STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38E188	A. Building B. Wing	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracelen Care Center	10948 S.E. Boise Portland, OR 97266

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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. 41458 Based on observation, interview and record review it was determined the facility failed to ensure dignity for 1 of 3 sampled residents (#59) reviewed for dignity. This placed residents at risk for lack of dignity. Findings include: The facility's Quality of Life - Dignity policy revised 3/11/22 revealed: -Residents shall be treated with dignity and respect at all times and -Demeaning practices and standards of care that compromise dignity are prohibited. Resident 59 was admitted to the facility in 11/2022 with diagnoses including stroke and hemiplegia/hemiparesis (the loss of ability to move part or most of the body) of the non-dominant side. Resident 59's 11/18/22 Admission MDS indicated the resident was cognitively intact. Multiple random observations from 1/8/23 through 1/17/23 between the hours of 8:00 AM and 11:50 PM revealed food and cups of liquid were frequently observed on the bedside table near Resident 59's urinal. On 1/13/23 at 11:47 AM Staff 3 (RNCM) and surveyor were with Resident 59 when Staff 31 (CNA) brought Resident 59's lunch into her/his room. Staff 31 removed the plastic wrap from Resident 59's plate then set the plate followed by cups of liquid on the bedside table approximately one inch from Resident 59's partially filled urinal and in approximately two to three minutes, Staff 3 left the room and returned with Staff 31. Staff 3 asked Staff 31 to remove the urinal from the bedside table, remove and discard the food and liquids from the bedside table, disinfect the bedside table and provide the resident with a new plate of food and liquids. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/17/23 at 2:13 PM Resident 59 stated staff frequently placed her/his food and liquids on the bedside table next to or near the urinal and she/he did not like staff putting her/his food and liquids next to the urinal, she/he asked staff to move the urinal but it was always a major issue to get anything done. Resident 59 stated sometimes she/he was laying in bed and staff put the nearly full urinal right by her/his plate of food then placed the bedside table over her/him so she/he could eat. Resident 59 stated her/his urinal sometimes sloshed over and spilled on her/his bedside table or bed linens and smelled. The resident stated the urinal often left a ring on the bedside table and staff put her/his silverware in the dirty area. Resident 59 stated she/he would not have pee sitting on her/his dining room table at home and did not want that done at the facility, either. On 1/18/23 at 11:19 AM Staff 1 (Administrator) and Staff 2 (DNS) were provided with the findings of this investigation and acknowledged this practice showed a lack of respect for resident dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43689 Based on interview and record review it was determined the facility failed to notify a resident's representative in a timely manner regarding a resident-to-resident incident for 1 of 3 sampled residents (# 32) reviewed for accidents. This placed residents and responsible parties at risk for lack of timely notification. Findings include: Resident 32 was admitted to the facility in 4/2018 with diagnoses including Huntington's disease (a progressive brain disorder) and a mental health disorder. Resident 32's Admission Record indicated: Witness 1 (Complainant) was Guardian, Care Conference Person, Emergency Contact #1, and Next of Kin. A FRI revealed on 10/14/22 Resident 32 was involved in an incident with Resident 31. It was reported Resident 31 stood behind Resident 32 and grasped and shook Resident 32's head. The facility Alleged Abuse Checklist form dated 10/14/22 revealed Witness 1 (Complainant) was notified of the incident on 10/17/22, three days after the incident occurred. On 1/8/22 at 6:25 PM Witness 1 stated the facility did not notify her until 72 hours after the incident. On 1/13/22 at 2:58 PM Staff 2 (DNS) stated it was the facility's policy to notify the family and/or representative immediately after an accident/incident.

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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 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. 39632 Based on interview and record review it was determined the facility failed to ensure resident care plans were revised to accurately reflect the resident needs for 2 of 9 sampled residents (#s 26 and 41) reviewed for ADLs and accidents. This placed residents at risk for unmet needs. Findings include: 1. Resident 26 was admitted to the facility in 3/2020 with diagnoses including stroke. Resident 26's 11/9/22 Quarterly MDS indicated the resident was not on Hospice. Resident 26's undated CNA Care Plan Reference Sheet indicated the resident was on Hospice. On 1/12/23 at 1:39 PM Staff 4 (RNCM) stated the CNA Care Plan Reference Sheet was designed to be used by staff, such as new CNAs and agency CNAs, who were unfamiliar with the resident. Staff 4 stated the reference sheet served as a quick reference with information about the resident and the type of care needed. Staff 4 reviewed Resident 26's CNA Care Plan Reference Sheet, stated Resident 26 was discharged from Hospice in 8/2022 and acknowledged the Care Plan was inaccurate. On 1/18/23 at 10:57 AM Staff 2 (DNS) stated she expected the CNA Care Plan Reference Sheet to accurately reflect Resident 26's health status so the resident received care that aligned with her/his actual needs. 