initially had head of bed elevated, and oxygen increased to 3 liters per minute (LPM). Lung sounds clear/diminished. Vital signs: blood pressure 146/85, Pulse of 90, respirations 28, and oxygen saturations 80%. Resident requested to be placed in a tripod position, fell ow nurse assisted to position, and one on one supervision initiated. Resident refused ambulance services. Symptoms resolved approximately 30 minutes after onset. Resident requested to be put back to bed with head of bed elevated. Every one-hour checks initiated, morning staff notified of incident and sent physician notification. R48's progress note dated 8/13/21, at 10:30 a.m. indicated R48 was transferred to the hospital via ambulance related to shortness of breath and low oxygen saturations. R48's discharge summary dated 8/25/21, indicated primary diagnosis for admission was hypercarbic (increase in carbon dioxide in the bloodstream)respiratory failure and acute on chronic congestive heart failure. The summary indicated between hospital discharge on 7/25/21 and hospital admission on 8/13/21, R48 had an 8.8 lb. weight gain. The summary indicated 1.5 liters of fluid was removed from R48's lungs. The discharge summary included new orders to change diuretic from Lasix to Torsemide and add 2-liter fluid restriction. R48's physician orders between 8/25/21 to 9/13/21 included: -Daily weights, notify physician for weight gain over 2 lbs. in a day OR 5 lbs. in a week (start date 8/25/21) -Fluid Restriction: 2 Liter-Document in progress note with total 24-hour fluids consumed (Start Date 8/25/21) -Torsemide 60 mg one time a day related to heart failure (start date 8/25/21) -Compression Stockings: Donn in a.m. prior to getting out of bed. Remove in evening once in bed (start date 8/25/21) (continued on next page)

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	245359	A. Building B. Wing	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Haven Care Center Inc	210 Northwest 3rd Street Pine Island, MN 55963

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R48's weight record was reviewed from 8/25/21 to 9/13/21; record lacked physician notification in accordance with physician orders until 9/7/21. -On 8/25/21, weight was 303.0 lbs. -On 8/26/21, weight was 308 lbs. -On 8/28/21, weight was 307.2 lbs. -On 9/2/21, weight was 310.0 lbs. -On 9/3/21, weight was 312.6 lbs. -no weight was recorded on 9/4/21 according to physician's orders -On 9/5/21, weight was 315.0 lbs. -On 9/7/21, weight was 315.0 lbs. R48's physician notification dated 9/7/21, indicated R48 had a 13 lb. weight increase since 8/31/21 with no other symptoms. The note indicated R48 had +2 pitting edema to both lower extremities. The note also included, He does have some complaints of shortness of breath with exertion but is able to catch his breath when at rest. Lungs are clear bilaterally anterior and posterior. R48's fluid intake record was reviewed along with nursing progress notes for the 24-hour fluid intake evaluation. Fluid intake was not consistently documented every shift; with the lack of documented intake on the 24-hour fluid intake it could not be calculated/reviewed in accordance to the fluid restriction. R48's record identified between 9 different shift when R48's fluid was not monitored or documented from 8/25/21 to 9/13/21. During an observation and interview on 9/13/21, at 1:43 p.m. R48 sat up in his wheelchair. R48 stated he was in the hospital a couple of weeks ago for fluid overload and they had removed 24 liters of fluid. R48 stated when he got back from the hospital, he weighed 303 lbs. but was back up again to 315 lbs. R48 stated before he went to the hospital, he had been around 330 to 335 lbs. R48 stated he had felt so much better after all the fluid was removed, and thought it had steadily progressing over time, and indicated he would have to pay closer attention to his weight gains. During an interview on 9/15/21, at 8:24 a.m. medical director stated there were clear expectations nursing notify the physician when there was a weight gain in accordance with physician order. Medical director indicated the most objective measurement for fluid volume monitoring is weight gain. Medical director stated nursing needed to be monitoring/evaluating edema for the effectiveness of the treatments and medications. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/21, director of nursing (DON) stated she expected the physician be notified of weight gain in accordance with physician orders. DON stated the expectation of monitoring edema daily and findings documented accurately. DON stated if there was a weight gain, an evaluation needed to be done to determine if the weight gain was related to fluid, the evaluation should include a complete respiratory assessment, resident interview, and assessing for edema in extremities, hips, and abdomen. DON indicated if there was a change the physician needed to be notified. DON stated the episode of shortness of breath should have been documented in its entirety with a complete assessment and passed along in shift report for continual monitoring. R36 R36's face sheet indicated R36 was admitted to the facility on [DATE], with diagnoses of congestive heart failure, chronic kidney disease stage 4, and hyperkalemia. R36's hospital discharge summary dated 7/20/21, indicated R36 was admitted in part related to fluid overload with a primary diagnosis of hyperkalemia (high potassium) and had a history of hospitalization for heart failure exacerbation with the last visit in May 2021. The discharge summary included, would recommend short term rehab to allow for closer monitoring of his weights/fluid status to determine appropriate dosing of diuretic in the outpatient setting. The summary indicated R36's dry weight of 303.6 lbs. The discharge summary also included an order for daily weights with close monitoring. R36's physician orders included: -Daily weights notify physician for weight gain of over 2 lbs. in a day or over 5 lbs. in a week (start date 7/23/21). -Lasix (diuretic medication) 10 mg (milligrams) in the morning for fluid retention's (start date 7/23/21). R36's care plan dated 7/25/21, identified R36's diagnosis of congestive heart failure. Associated interventions included, elevate feet when sitting up in chair to help prevent dependent edema, monitor for signs and symptoms of hypovolemia/hypervolemia [medical condition when you have too little/too much fluid in your body], monitor/document/report to MD as needed the following signs/symptoms: Edema; weight gain of over 2 lbs. a day; neck vein distention; difficulty breathing; increased heart rate; elevated blood pressure; skin temperatures; monitor breath sounds for crackles. R36's physician visit dated 8/27/21, indicated R36's weight was stable on low dose of Lasix; weight was 299. 6 lbs. and on admit on 7/20/21 was 298 lbs. R36's weight record reviewed between 8/27/21 and 9/13/21, identified an increase in weight over 2 lbs. in a day or over 5 lbs in a week; record lacked evidence of physician notification. R36's weights included: -On 8/28/21, weight was 302.2 lbs. -On 8/30/21, weight was 302.8 lbs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 8/31/21, weight was 304.2 lbs. -On 9/3/21, weight was 306.6 lbs. -On 9/4/21, weight was 308.0 lbs. -On 9/6/21, weight was 308.4 lbs. -On 9/7/21, weight was 310.0 lbs. -On 9/9/21, weight was 313.4 lbs. -On 9/11/21, weight was 315.0 lbs. -On 9/12/21, weight was 315.4 lbs. -On 9/13/21, weight was 314.2 lbs. During an observation on 9/13/21, at 3:21 p.m. R36 sat in his wheelchair with his feet down on the floor. R36 was wearing regular cotton socks and was observed to have edema from ankle to just below the knee. R36 stated he had a history of congestive heart failure and had been in the hospital for it. During an observation and interview on 9/14/21, at 8:13 a.m. R36 sat in his recliner with his feet elevated. R36 was observed to have edema in both legs from ankle to just below the knee. R36 stated that he had not slept very well last night, he woke up short of breath and indicated he called for staff to assist him to his recliner. R36 stated the shortness of breath resolved once he was sitting up. R36 stated, according to my doctor the fluid in my legs is making it hard for me to breath. R36's progress note dated 9/14/21, at 3:56 a.m. did not address R36's episode of shortness of breath and indicated R36 did not have edema present. R36's documented oxygen saturations were 90% on room air, which was below R36's average of 93-98%. During an interview on 9/14/21, at 12:05 p.m. licensed practical nurse (LPN)-D was asked, how often do you measure edema, LPN-D stated he had never measured edema while working at this facility, stated he would only measure the edema if the resident had ace wraps or if physical therapy had reported concerns of edema. During an observation and interview on 9/14/21, at 12:11 p.m. LPN-D entered R36's room, R36 was sitting in his wheelchair with his feet down on the floor. LPN-D requested permission to evaluate edema; R36 consented. LPN-D stated R36 had 2+ pitting edema around both right and left ankles and 3+ to 4+ edema from lower shin to just below the knee on both legs. Although, R36's progress note dated 9/14/21, at 12:32 p. m. entered by LPN-D, reflected R36 had No edema present even though LPN-D had evaluated the edema at 12:11 p.m. in the presence of the surveyor. 40553 R44 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	According to R44's electronic health record (EHR) admission record/face sheet included diagnosis of chronic congestive heart failure, cardiomyopathy (damaged heart muscle), high blood pressure, chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs). R44's quarterly Minimum Data Set (MDS) assessment dated [DATE], R44's primary medical condition was considered to be a medically complex condition. R44's physician orders instructed nursing staff to monitor and evaluate R44 for fluid overload and reduce the risk of fluid overload. The following orders included: 2 L (liters) fluid restriction-document total consumed each shift. NOC (night shift) will total every day shift, Document progress note with total 24 hour fluids consumed; Daily weights-->notify provider if >189 lbs in the morning; Document progress note on edema location, pitting edema noted, skin intact (fluid weeping) lung sounds, weight, CNP [certified nurse practitioner] followed up on 8/13/21 and increased torsemide [diuretic]. Edema to BLE [bilateral lower extremities]. Every evening shift until resolved, Wrap legs daily with ACE bandages on in am and off at HS [bedtime]. R44's orders also included medications to control heart, blood pressure and to relieve edema: Metoprolol succinate capsule ER 24 hour sprinkle 25 mg, give 12.5 by mouth in the morning, Spironolactone tablet, give 50 mg by mouth one time a day, Torsemide tablet 20 mg, give 40 mg by mouth two times a day. R44's Torsemide dose had increased on 8/13/21 from 20 mg to 40 mg and increased again on 8/16/21 to be taken twice a day instead of once per day. A review of R44's daily weight was not recorded on 9/3, 9/5, 9/10 or 9/11. On 9/12, 9/13 and 9/14 his weight exceeded 189 pounds. A physician order dated 8/14/21 included instructions for a progress note to be written daily on R44's edema location, pitting edema noted, skin intact (fluid weeping), lung sounds and weight. A review of R44's record for September identified missing progress notes for 9/9/21-9/11/21 no note related to edema, weight, or lung sounds 9/12/21-weight was taken after lunch. Will reweight [sic] tomorrow and reassess. Resident is asymptomatic. No additional information related to edema or lung sounds. 