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	345174	A. BUILDING _____ B. WING _____	C 08/07/2024

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ELEVATE HEALTH AND REHABILITATION	91 VICTORIA ROAD ASHEVILLE, NC 28801

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E 000	Initial Comments An onsite recertification and complaint investigation survey was conducted from 07/22/24 through 07/26/24. The survey team returned to the facility to validate the facility's credible allegation for IJ removal on 08/01/24. Additional information was obtained offsite on 08/7/24. Therefore, the exit date was changed to 08/07/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# RBC711.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 07/22/24 through 07/26/24. The survey team returned to the facility to validate the facility's credible allegation for IJ removal on 08/01/24. Additional information was obtained offsite on 08/7/24. Therefore, the exit date was changed to 08/07/24. Event ID# RBC711.Event ID# RBC711. The following intakes were investigated: NC00207911, NC00208153, NC00209329, NC00210231, NC00210289, NC00210445, NC00211048, NC00211222, NC00211540, NC00213961, NC00214383, NC00214484, NC00214651, NC00215127, NC00215394, NC00215499, NC00216630, NC00216816, NC00217062, NC00217605, NC00217699, and NC00219690. 16 of the 62 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K) CFR 483.25 at tag F684 at a scope and severity (J)	F 000		

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

Electronically Signed | 08/25/2024

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F 000	Continued From page 1 CFR 483.25 at tag F690 at a scope and severity (K) The tags F684 and F690 constituted Substandard Quality of Care. Immediate Jeopardy began for F580 and F690 beganon 05/16/24 and was removed on 07/27/24. Immediated Jeopardy for F684 began on 7/24/24 and was removed on 7/26/24. An extended survey was conducted.	F 000		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		8/10/24

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F 580	Continued From page 2 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and Medical Director (MD) interviews, the facility failed to notify the physician of a Urologist appointment on 5/16/24 for Resident #53 that resulted in an order for a CT (computed tomography) scan for renal stones (small, hard deposit that forms in kidneys) and a follow-up appointment following the CT scan to determine treatment which included surgery for removal of renal stones and right ureteral (tubes composed of smooth muscle that transport urine from the kidneys to the urinary bladder) stent exchange (procedure that replaces an existing stent with a new one) not being completed. Resident #53 experienced and was	F 580	1) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. On 7/25/24, the Medical Director (MD) was notified by the Director of Nursing (DON) of Resident #31□s right heel wounds and treatment orders received and implemented. 2) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible	

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treated for urinary tract infections (UTI) and on-going hematuria (blood in urine) while waiting to see the urologist. Resident #53's prolonged treatment for his renal stones made him susceptible to persistent kidney obstruction, which could cause permanent kidney damage and a higher risk for sepsis (bodies improper response to an infection). This deficient practice affected 2 of 3 residents reviewed for notification (Resident #53 and #31).

Immediate jeopardy began on 5/16/24 when the facility failed to notify the physician of ordered treatment from the urologist following a urology appointment for Resident #53. Immediate jeopardy was removed on 7/27/24 when the facility implemented an acceptable credible allegations of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put into place are effective.

Example #2 for Resident #31 was cited at a scope and severity of D.

Findings included:

1. Review of Resident #53's hospital discharge summary dated 4/25/24 revealed he had been hospitalized from 4/18/24 to 4/25/24 for obstructing ureteral stones with hydronephrosis (swelling of one or both kidneys due to urinary buildup), UTI, and sepsis. Diagnostics showed he had an obstructing right mid ureteral stone with upstream moderate hydronephrosis and several

allegation of immediate jeopardy removal.

On 8/5/2024, the treatment aide completed body audits on all current residents and the DON discussed findings with the MD ensure appropriate notification of resident wounds and skin concerns.

3) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal.

Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency licensed nurses on their responsibility to notify the MD or Nurse Practitioner (NP) with changes in resident condition, including medical referrals/appointments and follow-up orders from outside medical providers and new resident wounds or changes in skin condition. Newly hired facility and agency licensed nurses not receiving education by 8/9/24, will receive education prior to first worked shift. The DON will monitor and track education completion.

4)The DON, ADON or UM will audit five (5) random residents to ensure the MD/NP is notified of outside medical referrals/appointments and any new orders and of new wounds or changes in skin condition. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the

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F 580	Continued From page 4 punctate (stone with sharp points) left ureteral stones. Urology was consulted during his hospitalization to provide intervention for his urinary obstruction. He was taken to the operating room on 4/19/24 by the urologist and a stent was placed in his right ureter. His discharge summary read in part, return to the facility today, follow-up with urology next 1-2 weeks, for needed surgery for treatment of renal stones and possible stent exchange. Resident #53 was readmitted to the facility on 4/25/24 with diagnoses including calculus (kidney stones) of kidney, UTIs, sepsis, and aphasia (language disorder affecting communication). Review of facility transportation schedule for May 2024 revealed Resident #53 had a scheduled urology appointment on 5/16/24 at 9:00 AM. There was no record of the 5/16/24 urology appointment or office notes from the appointment in Resident #53's electronic medical record. A telephone interview was conducted on 7/24/24 at 1:18 PM with the Urology Office Practice Manager. The practice manager revealed Resident #53 was seen at the urology office for a scheduled appointment on 5/16/24 accompanied by staff from the facility. After reviewing the office note from 5/16/24, the practice manager stated Resident #53 was seen for follow-up for renal stones and stent placement and recommended order for CT scan to determine treatment for renal stones and stent. She revealed Resident #53's order for the CT scan for renal stones was completed by the urology office during the visit, uploaded into the system, so it would be available for imaging when the CT appointment was made.	F 580	once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with MD/NP notification requirements. Completion Date: 8/10/2024	

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The practice manager stated the facility was responsible for making sure the imaging appointment was made to complete the CT scan and then once the CT scan was completed a follow-up appointment would need to be made for treatment. She revealed this information was verbally discussed with Resident #53 and the facility staff that accompanied him to the visit and provided in writing as part of the office note given to the facility staff on that day. She stated the facility never followed through with making the appointment for the CT scan and the order from 5/16/24 was still in the system, and according to Resident #53's records no referrals or request for appointments had been made until last week on 7/18/24, when an appointment was requested for Resident #53's on-going hematuria and scheduled for 8/07/24.

Review of urology office note dated 5/16/24 read in part: Resident #53 was accompanied to appointment by nursing assistant (NA) #11, ordered for CT scan of renal stones to be completed to determine size and quantity of renal stones and then follow-up appointment with urology for surgical treatment to remove renal stones and stent placement. The surveyor requested and received a copy of this office visit note dated 5/16/24 from urology office on 7/24/24.

Review of Resident #53 medical progress notes from May 2024 through July 2024 revealed the following:

A medical provider progress note dated 6/11/24 read in part: follow-up visit for urinary problems, Resident #53 was found to have blood in urine by staff, an order was provided for a urinalysis (UA)

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and complete blood count (CBC). Plan of treatment: monitor for further hematuria, UA pending, KUB (kidney, ureter, bladder) ordered and pending.

An order entered by the Medical Director (MD) dated 6/11/24 read in part: one time UA with C&S (culture and sensitivity) for blood in urine and complaint of pelvic pain and one-time KUB for pelvic pain.

Lab results showed Resident #53 had a UA, CBC, and CMP (complete metabolic panel) completed on 6/12/24. The urine C&S report dated 6/14/24 showed CBC and CMP were normal, UA showed 3+ blood, 2+ leukocytes, nitrite positive, and urine culture was negative with no growth and range within normal limits. KUB showed replacement of g-tube was needed due to cap malfunction.

A medical provider progress note dated 6/14/24 read in part: follow-up visit: Resident #53 had recurrent hematuria, and last two cultures had no growth. Plan of treatment: follow up urine culture, start cefadroxil (antibiotic to treat bacterial infections) empirically (antibiotics are administered prior to the specific cause of the infection is known) considering hematuria, check CBC, referral to urology for recurrent hematuria.

An order entered by the MD dated 6/14/24 read: order for urology consult.

A progress note from the Nurse Practitioner (NP) dated 6/17/24 read in part: Resident #53's urine culture remains negative, plan to continue with antibiotics due to hematuria and urology appointment pending.

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A medical provider progress note dated 6/18/24 read in part: start antibiotic empirically considering hematuria and pyuria (high levels of white blood cells in urine), have to treat empirically with evidence of UTI but no growth, referral to urology for recurrent hematuria to evaluate for other possible causes as well

A progress note from the NP dated 6/21/24 read in part: Resident #53 still has blood in his urine, currently on antibiotics for UTI although cultures were negative, urology appointment pending.

A nursing progress note dated 6/25/24 read in part: staff noted Resident #53 crying "ow" when peri care performed, some redness noted to testicles and dark red/brown urine noted to briefs. Peri care was performed and cream to peri area applied. Staff will continue to notify the physician for continuation of Resident #53's symptoms while on antibiotics and will continue to monitor.

A progress note from the NP dated 6/25/24 read in part: Staff reported dark urine in Resident #53's brief, he denies any pain, fever, or chills. He is more interactive today than typical, smiling, in no distress. Able to speak a few words. He has urology appt pending for hematuria. Recently completed antibiotic for suspected UTI. He denies issues today, history always difficult to obtain due to aphasia but he is more interactive today than usual and shakes his head "no" and says "no" when I ask about pain, fever or chills. Dark urine may be due to known hematuria, urology appt pending. Recently finished antibiotics for suspected UTI although cultures were negative. No signs of infection today, vitals stable, mood stable.

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A medical provider progress note dated 7/02/24 read in part: Resident #53 had recurrent hematuria, last two cultures had no growth though evidence of UTI present through inflammatory cells, started empiric antibiotics. Plan of treatment: treated with antibiotics empirically considering hematuria and pyuria, however hematuria persists, urology appointment previously requested and remains pending to evaluate for other possible causes as well such as bladder tumor.

A progress note from the NP dated 7/10/24 read in part: continued blood in urine per staff, urology appointment pending for hematuria.

A medical provider telehealth note dated 7/14/24 read in part: hematuria with foul odor. Orders received: Obtain CBC (rule out anemia), UA w/ CX (test for germs or bacteria in urine that can cause an infection) (rule out infection) STAT (with no delay) and notify a clinician of any change in condition.

A progress note from the NP dated 7/15/24 read in part: Staff reported blood in urine with an odor, UA was ordered over the weekend by the on-call physician but had not been completed. Resident #53 reports pain from urinating, although it is difficult to get a full answer due to aphasia. Resident #53 nods 'yes' when asked if he had fever or chills, nods "no" to back pain or nausea. Plan of treatment: UA for odor and potential dysuria. Resident #53 has had blood in his urine for the last few weeks and is pending urology appt.

Lab results showed Resident #53 had a UA

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completed on 7/16/24. The urine C&S report dated 7/18/24 showed no growth of organisms and levels within normal limits.

An order was received from the NP on 7/18/24 for urology consult.

An interview was conducted on 7/23/24 at 1:47 PM with the Medical Director (MD). The MD revealed he was familiar with Resident #53 and his on-going bladder issues. He stated Resident #53 was seen at the hospital in April 2024 for altered mental status and was diagnosed with a UTI and sepsis secondary to renal stones and required placement of a stent. He revealed Resident #53's hospital discharge recommendations were for him to follow-up with urology within 1-2 weeks for needed surgery as treatment for his renal stones and stent exchange. The MD stated to his knowledge there had not been a urology consult scheduled for Resident #53 at this time, although he had ordered and continued to note the need for a urology consult in his progress notes and asked surveyor if "she could possibly make the appointment" since one had not been made. He revealed Resident #53 had on-going hematuria with no positive UA and needs a urology appointment to determine further treatment.

An interview was conducted on 7/25/24 at 11:07 AM with the Director of Nursing (DON). She stated she had started her employment as the DON at the facility on 5/28/24 but had previously worked at the facility as the DON for a year prior. She stated she was not employed with the facility during the time of Resident #53's hospitalization in April 2024 and was not aware of him being seen for a follow-up appointment with urology on

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5/16/24 and she had not been made aware of any orders from that appointment for a CT scan of renal stones to be completed or a follow-up appointment for treatment needing to be made. She revealed the facility should have made sure the physician was aware of Resident #53's urology appointment on 5/16/24 and the outcomes from the appointment to ensure the CT scan and follow-up appointment had been completed in a "timelier manner" especially since Resident #53's on-going hematuria could have been from the renal stones and stent placement and all his UAs were normal.

A follow up telephone interview was conducted on 7/25/24 at 2:48 PM with the MD. The MD stated he had no knowledge of Resident #53 being seen for a urology appointment on 5/16/24 and had never received any orders or office visit notes from that appointment for him to review. The MD asked how the Surveyor was made aware of the urology appointment the resident had on 5/16/24. The MD was informed the appointment was listed on the facility transportation schedule for May 2024 and the Surveyor contacted the urology office for information about the appointment and received the office visit notes. The Surveyor read MD the note from the urology office visit on 5/16/24 and notified him of the order for the CT scan and need for follow-up appointment to determine treatment. The MD stated again he had no knowledge of the 5/16/24 appointment and reported he should be made aware of all resident appointments so he can know to look for visit notes from the appointment to review for any changes in medications, diet orders, and recommended treatments. He revealed he had written in Resident #53's progress notes since May 2024 to present that he needed a urology

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consult and wrote a specific order for a urology consult in June 2024 and each time he asked administration or nursing staff about the urology consult he was always told they were in the process of making the appointment or the appointment was pending. He stated physician orders should be followed and completed in a timely manner and Resident #53 matter should have been taken seriously and handled before now due to the seriousness with his on-going hematuria with normal labs. The MD revealed he believed due to Resident #53 having normal labs that his on-going bleeding was coming from his renal stones, stent, or from something possibly worse like a bladder tumor. He also revealed Resident #53 often appeared comfortable, and although his pain level was hard to determine due to his aphasia, Resident #53's pain would come and go depending on if the stones were moving. When the MD was asked if he was aware of Resident #53 having a urology appointment scheduled for 8/07/24, he stated no he had not been made aware of that appointment until now. The Surveyor informed the MD of the appointment.

An interview was conducted on 7/26/24 at 3:21 PM with the Administrator. The Administrator stated she began her employment with the facility in June 2024 and was not familiar with Resident #53's medical issues or his need for a scheduled consult appointment until now. She revealed the facility should have followed-up from Resident #53's May 2024 appointment and made sure all orders and recommendations were followed. She revealed the physician should be notified of all orders, recommendations, and follow-up appointments for residents, so they are followed by staff and completed in a timely manner.

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The facility was notified of immediate jeopardy on 7/26/24 at 6:56 PM.

The facility provided the following plan for IJ removal.

F580: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to notify the Medical Director of the appointment with the Urologist, order for CT scan, and follow-up appointment to schedule surgery for treatment. Resident #53 was seen by the Urologist on 5/16/24 and returned with orders for a CT scan for renal stones and a follow-up appointment to schedule surgery for treatment of the renal stones after the CT scan was completed.

On 7/26/24, the Quality Assurance Process Improvement (QAPI) Committee (Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS), Social Worker (SW), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ), and Medical Director (MD) held an Ad Hoc meeting to discuss root cause analysis of the facilities failure to ensure the physician is informed of any resident outside medical appointments and provided with any orders or notes from those appointments to be reviewed for any changes in treatment, medications, diet, orders for labs or scans, and follow-up appointments that would need to be scheduled. Root cause analysis determined that the facility failed during clinical morning meeting on 5/17/24 to ensure we received documents from the urology

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appointment on 5/16/24 which indicated the need for a follow up appointment, CT scan, and an appointment to schedule surgery. The facility has updated the clinical morning meeting process, upcoming appointment schedule and provided education.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On 7/26/24, the Regional Director of Clinical Services (RDCS) reviewed the current facility residents to ensure the Medical Director was made aware of upcoming appointments. Upcoming appointments for the next 30 days were placed on the electronic health record dashboard making them accessible to medical director and nurse practitioner.