47000 2. Resident 41 was admitted to the facility in 6/2018 with diagnoses including frontotemporal dementia (a type of dementia characterized by changes in emotions, behavior, personality and language). Resident 41's 12/20/22 Significant Change of Condition Assessment ADL CAA indicated the resident recently admitted to Hospice and a geri chair (a large, padded chair with a wheeled base designed to assist people with limited mobility) was ordered to provide comfort. The Physical Restraints CAA indicated the restorative program was discontinued. Resident 41's 12/2022 Care Plan revealed the resident was on a restorative plan in order to maintain or improve strength and endurance in daily activities. Resident 41's current CNA Care Plan Reference Sheet revealed the resident utilized a wheelchair with a seat belt. The Care Plan made no reference to Hospice services being provided. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/22 at 10:12 AM Staff 4 (RNCM) stated the CNA Care Plan Reference Sheet was designed to be used by staff, such as new CNAs and agency CNAs, who were unfamiliar with the resident and was based on resident care plans. Staff 4 stated Resident 41 was on Hospice and utilized a geri chair for comfort. Staff 4 reviewed Resident 41's CNA Care Plan Reference Sheet and stated Resident 41 no longer utilized a regular wheelchair with a seatbelt. Staff 4 acknowledged the CNA Care Plan Reference Sheet was not revised and missed any reference to Hospice services. Staff 4 also reviewed Resident 41's Care Plan and confirmed the resident was no longer on a restorative plan and acknowledged the Care Plan was not revised to reflect the changes. On 1/13/23 at 10:12 AM Staff 2 (DNS) stated she expected both the CNA Care Plan Reference Sheet and Care Plan to be revised when necessary to accurately reflect Resident 41's health status so the resident received care that aligned with her/his actual needs.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47000 Based on observation, interview and record review it was determined the facility failed to ensure adequate supervision and a safe environment for 2 of 3 sampled residents (#s 41 and 58) reviewed for accidents. This failure placed residents at increased risk for injuries and resulted in Resident 41 sustaining a hip fracture from a fall. Findings include: 1. Resident 41 was admitted to the facility in 6/2018 with diagnoses including frontotemporal dementia (a type of dementia characterized by changes in emotions, behavior, personality and language). Resident 41's 8/31/22 Quarterly MDS indicated the resident's cognition was severely impaired, she/he required extensive assistance from at least two staff for transfers and was totally dependent on staff for locomotion on and off of the unit. Resident 41's 9/12/22 Morse Fall Scale revealed the resident was at high risk for falling. A review of Resident 41's 9/14/22 Care Plan revealed the resident was at risk for falls due to cognitive impairment and lack of impulse control and included the following interventions related to safety and falls: -The resident's room was to be kept free from clutter and floors free from spills; -A fall mat was to be in place; -A tab alarm was to be in place when the resident was in bed; -A seatbelt and tab alarm were to be in place when the resident was in her/his wheelchair; -The bed was to be in the lowest position when occupied; and -The resident was not to be left unattended with her/his bed in the highest position. A review of Resident 41's progress notes revealed she/he fell on [DATE] and 10/1/22 as a result of failed self transfers. A 12/1/22 FRI Form revealed Resident 41 was sent to the hospital on 11/29/22 and returned to the facility on [DATE] with a diagnosis of a left hip fracture, cause unknown. A review of the facility's 12/5/22 Incident Note completed by Staff 4 (RNCM) revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-11/28/22 Staff 36 (CNA) left the resident unattended in bed with her/his bed in the high position before leaving for a break. While Staff 36 was on her break, the resident was found on the floor in the middle of her/his room. Staff 44 (Agency LPN) determined the resident did not experience discomfort with transferring from the floor into her/his wheelchair and did not have problems standing or pivoting. Staff 44 did not inform Staff 36 the resident had fallen when she returned from her break. -11/29/22 Resident 41 was transferred to the hospital as she/he was observed