9/13/21-no note related to edema, weight, or lung sounds (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	9/14/21 at 3:42 p.m. assessment conducted: resident is alert and oriented x3, oxygen levels 92-93% on 1 L, wheezing auscultated bilaterally, 4+ edema of R and L extremities. Weight for today 190.2 lb. Nurse manger notified of change in weight, ACE wrap applied, resident left building for scheduled appointment. On 9/14/21, at 8:19 a.m. R44 was observed lying in bed in his room, resting. His facial appearance and limbs was red and flushed. A one liter jug of ice water was noted to be sitting at his bedside. An oxygen concentrator was beside the bed and was running, but R44 did not have a nasal cannula in his nose. On 9/14/21, at 8:43 a.m. R44 was observed sitting on the side of his bed. His legs were bare and swollen from the knees down. R44 had difficulty speaking, but was able to communicate through short phrases, gestures, some writing and answering yes, no questions. He indicated he had noticed his legs were swollen and gestured to show they were getting bigger. He also tapped on his abdomen. He indicated his legs should be wrapped. His hands were slightly swollen and he held them up to be seen. On 9/14/21, 12:03 p.m. R44 was observed to be lying in bed with his legs bare. Registered nurse (RN)-C entered the room with two elastic compression wraps and informed R44 he should have his legs wrapped before going out for the day. RN-C started wrapping R44's right leg at the toes and performed a figure eight wrap. He asked, do you like it tight? No, just a little loose? After reaching R44's knee, there was a considerable amount of wrap still on the roll, so RN-C proceeded to wrap the leg back down to the ankle. Following the right leg, RN-C wrapped the left leg in the same manner. RN-C stated the wraps were too long, and that he should have gone to find different wraps; however, RN-C did not go find any other wrap. At 9/14/21, 12:15 p.m. R44 indicated he had not been weighed. RN-C stated R44 was to be weighed every day. RN-C called to a passing nursing assistant (NA-F) who said R44 had not been weighed. Another nursing assistant, NA-C stated daily weights were to be done every morning as soon as possible, before eating and confirmed that R44 had not yet been weighed for unknown reasons. NA-C weighed R44 and reported a weight of 195 lbs. During an interview on 9/14/21 at 12:17p.m. RN-C confirmed that R44 had an order to monitor edema. He stated the best way to assess edema was to squeeze the feet and watch how much indent would occur and confirmed he had not done this but would do it later. RN-C noted R44's weight should be re-checked because it was more than the day before. RN-C confirmed he had been working the day before and had documented a weight of 191.6, but had not called the medical provider, stating he had not seen the order to call the provider for a weight greater than 189 lbs. RN-C stated an increase in weight and edema indicated a possible fluid overload. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	According to an interview 9/14/21, 12:42 p.m. the nurse manager for the unit, RN-D, said a daily weight was to be done before breakfast, and edema monitoring and compression wraps should also be done early in the morning. Edema monitoring, RN-D confirmed, should be accomplished prior to the application of the compression wraps. RN-D stated a nurse should find a shorter set of compression wraps if the ones they had were too long. RN-D said a nurse should notify medical providers when a resident has a change in condition or when an order was left for notifications to be done. The expectation for notification method would be to write out an SBAR (situation, baseline, assessment, result/request) form and send it to the provider immediately, but any nurse should also be able to call a provider with a report. RN-D was not aware of any guidelines saying it must be the nurse manger to call. RN-D confirmed that R44 had an order for a daily weight to be done, but upon review of his EHR stated, it has not been done daily. RN-D stated an expectation of nurses to document on R44's condition in a daily progress note as outlined in his orders with lung sounds, edema, changes in weight, but confirmed that this information was not done daily, saying, it looks like there is no documentation since the 12th. According to an interview 9/14/21, 12:57 p.m. with the director of nursing (DON) the DON stated an expectation that daily weights be done at the same time each day, preferably right away upon rising before breakfast. DON also stated an expectation for compression wraps to be applied before getting up for the day. In relation to monitoring edema, DON stated some physicians like to have edema checked later in the day, such as in the afternoon, to see if the condition progresses when the resident is up, but in general, edema monitoring should be done in the morning prior to the application of the compression wraps. DON said that when monitoring a resident for problems with fluid excess it was expected that nurses would do daily weights, monitor lung sounds, vital signs and sometimes abdominal girth if ordered. DON stated any orders should be initialed as being completed in the treatment administration record (TAR), but a progress note should be written as well. During an interview 9/15/21, 8:46 a.m. with the facility medical director (MD-A), he stated he was watching R44's condition closely as he had a perplexing presentation, their interventions had not been fully successful and R44's clinical trajectory continues to decline. MD-A stated unchecked fluid intake would be problematic, although he was currently stable. The primary concern for R44, according to MD-A was an exacerbation of his heart failure. A request was made of the facility for a policy on fluid/edema management and monitoring, but this was not provided. The Heart Failure-Clinical Protocol policy revised November 2018 covered only expectations of physicians and did not address nursing care.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 40553 Based on interviews and document review, facility failed to ensure that 1 of 1 resident (R24) was offered regular vision appointments with a specialist for her failing eyesight. Findings include: According to the electronic health record (EHR) Admission Sheet/face sheet, R24 had a diagnosis of macular degeneration (loss of central vision). According to a physician's note dated 4/25/2019, R24 had severe glaucoma in both eyes and macular degeneration in both eyes. An annual minimum data set (MDS) assessment 7/9/2021 indicated R24 was cognitively intact with no memory problems. A facility Long Term Care Evaluation dated 6/30/21 done to inform the MDS did not include any information about R24's current visual status. According to R24's care plan, a focus problem area (not dated) indicated R24 was at risk for further decreased/impaired vision related to macular degeneration, glaucoma, generalized aging. Sees shadows and shapes with current glasses. An associated intervention (not dated) indicated an offer is made periodically and PRN to set up an eye exam consultation for resident to ensure appropriate meds and compensatory mechanisms are provided. During an interview 9/13/21, 3:12 p.m. R24 stated she had major vision issues and was mostly blind. She stated she could barely make out the red and white checked blanket on her walker approximately two feet away, and all she could see beyond that was what she thought might be a curtain, but she was not sure. To her left, about four feet away was a bare wall and she stated she thought it was just blank bricks or maybe there was a curtain, but she could not tell. She was unable to see the wall to her left which was about 8 feet away. R24 said she was concerned that she had not been to see the eye specialist for some time, and although she knew her vision could not be improved, she felt it was important to have her medications reviewed so as to maintain what little vision she had. R24 stated she had four children but was concerned that her family was unable to assist with making any appointment or assisting her to an appointment. She did not recall being offered any vision appointments. According to an interview on 9/15/21, 10:37 a.m. a registered nurse (RN-D) managing the unit stated the facility had recently had in-house ophthalmology services for the residents, but RN-D was unable to find record that services had been offered to R24 and confirmed she had not been seen. RN-D stated such services should be offered at quarterly care conferences but was unable to find record that such services had been offered to or declined by R24. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an interview 9/15/21, 11:46 a.m. the licensed social worker (LSW) stated the facility should offer any medical follow-up visits as needed. LSW also said R24 was known to be concerned about her family and their ability to provide assistance to her, as she had always been the caregiver of their family. Because of this, LSW said, R24 would not ask her family for any help with appointments. LSW did not know if R24 had regular appointments set up to evaluate her vision problems but stated this should be offered at quarterly care conferences. LSW was unable to find documentation indicating any such services had been offered to or declined by R24. LSW stated that given R24's significant vision loss she should see a vision specialist. On 9/16/21, 8:30 a.m. the director of nursing (DON) confirmed that the EHR did not contain recent documentation by nursing staff of R24's current visual status. DON stated she was unable to find any documentation that R24 was offered an appointment with the eye doctor. DON stated an expectation that vision, hearing and dental visits be offered at every care conference and as needed, and stated this offer and the resident response should be documented. DON stated if the information was not documented, one could not assume that it had been done. A request was made for a facility policy related to arranging medical appointments for residents. The facility provided a policy related to transporting to residents, but the information did not apply.