Effective 7/26/24, all current facility and agency licensed nurses and medical records clerk were in-serviced on facility policy on Notification of Change and new process as follows: When a resident is admitted to the facility, the discharge summary is to be reviewed by the admitting nurse to determine if any appointments need to be made after discharge. The licensed nurse will then enter the order for the referral or appointment into electronic health record. This is also to include readmissions and consultations. The licensed nurse will notify the medical director (MD) of the need for an order on the discharge summary, on admission/re-admissions or consultations. The licensed nurse will then place a copy of the order in the medical record box located at each nursing station. Medical records will check each box every morning before the morning meeting and bring the copy of the order

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for the appointment or consultation to the morning meeting for review. The order will then be verified and entered/updated into the electronic health record (HER) system. A copy of the order will then be given to the transporter by the medical record staff member for the appointment to be placed on the calendar. A copy of the order will then be placed into the MD box for notification. Appointments will be entered onto the EHR dashboard during the daily meeting for MD to review. All appointments will be reviewed daily during the clinical morning meeting for accuracy and follow-up. The previous day's appointments will be reviewed during the daily clinical meeting to make sure that any correspondence has been reviewed and followed up on. Newly hired facility and agency licensed nurses not receiving education by 7/26/24, will receive education prior to first worked shift by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), or Administrator.

Effective 7/26/24, the daily schedule will be monitored to ensure education is completed prior to the first shift worked. Education will be completed by the DON, ADON, UM, or Administrator and monitoring of completion will be tracked by the active employee report.

Effective 7/26/24, the Administrator and DON are ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 7/27/24

The credible allegation for the immediate jeopardy removal was validated on 08/01/24 with a removal date of 07/27/24.

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A review of in-service education records dated 07/26/24 indicated education was provided to the Medical Record Clerk and nurses including agency nurses on "Notification of change and new process" by DON. It was to ensure the Medical Director was informed of any residents outside medication appointments and provided with any orders or notes from those appointments to be reviewed for any changes in treatment, orders for labs or scans, and follow-up appointments that needed to be scheduled.

Interviews with the Medical Record Clerk and the nursing staff including agency nurses revealed they had been educated on notifying the Medical Director of upcoming follow up appointment, labs or scans, and an appointment to schedule surgery. They were able to describe the new notification process and verbalized understanding of the in-service education.

The audit completed by the Regional Director of Clinical Services on 07/26/24 was reviewed. The Medical Director was made aware of all residents' upcoming appointments.

The facility's date of immediate jeopardy removal of 07/27/24 was validated.
2. Resident #31 was readmitted to the facility on 6/19/24 with diagnoses that included non-pressure chronic ulcer of left heel and midfoot and diabetes mellites type 2.

Review of Resident #31's hospital discharge summary dated 6/19/24 revealed he had diagnoses of bilateral diabetic foot ulcers and peripheral arterial disease (PAD). The discharge summary revealed he had a chronic diabetic ulcer

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to his right forefoot and a new ulcer to his left lateral heel that required surgical intervention during his hospital stay.

Review of the podiatry office visit note dated 7/2/24 revealed he had a wound located to his right forefoot overlying the 4th metatarsal and a non-pressure chronic ulcer of the left heel and midfoot. The office note did not mention a wound to his right heel.

Review of the podiatry office visit note dated 7/22/24 stated Resident #31 was being seen for follow up of a wound, located on the right lateral dorsal (top) foot and left medial plantar (bottom of the foot) heel. Under the section of the note labeled: skin right foot and ankle the note read "ulcer, NEW blister on the medial heel".

An observation and interview were conducted with the Treatment Nurse Aide (NA) on 7/24/24 at 1:35 PM. The Treatment NA was observed performing the wound care for Resident #31's bilateral foot wounds. The Treatment NA stated that the wound to Resident #31's right heel was a "new wound". The Treatment NA explained she had found the right heel wound "one week and three days ago" while she had been performing the wound care for his other foot ulcers. The Treatment NA stated she had "been putting iodine on it every day". She said there was not an order for the iodine to be applied to Resident #31's right heel, the Treatment NA stated the Iodine was "an off the record thing". The Treatment NA stated she had told Unit Manager (UM) #1 about the new area to Resident #31's right heel and that UM #1 had told her to "put iodine on it". The Treatment NA said she had not spoken to anyone else about the right heel wound. The Treatment

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NA explained she could not enter orders into the electronic computer system and that she just remembered she needed to put Iodine on it every day.

An interview was conducted with UM #1 on 7/24/24 at 4:11 PM. UM #1 stated that she was not aware that Resident #31 had a new wound to his right heel. She said the Treatment NA had not come to her about the wound to Resident #31's right heel and that she had not told the Treatment NA to put Iodine on it.

A review of the electronic medical record for Resident #31 revealed there was not a treatment order for the right heel wound.

An interview was conducted with the Podiatrist on 7/24/24 at 5:31 PM. The Podiatrist stated that the wound to Resident #31's right heel was a new wound. She stated that she had seen the right heel wound during Resident #31's office visit on 7/22/24. The Podiatrist said the facility had not notified her about the new wound on the right heel. The Podiatrist stated that if the facility had notified her, she would have given treatment orders for the right heel.

An interview was conducted with the Medical Director on 7/26/24 at 3:05 PM. He stated that he knew Resident #31 had wounds to both of his feet but could not remember specifically where they were located. The Medical Director reviewed his notes and could not find where he had been notified of the new wound to Resident #31's right heel. The Medical Director stated he expected the staff to notify the wound care provider of new wounds or that they could notify him if unable to reach the wound care provider, so new wound

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F 580	Continued From page 18 care orders could be given. An interview was conducted with the Director of Nursing (DON) on 7/26/24 at 4:34 PM. The DON stated that the Treatment NA should have notified the nurse when she found the new wound to Resident #31's right heel and that then the nurse should have notified the physician to get new wound care orders. The DON said there were no wound care orders for the right heel because the Treatment NA had not reported the wound. An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator stated that the Treatment NA should have notified the nurse when she found the wound to Resident #31's right heel and then the nurse should have notified the physician and obtained orders for wound care. The Administrator stated there was a breakdown in communication.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		8/10/24

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right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to protect the private health information for 1 of 1 sampled resident by leaving confidential medical information unattended in an area accessible to the public (Resident #45).

The findings included:

Resident #45 was admitted to the facility on 12/21/22.

A continuous observation was made on 07/23/24 from 2:09 PM through 2:12 PM of an unattended wound care cart on the lower 200 hall. The Treatment Nurse Aide left the wound care cart unattended with the Treatment Administration Records (TAR) of Resident #45 visible on the wound care cart's computer screen. The screen

1) On 7/23/24, the Assistant Director of Nursing (ADON) provided immediate reeducation to the treatment CNA on residents right to confidentiality of private records when Resident # 45□s confidential medical information was left unattended in an area accessible to the public.

2) On 8/2/24, the Director of Nursing (DON) made an observational round of the facility to ensure staff are not leaving residents private medical information unattended and confidential medical information is maintained. No concerns observed.

3) Effective 8/9/2024, the Assistant

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F 583	Continued From page 20 showed the name and the picture of Resident #45. The surveyor could easily access information related to her current medications and other private health information. The unattended computer was accessible by anyone passing by the wound care cart. During an interview with the Treatment Nurse Aide on 07/23/24 at 2:15 PM, she explained while she was looking for Resident #45 to provide wound care, she answered a call light triggered in the hallway and it had distracted her. She forgot to turn on the privacy protection screen before leaving the wound care cart. She stated it was an oversight and acknowledged that it was inappropriate to leave residents' private health information unattended. She indicated that she had completed the Health Insurance Portability and Accountability Act (HIPAA) training provided by the facility a couple months ago. During an interview conducted on 07/24/24 at 9:58 AM, the Director of Nursing (DON) stated she expected all the nurses to turn on the privacy protection screen before leaving the wound care cart to ensure all the confidential personal and medical information were protected. It was her expectation for all the staff to follow the HIPAA guidelines when working in the facility. An interview was conducted with the Administrator on 07/24/24 at 10:05 AM. She stated the facility provided HIPAA training for all the staff during orientation and all the exiting staff would be re-trained at least once a year. Nursing staff should at least minimize the screen before leaving the computer unattended. It was her expectation for all the staff to safeguard residents' personal health information all the time.	F 583	Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency staff on residents right to personal privacy and confidentiality of his or her personal and medical records. Education also included the importance of never leaving computers unattended in an area that is accessible to the public. Newly hired facility and agency staff not receiving education by 8/9/24, will receive education prior to first worked shift. The DON will monitor and track education completion. 4)The DON, ADON or UM will audit five (5) random staff to ensure resident privacy is maintained. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with resident privacy requirements. Completion Date: 8/10/2024	

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F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Nurse Practitioner, Medical Director, and Podiatrist interviews the facility failed to apply the ordered dressing for a resident (Resident #31) with diabetic foot ulcers when the Treatment Nurse Aide (NA) applied a Coban 2 two-layer compression system (a two layer system: a Comfort Foam Layer (Layer 1) and a Compression Layer (Layer 2) that provides therapeutic compression) to Resident #31's feet instead of using regular Coban (a self-adherent wrap). Resident #31 experienced the toes on his right foot turning purple after the right foot dressing was applied by the Treatment NA and dusky gray skin discoloration under the left foot dressing when the dressing was removed. Had the dressing been left in place, there was a high likelihood for blood circulation problems, vessel blockage or development of new wounds. In addition, the facility failed to perform wound assessments for Resident #31 who had diabetic foot ulcers and failed to obtain treatment orders for a new wound that had been found to Resident #31's right heel one week and three days prior. This deficient practice occurred for 1 of 1 resident	F 684	1) Immediate jeopardy was removed for Resident #31 on 7/26/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility failed to follow physician□s orders for Resident #31□s diabetic ulcer to the right foot (aquacell silver, 4x4 gauze, kerlix and coban). Resident #31□s diabetic ulcer of the left foot (medihoney, aquacell, 4x4 gauze, kerlix and coban). The wound dressing for Resident #31 was removed and the correct dressing applied. 2) Immediate jeopardy was removed for Resident #31 on 7/26/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. Because all residents with wounds are at risk when a physician□s order is not followed and can cause worsening of the wound and other complications the following plan has been devised: On 7/25/2024, the licensed nurse unit manager immediately removed the	8/9/24

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F 684	Continued From page 22 reviewed for diabetic foot ulcers (Resident #31). Immediate jeopardy began on 7/24/24 when the Treatment NA applied Coban 2 two-layer compression system onto Resident #31's left and right feet instead of regular Coban during his diabetic foot ulcer dressing change. Immediate jeopardy was removed on 7/26/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective and to address the deficient practices in examples 1.b. and 1.c. The findings included: 1.a. Review of the package instruction inserts for Coban 2 two-layer compression system read in part: Coban 2 Compression system is not designed or intended for use except as indicated. Indications for use: Coban 2 Compression System is indicated for the management of venous leg ulcers, lymphedema and other clinical conditions where compression is appropriate. General considerations and warnings: 1. Coban 2 Compression System should be used under the supervision of a licensed health care professional, 2. Wrapping too tightly may impair circulation. Monitor the area of application frequently for signs of discoloration, pain, numbness, tingling or other changes in sensation and swelling. 3. At the discretion of the health care professional patients or their care providers can be trained to apply the bandage for	F 684	incorrect dressing from Resident #31□s right foot ulcer when notified by the surveyor that on 7/24/24 the incorrect dressing was applied. A registered nurse assessed the dressing on Resident #31□s left foot ulcer on 7/24/24 to ensure it was not impeding circulation with no alteration in circulation noted. On 7/25/24, the licensed nurse applied the correct dressing per physician□s order. On 7/25/24 the DON assessed Resident #31 for pain and completed a full skin assessment on resident there was no increase in pain or new skin alterations observed. On 7/25/24 the nurse practitioner assessed the resident and was notified of the incorrect wound dressing. No new orders were received at that time due to no harm or significant changes in wound status resulting from incorrect dressing. On 7/25/24 Resident #31□s family was present in the facility and notified of incorrect treatment. On 7/25/24 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of all current facility residents with all pressure and non-pressure wound care orders to ensure the correct physician ordered treatment was in place. All resident treatments and dressings were correct and matched the physician□s order. The Regional Director of Clinical Reimbursement (RDCR) reviewed resident□s care plans to ensure appropriate care plans were in place for all current facility residents with non-pressure and pressure wounds. The ADON removed the two-layer	

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F 684	Continued From page 23 subsequent applications. Directions for use: Apply the Compression System in a dorsiflexed position (foot at 90-degree angle). Layer 1: the inner comfort layer: Apply this layer with the foam side against the skin, using just enough tension to conform to the shape of the leg with minimal overlap. 1. Start the application with a circular winding at the base of the toes, beginning at the fifth metatarsal head (bone in the foot that connects to the base of the toes). 2. The second circle of winding should come across the top of the foot so that the middle of the bandage width approximately covers the articulating (location where two or more bones meet and join) aspect of the ankle joint. 3. Bring the next winding low, around the back of the heel leaving the plantar aspect (bottom of the heel) of the heel uncovered. Covering the plantar heel is not needed and extra winding over the ankle may make the completed application unnecessarily thick. 4. The layer may not conform completely over the Achilles tendon (tendon at the back of the leg that joins the muscles in the calf to the bone of the heel) area. The excess material will be smoothed down without discomfort when covered by the compression layer. 5. Proceed up to the knee with minimal overlap, using just enough tension to conform to the shape of the leg. Cut off excess material. Light pressure applied at the end of the bandage ensures that it stays in place during application of the compression layer. Layer 2: the outer compression layer. The compression layer is designed to be applied at	F 684	compression system from the treatment carts and supply room to ensure it would not be confused with coban. 3) Immediate jeopardy was removed for Resident #31 on 7/26/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. On 7/25/24, the Administrator, Director of Nursing (DON), Vice President of Operations (VPO), Regional Director of Clinical Services (RDCS), Unit Manager, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review the facility Wound Treatment Management Policy and to determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the facility failed to follow the Wound Treatment Management Policy by failing to follow physician□s order for wound care treatments due to basic human error related to the two-layer compression system bandage box being labeled Coban2 being applied instead of coban which was ordered (generic form labeled latex flexible cohesive bandage). A plan was formulated by the QAPI committee to address the identified issue to include a review of education, audit/monitoring needs, and QAPI committee responsibilities in reviewing for compliance. To address the root cause the facility implemented education on differentiating the two types of wraps and removed the Coban2 from the treatment	