to be unresponsive. -11/30/22 Resident 41 returned to the facility from the hospital with a diagnosis of left hip fracture. -12/5/22 the left hip fracture was a result of the resident attempting to self transfer and being left unattended in her/his room with her/his bed in a high position. Resident 41's care plan was not followed. A review of Resident 41's health record revealed the following related to Resident 41's fall on 11/28/22: -No evidence the resident was assessed for injury or pain; -No evidence neurological checks were completed; -No evidence the resident was put on alert charting to assess for signs of latent injury; -No evidence an investigation into the root cause of the fall was initiated; and -No evidence the DNS, RNCM, the resident's responsible party or staff working the next scheduled shift were notified the resident experienced a fall. An attempt was made to contact Staff 44 via phone and no return phone call was received. On 1/8/23 at 1:40 PM Witness 8 (Family Member) stated she received a phone call on 11/29/22 at 5:00 PM from Resident 41's attending physician at the hospital who informed her the resident had sustained a left hip fracture which appeared to be from the result of a recent fall. On 1/8/23 at 2:05 PM Staff 36 stated Resident 41 was considered at risk for falls prior to the resident's 11/28/22 fall. She stated Resident 41's care plan at the time of the 11/28/22 fall was for the resident to be supervised when in bed if the bed was in a high position. Staff 36 confirmed she was Resident 41's assigned CNA on 11/28/22. She stated she left Resident 41 in bed unattended with her/his bed in a high position as the resident was not finished drinking her/his liquids before leaving for her break. She stated she was not informed of Resident 41's fall when she returned from her break but was made aware a few days later when she was called by Staff 4 (RNCM) who was completing the fall investigation. On 1/11/23 at 11:32 AM Staff 37 (CNA) stated she worked on 11/28/22 and checked on Resident 41 after she heard a noise coming from the resident's room. She stated she entered the room and discovered the resident on the ground and the resident's bed was raised to a high position. She stated she assisted the resident off of the ground with the help of the nurse and another CNA. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/13/23 at 10:12 AM Staff 4 (RNCM) stated Resident 41's bed should have been at knee level for care and during meal times and the resident should have been supervised during these instances. She confirmed Staff 36 should have lowered the resident's bed prior to leaving the room on 11/28/22. Staff 4 further stated Staff 44 should have informed the DNS, RNCM, family and staff working the next shift of the resident's fall, documented her assessment of the resident, started an incident report and initiated alert monitoring. On 1/19/23 at 10:41 AM Staff 2 (DNS) was informed of the findings and no additional information was provided. 2. Resident 58 was admitted to the facility in 10/2022 with diagnoses including alcohol abuse and Wernicke's encephalopathy (a degenerative brain disorder caused by the lack of vitamin B1). Resident 58's 10/19/22 Wandering Risk Scale revealed the resident to be at risk to wander. Resident 58's 10/26/22 Admission MDS revealed the resident was moderately impaired in terms of cognitive functioning, was independent for locomotion on and off the unit and wandered. Resident 58's 10/26/22 Admission MDS Behavior CAA revealed the resident eloped from the facility shortly after her/his admission due to a malfunction of the keylock pad equipment on the facility's east gate. The resident exited out the east gate and she/he was found shortly thereafter in the facility's parking lot. The resident had wandering/exit-seeking behaviors and regularly talked about returning home and drinking whiskey. Resident 58's 11/28/22 Wandering/Wants To Go Home/Elopement Risk Care Plan listed the following interventions: -Assess and provide appropriate seating in dining room; -Complete wandering assessment on admission, 72 hours post admission, one month post admission, quarterly and as needed; -Encourage socialization with other appropriate residents and provide activities; -Reinforce reasons for placement; -15 minute checks and -Assign one to one if staff were available. A 12/27/22 FRI Form revealed Resident 58 eloped from the facility from the outer east gate which was discovered to be unlocked. A review of the 15 Minute Safety Checks CNA Task completed on 12/27/22 revealed no evidence Resident 58 was checked on from 7:00 PM to 7:43 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the 12/30/22 Incident Review/Summary completed by Staff 4 (RNCM) indicated Resident 58 walked outside every day since his admission trying to get the gates open. This Review/Summary revealed the following about the resident's 12/27/22 elopement: -15 minute checks of Resident 58 were completed by Staff 40 (CNA) until she went on break at 7:00 PM and did not resume until she returned from break at approximately 7:30 PM. Staff 