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F 0686 Level of Harm - 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** 34985 Based on observation, interview, and document review the facility failed to comprehensively assess risk for pressure ulcers, and develop and implement interventions to prevent pressure ulcer injuries for 1 of 2 residents (R175). The facility's failures resulted in harm when R175 developed a stage 2 pressure ulcer and a deep tissue pressure ulcer. In addition, the facility failed to complete comprehensive assessments for pressure ulcers and failed to follow physician orders for 1 of 4 residents (R61) reviewed for pressure ulcers. Findings include R175's face sheet dated 9/16/21, included diagnoses of dementia with behavioral disturbance and congestive heart failure. R175's significant change minimum data set (MDS) assessment dated [DATE], indicated R175 had severe cognitive impairment. The MDS identified R175 required extensive assistance from two or more staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated R175 was occasionally incontinent of urine and bowel. The MDS identified R175 was at risk for pressure ulcers and did not have pressure ulcers or moisture associated skin damage at the time of the assessment. The MDS indicated pressure reducing device for chair was not used for chair however a pressure reducing device was used for bed and identified R175 did not have a turning and repositioning program. R175's record lacked a comprehensive assessment for risk of skin breakdown after R175 became dependent on staff for mobility. R175's care plan did not identify the level of assistance in accordance with the MDS. R175's toileting care plan dated 9/1/20, directed staff to toilet R175 upon rising, after breakfast, before and [after] all other meals, at bedtime, on night rounds, and as needed. R175's skin care plan dated 10/17/2019, indicated R175 has the potential for pressure ulcer development r/t [related to] immobility. [R175] has thin, fragile skin prone to bruising, skin tears, and age related petechiae (pinpoint, round spots that appear on the skin as a result of bleeding). Associated interventions included follow facility policies/protocols for the prevention of skin breakdown R175's Skin Only Evaluation dated 9/10/21, at 11:44 p.m. indicated skin warm and dry, normal color, turgor normal, and had a skin tag on right upper abdomen. During an observation on 9/13/21, at 7:40 p.m. R175 laid on her back in bed. R175's room smelled of urine. RN-H and nursing assistant (NA)-H were at bedside encouraging R175 to roll over to allow them to change her saturated incontinent garment. R175's mattress protectors was observed to also be urine soaked. R175's behavior progress note dated 9/13/21, at 10:41 p.m. included tonight nurse and nursing assistant got R175 out of bed. Pain medication was offered at the beginning of the process, she did not understand. It was attempted to roll R175 she yelled out in pain and started hitting. The morphine was given and more communication about the process was provided. After several attempts to motivate the patient we rolled her on her side, washed and laid new pads down. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 9/14/21, at 7:00 a.m. R175 sat in her wheelchair in a hospital gown. At 7:50 a.m. licensed practical nurse (LPN)-D stated R175 had been in the wheelchair all night because she had been restless, stated an unawareness of the last time R175 had been toileted or changed. During an observation on 9/14/21, at 8:50 a.m. R175 was given her breakfast tray. At 9:27 a.m. R175 continued to sit in her wheelchair by the nursing station with her breakfast in front of her. During an observation and interview on 9/14/21, at 12:04 p.m. R175 continued to sit in her wheelchair by the nursing station. Licensed practical nurse (LPN)-D stated R175 had been sitting there since he got there this morning, and stated he was not aware if NAs had checked her incontinent brief or repositioned her. LPN-D stated R175 had nodded off for an hour maybe two in her chair. During an observation on 9/14/21, at 12:20 p.m. R175 remained by the nursing station. At 12:32 NA-A asked LPN-D how R175 transferred. LPN-D stated an unawareness and stated he would call therapy. NA-A was asked when R175 had last been toileted, NA-A stated the last time was between 6:00 a.m. and 7:00 a.m. when she assisted the night shift aide. At 12:49 p.m. R175 was transferred via full body mechanical lift to her bed by NA-A and NA-B. When NAs removed R175's incontinent garment, it was observed to be heavily saturated with urine. When R175 rolled onto her right side, a dark purple/blue area with a small wound that was bleeding was observed on her lower left buttock and small reddened area was observed on her right lower buttock. NA-A exited the room to get registered nurse (RN)-D. RN-D entered the room, RN-D observed the impaired skin integrity, and indicated R175 had a stage 1 pressure ulcer to the right buttock and the left buttock wound was a stage 2 and would have to do further evaluation if the wound was a deep tissue injury. RN-D stated the left buttock had more redness than the right and appeared irritated. R175 was very cooperative with RN-D during the assessment and with application of new brief. During an interview on 9/14/21, at 3:38 p.m. RN-D stated the wound on her left buttock was a deep tissue injury, with an open stage 2 pressure injury. RN-D stated she had conversed with family member who thought that R175 had a history of a pressure ulcer to the same area. RN-D stated within the last several weeks R175 had an increased need to for assistance; she used to be independent with bed mobility and positioning herself. RN-D reviewed R175's care plan and verified the care plan was not consistent with the level of care R175 required and the MDS assessment. RN-D confirmed the care plan did not identify how often R175 needed to be turned and repositioned and an assessment to determine tissue response to pressure over time had not been completed after R175's change in condition. RN-D stated the nurse should have questioned/prompted or directed NAs to reposition R175 if there was a question of how long R175 was sitting in her chair next to the nursing desk. RN-D stated if R175 was refusing care then, it was expected the NA's reattempt or get someone else to attempt, report to the nurse on the floor, nurse should then attempt and notify the charge nurse of continued refusals. RN-D indicated, if necessary, the physician should be contacted for further medical management if interventions were unsuccessful. RN-D stated the refusals with interventions and the effectiveness of the interventions needed to be documented. R175's progress note dated 9/14/21, 9:24 p.m. identified R175 had left buttock stage 2 deep tissue injury 2 centimeters (cm) x 0.9 cm. Injury is purple/blue in color, small tear which had fresh red blood around the edges, less than 0.5 cm in diameter of fresh red blood in center of injury. The evaluation indicated dietary would be consulted, and care plan revised to include repositioning schedule and behavior plan for increased need in cares including barrier cream and hydrating lotion for dry skin for comfort. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/21, at 8:24 a.m. medical director stated a familiarity with R175 and indicated R175 had worsening heart failure and advancing dementia; goals of care were conservative. Medical director indicated an awareness of R175's behaviors of rejection/refusals of medications and compression management for edema, however, was not aware of rejection/refusals for repositioning/toileting. Medical director indicated an expectation of routine skin assessments and a repositioning plan be in place for the prevention of pressure ulcers. Medical director stated if a resident demonstrated self-neglecting behaviors the physician (or hospice) needed to be notified; residents can't sit in their own urine, it would need further evaluation. When asked if the duration of time R175 sat in her wheelchair without positioning or changing incontinent brief contributed to the pressure ulcers, medical director stated Yes, that would be the definition of a pressure ulcer. During an interview on 9/15/21, at 11:34 a.m. director of nursing (DON) indicated R175 should have been assessed for a turning and repositioning program after her mobility declined. DON stated the expectation residents were toileted in accordance with their care plan. DON stated if residents refused, the expectation was the nurse be notified, and ultimately the physician if necessary for further medical intervention. R61 R61's hospital discharge summary dated 8/11/21, indicated R61 had a left buttock stage 2 pressure ulcer that had been identified on 7/16/21; plan for treatment included cleanse skin with wound cleanser, pat dry, and cover with foam boarder dressing, change dressing daily and as needed. The discharge summary also identified an unstageable pressure ulcer on a leg with orders for wound care. R61's Admission skin assessment dated [DATE], did not identify presence of pressure ulcers. The note indicated resident refused with no further information or interventions for refusal. R61's physician order dated 8/11/21, identified the left buttock pressure ulcer as outlined by the hospital discharge summary, however had a stop date of 9/2/21. R61's physician order dated 8/11/21 included: Leg Pressure Injury Treatment: Cleanse affected area daily with normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (soft black eschar), cover with mepilex border (sacral or large size). R61's physician order dated 8/14/21 included: Daily skin monitoring. If changes, document in skin alterations and wounds progress note. Wound: pressure injury to left lower extremity-unstageable, left buttock pressure stage 2. R61's record identified the left lower extremity pressure ulcer was not comprehensively assessed until 8/16/21, even though there were physician orders upon admission. In addition, the record lacked evidence R61's left buttock pressure ulcer had not been comprehensively assessed after facility admission, even though there was a physician ordered treatment for the wound upon admission and an order that directed both pressure ulcers be monitored daily. R61's skin evaluation dated 8/16/21, indicated R61 had an unstageable pressure ulcer on the left lower extremity (location on extremity was not identified) that measured 1.5 cm (centimeters) x 0.9 cm. The skin evaluation did not identify the presence of a stage 2 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R61's admission Minimum Data Set (MDS) assessment dated [DATE], identified R61 had one stage 2 pressure ulcer and one unstageable pressure ulcer. R61's skin evaluation dated 8/23/21 and 8/31/21, did not identify the stage 2 pressure ulcer. R61's record did not indicate why the physician ordered treatment to the left buttock was discontinued on 9/2/21. R61's skin evaluations dated 9/7/21 and 9/8/21, did not identify the left buttock pressure ulcer. R61's physician order dated 9/13/21, included, Leg Buttocks Pressure Injury Treatment: Cleanse affected area daily with normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover with mepilex border (sacral or large size). During an interview on 9/14/21, at 9:15 a.m. licensed practical nurse (LPN)-D indicated R61 only had one wound treatment to complete; the unstageable ulcer on the left calf. During an observation on 9/14/21, at 9:21 a.m. licensed practical nurse (LPN)-D explained to R61 he was going to complete