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F 684	Continued From page 24 full stretch throughout the application. 1. Start the application with a circular winding at the base of the toes, beginning at the fifth metatarsal head. 2. Complete up to three figures of eight around the ankle ensuring the entire heel is covered with at least two layers. 3. Proceed up the leg with 50 % overlap to cover the entire inner comfort layer. Maintain consistent stretch throughout the bandaging process. 4. Following the application press lightly on the entire surface of the application to guarantee optimal conformability and to ensure that the bandage adheres to itself and to the inner comfort layer. Resident #31 was readmitted to the facility on 6/19/24 with diagnoses that included non-pressure chronic ulcer of left heel and midfoot and diabetes mellites type 2. Resident #31's hospital discharge summary dated 6/19/24 revealed he had diagnoses of bilateral diabetic foot ulcers and peripheral arterial disease (PAD). The discharge summary revealed he had a chronic diabetic ulcer to his right forefoot and a new ulcer to his left lateral heel that required surgical intervention during his hospital stay. The quarterly Minimum Data Set (MDS) assessment dated 6/24/24 revealed Resident #31 had moderate cognitive impairment. He was coded for being at risk for development of pressure ulcers. Resident #31 was also coded on the MDS for surgical wounds and surgical wound care. He had no behaviors or rejection of care documented. Resident #31 had a surgical wound care plan last revised on 6/21/24 for right lateral foot converted	F 684	carts and supply room. On 7/25/24, the DON and ADON completed education to current facility and agency Licensed Nurses on the facility Wound Treatment Management Policy and Medication Orders Policy. Education included the following: a) the facility□s wound care protocol and the expectation of each Licensed Nurse for following physician□s orders when administering wound care b) the 5 p□s circulation acronym pain, pallor, pulse, paresthesia, and paralysis when observing resident□s for circulatory compromise related to wound treatment dressing and role of Licensed Nurse c) how to differentiate two layer compression system from coban when administering wound treatments d) the risks of applying the incorrect dressing that could include worsening wounds, tourniquet effect, circulatory occlusion, infection, loss of limb. The current facility and agency Licensed Nurses and newly hired facility and agency licensed nurses not receiving education on 7/25/24 will not be allowed to work until completed. The DON will utilize an active employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the RDCS on 7/25/24. Education will also be included during orientation for newly hired facility and agency Licensed Nurse, to be completed by Director of Nursing or Nurse Manager. Effective 7/25/24, the facility will not assign unlicensed assistive personnel (UAP) to provide wound treatments moving forward. UAP staff and licensed	

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F 684	Continued From page 25 on 6/8/24 from diabetic ulcer to surgical wound post right foot incision and drainage. He also had a surgical wound care plan for left calcaneal (heel bone) and diabetic ulcer converted to surgical 6/15/24 post debridement and partial closure. The care plan goals included that the wounds would improve by next review and would not become infected. The care plan interventions included treatments as ordered. The podiatry office visit note dated 7/2/24 revealed he had a wound located to his right forefoot overlying the 4th metatarsal and a non-pressure chronic ulcer of the left heel and midfoot. Under instructions the note read: Right foot primary dressing: Aquacel silver (Ag) (an absorbent wound dressing with silver. The silver has antimicrobial properties), Secondary dressing 4x4 gauze, Kerlix (a gauze wrap dressing), and Coban (a self-adherent wrap). Left foot ulcer primary dressing: Medi Honey (wound treatment used to decrease bacteria in the wound bed), Aquacel Ag, secondary dressing 4x4 gauze, Kerlix, and Coban. Change dressings Monday, Wednesday, Friday and as needed for drainage. Resident #31's care plan last reviewed on 7/8/24 revealed he had a skin care plan for potential for impaired skin integrity related to decreased mobility, bladder/bowel incontinence and need for extensive assistance with bed mobility. The care plan goal was for Resident #31 to not develop further breakdown through the next review. The care plan interventions included: to conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. The podiatry office visit note dated 7/22/24 stated Resident #31 was being seen for follow up of a	F 684	nursing staff notified of change in staffing assignments by DON and ADON on 7/25/24. Effective 7/25/24, the DON notified a licensed nurse who has received education that they will be assigned to administer wound care treatments on 7/26/24. The ADON or DON will ensure a licensed nurse is assigned to provide wound treatments moving forward. 4)The DON, ADON or UM will audit five (5) residents with wound to ensure that treatments are administered with the correct dressing as ordered. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with quality of care for residents with wounds. Completion Date: 8/9/2024	

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wound, located on the right lateral dorsal (top) foot and left medial plantar (bottom of the foot) heel. Under the section of the note labeled: skin right foot and ankle the note read "ulcer, NEW blister on the medial heel". Right foot and heel primary dressing: Aquacel silver (Ag), Secondary dressing 4x4 gauze, Kerlix, and Coban. Left foot primary dressing: Medi Honey, Aquacel Ag, secondary dressing 4x4 gauze, Kerlix, and Coban. Change dressings Monday, Wednesday, Friday and as needed for drainage.

A review of Resident #31's active physician orders and Treatment Administration Record (TAR) for July 2024 revealed that Resident #31 had the following wound care orders:

- An order dated 7/10/24 that read: Left foot apply Medi Honey, Aquacel, 4x4, kerlix and Coban every day shift every Monday, Wednesday, Friday for wound care

- An order dated 7/10/24 that read: Right foot apply, Aquacel silver (Ag), 4x4, kerlix and Coban. every day shift every Monday, Wednesday, Friday for wound care.

A continuous wound care observation and interview was conducted on 7/24/24 from 1:35 PM to 2:22 PM when the Treatment NA completed wound care for Resident # 31.

The Treatment NA gathered the wound care supplies from the treatment cart that included: 4x4 gauze, wound cleanser, Kerlix, Medi Honey, and a box labeled "Coban 2 two- layer compression system" (provides high compression through a 2-layer compression bandage system, it is used in the treatment of conditions such as

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venous leg ulcers and lymphedema).

The Treatment NA removed Resident #31's left foot dressing. An ulcer was visible to the lateral left heel with areas of thick dark tissue along the edge, sutures were present along the edge, the center of the wound had areas of granulation (new) tissue and mild slough (by-product of the inflammatory phase of wound healing)

The Treatment NA sprayed wound cleanser on to a layer of 4x4 gauze and cleaned the left heel wound. She then applied Medi Honey to a layer of 4x4 gauze and applied it directly against the wound. The Treatment NA used kerlix to wrap the left foot from midfoot to approximately 3 inches above the ankle.

The Treatment NA opened the box labeled Coban 2 two- layer compression system and removed the two wraps from inside the box. She proceeded to wrap Resident #31's left foot using the foam layer from the 2-layer compression system box. She started the wrap at the left mid foot and wrapped it upward and around the ankle in a figure 8 pattern. The wrap extended approximately 3 inches above the ankle. She then overlapped the foam layer by wrapping it back down from the ankle to midfoot.

The Treatment NA wrapped the foam layer around the mid foot 3 times, cut the wrap using scissors, and smoothed it to self-adhere at the top of the midfoot. The wrap was applied with Resident #31's left foot in the dropped position.

The Treatment NA opened the outer compression layer wrap from the Coban 2 two- layer compression system. Starting at the left mid foot

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she wrapped the outer layer compression wrap over the foam layer in an upward motion to approximately 3 inches above the ankle and then back down to the midfoot. She cut the outer layer compression layer wrap with scissors and smoothed the wrap to self-adhere on the top of the mid foot.

The Treatment NA removed the dressing from the right foot. The Treatment NA sprayed wound cleanser on to a layer of 4x4 gauze and cleaned the right lateral forefoot wound. The wound was surgically closed with sutures. She applied Medi Honey to a layer of 4x4 gauze and applied it directly against the wound. The Treatment NA used kerlix to wrap the right foot from mid foot toward the toes and then back upward to mid foot and back to the toes four times.

The Treatment NA used the foam layer and wrapped the right foot starting at mid foot and down toward the toes then back up to mid foot 4 times until the remainder of the foam layer wrap was used. She smoothed the edge of the foam layer to self-adhere at the mid foot. She applied it with wrap to his right foot with the foot in the dropped position.

The Treatment NA then used the remainder of the compression layer wrap and wrapped Resident #31's right foot starting midfoot and down toward the toes and then back up to the mid foot three times. The wrap stopped at the top of the toe line and his toes were visible sticking out of the wrap.

An observation at 2:12 PM of Resident #31's right foot revealed all his toes were a dark purple color. The color of his left foot and toes was a normal fair ivory skin tone.

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The Treatment NA did not check the snugness of the wraps or the circulation to Resident #31's left or right foot after the wraps were applied.

The Treatment NA reapplied the off-loading boots to Resident #31's left and right foot. Adjusted his blankets and went to exit his room.

At 7/24/24 at 2:17 PM the Treatment NA was stopped by the surveyor and asked if Resident #31's toes on his right foot were normally a purple color. The Treatment NA went back to Resident #31's bedside to check his toes. His toes continued to be a purple color.

The Treatment NA stated that Resident #31's toes were not normally purple and that the dressing was too tight. The Treatment NA completely removed the outer layer compression wrap and the foam layer wrap from the right foot (the two wrap layers were adhered together). Once the 2-layer wrap was removed from the right foot, Resident #31's toes turned normal skin color and the purple discoloration resolved. The Treatment NA smoothed the wrap and then reapplied it with visible looseness around Resident #31's right foot. The color to the left foot and toes continued to remain normal skin color.

An interview was conducted with the Treatment NA on 7/24/24 at 2:24 PM. The Treatment NA explained she had used the box labeled "Coban 2 two-layer compression system" for Resident #31's wound care because the order had said to use Coban. The Treatment NA stated that she had not previously used the box labeled Coban 2 two-layer compression system for Resident #31's wound care. She explained she had first seen the

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Coban 2 two-layer compression system box on the treatment cart a couple of days ago. The Treatment NA stated she thought it had been ordered for Resident #31 because it said Coban on the box. The Treatment NA said she had previously used the individual packaged flexible cohesive bandage when doing Resident #31's wound care. The Treatment NA explained that when she had seen the new box labeled Coban 2 two-layer compression system on the treatment cart she had thought that was what she was supposed to use because the box said Coban on it and the packaging for the flexible cohesive bandage she had been using did not say Coban on it. She stated that she had used both wraps that had been in the Coban 2 two-layer compression system box because she thought the two wraps together was what Coban was. The Treatment NA confirmed that Coban was what had been ordered for Resident #31's wound care and not the two-layer compression wrap system she had applied. The Treatment NA stated she had not applied the Aquacel that was part of his treatment orders, because the facility had been out of Aquacel for two weeks. The Treatment NA stated she had told UM #1 that the Aquacel had been out.

On 7/26/24 at 10:15 AM a follow up interview was conducted with the Treatment NA. She stated that after performing Resident #31's wound care on 7/24/24 she went to the Assistant Director of Nursing (ADON) and told the ADON she had put the wrong wrap on when performing Resident #31's wound care to his feet. She stated she told the ADON she had applied the box labeled Coban 2 two-layer compression system instead of regular Coban. The Treatment NA stated she told the ADON that she had applied both wraps from

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the Coban 2 two-layer compression system box and did not think she had applied the correct wrap. The Treatment NA said she told the ADON she needed more information and clarification because she did not understand Resident #31's wound care orders and had done the dressing wrong. The Treatment NA stated she asked the ADON to check the dressings she had applied to Resident #31's feet to make sure the dressings were correct because she had applied the two-layer wrap instead of the regular Coban. The Treatment NA stated she had also talked to Nurse #4 and asked her to check the dressings she had applied to Resident #31's feet and asked her to assess his feet. The Treatment NA stated that she told Nurse #4 about Resident #31's right foot "toes turning blue" when she had applied the dressing to his right foot. The Treatment NA said she had received education on generic equivalent for brand name wound care products. She stated that she did not realize there was a generic for Aquacel.

An interview was conducted with the ADON on 7/25/24 at 3:52 PM. The ADON stated that the Treatment NA "had self-reported" after doing Resident #31's wound that she had done his dressings wrong. She stated that the Treatment NA had said she had messed up the entire dressings to Resident #31's feet and done it wrong. The ADON said she did not go and check the dressings on Resident #31's feet. The ADON stated she asked Nurse #4 to check Resident #31's dressings. The ADON explained Nurse #4 said the dressings to Resident #31's feet were put on correctly and looked fine and that was why she did not go look at it herself. The ADON said that on 7/24/24 Nurse #4 had assessed Resident #31 and checked his circulation and said it looked

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fine and the dressings on his feet were appropriate.

A telephone interview was conducted with Nurse #4 on 7/25/24 at 4:01 PM. Nurse #4 stated the Treatment NA was anxious about the dressings she had applied on Resident #31's feet and had asked her to assess the situation. Nurse #4 said she had looked at the bandages applied to his left and right feet and was able to insert her middle finger up under the dressing and that the dressings were not tight. Nurse #4 stated she checked Resident #31's circulation in his feet and it was good. Nurse #4 stated she did not see any purple discoloration to his toes or skin. She said she did not have any concerns about the dressings on his feet or she would have redone them. Nurse #4 confirmed that Resident #31 had a 2-layer wrap in place to his left and right feet. Nurse #4 said she could see a foam layer and then an outer layer when she assessed the dressings to Resident #31's feet. Nurse #4 said that she could not remember exactly what Resident #31's wound care orders were but that the order included Kerlix and then Coban for the finishing dressing. Nurse #4 stated that she had not checked Resident #31's orders before she had gone to assess and check his dressings. Nurse #4 stated "an upper management lady" had asked her to check the dressings, but she could not remember specifically who. She stated that the Treatment NA had also asked her to check Resident #31's dressings to his feet because she was worried about his profusion (blood flow to tissue) and had said she had done the dressing wrong.

A telephone interview was conducted with the Podiatrist on 7/24/24 at 5:31 PM. The Podiatrist

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said Resident #31 did not have sensation or feeling in his feet but that his toes turning purple on his right foot would mean the dressing was too tight. She stated that if the dressing to his right foot had been left in place it could have caused issues. She explained the issues that could be caused were circulatory/ occlusion issues with a tourniquet effect. It could cause irritation and could cause new wounds to develop if it was too tight. The Podiatrist said she had not ordered compression wraps for Resident #31. She said compression wraps were for patients with venous ulcers or who had a lot of swelling, and that Resident #31 did not have any of that and compression wraps were not appropriate for him.

An observation and interview were completed on 7/25/24 at 8:56 AM with Unit Manager (UM) #2 when she went to assess the dressings on Resident #31's feet. Resident #31 was lying in bed with his offloading boots on both feet. The same dressings were in place to Resident #31's feet that had been applied by the Treatment NA on 7/24/24. Resident #31's toes to his right foot were normal skin color. UM #2 removed the dressing from his right foot, there was no skin discoloration under the dressing. The wounds to his right foot had not changed in appearance from the prior observation on 7/24/24. Resident #31's left foot from the end of the dressing at his mid foot to his toes was a normal color. UM #2 removed the dressing from his left foot. Resident #31's skin that had been covered by the dressing had a noticeable color difference. His skin under where the dressing had been removed was a dusky light gray, you could see a prominent outline of where the dressing had been from the discoloration. There was a small maroon/ purple area of discoloration approximately 0.5 x 0.5 cm

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(centimeters) located on the top of his left foot located approximately 2 inches below the ankle. UM #2 confirmed there was a discoloration of the skin under where the dressing had been to his left foot. UM #2 stated she was not sure what the small maroon/ purple area of discoloration was to the top of his foot. UM #2 touched the area, and it did not blanch, she said the area did not feel raised or fluid filled. The wound to Resident #31's left heel was visualized with no changes from the prior observation on 7/24/24. When UM #2 removed the dressings from Resident #31's feet she stated there was a foam layer and then an outer layer over the foam and said it was the type of dressing she had seen used for compression wraps. UM #2 said Resident #31's orders were just for Coban and that she did not know why the Treatment NA had applied the Coban two-layer compression instead of just the Coban.

An observation and interview were conducted with the Nurse Practitioner (NP) on 7/25/24 at 12:50 PM. The NP said that if compression wraps were applied too tight in extreme cases it could cause blood flow impairment but more likely would cause skin irritation or breakdown. The NP said if compression wraps were not applied in accordance with manufacturer instruction/ direction it could cause worsening of wounds. She said if you used any product not as recommended or designed to be used it could cause issues. The NP removed the dressings from Resident #31's left and right feet. The skin color under the dressing to his left foot had normalized. The NP visualized the small area of purple discoloration to the top of Resident #31's left foot. The surrounding area of Resident #31's left foot was normal skin color. The NP said she was unsure what the area was. She said if

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Resident #31's foot was in the dropped position, she could feel that the area was over a boney prominence. The NP said she could not feel the boney prominence if the left foot was positioned in the flexed upward position. Resident #31 did not have sensation in his feet or complain of any pain when examined by the NP. The NP stated that the area could be a new area of irritation from his dressing or could possibly be a bruise from the area being bumped on something. She was unsure how he could have bumped into the area because he always wore foam padded offloading boots on both of his feet. The NP said that Resident #31 was not a reliable historian.