40 stated the last time she saw the resident was around 7:00 PM prior to leaving for her break. -Staff 30 (CNA) along with the other CNA assisted another resident in the shower during Staff 40's break. -Staff 40 asked Staff 30 about Resident 58's whereabouts upon return from her break around 7:30 PM. Staff 30 assisted a resident in the shower at this time. -Staff 30 notified Resident 58 was missing around 7:30 PM to 7:35 PM. -It was determined the resident had eloped after the east gate was discovered to be unlocked at approximately 7:45 PM. The facility's video camera footage confirmed Resident 58 eloped through the east gate which was unlocked. Observations of Resident 58 conducted between 1/9/23 and 1/18/23 from 8:00 AM to 4:40 PM revealed the resident to be in bed either watching television, reading the newspaper or walking outside of the facility within the gated grounds. The resident was observed to frequently walk from the west to the east side of the building and push on the east gate. On 1/8/23 2:31 PM Resident 58 reported she/he independently took a trip to the city of Cornelius on TriMet (public transportation company) approximately a week prior. The resident reported falling a few times when on this outing and stated she/he was helped by strangers. On 1/11/23 at 12:05 PM Staff 37 (CNA) stated Resident 58 had a CNA regularly scheduled to provide one to one supervision but this was discontinued. Staff 37 stated when Resident 58's exit-seeking behavior was observed to be more frequent/heightened during a shift, staff reported this behavior, and if there was availability, the resident was assigned a staff person to provide one to one supervision. Staff 37 observed Resident 58's exit-seeking behavior increased in the evenings and nights and the resident usually attempted to exit out of the east gate. On 1/13/23 at 8:54 AM Staff 16 (LPN) stated staff were supposed to redirect Resident 58 when she/he was observed wandering or exit-seeking. She stated CNAs were responsible for completing 15-minute checks of the resident and they implemented one to one supervision of Resident 58 when increased exit-seeking was observed and/or if the resident was talking about wanting to leave the facility. On 1/13/23 at 10:12 AM Staff 4 (RNCM) stated Resident 58 talked about eloping since her/his admission to the facility and the resident checked the integrity of the gates daily since her/his admission. Staff 4 stated the resident eloped in 10/2022 after punching random numbers on the east gate's keypad which opened the gate. After this 10/2022 elopement, Staff 4 stated Resident 58 received daily one to one staff supervision until 12/7/22 when the gates were repaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff 4 stated the 12/27/22 elopement was a result of a power outage and the magnet on the east gate malfunctioning. She stated on 12/27/22 the facility experienced three power glitches when the electricity in the building flickered but did not fully go out. She further stated staff had checked on the integrity of the gates until approximately 5:00 PM and they were locked. Staff 4 stated the gates had a 45-90 minute back up should the power completely go out. In the event of a power outage, a staff person was to chain the gates to prevent any potential resident elopements. Staff 4 stated Staff 39 (Staffing Coordinator) was assigned to train staff what to do in the event of a power outage. On 1/13/23 at 11:00 AM Staff 39 (Staffing Coordinator) stated she did not provide staff with any orientation specific to resident elopements or power outages, including what to do about the facility gates in the case of a power outage. On 1/13/23 at 2:33 PM Staff 40 (CNA) stated she was Resident 58's assigned CNA on the evening of 12/27/22. She stated she observed the resident to have increased wandering that evening as the resident was observed walking outside and around the building approximately every 30 minutes since the start of her shift at 2:00 PM. She further stated Resident 58 was not assigned one to one supervision despite her/his increased behaviors. She stated she took her break from 7:00 PM to 7:30 PM and informed the other two CNAs working in the east wing of the building. She then stated the CNAs were assisting another resident with a shower at the time she left for her break. At approximately 7:35 PM after returning from her break she went to check on Resident 58 and discovered the resident was missing. On 1/13/23 at 3:13 PM Staff 41 (Agency LPN) stated she was the nurse scheduled on the west wing on the evening of 12/27/22. She stated she observed Resident 58 to have increased wandering and exit-seeking behaviors on this evening of 12/27/22, but no one to one supervision was provided. She further stated she was not made aware of the resident's 10/2022 elopement until after her/his elopement on 12/27/22. Staff 41 was not aware of any elopement precautions, including the CNAs completing 15-minute checks on Resident 58. On 1/18/23 at 8:30 AM Staff 15 (CNA) stated Resident 58 gave various reasons where she/he was going when exit-seeking, including