the dressing change on his left calf; R61 gave consent. LPN-D donned gloves, removed the dressing, disposed of the dressing, then removed gloves. LPN-D then used a pen to write the date on the new dressing and donned new gloves without performing hand hygiene. LPN-D completed the dressing change per physician orders, removed gloves, and washed hands. During an interview on 9/14/21, at 9:26 a.m. LPN-D stated he should have done hand hygiene between glove changes. During an observation on 9/15/21, at 1:16 p.m. RN-B explained to R61 he was going to change the dressings on his left calf and left buttock; R61 gave consent. RN-B washed his hands and donned gloves, RN-B then removed R61's wound dressing from the left calf and through the dressings on the floor. RN-B then removed the cap from the saline bottle, put the ointments for the wound in the cap, opened a tongue depressor, and stirred the ointments together. RN-B then removed scissors from his left pocket and cut the non-stick dressing to the size of the wound. RN-B then used a Q-tip to spread the mixture of ointments onto the wound and applied the cover dressings. RN-B had the same gloves on throughout the procedure, in addition RN-B had not disinfected the scissors prior to or after the completion of the dressing change. RN-B then picked up the soiled dressings from the floor, took off gloves, and sanitized his hands. RN-B then informed R61 of the next dressing change on his left buttock. RN-B donned gloves and undid R61's incontinent brief, R61 was incontinent of stool, RN-B performed incontinent care (a dressing was not observed on R61's left buttock where there was a nickel sized superficial wound that was reddened), used an incontinent wipe to clean his gloves, walked to the bathroom and donned another pair of gloves (without disinfecting) over the gloves he already had on and applied the left buttock dressing per physician order. During an interview on 9/15/21, at 2:13 p.m. RN-B confirmed there was not a dressing to the buttock wound and there should have been, RN-B stated if the wound had been resolved it's not anymore. RN-B stated he should have changed his gloves and performed hand hygiene after taking off the old dressing. RN-B stated an unawareness if double gloving was appropriate for the procedure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/16/21, at 11:44 p.m. director of nursing (DON) stated an expectation that pressure ulcers were comprehensively assessed upon admission, weekly thereafter and as need, should be monitored for improvement or worsening daily with dressing changes. DON stated the expectation dressings were applied according to physician order. DON indicated appropriate hand hygiene was expected during dressing changes, gloves should be removed after dressing and removal and cleansing the wound, hand hygiene should be performed after each glove change. DON stated soiled dressings need to go into a garbage can and not on the floor, and scissors should be disinfected prior to using on a clean dressing. Facility policy Pressure Injury Risk assessment dated ,d+[DATE], included 1) The purpose of pressure injury risk assessment is to identify all risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. 2) Risk factors that increase a resident's susceptibility to develop or to not heal PU's include b) impaired/decreased mobility and decreased functional ability, the presence of previously healed PU, exposure to urinary and fecal incontinence or other source of moisture, altered skin status over pressure points, and cognitive impairment 6) once the assessment is conducted and risk factors are identified and characterized, a resident centered care plan can be created to address the modifiable risks for pressure injuries. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 4/2018, did not identify frequency of monitoring or completing comprehensive wound assessments. The protocol indicated a skin examine would be completed upon admission

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on observation, interview, and document review the facility failed to ensure appropriate management and services of an indwelling catheter that included; failed to obtain physician order for size and type of indwelling urinary catheter, failed to consistently document urinary output, failed to evaluate urinary output for potential complications, and failed to ensure documentation of routine catheter care, for 1 of 1 resident (R61) who had a recent hospitalization related to catheter infection. Findings include: During an observation on 9/13/21, at 2:55 p.m. R61 laid in bed, R61 was observed to have a urine collection bag secured to the right side of his bed. R61 stated he had been recently hospitalized because of a bad urinary tract infection from his catheter being mismanaged at another facility. R61's face sheet dated 9/16/21, identified R61 was admitted to the facility on [DATE], with diagnoses that included urinary tract infection, sepsis, acute renal failure, and urinary retention. R61's hospital discharge summary dated 8/11/21, the section Lines/Drains/Airways/Wounds included Indwelling Urinary Catheter Latex; Coude [curved type] 16 Fr [French]. The summary did not identify the size of the catheter balloon (balloon to hold catheter inside the bladder) R61's admission Minimum Data Set (MDS) dated [DATE], indicated R61 had an indwelling urinary catheter. R61's catheter care plan dated 8/11/21, indicated R61 had altered urinary elimination related to indwelling catheter due to prostate problems, history of urinary tract infection and scrotal swelling. The care plan did not identify the size and type of catheter R61 required. The care plan directed staff to complete catheter care per facility policy, empty urinary drainage bag every shift and as needed, record urine output every shift, and change catheter bag and catheter per physician order. R61's current physician orders did not identify an order for an indwelling catheter. The physician order dated 8/15/21, directed staff to change R61's catheter every 30 days. R61's physician order dated 8/11/21, indicated Flush foley catheter for decrease urine output, suspected obstruction as needed. R61's treatment administration record indicated R61's catheter was changed on 8/30/21. R61's progress note dated 8/30/21, identified the wrong type of catheter was inserted according to the hospital discharge summary. Progress note on 8/30/21, at 2:15 p.m. included Resident had monthly foley catheter change. 16F catheter inserted with 10cc [cubic centimeter] of sterile fluid for balloon. Resident tolerated catheter change with no c/o [complaints] of pain (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's recorded output documentation was reviewed between 8/24/21 through 9/14/21 in conjunction with nursing progress notes; the record identified urine output was not recorded every shift and/or recorded values were lower than R61's average the record lacked evaluation for catheter associated complications such as obstruction or symptoms of acute renal failure. -R61's record identified 10 instances or shifts where urine output was not recorded: on 8/24/21, 8/28/21, 8/29/21, 8/31/21, 9/1/21, 9/2/21, 9/6/21, 9/9/21, 9/11/21, and 9/13/21. -R61'2 record identified average overnight urinary output was 497 milliliters (ml), R61's record indicated decreased urine output: on 9/5/21 for night shift 100 ml, on 9/7/21 night shift 150 ml, and on 9/14/21 output was 100 ml for night shift. R61's record lacked evidence catheter care was provided in accordance with the care plan and facility policy. During an interview on 9/15/21, at 7:05 a.m. registered nurse (RN)-B was asked what size and type of catheter did R61 have? RN-B stated an unawareness of size and type of catheter, RN-B reviewed R61's physician orders and care plan and stated there was not a physician order for the indwelling urinary catheter, nor was the information in the R61's care plan. RN-B stated there had to be a physician order for the catheter that included the size and type of catheter and balloon size. When asked about R61's urinary output, RN-B stated urinary output was not recorded and stated an unawareness that urinary output was recorded in the record. RN-B was informed by an unidentified nursing assistant (NAs) recorded the output in the electronic medical record. RN-B then indicated that there was not enough time to go through and assess the amounts and there was a lot of other nursing tasks to complete. During an interview on 9/15/21, at 10:29 a.m. RN-B indicated he had checked R61's catheter, the size that was printed on the catheter was 16 Fr (French), however, the print did not identify the type. During an interview on 9/16/21, at 7:52 a.m. licensed practical nurse (LPN)-A reviewed R61's record and confirmed there was not an order for size and type of catheter R61 required. LPN-A stated she would have to call the physician to get an order. At 8:38 a.m. LPN-A observed R61's catheter and stated the print on the catheter indicated the size as 16 Fr, however, did not identify the type or balloon size. LPN-A indicated there was not a way to tell if R61 had the correct catheter in place. LPN-A stated she would not have changed the catheter without a physician order, stated she would also document in a progress note the catheter had been changed and if there were any complications, and how the resident tolerated the procedure. LPN-A stated that if there was a decrease in urine output, she would go check the catheter to make sure it was draining appropriately, if resident had decreased intake, would look for signs and symptoms of infection or acute renal failure. LPN-A stated she would document she completed an evaluation on the decrease and what she had done for interventions. LPN-A stated nursing assistants should be doing catheter care twice a day, morning, and evening cares. LPN-A reviewed R61's record and stated the record does not have documentation catheter cares have been completed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/21, at 11:44 a.m. director of nursing (DON) stated a catheter required a physician's order that identified the size and type of catheter and balloon size and there should have been an order obtained prior to changing the catheter. DON indicated the catheter should not have been changed without of physician order. DON stated urinary output needed to be documented every shift and amounts evaluated for possible issues related to the catheter, and the evaluation should be documented. DON stated catheter care should be completed at least twice per day and incontinent episodes. DON stated the catheter should be monitored to make sure urine is patent and draining. DON verified the lack of physician order for catheter, evidence of catheter care was provided, lack of every shift recorded output and evaluation when there was a decreased output. Facility policy Foley Catheter Insertion, Male Resident included 1) Verify there is a physician's order for this procedure. A facility policy/protocol was requested for indwelling catheter care and management and was not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40553 Based on observations, interview and document review, facility failed to ensure that respiratory equipment was maintained in a sanitary manner for 3 of 4 residents (R6, R54 and R64) reviewed for aerosolized medications and oxygen use and failed to ensure clear and accurate orders for oxygen administration for 1 of 3 residents (R44) also reviewed for oxygen use. Findings include: According to the electronic health record (EHR) Admission