A telephone interview was conducted on 7/26/24 at 3:05 PM with the Medical Director (MD). The MD stated he had been informed there had been an issue with wound care for Resident #31. He said if Resident #31's dressing was applied too tight and was left on for too long it could cause issues. He said if Resident #31's right foot dressing had been left in place until the next time it was scheduled to be changed two days later it could have caused issues. He said the issues it could cause depended on how tight the dressing was and if it was tight enough to block blood flow. He said if the dressing created light pressure it could cause swelling or back up of venous blood. He said if the dressing was extremely tight the dressing could cause lack of blood flow and that could cause necrotic areas to occur but said that could take a while to occur. He said a while depended on how much blood flow the area was getting that it could be hours or days. He said Resident #31's dusky gray skin discoloration that had been under the left foot dressing could have been from the dressing but that he was not sure. He said with Resident #31's left foot toes being

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normal color it did not sound like blood flow had been compromised. He said Resident #31's right foot toes turning purple meant the dressing to his right foot had been applied too tight. The MD stated the Treatment NA should have followed wound care orders and not placed the Coban 2 two-layer compression system on Resident #31. The MD stated it had been human error that the Treatment NA had not known difference.

An interview was conducted with the Director of Nursing (DON) on 7/25/24 at 10:20 AM. The DON said the Coban that was part of Resident #31's order was to secure the dressing and was not for compression. She said the Treatment NA should have checked Resident #31's circulation and that the dressings to Resident #31's feet were not applied too tight. The DON stated the Treatment NA should have used what had been ordered for Resident #31's wound care dressings. She said the Treatment NA should not have used the Two-layer compression system and that she should have used regular Coban for his dressing change. The DON stated that if the dressing to Resident #31's right foot where his toes had turned purple had been left in place it could have caused an issue. The DON explained the dressing could have caused decreased circulation to his toes and that decreased blood flow could have caused more wounds and more problems for Resident #31. The DON said the dusky gray skin discoloration that had been present when the left foot dressing had been removed could be from it being applied too tight or from swelling.

An interview was conducted on 7/25/24 at 5:45 pm with the Administrator. The Administrator stated that the Treatment NA should have

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followed the wound care orders for Resident #31. She said the Treatment NA should not have placed compression wraps on Resident #31 if it was not part of his orders. The Administrator said that if the Treatment NA had been unsure if she was using the correct thing then she should have asked the nurse. The Administrator stated that the Treatment NA should have checked Resident #31's circulation after applying the dressings to his feet before leaving his room.

The Administrator was notified of the immediate jeopardy on 7/25/24 at 5:45 PM.

The facility provided the following allegation of immediate jeopardy removal.

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to follow physician's orders for Resident #31's diabetic ulcer to the right foot (aquacell silver, 4x4 gauze, kerlix and coban). Resident #31's diabetic ulcer of the left foot (medihoney, aquacell, 4x4 gauze, kerlix and coban).

Because all residents with wounds are at risk when a physician's order is not followed and can cause worsening of the wound and other complications the following plan has been devised:

On 7/25/2024, the licensed nurse unit manager immediately removed the incorrect dressing from Resident #31's right foot ulcer when notified by the surveyor that on 7/24/24 the incorrect dressing was applied. A registered nurse

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assessed the dressing on Resident #31's left foot ulcer on 7/24/24 to ensure it was not impeding circulation with no alteration in circulation noted. On 7/25/24, the licensed nurse applied the correct dressing per physician's order. On 7/25/24 the DON assessed Resident #31 for pain and completed a full skin assessment on resident there was no increase in pain or new skin alterations observed. On 7/25/24 the nurse practitioner assessed the resident and was notified of the incorrect wound dressing. No new orders were received at that time due to no harm or significant changes in wound status resulting from incorrect dressing. On 7/25/24 Resident #31's family was present in the facility and notified of incorrect treatment. On 7/25/24 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of all current facility residents with all pressure and non-pressure wound care orders to ensure the correct physician ordered treatment was in place. All resident treatments and dressings were correct and matched the physician's order. The Regional Director of Clinical Reimbursement (RDCR) reviewed resident's care plans to ensure appropriate care plans were in place for all current facility residents with non-pressure and pressure wounds. The ADON removed the two-layer compression system from the treatment carts and supply room to ensure it would not be confused with coban.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 7/25/24, the Administrator, Director of Nursing (DON), Vice President of Operations (VPO),

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Regional Director of Clinical Services (RDCS), Unit Manager, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review the facility Wound Treatment Management Policy and to determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the facility failed to follow the Wound Treatment Management Policy by failing to follow physician's order for wound care treatments due to basic human error related to the two-layer compression system bandage box being labeled "Coban2" being applied instead of coban which was ordered (generic form labeled "latex flexible cohesive bandage"). A plan was formulated by the QAPI committee to address the identified issue to include a review of education, audit/monitoring needs, and QAPI committee responsibilities in reviewing for compliance. To address the root cause the facility implemented education on differentiating the two types of wraps and removed the "Coban2" from the treatment carts and supply room.

On 7/25/24, the DON and ADON completed education to current facility and agency Licensed Nurses on the facility Wound Treatment Management Policy and Medication Orders Policy. Education included the following: a) the facility's wound care protocol and the expectation of each Licensed Nurse for following physician's orders when administering wound care b) the 5 p's circulation acronym pain, pallor, pulse, paresthesia, and paralysis when observing resident's for circulatory compromise related to wound treatment dressing and role of Licensed Nurse c) how to differentiate two layer compression system from coban when

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administering wound treatments d) the risks of applying the incorrect dressing that could include worsening wounds, tourniquet effect, circulatory occlusion, infection, loss of limb. The current facility and agency Licensed Nurses and newly hired facility and agency licensed nurses not receiving education on 7/25/24 will not be allowed to work until completed. The DON will utilize an active employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the RDCS on 7/25/24. Education will also be included during orientation for newly hired facility and agency Licensed Nurse, to be completed by Director of Nursing or Nurse Manager.

Effective 7/25/24, the facility will not assign unlicensed assistive personnel (UAP) to provide wound treatments moving forward. UAP staff and licensed nursing staff notified of change in staffing assignments by DON and ADON on 7/25/24.

Effective 7/25/24, the DON notified a licensed nurse who has received education that they will be assigned to administer wound care treatments on 7/26/24. The ADON or DON will ensure a licensed nurse is assigned to provide wound treatments moving forward.

Effective 7/25/24, the Administrator and Director of Nursing will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 7/26/24

On 07/26/24, the facility's credible allegation for immediate jeopardy removal with correction date

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of 07/26/24 was validated on-site by record review, observation, and interviews with staff.

Interviews with facility and agency licensed nurse interviews were conducted and revealed they had received education on the facility's wound treatment management policy and medication orders policy. The licensed nurses were able to verbalize the facility's wound care protocol and the importance of following physician orders when performing wound care. The licensed nurses stated they had received education on the 5 P's (circulation assessment that includes pain, pallor, pulse, paresthesia, and paralysis) explain of circulation and were able to verbalize what the 5 P's of circulation acronym stood for, the importance of checking for circulation after dressing application, and how to check for circulatory compromise. The licensed nursing staff stated they had been educated by the facility on the difference between Coban and Coban 2 two-layer compression system and expressed understanding of the difference. The licensed nurses verified that Coban 2 two-layer compression system had been removed from the treatment cart and supply room. All facility and agency Licensed Nurses and newly hired facility and agency licensed nurses that have not received the above in-service by 07/25/24 would not be allowed to work until they had completed this education.

The facility's treatments/ wound care was verified as no longer being performed by unlicensed assistive personal effective 7/26/24. A licensed nurse performed the treatments and wound care for residents was being performed by a licensed nurse. An observation was completed on 7/26/24 of the licensed nurse performing resident wound

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care. During the wound care observation, the licensed nurse performed the wound care in accordance with the physician orders with no issues identified. An observation was completed of Resident #31 on 7/26/24 and revealed he had the correct dressing in place to his feet.

The immediate jeopardy removal date of 07/26/24 was validated.

1.b. Review of Resident #31's care plan last revised on 6/21/24 revealed that he had a surgical wound care plan for: right lateral foot converted on 6/8/24 from diabetic ulcer to surgical wound post right foot incision and drainage. He also had a surgical wound care plan for: left calcaneal and diabetic ulcer converted to surgical 6/15/24 post debridement and partial closure. The Care plan goals included that the wounds would improve by next review and would not become infected. The care plan interventions included measure wounds weekly and document characteristics, and to observe for signs of infection.

Review of Resident #31's electronic medical record revealed there were no wound assessments for his left or right foot wounds.

Resident #31 had been seen by the Podiatrist in office for follow up of the wounds to his feet on 7/2/24 and 7/22/24.

Review of the electronic medical record revealed an order page date 7/2/24 from the podiatrist office. The document contained dressing change orders for his right foot and left foot wounds. The document did not contain any assessment information of his wounds from the office visit.

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There were no office visit notes in Resident #31's electronic medical record from his podiatry appointments on 7/2/24 or 7/22/24.

An interview was conducted with UM #2 on 7/25/24 at 8:56 AM. UM #2 said if a wound assessment needed to be completed it populated as a user defined assessment task on the residents' electronic medical record and that the UM or floor nurse would complete it. UM #2 said that the facility did not always do wound assessments for residents who were followed by the podiatrist for their wounds on the weeks they did not go to the podiatrist office. UM #2 said she thought Resident #31 went to the Podiatrist every 2 weeks. She was unsure if Resident #31's wounds were assessed by the facility on the weeks that he did not go to the podiatrist office.

An interview was conducted with the Assistant Director of Nursing (ADON) on 7/25/24 at 9:31 AM. The ADON said she was unsure how often Resident #31 was seen at the podiatrist office for evaluation and follow up of the wounds to his feet. She said the floor nurse or UM was responsible for doing the wound assessments on the weeks he did not go to the podiatrist office.

An interview was performed on 7/26/24 at 9:40 AM with the Minimum Data (MDS) Nurse. She stated that wound assessments should be done by the wound nurse weekly but that currently the facility did not have a wound nurse. The MDS nurse explained that the wound assessments were not scheduled for the nurses to do under the defined assessment task list. She stated the nurse would have to know they needed to complete the wound assessment and that the nurse would have to open the assessment

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specifically to complete it. The MDS nurse stated that wounds should be assessed weekly. She said if a Resident was going out of the facility for wound care the facility should still be doing a wound assessment every week and it should be done by the nurse.

An interview was conducted on 7/26/24 at 6:03 PM with the Podiatrist. She said that she had not specified the facility could not perform wound assessments for Resident #31. The Podiatrist stated she would not tell the facility they could not assess or measure Resident #31's wounds, she said that would be up to the facility and their protocol.

An interview was conducted on 7/26/24 at 3:05 PM with the Medical Director (MD). The MD said it was important for the facility to ensure they get the notes from Resident #31's podiatry office visits to outline the wound care orders. He said that wound monitoring and assessment should be done. He said the wound assessment and measurements helped determine if a wound was improving or declining and if the wound treatment was effective. He did not say how often the facility should be doing wound assessments for Resident #31.

An interview was conducted with the Director of Nursing (DON) on 7/26/24 at 4:24 PM. The DON said Resident #31 was seen by the podiatrist every 2 weeks for follow up of his left and right diabetic foot wounds. The DON stated that a wound assessment should have been completed by the floor nurse or UM, for Resident #31's wounds on the weeks that he did not go to the podiatrist office. The DON said the wound assessment helped determine if a wound was

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healing or deteriorating and if the treatment was working. The DON said she thought that the wound assessment for Resident #31's left, and right foot diabetic wounds not being done had occurred because the nurses had thought they did not need to do them since he was being seen at the podiatrist office. The DON said that was not correct and that the nurses should have done the wound assessments for Resident #31's wounds. The DON said the facility should have made sure they had the podiatry office visit notes and podiatry orders for Resident #31 and was not why it had not been done.

An interview was conducted with the Administrator on 7/26/224 at 5:23 PM. The Administrator stated that wounds should be monitored, assessed, and documented on weekly. The Administrator said there should be better communication between the facility and the podiatrist's office. She said the facility should have made sure they obtained the notes from Resident #31's podiatry office visits. She said she was not sure why Resident #31's wound assessments had not been done or why the facility did not have the notes from his podiatry office visits, but that it needed to have been done.

1.c. An observation and interview were conducted on 7/24/24 at 1:35 PM while the Treatment NA performed wound care for Resident #31. The Treatment NA pointed to a wound on Resident #31's right heel and stated the wound was a new wound. The wound was covered with thick tissue, with areas of brown and maroon discoloration. She said she had found the wound to Resident #31's right heel one week and three days ago. The Treatment NA said she had been putting iodine on the wound. The Treatment NA said

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there was not an order for the iodine that it "was an off the record thing".

Review of Resident #31's treatment administration record (TAR) and active physician orders for July 2024 revealed there was not a treatment order for the new wound to Resident #31's right heel or an order for iodine to be applied to the right heel. The facility did not have standing orders for wound care.

An interview was conducted with UM #1 on 7/24/24 at 4:11 PM. UM #1 said she was not aware of the wound to Resident #31's right heel. She was unaware that the Treatment NA had been applying iodine to the wound on Resident #31's right heel.

An interview with the Medical Director was performed on 7/25/25 at 3:05 PM. He said that the Treatment NA should have notified the nurse, and the nurse should have called the wound care provider or himself to obtain treatment orders for the wound to Resident #31's right heel.

An interview was conducted on 7/26/24 at 10:20 AM with the Director of Nursing (DON). The DON said the Treatment NA was not allowed to decide or change the treatment for a wound. She said the facility did not have standing orders for wound care. The DON said the Treatment NA should have notified the nurse of the wound to Resident #31's right heel so the nurse could obtain treatment orders from the physician.