going to the bar. Staff 15 stated the resident told her she/he pushed on the gate every day to see if it was locked. On 1/18/23 at 9:34 AM Staff 8 (Maintenance Director) stated he checked the east and west gates on a daily basis to make sure they were locked since Resident 58's 10/2022 elopement. On 12/27/22, Staff 8 stated he and his assistant checked on the east and west gates approximately three times to make sure they remained locked due to the storms and power flickering that occurred on that day. He further stated he checked on the gates around 5:00 PM before leaving for the day and thought all staff were aware of the gate being a potential problem. Before leaving for the day, he spoke to Staff 42 (LPN) because he was worried about the possibility of the gates malfunctioning. He stated he informed Staff 42 of Resident 58's previous elopement and of the gates' previous malfunction. He confirmed there was no system in place for monitoring the gates to make sure they remained locked after he left the facility. On 1/18/23 at 12:44 PM Staff 42 stated Staff 8 did not provide with any warning about the possibility of the gates malfunctioning. She stated she was not made aware of Resident 58's prior elopement in 10/2022 until after her/his 12/27/22 elopement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/19/23 at 10:41 AM Staff 2 (DNS) was informed of the findings of this investigation and provided no additional information.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41458 Based on interview and record review it was determined the facility failed to ensure RN coverage for eight consecutive hours per day 7 days per week for 9 out of 100 days reviewed for staffing. This placed residents at risk for lack of timely assessments and care. Findings include: Review of the Direct Care Staff Daily Reports from 7/1/22 through 8/31/22 and 12/1/22 through 1/8/23 revealed on 7/3, 7/10, 7/11, 8/12, 8/13, 8/14, 12/15, 12/26 and 1/2 there was no RN coverage for eight consecutive hours. On 1/17/23 at 8:41 AM Staff 2 (DNS) acknowledged the facility lacked RN coverage on the identified days.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. 43689 1. Based on observation, interview, and record review it was determined the facility failed to implement infection control measures for a resident with exposed blood and bloodborne pathogens including Viral Hepatitis C for 1 of 1 sampled resident (#52) reviewed for infection control. This failure resulted in an immediate jeopardy situation. Resident 52 walked throughout the facility with an open bleeding head wound, touched various surfaces in common areas and held a bloodstained blanket with bloodstained hands. This placed all residents and staff at risk to contract Viral Hepatitis C, a life-threatening virus. Findings include: According to the CDC website, section titled, Hepatitis C Review, dated 7/28/20, Viral Hepatitis C is highly infectious and is spread through contact with blood from an infected person and inadequate infection control. Viral Hepatitis C can remain active on dry surfaces and equipment for up to six weeks, resulting in a longer period for transmission. Potential adverse outcomes of Viral Hepatitis C include cirrhosis, liver cancer and death. According to the CDC website, section titled, Recommendations for Prevention and Control for Viral Hepatitis C dated 8/7/20, included the following guidance: health-care workers should follow universal blood/body fluid precautions, wear gloves if they must touch another person's blood or open sores and avoid sharing and/or touching personal care items that might have blood on them, such as toothbrushes, razors, nail clippers, etc. Resident 52 was admitted to the facility in 6/2021 with diagnoses including moderate vascular dementia with behavioral disturbance, malignant melanoma (skin cancer), and Viral Hepatitis C. Resident 52's 9/9/22 Care Plan indicated the resident was at risk for actual skin impairment/pressure ulcer and had a sebaceous cyst (a type of liquid-filled bump that occurs on the skin) on top of her/his head. The care plan also indicated Resident 52 was resistant to treatment and ADL cares. The care plan lacked person-centered interventions related to the resident's bleeding cyst. The 10/5/22 Quarterly MDS indicated Resident 52 was severely cognitively impaired, required limited assistance with ADL care and was independent with ambulation. She/he was coded as having an open lesion other than ulcers, rashes, cuts (e.g., cancer lesion). On 1/8/23 between the hours of 11:27 AM and 4:23 PM observations were made of Resident 52. Resident 52's head had a golf-ball sized, protruding red nodule which was actively bleeding down both sides of her/his face and neck. Resident 52 was observed lying in her/his bed with bloodstained sheets and a blanket. Resident 52 walked independently throughout the facility and in communal areas, wore blood stained clothing, carried a bloodstained blanket, had an exposed bloody head wound, and touched/handled a communal chair in the dining room. Resident 52's hands were soiled with dried blood the entire time. Resident 52's hands were observed to have blood on each finger pad, on top of and under her/his nails. Interviews on 1/9/23 revealed the following: (continued on next page)