Record/face sheet, R6 had diagnoses of shortness of breath, acute on chronic diastolic (congestive) heart failure, chronic combined systolic (congestive) and diastolic heart failure, acute and chronic respiratory failure with hypoxia and with hypercapnia, as well as a diagnosis of chronic obstructive pulmonary disease and asthma. According to a physician's order dated 6/3/2021, R6 was able to self-administer nebulized medications and inhalers after set-up by a nurse. Physician orders also included an order for Budesonide Suspension 1mg/2mL (a steroid to reduce respiratory inflammation), inhale orally in the evening and in the morning. Additionally, R6 had a physician order for Ipratropium-albuterol solution (to open pulmonary airways) 0.5-2.5 (3)mg/3mL, inhale four times a day. R6's care plan in the EHR had a focus problem area (not dated) that indicated R6 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean. On 9/13/21, 6:53 p.m. R6 was observed to pick up the medication cup and mouthpiece for medication aerosolization that had been lying on the bedside stand and attached to her nebulization machine by tubing. The cup did not appear to be clean as it had some signs of moisture inside the container. R6 opened the cup and poured in a solution from a plastic vial. She stated the nurse had given her the medication to self-administer, and she had been okayed to self-administer any aerosolized medication. The nurse was not in the room. R6 confirmed that she had not cleaned the cup and did not know if any staff had cleaned the equipment since she had last had her treatment. No nurse was present in the room when R6 poured the solution into the cup and started the machine. On 9/15/21, 8:40 a.m. R6's nebulizer medication cup with mouthpiece attached were observed to be laying inside R6's bedside stand drawer on top of various personal items such as old letters, lotion bottles, etc. The cup was attached to tubing that extended up out of the drawer and was attached to the nebulization machine. R6 said she had not used the equipment since the evening before and stated she had not observed anyone coming into her room to clean the equipment. She confirmed that she had placed the cup inside her drawer after using it so it would not fall on the floor. R54 According to R54's EHR Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse. R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could self-administer medications; however, the care plan failed to indicate who was responsible for keeping the equipment clean. On 9/13/21, 4:51 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to the face mask for administration and connected to the nebulization machine by tubing. The cup and mask were laying on the counter beside the machine. R54 was not sure if staff cleaned the equipment and could not confirm it had been cleaned that day. The mask looked visually soiled with many specks and smudges on the inner portion of the mask, the cup had moisture droplets. On 9/14/21, 2:20 p.m. R54's medication cup for aerosolization of medication was observed to remain connected to a face mask that appeared soiled, and to tubing connected to R54's nebulization machine. An empty medication vial was sitting next to and behind the nebulizer. The cup and mask were laying on their side on the counter. R54 stated she was able to self-administer medications and she had last used the machine around noon. R54 confirmed the medication cup and mask had not been cleaned. An unopened container of respiratory medication for aerosolization was laying on the counter as well, and R54 stated the nurse left it so she could take it whenever she got short of breath, and she would not have to call the nurse. R54 confirmed she did not need the medication at that time. According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) stated that when a resident was done with a nebulization treatment the nurse should return and clean the medication cub and the mouthpiece or facemask. RN-C confirmed he had not returned to R54's room to clean the equipment. A review of R54's medication administration record (MAR) indicated RN-C had provided R54 her last dose of aerosolized solution at noon. During an interview 9/14/21, 3:48 p.m. a licensed practical nurse (LPN-C) stated a nurse is responsible to keep the nebulization equipment clean even if a resident self-administers medication. LPN-C said the cup and mouthpiece, or facemask should be detached from the tubing and then washed. LPN-C said the med cup and mouthpiece/mask should then be left to dry on a fresh towel after every use. On 9/15/21, 8:35 a.m. R54's nebulizing machine remained on the counter at her side with the tubing connected to a medication cup and face mask which were laying on their side. A small white crusty area of dried solution was observed directly under the medication cup, on the counter. A review of R54's MAR at that time indicated no nebulization treatment had yet been given that morning. This was confirmed by R54. The last documented dose of any medication that would be given using the nebulizing equipment was at 10:00 p. m. on 9/14/21. According to an interview 9/15/21, 10:28 a.m. RN-D, unit manager said the mouthpiece or face mask and medication cup should be detached from the nebulizer after treatment, rinsed off and then set out to dry. This was to be done as soon as nebulization was complete. RN-D said a resident could turn on the call-light to let the nurse know they had finished their treatment, or the nurse should return to the room as soon as possible after the treatment was likely to be completed. R44 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the EHR R44's admission record/face sheet, R44 had been admitted to the facility with a primary diagnosis of chronic combined systolic (congestive) and diastolic (congestive) heart failure in which the heart is no longer able to sufficiently circulate blood to meet the bodies need, and with a component of fluid overload. R44 also had significant pulmonary dysfunction with a diagnosis of chronic obstructive pulmonary disease, shortness of breath, a dependence on supplemental oxygen and a history of pleural effusion (fluid in lungs) among many other co-morbidities. According to a quaterly Minimum Data Set (MDS) assessment dated [DATE], R44's primary medical condition was considered to be a medically complex condition. R44 had a physician's order dated 7/29/21 indicating supplemental oxygen to maintain oxygen saturations >90%; document in progress note: LPM (liters per minute) and O2 saturations with and without every shift. A review of R44's treatment administration record (TAR) for 9/01/21 through 9/14/21 showed nurses had signed each shift acknowledging the order, but not further documentation of oxygen saturations or rate of oxygen flow was seen in the TAR. A review of R44's progress notes from 9/01/21 through 9/14/21 failed to show daily shift nurse documentation on this same information, and in fact, contained such notes only on 9/4/21 12:56 p.m. and on 9/14/21, 3:42 p.m. On 9/14/21, 8:55 a.m. R44 was observed resting in his bed and had oxygen running at 1.5 lpm via nasal cannula. R44 shrugged when asked about his oxygen, but then wrote a note indicating he thought his O2 order was for 1.1 LPM (the oxygen concentrator did not have increments to allow 1.1 LPM) According to an interview 9/14/21, 3:50 p.m. LPN-C stated R44 does not use his oxygen all the time. LPN-C stated she did not remember R44 having an oxygen saturation lower than 90% when she was working but stated she had seen him using his oxygen. LPN-C said they should document his oxygen saturation and the amount of oxygen he was using each shift. LPN-C confirmed the order did not say how many liters of oxygen per minute to apply, but thought 2 LPM was pretty normal, but it doesn't stay that in the order. LPN-C thought the facility had a standing order to start residents on 2 LPM if they needed oxygen but was unable to find this order. LPN-C stated that if R44 had an oxygen saturation level less than 90% she would start oxygen at 2 LPM and then titrate it down until he was stable and maintained his saturations greater than 90%. LPN-C also indicated they should keep the equipment clean but confirmed there was no order to change R44's tubing. LPN-C did not know when R44's oxygen tubing or nasal canula had been changed. According to an interview 9/15/21, 10:33 a.m. RN-D stated it was the expectation to check a resident's oxygen saturation levels each shift if they required oxygen use. RN-D said if a physician's order said to keep a resident's saturations above a certain percent, the nurse should use between 1 LPM and 5 LPM using a nasal cannula. RN-D said the 1-5 LPM recommendation it's in my brain somehow, let me check on that for the procedure. RN-D stated she thought an LPN could make the decision on what level of oxygen to start a resident on, but they should alert an RN to do an assessment as well. RN-D said if a resident's oxygen order was not clear, a nurse should call the provider to get a new order. (continued on next page)

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	245359	A. Building B. Wing	09/16/2021

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated an expectation for nurses to clean the medication nebulization equipment after a dose was provided. DON said the medication cup could contain residual medication and/or condensation and this must be promptly cleaned. DON said the cup chambers and the face mask/mouthpiece should be cleaned and then inverted onto a clean dry paper towel. DON also stated this was not a resident's responsibility, and although a resident may choose to clean the equipment, it really should be done by a nurse. DON also said an LPN cannot make the decision as to what level of oxygen a resident should be started on, and it is not within an LPN scope of practice to titrate. DON said an order for oxygen should clearly state the amount of oxygen to be provided in LPM. In an emergency, DON said nurses could follow the facility policy to initiate oxygen, but then they should seek out an order for on-going administration. Oxygen orders should also include instructions for cleaning and changing equipment such as tubing. The Administering Medications through a Small Volume (handheld) nebulizer policy revised October 2010 provided the following directions related to cleaning the equipment: Rinse and disinfect the nebulizer equipment according to facility protocol, or (a) wash pieced with warm soapy water; (b) rinse with hot water; (c) place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for 5 minutes;(d) rinse all pieces with sterile water (NOT tap, bottled or distilled); and (e) allow to air dry on a paper towel. The policy indicated, when equipment is completely dry, store in a plastic bag . The Oxygen Administration policy revised October 2010, indicated a nurse should first verify there is a physician's order for oxygen administration. The document included the following directions, turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liter per minute. Required documentation listed: date and time, rate of oxygen flow, route and rationale, frequency, and duration of the treatment. Documentation was also to include reason for the administration, any assessment data obtained before, during and after the procedure. The policy did not provide information about care of the oxygen equipment for those who require the on-going use of such equipment. 