An interview was conducted with the Administrator on 7/26/25 at 5:23 PM. The Administrator said the Treatment NA should have reported the new wound to Resident #31's right

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F 684	Continued From page 47 heel to the nurse so that the nurse could obtain wound care orders from the physician.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to follow physician orders for 2 of 3 wounds (pressure ulcer of the coccyx and pressure ulcer of the back) for 1 of 2 residents reviewed for wound care (Resident #3). The findings included: Resident #3 was admitted to the facility on 08/31/2021 and readmitted to the facility on 05/31/2024 with diagnoses which included chronic respiratory failure with hypoxia, end stage renal disease (ESRD), epilepsy, diabetes mellitus (DM), and congestive heart failure (CHF). Review of Resident #3's quarterly Minimum Data	F 686	1) On 7/24/24, the Director of Nursing (DON) notified the Medical Director of the wound treatment error for Resident #3 and no new orders received. Resident #3 will continue to receive wound treatments by a licensed nurse as ordered by the medical provider. 2) On 8/5/24, the DON made wound observations of the licensed nurse providing wound treatments to current facility residents with pressure wounds to ensure treatments are administered as ordered utilizing the correct dressing. An inventory audit was also completed on 8/5/24 by the DON to ensure availability of appropriate wound treatment supplies and	8/10/24

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F 686	Continued From page 48 Set (MDS) assessment dated 06/12/2024 revealed he had moderately impaired cognition with no behaviors. The MDS also indicated Resident #3 was totally dependent for all activities of daily. The assessment additionally revealed he had three unhealed stage IV pressure ulcers and had a pressure reducing device for bed, nutrition, and hydration interventions to manage skin problems, pressure injury care, and application of medications and dressings. Review of Resident #3's Treatment Administration Record (TAR) dated 07/01/24 through 07/25/24 revealed the following orders for wound care: Coccyx: Cleanse with wound cleaner, cover with calcium alginate (a highly absorbent material which manages moderate to heavy wound drainage and promotes a moist wound environment conducive for wound healing) and bordered foam dressing every day shift (7:00 AM to 7:00 PM) for wound healing. Lower back wound: Cleanse with wound cleaner, cover with calcium alginate and bordered foam dressing every day shift (7:00 AM to 7:00 PM) for wound healing. Review of the wound care Nurse Practitioner notes date 07/11/2024 revealed orders for: Coccyx Wound: Cleanse with ½ strength hypochlorite solution (diluted bleach), apply calcium alginate and foam dressing; change daily and as needed. Back Wound: Cleanse with ½ strength hypochlorite solution, apply calcium alginate and foam dressing; change daily and as needed.	F 686	dressings for residents as ordered by the physician. No concerns identified. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency staff licensed nurses on treatment and services to prevent and heal pressure wounds. Education also included the importance of following physician orders and utilizing the correct, ordered supplies and dressings to ensure appropriate healing. Newly hired facility and agency licensed nurses not receiving education by 8/9/24 will receive education prior to first worked shift. The DON will monitor and track education completion. 4)The DON, ADON or UM will audit five (5) residents with pressure wounds to ensure treatments are administered as ordered. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with treatment to prevent and heal pressure wounds. Completion Date: 8/10/2024	

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F 686	Continued From page 49	F 686		

An observation of wound care was made with Resident #3 on 07/24/2024 at 10:10 AM with the Treatment nursing assistant (NA). The Treatment NA gathered her supplies for the wound care and proceeded to change the dressing to Resident #3's coccyx. The Treatment NA positioned Resident #3 on his side and observed that the coccyx wound was open to air and there was no dressing intact to Resident #3's coccyx. The Treatment NA cleaned Resident #3's coccyx wound with wound cleaner, applied collagen powder (a powder that absorbs wound drainage while providing an optimal moist environment to enhance wound healing) to the wound and covered the wound with a bordered gauze dressing. The Treatment NA then moved to Resident #3's back wound, removed the old dressing, cleaned the wound with wound cleanser and applied medi-honey (an agent that supports the removal of dead tissue and aids in wound healing) to the wound bed and covered the wound with a bordered gauze dressing.

An interview was conducted with the Treatment NA on 07/24/2024 at 3:07 PM revealed she had been doing wound care for about one month. She further revealed that she was overwhelmed and could not remember everything that she needed to do with Resident #3's wound care. The Treatment NA also stated that she put collagen powder in Resident #3's coccyx wound and medi-honey on Resident #3's back wound. She further explained that she should have just used calcium alginate on both wounds according to the TAR. She also stated she was nervous about being watched and did a very bad job with Resident #3's wound care.

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An interview was conducted with the wound care Nurse Practitioner (NP) on 07/25/2024 at 12:58 PM. The NP revealed that she had cared for Resident #3 for quite a long time and his wounds were unavoidable due to his multiple co-morbidities and poor health status. She further revealed that she expected the facility staff to follow her wound care orders as written on her wound notes.

An interview on 07/26/2024 at 11:29 AM with the Director of Nursing (DON). The DON stated she expected the wound treatments to be done as prescribed by the wound care practitioner or the physician. She stated she thought the Treatment Nurse Aide was nervous about being watched during wound care and became overwhelmed. She further stated that the Treatment Nurse Aide also realized that she had provided incorrect wound care for Resident #3's coccyx and back wounds. The DON also stated that she could not explain the discrepancies between the ordered wound care treatments and the treatment that was provided by the Treatment Nurse Aide. She further explained that the most recent NP's wound care orders must have not been entered into the computer system and the old orders were still showing on the order panel for Resident #3.

An interview was conducted with the facility's Medical Director on 07/26/2024 at 3:11 PM. The Medical Director stated that he expected the nursing staff to follow physician orders for dressing changes and wound care.

An interview was conducted with the Administrator on 07/26/2024 at 5:07 PM. The Administrator revealed that she expected all orders, procedures, and protocols to be followed

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F 686	Continued From page 51 when providing wound care.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to ensure smoking assessments were completed accurately and timely to reflect residents smoking status and level of supervision for 2 of 5 residents reviewed for smoking (Resident #65 and Resident #57). Findings Included: 1. Resident #65 was admitted to the facility on 2/26/24 with diagnosis that included chronic respiratory failure and muscle weakness. Review of revised care plan dated 3/19/24 revealed Resident #65 was assessed as a supervised smoker and vaper and at risk for injury related to smoking activity. Interventions included, in part, inspect room every shift to ensure resident does not have vapes, if identified remove and if refuses room check notify administrator, supervised smoker, maintain	F 689	1) On 7/25/24, the licensed nurse completed smoking assessments for Resident #57 and Resident #65 to accurately reflect current smoking status as a supervised smoker and updated smoking care plan accordingly. 2) On 8/8/24, the Director of Nursing (DON) completed an audit of all current residents to ensure those who smoke have current smoking assessments that accurately reflect smoking status as independent or requiring staff supervision for safety. Revisions to care plans and updated smoking assessments were completed as needed. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency staff on ensuring residents are free from accident hazards specifically as it relates to residents who smoke and the need to	8/10/24

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lighting material at nurse's station, and direct supervision to be provided to resident during entire smoking period.

A review of Resident #65's electronic medical record revealed that he had a smoking assessment completed on 4/15/24 that indicated he currently smoked, did not wish to quit smoking, was assessed an independent smoker and did not require supervision while smoking.

The annual Minimum Data Set (MDS) dated 6/14/24 revealed Resident #65 was cognitively intact and was coded for tobacco use.

Observation and interview on 7/22/24 at 11: 15 AM revealed Resident #65 returning to his room from outside smoking area. Resident #65 stated he was only allowed to smoke during scheduled times and must be supervised by staff while smoking. No further observations of Resident #65 smoking were available due to him not wanting to go outside.

An interview was conducted with Personal Care Assistant (PCA) #1 on 7/24/24 at 1:04 PM revealed she had been employed with the facility for the past couple of months and part of her job responsibilities was to supervise smokers during their scheduled smoking times and provide them with their smoking materials and smoking aprons if required. She stated she was provided a list of unsupervised and supervised residents who smoke, and the unsupervised residents were allowed to smoke anytime and kept their smoking materials locked in a box located outside in the smoking area and were responsible for keeping up with the key. She revealed residents who required supervision while smoking had

provide supervision to those who are not deemed safe to smoke without staff supervision. Education also included the responsibility of the licensed nurse to complete a smoking assessment upon admission, quarterly and with changes in condition or smoking status. To ensure proper communication for staff who supervise residents who smoke, the DON will maintain a master smoking status log and post at the nurses station. The DON will also monitor smoking assessments for timely, accurate completion by the licensed nurse upon admission, quarterly and with changes. Monitoring will occur during morning clinical meetings and during weekly risk meetings while reviewing residents who smoke. Newly hired facility and agency staff not receiving education by 8/9/24 will receive education prior to first worked shift. The DON will monitor and track education completion.

4) The DON, ADON or UM will audit five (5) residents who smoke to ensure supervision independence is provided as per the smoking assessment and that assessments are completed accurately and timely. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks.

The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as

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F 689	Continued From page 53 designated smoking times they were allowed to smoke and their smoking materials were kept locked in a cart at the nurse station and staff providing the supervision were responsible for distributing the residents their smoking materials, lighting their cigarettes, supervising while smoking, and assist with extinguishing cigarettes when needed. The PCA #1 stated she was not responsible for completing smoking assessments and was only aware of a resident's smoking status from the provided smoking list. She revealed she was familiar with Resident #65 and that he preferred to smoke and vape. She stated when Resident #65 would come for scheduled smoking times she would assist him with removing his oxygen tank from his wheelchair prior to going outside to smoke. PCA #1 revealed she was not aware of Resident #65 being assessed as a safe smoker and the smoking list she had been provided had him listed as a supervised smoker. She stated to her knowledge there had been no smoking incidents with Resident #65 and no issues with his ability to smoke safely, except for him being caught with vapes in his room and believed maybe that was why he was required supervision. An interview conducted with the Director of Nursing (DON) on 7/25/24 at 11:07 AM revealed nursing staff were responsible for completing resident smoking assessments upon admission, annually and quarterly, or when a change in condition had occurred to determine if a resident was an unsupervised or supervised smoker. She stated these assessments were also reflected in the resident smoking care plan and on the smoking list that was provided to staff. She revealed Resident #65 had been made a supervised smoker several months ago due to	F 689	necessary to maintain compliance and ensure residents are free from smoking accidents. Completion Date: 8/10/2024	

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incidents of having vapes in his room, she was not sure why his last smoking assessment had him as an unsupervised smoker when staff should have assessed him as a supervised smoker. The DON stated all resident smoking assessments should be completed accurately to assure the correct information was being recorded on the resident care plan and the resident was being provided with the correct level of supervision.

An interview was conducted with the MDS Coordinator on 7/26/24 at 9:19 AM revealed she was not responsible for completing resident smoking assessments and would only review those assessments when completing the residents annual MDS assessment. She stated prior to completing the annual assessment, she would review the resident's most recent smoking assessment to assure the care plan reflected the resident smoking status per the assessment. She revealed nursing staff was responsible for informing her of any changes with a resident's smoking status and the most recent smoking assessment completed prior to Resident #33 annual MDS assessment showed he was a supervised smoker and that was what was reflected in his care plan.

An interview was conducted with Administrator on 7/26/24 at 3:21 PM revealed all resident smoking assessments should be completed accurately to assure the information reflected in the resident care plan and provided to staff was accurate and ensure the correct form of supervision was being provided.

2. Resident #57 was admitted to the facility on

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F 689	Continued From page 55	F 689		

3/31/23 with diagnoses that included dementia and nicotine dependance.

A review of Resident #57's electronic medical record revealed that he had a smoking assessment completed on 3/31/23 that indicated he currently smoked, did not wish to quit smoking, and required supervision while smoking. No additional smoking assessments had been completed for Resident #57 since 3/31/23

The quarterly Minimum Data Set (MDS) assessment dated 6/1/24 revealed Resident #57 was cognitively impaired. The quarterly MDS did not include information about tobacco use. Review of Resident #57's annual MDS dated 2/12/24 revealed he was coded for current tobacco use. He had no behaviors or rejection of care documented on either MDS.

Review of Resident #57's care plan last reviewed on 6/13/24 revealed he had a care plan for supervised smoking that stated: assessed to be a supervised smoker and at risk for injury related to smoking activity. The care plan goals included: adherence to facility smoking policy through next review date, will remain free from smoking related injuries through next review. The care plan interventions included: supervised smoker, assess for any safe adaptive equipment needs and implement as needed per assessment, offer smoking apron, maintain lighting material at the nurses station, direct supervision to be provided to resident during entire smoking period, intervene when smoking in unsafe manner or area, monitor for changes in ability to maintain safety during smoking and reassess as needed, monitor smoking patterns and behavior for poor

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safety.

Review of the facility provided supervised smoker list revealed Resident #57 was included on the list as a supervised smoker.

An interview was conducted with Resident #57 on 7/23/24 at 9:28 AM. He stated that he smoked cigarettes sometimes. He could not recall the last time that he had smoked.

An interview was conducted with Nurse #2 on 7/23/24 at 2:45 PM. Nurse #2 said that Resident #57 was an occasional smoker.

An interview was conducted with Nurse Aide (NA) #2 on 7/24/24 at 10:12 AM. NA #2 Resident #57 smoked cigarettes sometimes but was not an everyday smoker. NA #2 explained Resident #57 smoked when he was in the mood to do so. She did not say how often Resident #57 smoked. NA #2 said she had seen Resident #57 go outside and smoke recently during the last couple of weeks but was unsure when exactly.

An interview was conducted with NA #1 on 7/24/24 at 10:13 AM. NA #1 stated Resident #57 smoked cigarettes sometimes when he was in the mood to smoke. NA #1 stated she had seen Resident #57 outside smoking a couple of weeks ago. She could not say when exactly.

An interview was conducted on 7/24/24 at 2:48 PM with Unit Manager (UM) #2. UM #2 explained a smoking assessment was conducted on admission for all residents. UM #2 said a smoking assessment should also be completed anytime a resident started to smoke or requested to smoke. UM #2 said smoking assessments were then

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completed for residents who smoked quarterly but did not know who was responsible for completing them. UM #2 stated that during the morning meetings management would tell her if something such as an assessment needed to be updated or completed for a resident. She said no one had asked her to complete a smoking assessment for Resident #57.

An interview was conducted on 7/25/24 at 10:20 AM with the Director of Nursing (DON). The DON stated that smoking assessments should be done on admission, as needed for smoking changes, and then quarterly. The DON stated that Resident #57 should have had additional smoking assessments completed since his admission. The DON was unsure why Resident #57 smoking assessment had been missed.

An interview was conducted with the MDS Nurse on 7/26/24 at 9:19 AM. The MDS nurses explained she did not look for or review the smoking assessments when she did the care plan or MDS assessments. The MDS Nurse explained she knew who smoked because the facility had a lot of smokers and kept a list of who smoked. She said if someone started smoking then it was talked about in the morning meeting. The MDS Nurse stated the UM or floor nurses were supposed to do the smoking assessments quarterly and that Resident #57 should have had a smoking assessment completed quarterly. The MDS Nurse said she thought Resident #57's smoking assessment had been missed because he did not smoke all the time and that some staff had been unaware that he smoked.

An interview was conducted with the Medical Director (MD) on 7/26/24 at 2:55 PM. The MD

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F 689	Continued From page 58 stated that the facility should do smoking assessments for residents who smoke. He said smoking assessments should have been done for Resident #57. He did not say how often smoking assessments should be done. The MD said how the facility managed smoking was up to the facility policy and that he would defer to the facility policy on smoking. An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator stated that smoking assessments should be completed quarterly. She stated that Resident #57 should have had a quarterly smoking assessments completed. The Administrator did not know why Resident #57's quarterly smoking assessments had not been done.	F 689		
F 690 SS=K	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		8/9/24

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F 690	Continued From page 59 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Nurse Practitioner (NP), Medical Director, urology office staff, and the Urologist the facility failed to follow an order from a Urologist appointment on 5/16/24 for a CT (computed tomography) scan for ureteral stones and a follow-up appointment following the CT scan to determine treatment which included surgery for removal of ureteral stones and right ureteral stent exchange for Resident #53. Resident #53 was previously hospitalized for obstructing ureteral stones (kidney stones that get stuck in tubes composed of smooth muscle that transport the urine from the kidneys to the bladder) with hydronephrosis (swelling of one or both kidneys due to urine build up), urinary tract infection (UTI), and sepsis (a serious condition in which the body responds improperly to an infection). Resident #53 also had a stent (a small tube placed in the ureter that allows the urine to drain) placed for	F 690	1) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. 2) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. 3) Immediate jeopardy was removed for Resident #53 on 7/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. 4) The DON, ADON or UM will audit five (5) residents to ensure referrals for urology specialists are processed timely and medical appointments made, follow-up orders and inhouse medical	

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F 690	Continued From page 60 renal stone obstruction on 4/19/24 and returned to the facility on 4/25/24. The hospital discharge summary for Resident #53 specified a follow-up appointment for further assessment by Urology within 1-2 weeks for needed surgery to remove renal stones and possible stent exchange. Resident #53 was treated for UTIs and on-going hematuria (blood in urine) while waiting to see the urologist. Resident #53's prolonged treatment for his renal stones made him susceptible to persistent kidney obstruction, which could cause permanent kidney damage and a higher risk for sepsis. This deficient practice affected 1 of 3 residents reviewed for urinary catheter or urinary tract infection (Resident #53). Immediate jeopardy began on 5/16/24 when the facility failed to follow up with urology recommendations for Resident #53. Immediate jeopardy was removed on 7/27/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: 1. Review of revised care plan dated 2/06/24 revealed Resident #53 was at risk for urinary complication related to incontinence and complications would be avoided or minimized daily through next review. Interventions included Resident #53 was always incontinent, provide incontinence care on routine rounds and as needed, assess, document, and report any signs or symptoms of urinary tract infections (burning,	F 690	provider orders are reviewed, communicated and completed as ordered and indicated as related to urology. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance and ensure residents with bowel incontinence receive quality care. Completion Date: 8/9/2024	

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bladder/flank pain, dysuria, fever, foul odor of urine, concentrated urine, change in mental status or unusual behavior) report abnormal findings to physician, evaluate skin with each episode and report any redness, skin breakdown, rash, pain, burning or odorous urine to nurse, and administer medications as ordered.