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	38E188	A. Building B. Wing	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-12:35 PM Staff 19 (CNA) stated Resident 52 often picked at the exposed head wound and refused hand hygiene. Staff 19 stated Resident 52 often removed the gauze head bandage and discarded the soiled gauze bandage throughout the facility, including the communal bathroom. -12:36 PM Staff 35 (CNA) stated Resident 52 refused bandaging and treatment of her/his head wound. Staff 35 stated Resident 52 discarded the soiled gauze bandage in the dining room and communal bathroom. Staff 35 stated Resident 52 often picked at the exposed head wound and blood dripped down her/his face. Staff 35 stated Resident 52 easily became agitated and often refused hand hygiene. -12:36 PM Staff 5 (RN/IP) stated Resident 52 had a cancerous tumor on her/his head. Staff 5 stated Resident 52 refused treatment and bandaging of the head wound, walked around the facility with the exposed head wound bleeding, and stated it's an ongoing problem. Staff 5 stated Resident 52, can't keep from messing with it, there's nothing much else we can do. -12:36 PM Staff 3 (RNCM) stated Resident 52 could become belligerent and refused bandaging of the exposed head wound. Staff 3 stated Resident 52 often picked at the exposed head wound and had blood run down her/his face. Staff 3 stated it's an infection control issue because Resident 52 bled and walked around the facility. Staff 3 stated Resident 52 often refused hand hygiene and her/his hands were a mess. -12:40 PM Staff 30 (CNA) stated Resident 52 picked at the exposed head wound, removed, and discarded the soiled gauze bandage throughout the facility daily. Staff 30 stated Resident 52 often refused hand hygiene. Resident 52's 1/9/23 physician order indicated: Keep growth on top of head clean, dry, and covered with gauze at all times. To prevent infection and to contain blood. If resident refuses, reapproach in 15 minutes. On 1/9/23 at 2:24 PM Staff 1 (Administrator) was notified of an immediate jeopardy (IJ) situation related to the facility's failure to do the following: - Failure to have a system in place to ensure Resident 52's hands and personal property were clean and free from blood. - Failure to ensure the physician orders were followed to keep growth on top of her/his head clean, dry, and covered with gauze at all times to prevent infection and to contain blood. - Failure to have a system in place to ensure staff followed appropriate infection control practices and standard precautions. - Failure to ensure residents and staff did not contract Viral Hepatitis C. On 1/9/23 at 7:28 PM the facility submitted a removal plan which was reviewed and approved. The IJ removal plan indicated the facility would implement the following actions: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Resident 52 was moved to a private room and was assigned a one-on-one caregiver 24 hours a day seven days a week as of 1/9/23 at 7:00 PM. The resident's room was stocked with uncontaminated furniture and a commode to reduce the use of the communal bathroom. Resident 52's former room was completely disinfected by housekeeping as soon as the resident moved. - The assigned one-on-one caregiver would have gloves, appropriate alcohol-based hand sanitizer, and clean rags and/or paper towels to clean the resident's hands. When the resident's hands become visibly soiled the one-on-one caregiver would take the resident to the sink and wash her/his hands with soap and water. The resident's clothing would also be changed when contaminated. If the resident refused to change clothes or wash her/his hands, she/he would be re-approached by the one-on-one caregiver or nurse every 15 minutes until the task (washing hands or changing clothes) was completed. - The one-on-one caregiver would have separate red biohazard bags and garbage bins available in the resident's room, one for any waste, another for laundry, washable linen, and clothes. The one-on-one caregiver would have virucidal disinfectant to clean the surfaces in the resident's room when she/he was contaminated with blood. Housekeeping would clean the resident's room once each day shift and evening shift. PPE supplies would be set up in three drawer infection control bins accessible to staff. The supplies would be used in the room and on the portable tote, stocked with appropriate disinfectants and used by the one-on-one caregiver when the resident was up and ambulating. - The IP, RN Educator, or Staffing Coordinator would educate each CNA prior to becoming a one-on-one caregiver. If education was needed after hours, the charge nurse would provide the education. The education would be provided verbally and with a handout for reference. A copy of this education would be kept in the three-drawer bin located in the resident's room. This education would include disinfectant