44645 R64 Oxygen Use R64's admission MDS dated [DATE], indicated R64's cognition was intact. R64 required extensive physical assistance from staff for all activities of daily living (ADLs) and received oxygen therapy. R64's face sheet printed 9/16/21, indicated R64's diagnoses included obstructive sleep apnea, degenerative disease of the nervous system, type 2 diabetes mellitus, and chronic kidney disease. R64's physician orders indicated an order dated 8/12/21, for Oxygen 1 liter every evening and night shift. On HS (bedtime) and off in AM for sleep apnea. R64's care plan, printed 9/16/21, did not indicate interventions related to oxygen. Additionally, R64's care plan did not indicate interventions related to sleep apnea. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's September 2021, Electronic Treatment Administration Record (ETAR) printed 9/16/21, indicated R64's oxygen had been placed on every HS (bedtime) and off every AM from 9/1/21 through 9/15/21. Additionally, R64's ETAR indicated a start date of 9/20/21, to change and date oxygen tubing every Monday evening. The record lacked documentation indicating the oxygen tubing had been changed prior to 9/16/21. On 9/14/21, at 8:31 a.m. R64's oxygen tubing with nasal cannula was observed on the floor, under a chair in R64's room. On 9/15/21, at 7:48 a.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. On 9/15/21, at 12:55 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. On 9/15/21, at 3:25 p.m. R64's oxygen tubing with nasal cannula was observed on the floor in the same location, under a chair in R64's room. During an interview on 9/15/21, at 3:42 p.m. licensed practical nurse (LPN)-F confirmed R64's oxygen tubing with nasal cannula was on the floor, under a chair in R64's room. LPN-F stated, That's not good, that should not be on the floor. LPN-F picked up the tubing, removed it from the oxygen concentrator and stated that he would replace it with a new nasal cannula and new tubing. When LPN-F was asked why the nasal cannula should not be on the floor, LPN-F stated, because of infection control. When LPN-F was asked what should have been done with the tubing when not in use, he stated the tubing should have been placed on the hook located above the oxygen concentrator, not on the floor. During an interview on 9/16/21, at 2:07 p.m. the Infection Preventionist (LPN)-E stated when oxygen was not in use, the tubing should have been wrapped up and placed on the oxygen concentrator, not on the floor or bed. Additionally, LPN-E stated that if the nasal cannula had been used after it had been on the floor, it could cause infection, staph, MRSA, E-coli, a lot of bad things. Facility policy, Oxygen Administration revised 10/10, did not address placement of the oxygen tubing when not in use. Additionally, the policy did not address any changing of oxygen tubing.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40553 Based on interview and document review the facility failed to implement staff to answer call lights in a timely manner to meet resident physical needs and a psychosocial sense of security which had the potential to affect any of the residents residing in the facility who use a call-light independently or with assist from visitor. Findings include: According to R19's electronic health record (EHR) Admission Record (face sheet), R19 had diagnoses of muscle weakness, difficulty walking, history of falls and history of a broken hip. R19's EHR care plan included a focus problem area (not dated) that indicated she was at risk for falls and a corresponding intervention indicated staff should ensure the call-light was within reach and educate R19 to use it to call for assistance. According to R51's EHR Admission Record, R51 had paralysis of the right side, his dominant side. R51's EHR care plan included a focus problem area (not dated) that indicated he was at risk for falls related to gait and balance problems. A corresponding intervention indicated staff should encourage R51 to use his call-light to request assistance. Another focus problem area (not dated) indicated R51 had the potential for bladder incontinence and assistance to toileting should be offered upon rising, before and after meals, at bedtime and during the night. According to R51's MDS, 8/11/21, indicated R51 required extensive assistance of one person with toileting. According to an interview on 9/13/21, 12:51 p.m. R19 stated she had turned her call light on during the night a few days before, and staff did not arrive for over an hour. R19 said she has generally been able to transfer herself, but she had pain in her flank, and she was not feeling well. She said she ended up voiding in her bed and was wet from head to toe and I peed all over everything. When a staff person arrived, R19 said she talked to him about the extended wait, and he apologized to her but did not say why it took so long. R19 was unable to identify the staff person. She said that problems with call light wait time tended to occur during the night shift. According to an interview on 9/13/21, 2:48 p.m. R51 said he required assistance to get to the bathroom, but on the past weekend, a few days prior, he had turned on his call-light for assistance, but after waiting for a long time with no response, he managed to get up on his own, get into his wheelchair, go to the bathroom, use the toilet, and then go back to bed. R51 said about an hour and a half later a man came in to turn off his call-light and asked what he needed. It had been so long that R51 had fallen back to sleep. R51 told the staff person that he had already taken himself to the bathroom and no excuse was offered for the wait time. R51 indicated frustration and anger about this instance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A sample record of call-light times was requested for R19 and R51's unit dated 9/4/21 through 9/14/21. This report confirmed that on 9/12/21 it took staff one hour and sixteen minutes to respond to R19's call light at 3:25 a.m. and one hour and 19 minutes to R51's call light at 3:20 a.m. According to an interview 9/16/21, 10:03 a.m. a registered nurse (RN-H) stated she had worked during the night on the past weekend but was not on the same unit as R19 and R51. RN-H was unaware of any reported significant events in the building that night which would have interfered with staff answering a call light for an extended period of time. According to an interview 9/16/21, 11:06 a.m. the facility administrator stated there had been concerns about lengthy call-light response in the past and said he had had one other resident complain about call light times in the past few days but was not aware of R19 or R51's concerns. Administrator stated it was the facility expectation for staff to check on a resident when a call-light comes on, and if they are not able to immediately attend to the resident concerns, they are to let them know when they would be back to assist. The Administrator said typically, it is our rule of thumb, if a light is on for 20 minutes or longer, we need to ask, what is the reasoning behind that? The Administrator had no knowledge of any events in the facility over the last week that might have caused a slow response but did say an incident of a staff person sleeping had been reported but was unsure if there was any correlation. On 9/16/21, 11:55 a.m. during an interview, nursing assistant (NA- C) said she had worked Sunday night (9/12 to 9/13/21) and had heard that call-light response time had been extended the previous night but had not heard if there was a reason or event that would have caused this. NA-C said she understood the nurse who worked on the day shift was going to write up a concern form to report it to leadership. The Answering the Call Light policy revised March 2021 indicated staff should indicate the approximate time it will take for you to respond, if the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. Additionally, the procedure indicates that staff should document any complaints made by resident and the request or complaint was addressed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34985 Based on interview and document review the facility failed to offer/attempt non-pharmacological interventions prior to administration of as needed (PRN) psychotropic medications for 1 of 5 (R171) reviewed for unnecessary medications Findings include: R171's face sheet indicated R171 was admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder, recurrent moderate major depressive disorder, and insomnia. R171's physician order dated 9/8/21 indicated Ativan (antianxiety medication) 1 milligram (mg) by mouth every 8 hours as needed for intractable vomiting/withdrawal for 3 days. R171's progress notes and medication administration record reviewed between 9/8/21 through 9/11/21 identified R171 was administered Ativan, the record did not identify reason for administration however indicated the medication was effective and did not include documentation of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan was administered on 9/8/21, at 9:04 p.m., 9/9/21 at 8:20 p.m., 9/10/21, at 1:47 p.m. and 9/11/21, at 7:40 p.m. R171's Ativan order dated 9/8/21, was changed on 9/11/21; the order dated 9/11/21, indicated Ativan 1 mg by mouth every 12 hours as needed for anxiety and/or vomiting for 14 days. The record did not identify why withdrawal symptom was removed as justification for administration. R171's psychotropic Evaluation tool dated 9/11/21, had a checked box in response to the question, Does the resident have anxiety or nervousness that impairs his/her quality of life or limits participation in activities. The Note Section included currently has rx [prescription] for Ativan. The evaluation indicated the mediation improved the residents' symptoms. The evaluation did not describe R171's anxiety or nervousness and did not identify non-pharmacological interventions. R171's care plan did not identify diagnoses of anxiety with goals of care and non-pharmacological interventions. R171's record on 9/12/21, identified target behaviors for use of Ativan as 1. Nervousness 2. Withdrawal/refusal of care 3 nausea/vomiting. R171's progress notes and medication administration record reviewed between 9/12/21 through 9/14/21 identified R171 was administered Ativan, the record did not identify reason for administration, however indicated the medication was effective and did not include documentation of non-pharmacological interventions attempted or offered prior to administration. The record identified Ativan administered on 9/12/21 at 8:07 p.m., 9/13/21 at 9:25 p.m., and 9/14/21 at 8:33 p.m. During an interview on 9/15/21, at 10:02 a.m. nursing assistant (NA)-G stated he had not noticed any behaviors and R171 did not display anxiety that he had noticed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/21, at 8:44 a.m. registered nurse (RN)-D reviewed R171's record and verified the documentation did not identify how R171's nervousness/anxiety/withdrawal symptoms presented and stated the behaviors should be defined so they could be recognizable to staff. RN-D indicated the care plan did not identify non-pharmacological interventions that may help relieve anxiety symptoms and documentation did not reflect attempts of non-pharmacological interventions utilized or attempted prior to the administration. During an interview on 9/16/21, director of nursing (DON) reviewed R171's record and stated the target behaviors does not identify what the behaviors really are, and everybody displayed anxiety differently. DON stated as needed medications should be given for what they are specifically prescribed for and staff should offer and attempt non-pharmacological intervention