Review of nursing noted dated 4/18/24 revealed Resident #53 was lethargic and had altered mental status. The NP was notified and gave the order to send the resident to the emergency room (ER) for evaluation.

Review of Resident #53's hospital discharge summary dated 4/25/24 revealed he had been hospitalized from 4/18/24 to 4/25/24 for obstructing ureteral stones with hydronephrosis, UTI, and sepsis. Diagnostics showed he had an obstructing right mid ureteral stone with upstream moderate hydronephrosis and several punctate (stone with sharp points) left ureteral stones. Urology was consulted during his hospitalization to provide intervention for his urinary obstruction. He was taken to the operating room on 4/19/24 by the urologist and a stent was placed in his right ureter. His discharge summary read in part, return to the facility today, follow-up with urology next 1-2 weeks, for needed surgery for treatment of renal stones and possible stent exchange.

Resident #53 was readmitted to the facility on 4/25/24 with diagnoses including calculus (kidney stones) of kidney, urinary tract infection (UTI), sepsis, aphasia (language disorder affecting communication), hemiplegia and hemiparesis (paralysis) affecting right dominant side.

Review of progress note from the NP dated

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4/26/24 read in part: continue to monitor closely, will need to follow up with urology soon for renal stone management and stent change versus removal.

Review of quarterly Minimum Date Set (MDS) dated 5/03/24 revealed Resident #53 was severely cognitively impaired and dependent on staff for his activities of daily living. Resident #53 was also assessed as always being incontinent of both bladder and bowel.

Review of progress note from NP dated 5/06/24 read in part: continue to monitor Resident #53 closely and will need to follow up with urology soon for renal stone management and stent change versus removal.

Review of facility transportation schedule for May 2024 revealed Resident #53 had a scheduled urology appointment on 5/16/24 at 9:00 AM.

There was no record of the 5/16/24 urology appointment or office notes from the appointment in Resident #53's electronic medical record.

A telephone interview was conducted on 7/24/24 at 1:18 PM with the Urology Office Practice Manager. The Practice Manager revealed Resident #53 was seen at the urology office for a scheduled appointment on 5/16/24 accompanied by staff from the facility. After reviewing the office note from 5/16/24, the Practice Manager stated Resident #53 was seen for follow-up for renal stones and stent placement and recommended order for CT scan to determine treatment for renal stones and stent. She revealed Resident #53's order for the CT scan for renal stones was completed by the urology office during the visit,

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uploaded into the system, so it would be available for imaging when the CT appointment was made. The Practice Manager stated the facility was responsible for making sure the imaging appointment was made to complete the CT scan and then once the CT scan was completed a follow-up appointment would need to be made for treatment. She revealed this information was verbally discussed with Resident #53 and the facility staff that accompanied him to the visit and provided in writing as part of the office note given to the facility staff on that day. She stated the facility never followed through with making the appointment for the CT scan and the order from 5/16/24 was still in the system, and according to Resident #53 records no referrals or request for appointments had been made until last week on 7/18/24, when an appointment was requested for Resident #53 on-going hematuria and scheduled for 8/07/24.

Review of urology office note dated 5/16/24 read in part: Resident #53 was accompanied to appointment by facility nursing assistant (NA) (the name of the facility NA was provided in the note), ordered for CT scan of renal stones to be completed to determine size and quantity of renal stones and then follow-up appointment with urology for surgical treatment to remove renal stones and stent placement.

Further Review of Resident #49's electronic medical record revealed:

A medical provider progress note dated 6/11/24 that read in part: follow-up visit for urinary problems, Resident #53 was found to have blood in urine by staff, an order was provided for a urinalysis (UA) and complete blood count (CBC).

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Plan of treatment: monitor for further hematuria, UA pending, KUB (kidney, ureter, bladder) ordered and pending.

An order entered by the Medical Director (MD) dated 6/11/24 read in part: one time UA with C&S for blood in urine and complaint of pelvic pain and one-time KUB for pelvic pain.

Lab results showed Resident #53 had a UA, CBC, and CMP (complete metabolic panel) completed on 6/12/24. The urine C&S (culture and sensitivity) report dated 6/14/24 showed CBC and CMP were normal, UA showed 3+ blood, 2+ leukocytes (white blood cells), nitrite positive, and urine culture was negative with no growth and range within normal limits. KUB showed replacement of g-tube was needed due to cap malfunction.

A medical provider progress note dated 6/14/24 that read in part: follow-up visit: Resident #53 had recurrent hematuria, and last two cultures had no growth. Plan of treatment: follow up urine culture, start cefadroxil (antibiotic to treat bacterial infections) empirically (antibiotics are administered prior to the specific cause of the infection is known) considering hematuria, check CBC, referral to urology for recurrent hematuria.

An order entered by the MD dated 6/14/24 read: order for urology consult.

A progress note from NP dated 6/17/24 read in part: Resident #53 urine culture remains negative, plan to continue with antibiotics due to hematuria and urology appointment pending.

A medical provider progress note dated 6/18/24

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read in part: start antibiotic empirically considering hematuria and pyuria (high levels of white blood cells or pus in urine), have to treat empirically with evidence of UTI but no growth, referral to urology for recurrent hematuria to evaluate for other possible causes as well.

A progress note from NP dated 6/21/24 read in part: Resident #53 still has blood in his urine, currently on antibiotics for UTI although cultures were negative, urology appt pending.

A nursing progress note dated 6/25/24 read in part: staff noted Resident #53 crying "ow" when peri care performed, some redness noted to testicles and dark red/brown urine noted to briefs. Peri care was performed and cream to peri area applied. Staff will continue to notify the physician for continuation of Resident #53's symptoms while on antibiotics and will continue to monitor.

A progress note from NP dated 6/25/24 read in part: Staff reported dark urine in Resident #53's brief, he denies any pain, fever, or chills. He is more interactive today than typical, smiling, in no distress. Able to speak a few words. He has urology appt pending for hematuria. Recently completed antibiotic for suspected UTI. He denies issues today, history always difficult to obtain due to aphasia but he is more interactive today than usual and shakes his head "no" and says "no" when I ask about pain, fever or chills. Dark urine may be due to known hematuria, urology appt pending. Recently finished antibiotics for suspected UTI although cultures were negative. No signs of infection today, vitals stable, mood stable.

A medical provider progress note dated 7/02/24

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read in part: Resident #53 had recurrent hematuria, last two cultures had no growth though evidence of UTI present through inflammatory cells, started empiric antibiotics. Plan of treatment: treated with antibiotics empirically considering hematuria and pyuria, however hematuria persists, urology appointment previously requested and remains pending to evaluate for other possible causes as well such as bladder tumor.

A progress note from NP dated 7/10/24 read in part: continued blood in urine per staff, urology appointment pending for hematuria.
A medical provider telehealth note dated 7/14/24 read in part: hematuria with foul odor. Orders received: Obtain CBC (rule out anemia), UA w/ CX (test for germs or bacteria in urine that can cause an infection and rule out infection) STAT (without delay) and notify a clinician of any change in condition.

A progress note from NP dated 7/15/24 read in part: Staff reported blood in urine with an odor, UA was ordered over the weekend by the on-call physician but had not been completed. Resident #53 reports pain from urinating, although it is difficult to get a full answer due to aphasia. Resident #53 nods 'yes' when asked if he had fever or chills, nods "no" to back pain or nausea. Plan of treatment: UA for odor and potential dysuria. Resident #53 has had blood in his urine for the last few weeks and is pending urology appt.

During the interview conducted with the NP on 7/24/24 at 9:35 AM, she stated that she was made aware during her visit with Resident #53 on 7/15/24 the tests that had been ordered the

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previous evening by the on-call physician had not been completed. She revealed it was not uncommon for staff to receives orders from the on-call physician and wait before proceeding with those orders until the resident has been assessed by herself or the Medical Director especially if the test could cause the resident discomfort and the issue has been on-going. The NP stated Resident #53 had an on-going issue with blood in his urine and his previous labs had showed no UTIs, so she was fine with staff waiting until she could assess Resident #53 and there were no issues with the test being completed on 7/16/24.

Lab results showed Resident #53 had a UA completed on 7/16/24. The urine C&S report dated 7/18/24 showed no growth of organisms and levels within normal limits.

An order was received from NP on 7/18/24 for urology consult and was entered and stricken in Resident #53 medical chart on 7/19/24 by the Director of Nursing (DON).

Resident #53 had a CT scan of the abdomen, pelvis, and renal stones completed on 7/30/24. The report dated 7/30/24 read in part: ureteral stent in good position, 13 millimeter (mm) stone in the right kidney inferior poles (lower region of kidney) and nonobstructive nephrolithiasis (kidney stones) in the left kidney with 2 punctate stones in the superior (upper region of kidney) and inferior poles.

An interview was conducted on 7/23/24 at 1:47 PM with the Medical Director (MD). The MD revealed he was familiar with Resident #53 and his on-going bladder issues. He stated Resident #53 was seen at the hospital in April 2024 for

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altered mental status and was diagnosed with an UTI and sepsis secondary to renal stones and required placement of a stent. He revealed Resident #53 hospital discharge recommendations were for him to follow-up with urology within 1-2 weeks for needed surgery as treatment for his renal stones and stent exchange. The MD stated to his knowledge there had not been a urology consult scheduled for Resident #53 at this time, although he had continued to request for urology consult and asked surveyor if "she could possibly make the appointment" since one had not been made. He revealed Resident #53 had on-going hematuria with no positive UA and needed a urology appointment to determine further treatment.

An interview was conducted on 7/24/24 at 9:35 AM with the NP. The NP revealed she had been employed at the facility since March 2024 and was familiar with Resident #53. She stated Resident #53 was sent out to the hospital on 4/18/24 for altered mental status and during his hospital stay was diagnosed with sepsis related to UTI secondary to renal stones that required placement of a stent on 4/19/24. She revealed Resident #53 was discharged from the hospital on 4/25/24 and the hospital discharge summary recommended for him to be seen within a week or two at the urology office for needed surgery to remove renal stones and stent exchange. The NP stated she saw Resident #53 at the facility for a follow-up visit from his hospital stay on 4/26/24 and noted in her progress note his need for an appointment to be scheduled with urology to address the treatment for his renal stones and stent placement. She revealed she had discussed the importance of Resident #53 being seen by urology with nursing staff on several different

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occasions although she could not recall the exact dates and whom she spoke with, and she also continued to note in her progress notes from April 2024 until present about Resident #53's need to be seen by urology for treatment of his renal stones, stent placement, and on-going hematuria. She stated since Resident #53 hospital admission he continued to have on-going bleeding and each time a urinalysis was ordered for possible UTI, the results would show no growth and range within normal limits, and he received antibiotics off and on to assist with the on-going hematuria. The NP revealed no knowledge of Resident #53 having any appointments made with urology or being seen by urology since his hospital stay. She stated she believed Resident #53 on-going hematuria was coming from the renal stones, stents, or possibly from some worse bladder issue but either way he needed to be seen by urology to determine further treatment.

An interview was conducted on 7/24/24 at 10:40 AM with the Transport Scheduler. The Transport Scheduler stated she had been in the position as scheduler for resident appointments, transportation coordinator, and medical records since July 2024. She stated she had not received an order or referral for Resident #53 to be seen by the urologist until last week on 7/18/24. The Transportation Scheduler stated she contacted the urology office on 7/18/24 and scheduled an appointment for Resident #53 to be seen on 8/07/24. In discussing the referral process for scheduling resident appointments, the transport scheduler stated she receives an order in her box informing her if an appointment needs to be scheduled for a resident, she then contacts the provider and schedules the appointment, afterwards she places the resident name,

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appointment time, and name of provider under the date on the transportation calendar. She revealed if facility staff assisted residents with going to the appointment, then they were responsible for bringing back any notes from the appointment and giving them to nursing to review and a copy should also be given to medical records. She stated to her knowledge scheduled appointments were not documented in resident charts only on the transportation calendar until after the appointment is completed and notes or orders from that appointment are received and uploaded into the chart.

An interview was conducted on 7/24/24 at 10:55 AM with Unit Manager (UM) #1. UM #1 revealed she had been in her position as Unit Manager since June 2024. She stated she recalled receiving an order for a urology referral for Resident #53 in June 2024 and would have taken it to the transportation scheduler but could not recall who was working as the transportation scheduler at that time. She revealed she was not aware if an appointment was scheduled at that time or not and had no knowledge of Resident #53 having any previous urology appointments. Unit Manager #1 stated she had never been made aware of Resident #53 having a history of renal stones or stent placement and assumed the urology order from June 2024 had been for his on-going bleeding and possible UTI. She revealed Resident #53 having a history of renal stones and stent placement made more sense as to why he continued to have on-going bleeding, pain on and off, and his UAs being negative for UTIs. Unit Manager #1 stated when nursing receives an order to schedule an appointment, that order is given to the transportation scheduler to schedule the appointment and once that

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appointment has been completed any notes from that appointment should be returned to nursing for review, placed inside book for physician review, and copy sent to medical records. She revealed nursing was not always notified of a resident's scheduled appointment or provided notes from appointment for follow-up. Unit Manager #1 stated now knowing of Resident #53 history of renal stones and stent, urology appointment should have been scheduled sooner especially since he had on-going bleeding with no signs of a UTI.

A telephone interview was conducted on 7/24/24 at 11:16 AM with Nurse #10 who stated as of July 2024 he was only working at the facility on an as needed basis but had previously worked as a unit manager on the 200 hall and filled in as the transportation scheduler on an as needed basis during the month of June 2024. He stated he was vaguely familiar with Resident #53 due to him primarily working on the 200 hall and Resident #53 room was on the 100 hall. He also stated he had no knowledge of ever having received any orders regarding Resident #53. Nurse #10 revealed he had never received any orders pertaining to scheduling an appointment for Resident #53 to include during his time as the fill in scheduler and he would have remembered if he had ever received any orders to schedule an appointment for Resident #53 because he was not one of the residents he worked with on his hall so it would have stood out to him more if he had received an order for an appointment.

An interview was conducted on 7/24/24 at 1:46 PM with Nursing Assistant (NA) #11 who was named in the urology office note dated 5/16/24 as the facility NA who accompanied Resident #53 to

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his urology appointment. She stated she had been employed as an NA with the facility and during that time had been required to accompany residents to their scheduled appointments. She revealed she was familiar with Resident #53 and recalled accompanying him to his urology appointment on 5/16/24. NA #11 stated if she remembered correctly Resident #53 appointment was close by and did not last long, and while there the doctor discussed a test that Resident #53 needed to have done prior to coming back and they provided her with paperwork to take back with her to the facility. She revealed upon her return from the appointment, she let the nurse over Resident #53 hall know he was back and provided them with the paperwork from the appointment. NA #11 stated she could not recall who the nurse was working Resident #53 hall on that day but knows she gave them the paperwork and they should have followed up.