wipes, contact time, standard precautions, and what to do when the resident was mobile. The education would also include the duties expected of the one-on-one caregiver. There would be a sign off sheet when the education was completed for each CNA. Housekeeping would disinfect all community high touch areas four times a day and as needed. This would be done after breakfast and lunch, before dinner, and at bedtime. - A clarification was added to the physician order on the TAR as follows: if resident refuses the dressing changes per MD order re-approach in 15 minutes (one-on-one caregiver will stay with the resident to clean anything she/he touches). - An order was obtained from the physician to start hydroxyzine (anti-itch medication) TID to reduce the resident's anxiety, itching, and picking at wounds. - Hand hygiene will be done for each resident before and after each meal in addition to morning and bedtime routine and as needed for the bathroom/sneezing/touching nose and mouth or any other contamination. A portable tote with appropriate virucidal disinfectant for the one-on-one caregiver would be supplied when the resident was up and ambulating. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- A stat lab order was received and sent to the lab to confirm whether the resident had Viral Hepatitis C. If the resident's lab results showed the resident was positive there would be an order to treat if clinically appropriate. An order was received to test and treat all residents and staff for Hepatitis C, if the resident's lab results came back positive. Resident 52's Viral Hepatitis C diagnosis was from 2014. The facility would seek clarification if the Viral Hepatitis C was treated at that time. The resident was placed on alert charting for the nurse to check in with the resident and her/his one-on-one caregiver every hour to ensure the resident was free of blood on her/his clothing or body. On 1/10/23 at 10:00 AM the survey team determined all components of the IJ removal plan were in place and the immediacy was removed. Following the removal of the immediacy, noncompliance remained at isolated with no actual harm with potential for more than minimal harm that is not IJ. 41458 2. Based on observation, interview and record review it was determined the facility failed to ensure proper infection control practices were followed during meal service for 2 of 3 hallways. This placed residents at risk for infections. Findings include: a. Resident 59 was admitted to the facility in 11/2022 with diagnoses including stroke and hemiplegia/hemiparesis (the loss of ability to move part or most of the body) of the non-dominant side. Resident 59's 11/18/22 Admission MDS indicated the resident was cognitively intact. On 1/13/23 at 11:47 AM Staff 3 (RNCM) and surveyor were with Resident 59 when Staff 31 (CNA) brought Resident 59's lunch into her/his room. Staff 31 removed the plastic wrap from Resident 59's plate then set the plate followed by cups of liquid on the bedside table approximately one inch from Resident 59's partially filled urinal. Staff 3 observed Staff 31 place the uncovered food and cups of liquid next to and near Resident 59's partially filled urinal and in approximately two to three minutes, Staff 3 left the room and returned with Staff 31. Staff 3 asked Staff 31 to remove the urinal from the bedside table, remove and discard the food and liquids from the bedside table, disinfect the bedside table and provide the resident with a new plate of food and liquids once the bedside table was disinfected. Staff 3 confirmed this practice was an infection control problem. On 1/17/23 at 2:13 PM Resident 59 stated staff frequently placed her/his food and liquids on the bedside table next to or near the urinal. Resident 59 stated she/he did not like staff putting her/his food and liquids next to the urinal, she/he asked staff to move the urinal but it was always a major issue to get anything done. Resident 59 stated sometimes she/he was laying in bed and staff put the nearly full urinal right by her/his plate of food then placed the bedside table over her/him so she/he could eat. Resident 59 stated her/his urinal sometimes sloshed over and spilled on her/his bedside table or bed linens and smelled. The resident stated the urinal often left a ring on the bedside table and staff put her/his silverware in the dirty area. Resident 59 stated she/he would not have pee sitting on her/his dining room table at home and did not want that done at the facility, either. On 1/18/23 at 11:19 AM Staff 1 (Administrator) and Staff 2 (DNS) were provided with the findings of this investigation and acknowledged this practice was an infection control concern. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	46053 b. A review of the facility's 2020 COVID-19 Infection Control Prevention policy revealed: Staff will encourage and assist residents with hand hygiene prior to and after each meal . Resident 55 was admitted to the facility in 2/2022 with diagnoses including calculus of the bile duct with acute cholecystitis without obstruction (a condition characterized by stones in the pathway connecting the liver with the small intestine). Resident 49 was admitted to the facility in 12/2022 with diagnoses including cerebral stroke. On 1/12/23 at 11:47 AM Staff 18 (CNA) was observed delivering lunch plates to Residents 55 and 49 in their shared room. Staff 18 entered the residents' room without performing hand hygiene, adjusted Resident 55's bedding and call light and then cleared and repositioned her/his tray table. Staff 18 then exited the room, collected Resident 55's plate from the cart in the hallway, returned to place it on her/his table and removed the plastic cling wrap covering the food. Without performing hand hygiene, Staff 18 approached Resident 49's bedside and cleared and adjusted her/his tray table. Staff 18 exited the room, collected Resident 49's plate from the cart in the hallway and returned to place it on her/his tray table. Without performing hand hygiene, he removed the cling wrap covering the plate. He then returned to the cart in the hallway, collected two sets of cutlery wrapped in napkins, returned to the room and placed them on the Residents' tray tables. Staff 18 did not perform hand hygiene during this process nor did he offer assistance to Residents 49 and 55 to perform hand hygiene. Staff 18 confirmed he sometimes performed hand hygiene during this process but did not do it today. On 1/19/23 at 1:40 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 5 (RN/IP) acknowledged these findings and provided no further information. c. On 1/8/23 at 12:04 PM Staff 30 wore gloves as she pushed a lunch cart on the east hallway. Staff 30 removed plastic wrap on the lunch plates and delivered the plates to four of four rooms with no hand hygiene or change of gloves. On 1/13/23 2:32 PM Staff 30 confirmed she did not perform hand hygiene or change gloves when she passed the lunch plates. On 1/19/23 at 1:40 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 5 (RN/IP) acknowledged these findings and provided no further information. 3. Based on observation and interview, it was determined the facility failed to process laundry in accordance with accepted national standards in order to produce hygienically clean laundry and prevent the spread of infection to the extent possible for 2 of 2 laundry washing machines reviewed for infection control. This placed residents at risk of contaminated laundry. The findings include: According to the Center for Disease Control and Prevention: Guidelines for Environmental Control in Healthcare Facilities (2003); Laundry and Bedding Section G.II.D: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Do not leave damp textiles or fabrics in machines overnight. On 1/10/23 at 9:12 AM Staff 9 (HK/Laundry Supervisor) stated the laundry staff removed the final load of laundry from the washers and placed it in wire baskets at the end of every evening shift at approximately 10:00 PM. She reported housekeeping staff loaded wet laundry into the dryers at 6:30 AM the following morning. On 1/11/23 at 10:58 PM Staff 38 (LPN) provided access to the locked laundry facility using her key. No laundry staff were working and this part of the facility was locked for the night. Wet laundry was observed in two wire baskets covered with sheets and stationed adjacent to the two dryers. The sheets that covered the baskets were observed to be wet. Staff 38 confirmed the laundry was clean and wet and stated laundry should not be stored wet because mold and mildew could grow under these conditions. On 1/12/23 at 8:46 AM Staff 9 confirmed the wet laundry that was observed in the baskets on 1/11/23 at 10:58 PM was loaded into the dryers by laundry staff this morning without being rewashed. She stated this was how the laundry was handled every day. On 1/19/23 at 1:40 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 5 (RN/IP) acknowledged these findings and provided no further information. 4. Based on interview and record review, it was determined the facility failed to develop and implement a water management program and conduct a risk analysis assessment for potential areas of growth and spread of water borne pathogens. This placed all residents at risk for exposure to water borne pathogens. Findings include: On 1/17/23 at 2:25 PM Staff 8 (Maintenance Director) reported he did not complete a thorough analysis of the facility's water systems to identify and address the risk of water borne pathogens such as legionella. He reported his current plan to limit the risk of exposure to potentially harmful water borne bacteria involved flushing the eye wash stations regularly. He reported he did not complete regular testing of the facility's water supply nor did the facility contract with an agency to conduct a risk assessment or testing of the water supply on their behalf. Staff 8 confirmed the absence of a sustainable plan to mitigate the risks associated with the potential growth of water borne pathogens within the facility's water system. On 1/19/23 at 1:40 PM Staff 1 (Administrator), Staff 2 (DNS) and Staff 5 (RN/IP) acknowledged these findings and provided no further information.