first, documentation should identify which interventions were used and if which ones were effective, and if the resident refused then the refusals need to be documented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40553 Based on observation, interview and document review, facility failed to ensure that medications were properly labeled and secured for 1 of 2 residents (R54) observed for self-administration of nebulized/aerosolized medications. Findings include: According to R54's electronic health record (EHR) Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure and heart failure. According to a 5/11/2020 physician order, R54 could self-administer nebulized medications and meter dose inhalers once set up by the nurse. No order was found for R54 to keep medications at bedside. R54's care plan in the EHR had a focus problem area (not dated) that indicated R54 could self-administer medications; however, the care plan did not indicate R54 could keep medications at bedside. On 9/14/21, 2:20 p.m. R54 stated she was able to self-administer medications and she had last taken a dose of her medication at noon. An empty medication of aerosol solution was observed lying next to, and behind the nebulizer. An unopened container of respiratory medication for aerosolization was laying on the counter as well, and R54 stated the nurse left it so she could take it whenever she got short of breath, and she would not have to call the nurse. The plastic vial did not have a pharmacy label attached with any directions and did not have R54's name on it. A manufacture's stamp on the plastic vial indicated it contained Ipratropium-Albuterol Solution. R54 confirmed she did not need the medication at that time. According to an interview 9/14/21, 2:27 p.m. a registered nurse (RN-C) confirmed he had left the medication vial in R54's room even though she did not need an as needed (PRN) dose at that time. RN-C stated he was able to leave it there because R54 knows how to use it. During an interview 9/15/21, 10:28 a.m. RN-D, the unit manager stated a nurse was not to leave medications at a resident's bed side. According to RN-D, if a resident can self-administer a medication, the nurse must bring the medication in at the time it is ordered or if the order is for PRN the nurse must bring it in when needed and not before. RN-D said, leaving a medication at bedside could result in the dose not being taken at the proper time. Another nurse could potentially provide the next PRN or scheduled dose too soon, or back-to-back doses. RN-D stated the nurse should bring the medication in when needed, and then document the time the PRN dose was taken. A review of R54's medication administration record (MAR) for 9/14/21 showed RN-C documented giving R54 a scheduled dose of Ipratropium-Albuterol at 8:00 a.m. and at noon. No PRN dose of Ipratropium-Albuterol was documented on 9/14/21 and none were documented on R54's MAR since 9/10/21. The nurse for the evening shift on 9/14/21 documented administering the 4:00 p.m. dose, but no PRN dose. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an interview 9/15/21, 11:05 a.m. the director of nursing (DON) stated residents could self-administer medications if they had a physician's order and had been assessed as being able to do so. DON said medications were not to be left at bedside unless there was an order, and the facility had provided them a safe place to store the medications. DON indicated medications must be appropriately labeled with the resident's name and a pharmacy label if kept locked at bedside. The Storage of Medications policy revised November 2020 indicated drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications .Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling. .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40553 Based on interviews and document review, facility failed to ensure 2 of 2 residents (R24 and R3) were offered regular dental appointments to maintain oral comfort and reduce the risk of infection. Findings include: According to the electronic health record (EHR) Admission Sheet/face sheet, R24 had a diagnosis of dysphagia (difficulty swallowing) of the oropharyngeal phase (near mouth/throat). A facility Long Term Care Evaluation dated 6/30/21 done to inform the MDS did not include any information about R24's oral or dental status, and no other evaluation of oral status was found in the EHR. According to R24's care plan in the EHR, a focus problem area (not dated) indicated R24 was at risk for alteration in oral hygiene, and health related to being edentulous (no teeth), has upper and lower dentures. The focus problem indicated the dentures had been re-lined but did not indicate when that had occurred. The goal for this problem area was dated as having been initiated 6/01/2016. A corresponding intervention included: periodic offer is made to resident/family to set up dental appointments and PRN (as needed). During an interview 9/13/21, 3:12 p.m. R24 stated she was fitted with her current dentures prior to her admission to the facility some six years ago. She said the dentures had to be re-lined twice but have not been adjusted in recent years. She stated she frequently had to take them out of her mouth in-between meals because the dentures had started to irritate her gums. She stated she had four children but was concerned that her family was unable to assist with making any appointment or assisting her to an appointment. She did not recall being offered any dental appointments. According to an interview on 9/15/21, 10:37 a.m. a registered nurse (RN-D) managing the unit stated the facility was able to provide R24 with dental visits but was unable to record on the last time R24 had received any dental assessment. RN-D stated such services should be offered at quarterly care conferences but was unable to find record that such services had been offered to or declined by R24. According to an interview 9/15/21, 11:46 a.m. the licensed social worker (LSW) stated the facility should offer dental visits as needed. LSW did not know if R24 had had any dental visit but stated this should be offered at quarterly care conferences. LSW was unable to find documentation indicating any such services had been offered to or declined by R24. According to an interview 9/15/21, 12:14 p.m. a nursing assistant (NA-C) stated R24 puts her dentures in to eat her meals but will take them out in between because there is a little spot that irritates her. NA-C stated nurses were supposed to evaluate resident oral status and set up dental appointments if they see a problem. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/21, 8:30 a.m. the director of nursing (DON) confirmed that the EHR did not contain recent documentation by nursing staff of R24's current oral status. DON stated she was unable to find any documentation that R24 was offered a dental appointment. DON stated an expectation that vision, hearing and dental visits be offered at every care conference and as needed, and stated this offer and the resident response should be documented. DON stated if the information was not documented, one could not assume that it had been done. The Dental Services policy revised December 2016 indicated that selected dentists must be available to provide follow up care, and social services will assist residents with appointments and transportation arrangements. The policy also indicates that all dental services should be recorded in the resident's medial record. The Dental Examination/Assessment policy revised December 2013 indicated that residents shall be offered dental services as needed and upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist. 43084 R3 R3's annual Minimum Data Set (MDS) dated [DATE], indicated R3 had moderate cognitive impairment and was able to make his needs known. R3's face sheet dated 9/15/21, indicated R43's diagnoses included diabetes mellitus, heart failure and seizure disorder. R3's care plan dated 9/15/21, provided direction to offer resident or family to periodically offer dental appointments as needed. R3's Clinical Admission Evaluation dated 5/3/21 indicated R3 had obvious or likely cavity or broken natural teeth. This assessment did not indicate the provider should be notified of R3's dental status to obtain dental consult. R3's progress notes dated 5/27/20 thru 9/14/21, failed to address R3's dental needs and if a dental appointment was offered. On 9/13/21, at 1:21 p.m. R3 stated he was not offered to see in a dentist but would like to see a dentist due to several missing and broken teeth. On 9/15/21, at 10:26 a.m. registered nurse (RN)-I stated if a resident wanted a dental appointment, staff would make her aware and she would let medical records know to make the appointment. She could also be notified through the assessment process. The nurse completing the assessment should let RN-I know about the resident's need to see a dentist. RN-I confirmed R3's assessment dated [DATE], indicated R3 likely had cavities or broken teeth. RN-I stated she was not notified of R3's dental needs. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/21, at 2:42 p.m. director of nursing (DON) stated she expected dental services were offered if any issues came up. She would expect the nurse completing the assessment would update the resident's provider if concerns such as possible cavities or broken teeth were noted. Offering dental services were important as cavities can cause pain, increases the resident's risk for infection including sepsis (an infection of the blood stream).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40553 Based on observation, interview, and document review, facility failed to provide a system of coordination of care with their contracted hospice provider for 1 of 1 resident (R54) reviewed for hospice care. Findings include: According to R54's electronic health record (HER) Admission Record/face sheet, R54 had diagnoses of emphysema, acute and chronic respiratory failure, heart failure and anxiety among other co-morbidities. A focus problem area was noted in R54's care plan as follows: I have a terminal prognosis related to COPD and chronic diastolic heart failure. I began hospice care on 7/2/2021. The intervention list included the following, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, but failed to indicate any specific delineation of what responsibilities were those of hospice and which were responsibilities of the facility. A review of uploaded documents in R54's EHR failed to show a hospice care plan but did include an August-September 2021 schedule. A review of the schedule showed that the schedule was incomplete and did not include the name of a nurse manager, visit nurse or hospice aide or clear schedule. According to an interview on 9/13/21, 4:34 p.m. R54 confirmed that she was receiving hospice services, but stated, I don't know what we pay them for. R54 indicated she felt very anxious and said she had hoped having hospice services would help her, but said it seemed to make things more confusing. She reported communication issues between the facility and hospice and stated, [NAME] doesn't know what [NAME] has done. On 9/13/21 she was particularly concerned about wraps on her legs (Unna boots- a layered compression wrap that contains a gauze zinc dressing, covered by a dry dressing, covered by a compression wrap that can be left on for up to a week, but is often changed two to three times weekly if there are open wounds) stating she understood hospice was in-charge of applying them, but no-one from hospice had arrived and she didn't know if anyone would wrap her legs. She said there had been a massage therapist from hospice in to visit, but he didn't care for her leg wraps, and he wasn't able to tell her when there would be someone from hospice in to provide those cares. R54 said she had not received any schedule or calendar from the hospice service. No such document could be observed in her room. A basket with roller gauze and compression wraps was in the room without any instruction and without any indication of a zinc wrap. R54's legs were not wrapped at that time. According to an interview on 9/14/21, 2:26 p.m. R54 was upset, stating her wraps were taken off her legs so she could have a bath, but no one had come to replace them. She again said she understood hospice was supposed to apply the wraps, but she did not know when they would come. R54's legs were observed to be swollen. She was wearing non-slip socks, but no wraps. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an interview 9/14/21, 2:29 p.m. a registered nurse (RN-D), the unit manager stated the hospice should fax the facility a schedule and then the facility would upload that schedule into the EHR. RN-D did not believe the resident would receive a copy of that schedule and did not know if the hospice agency would provide them one when they visited. RN-D was unsure of the hospice schedule for R54, stating she thought a nurse was scheduled twice a week, but did not think they knew a specific date as hospice often changed days of visits if something else would come up. RN-D did not think R54 had a hospice nurse manager, and various nurses came to visit. RN-D thought a hospice aide was supposed to come twice weekly and she thought it would be on Mondays and Thursdays, but she was unsure if anyone had been there the day before. RN-D said it was expected for the hospice nurse to communicate with the facility staff, but said they usually talked to the nurse responsible for the hall where the resident lives rather than coming to the unit manager. RN-D confirmed that a hospice care plan had not been uploaded into the HER. On 9/14/21, 2:46 p.m. a telephone call was made to the hospice agency to reach out to R54's nurse manager or someone who could provide information. The person who took the phone call stated the nurse manager was not on duty and there was not another person who could take the call. Unknown individual stated the nurse manager was scheduled to visit the facility twice a week and would visit R54 on 9/15 and 9/16/21 (Wednesday and Thursday) this week, and then the next week on 9/21 and 9/23/21 (Tuesday and Thursday), but stated they do change the schedule if they need to send a nurse elsewhere. According to an interview 9/15/21, 1:42 p.m. a hospice nurse manager, RN-F stated a resident would know when she was coming because she would tell them. She stated she had not received any training to provide a written schedule to the resident, merely to provide a frequency of visits which she did verbally. She stated she liked to have a little leeway as they sometimes had to change their schedule. RN-F stated they did the same with hospice aid visits, but currently their aid had been sick for some time and now had resigned so she, RN-F, would do the aid work when she came to visit R54. RN-F said she would talk with the nurse who was on duty, and other nurses would be able to gather information by looking for any new orders or by looking for documentation in the EHR. RN-F confirmed there should be a care plan from the hospice agency but stated there was someone at the main office who was supposed to send the facility the care plan and any other documentation for the facility chart, and she did not know if anything had been sent. RN-F also stated the hospice nurse should make a note in the facility EHR after visiting but said she had lost her password so had not been doing so recently. RN-F said she did not regularly meet with the facility unit manager. As to R54's concerns regarding her leg wraps, RN-F stated the order said to change them as needed, and that hospice would change them when they were there for a visit. According to R54's physician orders, the facility was provided the following order on 9/10/21: [NAME] boot to LLE (lower left extremity). Hospice to change on visits. Change when needed. Contradictory orders were found in the physician's orders stating: remove ace wraps and apply Aveeno cream and tubi strips [grips] (a compression garment cut to length) at bedtime for edema 9/3/21. According to an interview 9/15/21, 2:12 p.m. the facility licensed social worker (LSW) stated that social service is the point person for hospice but for clinical aspects of care, the point person for communication would be the facility unit manager. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to interview 9/16/21, 8:17 a.m. the director of nursing (DON) stated a hospice agency should provide the facility with a schedule letting them know when the nurse and hospice aide or other team members would be visiting. DON was unsure if the residents were provided with the schedule but said they should be. DON stated the point person for communication in the facility was the unit clinical manager, that's part of their job responsibility. DON stated the facility manager should be aware of the hospice schedule and know how to access the information. Additionally, DON stated the unit manager should be familiar with, and communicate with the hospice nurse manager and familiar with the hospice plan of care. DON confirmed that the facility should have a copy of the hospice plan of care and the hospice provider and facility should clearly know who was doing what. DON stated the facility care plan should also provide this information and should include information about the agency but confirmed this was not included in the facility care plan. DON confirmed R54's EHR did not contain a care plan from the hospice agency, nor did it contain a clear and complete schedule of hospice visits. A request was made for a policy related to coordination of care with hospice, but facility did not provide one.

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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** 34985 Based on observation, interview, and document review the facility failed to perform hand hygiene when performing wound treatments to reduce the risk and/or prevent skin infections for 1 of 2 residents (R61) whose treatments were observed for pressure ulcers. Findings include R61's face sheet dated 9/16/21, included diagnosis of left buttock pressure ulcer stage 2 and pressure-induced deep tissue damage of other site. R61's admission Minimum Data Set (MDS) assessment dated [DATE], identified R61 had one stage 2 pressure ulcer and one unstageable pressure ulcer. R61's physician orders included: -Leg Buttocks Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size) (start date 9/13/21) -Leg Pressure Injury Treatment: Cleanse affected area daily w/ normal saline and gauze, apply nickel thick layer of Santyl covering entire wound bed (black soft eschar), cover w/ mepilex border (sacral or large size (start date 8/12/21) During an observation on 9/14/21, at 9:21 a.m. licensed practical nurse (LPN)-D explained to R61 he was going to complete the dressing change on his left calf; R61 gave consent. LPN-D donned gloves, removed the dressing, disposed of the dressing, then removed gloves. LPN-D then used a pen to write the date on the new dressing and donned new gloves without performing hand hygiene. LPN-D completed the dressing change per physician orders, removed gloves, and washed hands. During an interview on 9/14/21, at 9:26 a.m. LPN-D stated he should have done hand hygiene between glove changes. (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 observation on 9/15/21, at 1:16 p.m. RN-B explained to R61 he was going to change the dressings on his left calf and left buttock; R61 gave consent. RN-B washed his hands and donned gloves, RN-B then removed R61's wound dressing from the left calf and through the dressings on the floor. RN-B then removed the cap from the saline bottle, put the ointments for the wound in the cap, opened a tongue depressor, and stirred the ointments together. RN-B then removed scissors from his left pocket and cut the non-stick dressing to the size of the wound. RN-B then used a Q-tip to spread the mixture of ointments onto the wound and applied the cover dressings. RN-B had the same gloves on throughout the procedure, in addition RN-B had not disinfected the scissors prior to or after the completion of the dressing change. RN-B then picked up the soiled dressings from the floor, took off gloves, and sanitized his hands. RN-B then informed R61 of the next dressing change on his left buttock. RN-B donned gloves and undid R61's incontinent brief, R61 was incontinent of stool, RN-B performed incontinent care, used an incontinent wipe to clean his gloves, walked to the bathroom and donned another pair of gloves (without disinfecting) over the gloves he already had on and applied the left buttock dressing per physician order. During an interview on 9/15/21, at 2:13 p.m. RN-B stated he should have changed his gloves and performed hand hygiene after taking off the old dressing. RN-B stated an unawareness if double gloving was appropriate for the procedure. During an interview on 9/16/21, at 11:44 p.m. director of nursing (DON) stated appropriate hand hygiene was expected during dressing changes, gloves should be removed after dressing and removal and cleansing the wound, hand hygiene should be performed after each glove change. DON stated soiled dressings need to go into a garbage can and not on the floor, and scissors should be disinfected prior to using on a clean dressing. Facility policy Dressing, Dry/Clean dated 9/2013, included Steps in the Procedure: 5) Wash and dry your hands thoroughly 6) Put on clean gloves. Loosen tape and remove soiled dressing 7) Pull glove over dressing and discard into plastic or biohazard bag 8) Wash and dry your hands thoroughly. 9) Open dry, clean dressings. 10) [NAME] tape or dressing with date, time, and initials. 11) Wash and dry your hands thoroughly. 12) Put on clean gloves 15) Cleans the wound 17) Apply the ordered dressing 23) Wash and dry hands thoroughly

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43084 Based on interview and document review the facility failed to ensure 1 of 5 residents (R43) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R43's quarterly Minimum Data Set (MDS) dated [DATE], R43 had severe cognitive impairment. R43's medical record failed to address R43's vaccination status for pneumococcal and if these vaccinations were offered to R43. On 9/14/21, at 12:59 p.m. licensed practical nurse (LPN)-E confirmed documentation that would indicate R43 received the option for the pneumococcal vaccinations were offered at time of admission. On 9/15/21, at 9:59 a.m. family member (FM)-A confirmed she was R43's guardian. FM-A stated when R43 was admitted to this facility, she was not given the option for R43 to receive the pneumococcal vaccinations while in the facility. On 9/15/21, at 10:33 a.m. directory of nursing (DON) stated she expected unvaccinated residents were offered vaccines which included the pneumococcal vaccinations. If a vaccination was refused, then the resident and their family would receive education which include risk factors to an educated decision could be made. Facility policy, Influenza and Pneumococcal Immunizations, review date 2/2020, noted pneumococcal immunization status of all residents will be determined on admission. Vaccination will be offered.