A follow-up interview was conducted on 7/24/24 at 2:15 PM with the NP. The NP was informed by surveyor of Resident #53 appointment with urology on 5/16/24 and the order for a CT scan to be completed and follow-up appointment to determine treatment. She stated she was not aware of Resident #53 ever being seen by urologist since his discharge from the hospital and had she been made aware she could have followed up with making sure his CT scan was ordered, and his follow-up appointment was made. The NP was also not aware of his urologist appointment scheduled for 8/07/24 and his need for a CT scan prior to that appointment and stated she would place an order to make sure the CT scan was obtained prior to his 8/07/24 appointment, urology office had already placed an order for the CT scan to be completed and had

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also informed the imaging office.

A telephone interview was conducted on 7/24/24 at 4:11 PM with Nurse #11 who was scheduled as the nurse working Resident #53 hall on 5/16/24. Nurse #11 stated he primarily worked the 100 hall and was familiar with Resident #53. He revealed he was not aware Resident #53 had ever been seen by the urologist and did not recall ever being given paperwork for Resident #53 from a urology visit or orders for a CT scan to be completed. He stated typically when a resident returns from an appointment any paperwork they had received from the appointment was given to the scheduler, and if he had been given any paperwork or orders from an appointment, he would have notified the unit manager and placed the paperwork in the physician book for review.

An interview was conducted on 7/25/24 at 11:07 AM with the Director of Nursing (DON). She stated she had started her employment as the DON at the facility on 5/28/24 but had previously worked at the facility as the DON for a year prior. She stated she was not employed with the facility during the time of Resident #53 hospitalization in April 2024 and was not aware of him being seen for a follow-up appointment with urology on 5/16/24 and she had not been made aware of any orders from that appointment for a CT scan of renal stones to be completed or a follow-up appointment for treatment needing to be made. She stated during their morning IDT meetings they review physician progress notes regarding residents and discuss any residents with changes of condition. She did recall reviewing physician progress notes for Resident #53 stating his need for a urology consult to be made due to his on-going hematuria, but she assumed a referral

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for an appointment had been made or was pending awaiting a date. The DON revealed typically when a resident needs a consultation or an appointment to be made with another provider, nursing would input the physician order into the resident chart and provide the scheduler with a referral for them to schedule the appointment. She stated nursing was not always made aware of scheduled resident appointments but they should be so they could enter the date the order for the consult was completed, review visit note from the appointment, contact the provider office to request the visit note if needed, and notify the physician. She revealed the facility should have completed the CT scan and follow-up appointment from Resident #53 urology appointment on 5/16/24 and followed-up in a timelier manner with the physician order from 6/14/24 requesting a urology consult especially since Resident #53 on-going hematuria could have been from the renal stones and stent placement and all his UAs were normal. The DON was asked about Resident #53 receiving antibiotics for UTIs on-going when his UAs showed no growth and within normal limits and she stated she was not aware of Resident #53 receiving on-going antibiotics for UTI but typically when a resident is showing signs of a possible UTI they may start them on antibiotics first while awaiting their labs and UA results but if those show no growth or no signs of UTI then the antibiotics should be stopped and other forms of treatments discussed.

A telephone interview was conducted on 7/25/24 at 2:48 PM with the MD. The MD stated no knowledge of Resident #53 being seen for a urology appointment on 5/16/24 and had never received any orders or office visit notes from that

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appointment for him to review. The MD asked how surveyor was made aware of the urology appointment on 5/16/24 and was informed the appointment was listed on the facility transportation schedule for May 2024 and surveyor contacted the urology office for information about the appointment and received the office visit notes. Surveyor read MD the note from the urology office visit on 5/16/24 and notified him of the order for the CT scan and need for follow-up appointment to determine treatment. The MD stated again he had no knowledge of the 5/16/24 appointment and should be made aware of all resident appointments so he can know to look for visit notes from the appointment to review for any changes in medications, diet orders, and recommended treatments. He revealed he had written in Resident #53 progress notes since May 2024 to present that he needed an urology consult and wrote a specific order for a urology consult in June 2024 and each time he asked administration or nursing staff about the urology consult he was always told they were in the process of making the appointment or the appointment was pending. He stated physician orders should be followed and completed in a timely manner and Resident #53 matter should have been taken seriously and handled before now due to the seriousness with his on-going hematuria with normal labs. The MD revealed he believed due to Resident #53 having normal labs that his on-going bleeding was coming from his renal stones, stent, or from something possibly worse like a bladder tumor. He also revealed Resident #53 often appeared comfortable, and although his pain level was hard to determine due to his aphasia, Resident #53's pain would come and go depending on if the stones were moving.

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When the MD was asked if he was aware of Resident #53 having a urology appointment scheduled for 8/07/24, he stated no he had not been made aware of that appointment until now, surveyor informed the appointment had been made last week and she had notified the NP of the appointment and the need for Resident #53 to have a CT scan completed prior to his appointment and the NP had written an order for a CT scan to be scheduled but the urology office had already taken care of writing the order for the CT scan and notifying imaging and the CT scan had been scheduled for 7/30/24.

An interview was conducted on 7/26/24 at PM with the Administrator. The Administrator stated she began her employment with the facility in June 2024 and was not familiar with Resident #53 medical issues or his need for scheduled consult appointment until now. She revealed the facility should have followed-up from Resident #53 May 2024 appointment and made sure all orders and recommendations were followed and if the facility was not made aware of the appointment, they still should have followed up with the on-going recommendations from the physician for a urology consult prior to now. The Administrator stated she also believed the physicians and the administrative team should have followed-up sooner to see why the urology consult had not been made sooner and what the holdup was with securing an appointment. She revealed all orders, recommendations, and follow-up appointments for residents should be followed and completed in a timely manner.

Review of email received from the Urologist on 8/07/24 at 5:10 PM revealed when a patient was

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seen in the hospital for urinary issues that required a stent, urology would typically have patient follow-up in the office within 1-2 weeks to make sure the patient had recovered from their acute illness and to discuss the next steps in surgical intervention. He stated a CT scan would have been ordered during Resident #53 5/16/24 appointment to re-evaluate the size and location of the renal stones to help with surgical planning. The consequences of not having the CT scan or receiving treatment for the renal stones may cause an increased risk of recurrent infections with the indwelling stent. The Urologist stated with a stent in place, intermittent bleeding was expected, and some patients have pain with stents, and others often tolerate them without difficulty.

The Administrator was notified of immediate jeopardy on 7/26/24 at 4:14 PM.

The facility provided the following credible allegation of immediate jeopardy removal plan.

F690: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:
The facility failed to review and process orders from a 5/16/24 urology appointment for Resident #53 to have a CT scan and follow-up urology appointment to schedule surgery for treatment of renal stones after the CT was completed.

Because all residents with urology consultations are at risk when urology reports are not received and orders and follow-up appointments are not processed and scheduled, the following plan has been devised:
On 7/3/24, a urology referral for Resident #53

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was faxed by the facility medical record clerk and appointment received and scheduled for 8/7/24. On 7/25/2024, the Director of Nursing (DON) received and processed a physician order for a CT scan and provided a copy of the order to the medical records clerk who then requested and received an appointment on 7/30/24 for Resident #53.

On 7/26/24 the DON and Assistant Director of Nursing (ADON) completed an audit of all current facility residents with urology referrals to ensure orders and follow-up appointments were received and processed. Audit included a review of resident's most recent discharge summaries and current active orders to identify and validate that urology orders and follow-up appointments were received and processed as indicated. Additional residents identified with urology referrals were all validated to have orders and/or follow-up appointment received and processed as indicated.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On 7/26/24, the Administrator, Director of Nursing (DON), Vice President of Operations (VPO), Vice President of Clinical and Quality (VPCQ), Regional Director of Clinical Services (RDCS), Unit Manager, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review the facility process for receiving, reviewing and processing urology consultation reports, referrals and orders and to determine root cause of the deficient practice. By root cause analysis, the QAPI committee

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determined that the facility failed to have an effective monitoring process that ensures urology consultation reports are received and processed. A plan was formulated by the QAPI committee to address the identified issue to include education, audit/monitoring needs, and QAPI committee responsibilities in reviewing for compliance. To address the root cause, an updated process was formulated to ensure residents receive urology referrals and orders as indicated by the medical provider.

On 7/26/24, the DON completed education with the Interdisciplinary team (IDT) including the Administrator, ADON, Minimum Data Set (MDS) nurse, Social Worker, Medical Records Clerk, Transporter and Medical Director and currently facility and agency licensed on the process for receiving, reviewing and processing urology referrals and orders. Process: When a resident is admitted to the facility, the discharge summary is to be reviewed by the admitting nurse to determine if any appointments need to be made after discharge. The licensed nurse will then enter the order for the referral or appointment into electronic health record. This is also to include readmissions and consultations. The licensed nurse will notify the medical director (MD) of the need for an order on the discharge summary, on admission/re-admissions or consultations. The licensed nurse will then place a copy of the order in the medical record box located at each nursing station. Medical records will check each box every morning before the morning meeting and bring the copy of the order for the appointment or consultation to the morning meeting for review. The order will then be verified and entered/updated into the electronic health record (EHR) system. A copy of the order will then be

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given to the transporter by the medical record staff member for the appointment to be placed on the calendar. A copy of the order will then be placed into the MD box for notification. Appointments will be entered onto the EHR dashboard during the daily meeting for MD to review. All appointments will be reviewed daily during the clinical morning meeting for accuracy and follow-up. The previous day's appointments will be reviewed during the daily clinical meeting to make sure that any correspondence has been reviewed and followed up on

The current IDT members and facility and agency Licensed Nurses and newly hired IDT members and facility and agency licensed nurses not receiving education on 7/26/24 will not be allowed to work until completed. The DON will utilize an active employee list to track completion of education. This responsibility was communicated to the DON by the RDCS on 7/26/24. Education will also be included during orientation for newly hired IDT members and facility and agency Licensed Nurses, to be completed by Director of Nursing or Nurse Manager.

Effective 7/26/24, the Administrator and Director of Nursing will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 7/27/24

The credible allegation for the immediate jeopardy removal was validated on 08/01/24 with a removal date of 07/27/24.
A review of in-service education records dated 07/26/24 indicated education was provided to the Interdisciplinary team (IDT) including the

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F 690	Continued From page 81 Administrator, ADON, Minimum Data Set (MDS) nurse, Social Worker, Medical Records Clerk, Transporter, Medical Director and currently facility and agency licensed nurses on the "Process for receiving, reviewing and processing urology referrals and orders". The goal was to ensure all urology consultation reports or other discharge summaries were received, reviewed, and processed, and all the orders and/or follow up appointments were implemented as indicated. Interviews with the IDT team member, Medical Record Clerk, Transporter, and the nursing staff including agency nurses revealed they had been educated on the process for receiving, reviewing and processing urology referrals and orders. They were able to describe the new process related to urology referrals and orders, and verbalized understanding of the in-service education. The audit completed by DON and ADON on 07/26/24 was reviewed. All the residents with urology were validated to have orders and/or follow-up appointment received and processed as indicated. The facility's date of immediate jeopardy removal date of 07/27/24 was validated.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		8/10/24

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F 695	Continued From page 82 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, resident, and Nurse Practitioner interviews, the facility failed to obtain a physician's order for a resident who returned from the hospital on continuous oxygen (Resident #3) and the facility also failed to ensure oxygen was delivered at the prescribed rate (Resident #70). These practices occurred for 2 of 2 residents reviewed for respiratory care and services. The finding included: 1. Resident #3 was admitted to the facility on 08/31/2021. Resident #3 had diagnoses which included chronic respiratory failure with hypoxia, and congestive heart failure (CHF). Review of the care plan dated 08/05/2022 revealed Resident #3 was at risk for respiratory complications secondary to chronic respiratory failure with hypoxia requiring supplemental oxygen. The interventions included administer oxygen as ordered and observed for signs and symptoms of respiratory complications. Review of Resident #3's quarterly Minimum Data Set (MDS) dated 06/12/2024 revealed Resident #3 had moderately impaired cognition. The MDS also indicated Resident #3 was totally dependent for all activities of daily and had respiratory failure with hypoxia. The MDS did not indicate Resident #3 was receiving oxygen.	F 695	1) On 7/23/24, the Director of Nursing (DON) notified the Medical Director (MD) and received new orders for supplemental oxygen for Resident #3 and Resident #70. Oxygen will continue to be administered as ordered. 2) On 8/8/24, the Director of Nursing (DON) completed an audit of all current residents with supplemental oxygen to ensure administration as ordered by the physician. Order revisions received and initiated as ordered. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency direct care staff to include licensed nurses, nurse aides, therapy. Education included the responsibility of the licensed nurse to receive, transcribe and ensure compliance with physician orders related to supplemental oxygen therapy. Newly hired facility and agency nursing staff not receiving education by 8/9/24 will receive education prior to first worked shift. The DON will monitor and track education completion. 4) The DON, ADON or UM will audit five (5) residents with supplemental oxygen to ensure oxygen is administered as ordered	

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F 695	Continued From page 83 Observations of Resident #3 were completed on 07/22/2024 at 10:59 AM, 07/22/2024 at 3:50 PM, 07/23/2024 at 8:15 AM, and 07/23/2024 at 1:30 PM. During each of the observations Resident #3 was observed in bed with his nasal cannula in his nostrils and the oxygen concentrator set at 2 liter per minute. Review of the electronic medical record revealed there was no physician order for continuous or PRN (as needed) orders oxygen for Resident #3. An interview was completed on 07/23/2024 at 1:32 PM with Nurse Aide (NA) #3. NA #3 stated she does not do anything with oxygen settings. NA #3 further stated she did make sure the nasal cannula was in place and applied correctly for resident's receiving oxygen. An interview was conducted on 07/23/2024 at 1:50 PM with Medication Aide (MA)#2 who was assigned to Resident #3. MA#2 stated she usually checked to make sure the concentrator was set at the correct flow rate, but she had not checked the physician's orders for oxygen for Resident #3. MA#2 stated that she had worked with Resident #3 several times and he had always had oxygen on. An interview was completed on 07/23/2024 at 2:23 PM with Unit Manager #1. Unit Manager #1 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the flow rate. The Unit Manager also stated that she thought Resident #3 went to the hospital recently and returned the same day and the oxygen order must have fallen off Resident #3's order panel.	F 695	per rounding observation and order review. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with oxygen therapy. Completion Date: 8/10/2024	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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An interview was conducted with the Director of Nursing (DON) on 07/24/2024 at 11:40 AM. The DON stated that all residents receiving oxygen should have a complete physician's order for oxygen which included the flow rate.

An interview was conducted with the Nurse Practitioner (NP) on 07/24/2024 at 1:30 PM. The NP stated that all residents receiving oxygen required an active physician's order for the prescribed liters per minute of oxygen they were to receive. The NP further stated that Resident #3 had a long-standing history of respiratory failure with hypoxia and had used oxygen since his original admission date to the facility.

An interview was conducted with the Administrator on 07/26/2024 at 4:35 PM. The Administrator stated that all residents receiving oxygen should have an active physician's order in the electronic medical record.

2. Resident #70 was admitted to the facility on 02/15/2024. Resident #70 had diagnoses which included congestive heart failure (CHF), and asthma.

Review of the care plan dated 02/16/2024 revealed Resident #70 was at risk for respiratory complications secondary to congestive heart failure requiring supplementary oxygen. The interventions included to administer oxygen as ordered, encourage rest periods as appropriate, and observed for signs and symptoms of respiratory complications.

Review of the electronic medical record revealed a physician order for Resident #70 dated 06/07/2024 which read in part: oxygen at 2 liters

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	345174	A. BUILDING _____ B. WING _____	C 08/07/2024

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per minute via nasal cannula (NC) for shortness of breath related to CHF.

A review of Resident #70's quarterly Minimum Data Set (MDS) dated 06/13/2024 revealed Resident #70 was cognitively intact. Resident #70 was coded as receiving oxygen therapy.

Observations were completed of Resident #70 on 07/22/2024 at 11:49 AM, 07/22/2024 at 2:03 PM, and 07/23/2024 at 9:30 AM. During each of the observations Resident #70 was observed resting in bed with her nasal cannula in her nostrils, the oxygen concentrator was set at 1 liter per minute. Resident #70 was not in distress during any of the observations.

An interview was conducted with Resident #70 on 07/23/2024 at 1:22 PM. Resident #70 stated that she had been on oxygen since February of 2024 when she was newly diagnosed with CHF. Resident #70 further revealed that she needed her oxygen because she did get short of breath just lying in the bed.

An interview was completed on 07/23/2024 at 1:32 PM with Nurse Aide (NA) #3. NA #3 stated she does not do anything with oxygen settings. NA #3 further stated she did make sure the nasal cannula was in place and applied correctly for resident's receiving oxygen.

An interview was conducted on 07/23/2024 at 1:50 PM with Medication Aide (MA) #2 who was assigned to Resident #70. MA#2 stated she usually checked to make sure the concentrator was set at the correct flow rate during her morning medication pass, but she had not checked Resident #70's flow rate.

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An interview was completed on 07/23/2024 at 2:03 PM with Unit Manager #1. Unit Manager #1 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the flow rate. Unit Manager #1 also stated that the oxygen flow rate should be set as ordered by the physician. Unit Manager #1 said Resident #70 could not change her oxygen settings independently. Unit Manager #1 further explained she reviewed Resident #70's physician's orders and stated that Resident #70 should be on 2 liters continuous oxygen via nasal cannula.

An observation of Resident #70's oxygen flow rate was conducted on 07/23/2024 at 2:20 PM with MA #2. The MA#2 stated that Resident #70's oxygen flow rate was set at 1 liter per minute. MA #2 stated Resident #70's oxygen concentrator setting was set a 1 liter per minute. MA #2 corrected the oxygen setting and place the flow rate at 2 liters per minute. MA #2 stated when setting the correct liter, the ball on the concentrator gauge should have the line through it to indicate the ordered liter.

An interview was conducted with the Director of Nursing (DON) on 07/24/2024 at 11:40 AM. The DON stated that all residents receiving oxygen should have a complete physician's order for oxygen which included the flow rate. The DON further stated the nurses should review the physician's order, ensure the in-room concentrator was at the correct ordered liter, and make sure the ball was in the middle of the line for the correct ordered rate.

An interview was conducted with the Nurse

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F 695	Continued From page 87 Practitioner (NP) on 07/24/2024 at 1:30 PM. The NP stated that all resident receiving oxygen needed an active physician's order for the prescribed liters. The NP further stated the nurses should review the physician's order and ensure the in-room concentrator was at the correct ordered liter. An interview was conducted with the Administrator on 07/26/2024 at 4:35 PM. The Administrator stated that she expected all staff to follow the physician's order for oxygen setting.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		8/10/24

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F 761	Continued From page 88 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and pharmacist interviews, the facility failed to secure medications when a Medication Aide (Medication Aide #1) left medication at a resident's (Resident #57) bedside. Furthermore, the facility failed to discard expired medications on 2 of 4 medication carts (200 hall medication cart-2 and 100 hall medication cart-2) reviewed for medication storage and labeling. The findings included: 1. Resident #57 was admitted to the facility on 3/31/23 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/1/24 revealed Resident #57 was cognitively impaired. On 7/23/24 at 9:00 AM an observation was completed of Resident #57 and his room. Resident #57 was laying in his bed with his bedside table positioned next to his bed. A medication cup was observed sitting on his bedside table with one oblong yellow colored pill in the cup. He had a small plastic cup filled with water sitting next to the medication cup. Resident #57 was unable to say what the medication was in the cup or when it had been left. An interview was conducted on 7/23/24 at 9:01 AM with Medication Aide #1. Medication Aide #1 said she was the assigned medication aide for Resident #57 and that she had administered his morning medications today. She said she had	F 761	1) On 7/23/24, identified medications left at Resident #57 bedside by MA #1 and expired medications identified in 200 hall cart 2 and 100 hall cart 2 were immediately removed and properly disposed. 2) On 8/1/24, the Director of Nursing (DON) completed an audit of all facility medication storage areas and resident rooms to ensure proper storage and disposal and to ensure medications and biologicals are not left at residents bedside. No concerns identified. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency licensed nurses and medication aides on proper labeling and storage of drugs and biologicals. The licensed nurse is responsible for dating and labeling medications and biologicals including multidose medications and properly disposing prior to expiration date. The Unit Manager on each unit will be responsible for monitoring medication carts and rooms at a minimum of weekly as an additional layer of oversight. Newly hired facility and agency licensed nurses and medication aides not receiving education by 8/9/24 will receive education prior to first worked shift. The DON will monitor and track education completion.	

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F 761	Continued From page 89 stayed with Resident #57 while he took his medications this morning. Medication Aide #1 said that she had not checked the medication cup after Resident #57 took his medication in the morning to make sure he had taken it all. She said Resident #57 should not take medication by himself and that she should have checked the medication cup before leaving his room. An interview was conducted on 07/23/24 at 9:14 AM with Nurse #2. He stated Medication Aide #1 should not have left medication at Resident #57's bedside and that he could not self-administer his medication. Nurse #2 stated that medications should not be left at the bedside for any resident to take later because it was not the right thing to do, it was the wrong thing to do. Nurse #2 said Medication Aide #1 should have checked to make sure all the pills were taken, that the medication cup was empty before leaving the bedside, and not leave the medication cup at Resident #57's bedside. An interview was conducted with the Director of Nursing (DON) on 7/26/24 at 5:00 PM. The DON stated that Medication Aide #1 should have stayed with Resident #57 while he took his medications, should have checked that Resident #57 had taken all his medication, and should have checked that the medication cup was empty before leaving it at the bedside. The DON said medications should not be left at the bedside. An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator stated that Medication Aide #1 should have checked Resident #57's medication cup before leaving the room and that medications should not be left at the bedside.	F 761	4) The DON, ADON or UM will audit medication rooms and carts and make a rounding observation of resident rooms to ensure proper storage/labeling of drugs and biologicals. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with medication storage requirements. Completion Date: 8/10/2024	

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2. On 7/24/24 at 10:34 AM 200 hall Medication Cart #2 was reviewed with Nurse #4.

The following were discovered during the observation:

a. A bottle of Ferrous Gluconate had an expiration date of 5/2024. There were 91 pills in the bottle.

b. An opened multidose Glargine 100units (u)/milliliter (ml) insulin pen with an open date of 6/25/24.

An interview was conducted with Nurse #4 on 7/24/24 at 10:40 AM. Nurse #4 said that insulin was good for 28 days once it had been opened and that the insulin pen was no longer good. She said medication should be removed from the medication cart when it expired. Nurse #4 said she did not think the Ferreous Gluconate had been used. Nurse #4 said she had opened a new Glargine insulin pen this morning and had not used the one that was expired.

An interview was conducted with the DON on 7/26/24 at 5:00 PM. The DON said expired medications should be removed from the medication cart and discarded.

An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator said expired medications should be removed from the medication cart.

3. On 7/25/24 at 2:32 PM 100 hall Medication Cart #2 was reviewed with Nurse #4.

The following were discovered during the

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F 761	Continued From page 91 observation: a. A bottle of Bisacodyl stimulant laxative had an expiration date of 2/2024. There were 188 pills in the bottle. b. A bottle of Nitroglycerin sublingual 0.4 mg tablets had an expiration date of 2/2024. There were 21 tablets in the bottle. An interview was conducted with Nurse #4 on 7/25/24 at 2:38 PM. Nurse #4 said medication should be removed from the medication cart when it expired. An interview was conducted with the DON on 7/26/24 at 5:00 PM. The DON said expired medications should be removed from the medication cart and discarded. An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator said expired medications should be removed from the medication cart.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		8/10/24

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F 812	Continued From page 92 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label opened foods with a use by date stored for use in 1 of 1 reach-in refrigerators and 1 of 1 walk-in refrigerators. This practice had the potential to affect food served to residents. The findings included: a. On 7/22/24 at 10:20 AM an observation of the reach in refrigerator was conducted with the Cook. The observation revealed a sandwich in a plastic bag, 4 dessert cups, and a cup of fruit cocktail. No label with a date was present on those items. The observation continued to the walk-in refrigerator where there was no label with a date on the following: lettuce wrapped in plastic, open package of shredded cheese, container of unknown ingredients, container of pinto beans, 2 pieces of watermelon wrapped with plastic, container of barley. An interview on 7/25/24 at 10:05 AM with the Interim Dietary Manager revealed that the open foods should be labeled with a use by date 7 days after opening. She stated that she did not know why open foods had not been labeled.	F 812	1) On 7/22/24, the Dietary Manager properly disposed of improperly stored and unlabeled food items located in the reach-in and walk-in refrigerators in the kitchen. 2) On 8/1/24, the Administrator completed an audit of all food storage areas including the kitchen and nourishment rooms to ensure all food items are properly stored with open and expiration dates labeled. Improperly stored items were disposed of. 3) Effective 8/9/24, the Dietary Manager provided education to all current dietary staff and the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to all other current facility and agency staff the on guidelines for proper food procurement, storage, preparation and service to ensure safe, sanitary food services to residents. Education included the process of dating and labeling food items when opened with a use by date and disposing of prior to expiration. Newly hired dietary and other facility and agency staff not receiving education by 8/9/24 will receive education prior to first worked	

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F 812	Continued From page 93 An interview on 7/25/24 at 10:33 AM with the Administrator revealed she was aware of the kitchen concerns and has been working closely with the Dietary Manager to make improvements.	F 812	shift. The Director of Nursing (DON) will monitor and track education completion. 4) The Administrator or Dietary Manager will complete audits to ensure proper food storage by rounding observations of kitchen and nourishment rooms storage areas. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The Administrator will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with food storage requirements. Completion Date: 8/10/2024	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		8/10/24

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 95 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to maintain an accurate treatment administration record (TAR) when the Treatment Nurse Aide (NA) used a Nurse's (Nurse #3) login credentials for the electronic medical record to sign off treatments for 1 of 1 resident (Resident #31) reviewed for accurate and complete medical records. The findings included: A review of Resident #31's Treatment Administration Record (TAR) for June 2024 and July 2024 revealed that Resident #31's treatment orders scheduled on the day shift had been signed off as completed using Nurse #3's log in 28 times on the July 2024 TAR and 3 times on the June 2024 TAR. An interview was conducted on 7/24/24 at 1:30 PM with the Treatment NA. The Treatment NA said she was unable to log in to the electronic computer system to access the TAR. The Treatment NA said that there had been a mistake when her login for the electronic computer had been created and that she was unable to log in to	F 842	1) On 7/25/24, the Director of Nursing (DON) provided reeducation to the treatment nurse aide and Nurse #3 on maintaining an accurate treatment records and on the guidelines for maintaining accurate resident records with identifiable information by only utilizing login credentials specifically assigned you. A nursing progress note was entered by DON on entries that were made in error under wrong name to indicate the nurse aide who completed the treatments. 2) On 8/2/24, the DON completed an observational round of all current staff who have access to resident records and the Electronic Medical Record (EMR) to ensure accurate login credentials specifically assigned are used. No concerns identified. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education to current facility and agency staff on maintaining accurate resident records with	

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F 842	Continued From page 96 the system. The Treatment NA said she had been using Nurse #3's log information for the last 3-4 weeks to get into the electronic computer system and to sign off the treatments she had completed on the TAR. She explained that Nurse #3 was a night shift nurse and did not work the day shift. The Treatment NA stated that Nurse #3 had given her log in information to her to use. The Treatment NA explained she had told Nurse #3 she could not log into the computer a few weeks ago and that Nurse #3 had given the login information to her to use to "help her out". The Treatment NA said that Nurse #3 was aware that she had continued to use her log in information to sign off treatments on the TAR for the last 3-4 weeks. The Treatment NA stated she had seen Nurse #3 this morning (7/24/24) when Nurse #3 had been coming off the night shift and that she had mentioned to Nurse #3 that she was still using her log in information and that Nurse #3 had been okay with that. The Treatment NA stated she had told the Director of Nursing (DON) that she was having trouble with the computer turning off/on. She stated she had not told the DON specifically that she could not log in to the electronic computer system to access the TAR. The Treatment NA stated that she had not told the DON or anyone else that she had been using Nurse #3's log in information to access the electronic computer system and to sign off treatments. An interview was conducted with Nurse #3 on 7/26/24 at 8:45 AM. Nurse #3 said she worked night shift. Nurse #3 explained she had been off for a couple of weeks and had just started working again this week after being off. Nurse #3 stated she did not work on day shift and that she had not signed off treatments scheduled for the	F 842	identifiable information by only utilizing login credentials specifically assigned to you. The facility strictly forbids the use of another staffs login credentials and disciplinary action up to termination will be enforced. Newly hired dietary and other facility and agency staff not receiving education by 8/9/24 will receive education prior to first worked shift. The Director of Nursing (DON) will monitor and track education completion. 4) The DON, ADON or UM will audit five (5) staff with EMR login credentials by visual observation of login username displayed on computer device. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with resident records and identifiable information. Completion Date: 8/10/2024	

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day shift. Nurse #3 stated she had not given her log in information to the Treatment NA to use. Nurse #3 said the Treatment NA had not approached her when she had been going off shift this week about using her log in information. Nurse #3 said she was not okay with the Treatment NA using her log in information to sign off treatments because it made it look like she had performed the treatments and she had not. Nurse #3 stated the Treatment NA should not be signing of anything under her name.

An interview was conducted with the DON on 7/25/24 at 10:20 AM. The DON stated she had not been aware that the Treatment NA had been using Nurse #3's log in to complete the TAR. She stated that the Treatment NA had not approached her about not being able to log in to the electronic computer system. The DON said the Treatment NA had told her had a problem with getting the computer to turn off and on but that the Treatment NA had not told her she could not log in. The DON said it would have been easy to fix if the Treatment NA had told her. The DON stated that the treatment NA should not have used Nurse #3's log in to access the electronic computer system and sign off treatments on the TAR. The DON stated it made it appear that a nurse had completed the treatments when they had been completed by an NA.

An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator stated that it was not okay for the Treatment NA to access the electronic computer system or document on the TAR using Nurse #3's log in information. She said the Treatment NA should not have done that. The Administrator explained it had made it appear that Resident

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F 842	Continued From page 98 #31's wound care had been performed by a nurse (Nurse #3) instead of a Treatment NA.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		8/10/24

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F 880	Continued From page 99 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policy when the Treatment Nurse Aide (NA) did not perform hand hygiene and wore the same pair of gloves while doing wound care for two wounds and incontinence care for Resident #31. In addition, the Treatment NA failed	F 880	1) The Assistant Director of Nursing (ADON) provided reeducation to treatment nurse aide (NA) on 7/24/24 on the Hand Hygiene and Enhanced Barrier Precautions policy when infection prevention practices including proper hand hygiene and personal protective	

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F 880	Continued From page 100 to wear a gown while providing wound care for a resident (Resident #31) who required Enhanced Barrier Precautions (EBP) and did not wear personal protective equipment (PPE) per the facility's policy while doing wound care on Resident #31. The Treatment NA also failed to change her gloves and perform hand hygiene while providing several treaments and wound care for Resident #3. The Treament NA touched the resident, several surfaces in the room, and obtained supplies from the treament cart wearing the soiled gloves. In addition, Nurse #1 did not perform hand hygiene after removing soiled dressings with drainage and before donning new gloves to cleanse the wound for Resident #10. These deficient practices affected 3 of 3 residents reviewed for infection control practices (Resident #31, Resident #3, and Resident #10). The findings included: Review of the facility policy entitled Hand Hygiene dated 11/1/20 and last reviewed on 1/11/23 read in part: Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The hand hygiene table specified the following conditions for hand hygiene using either soap and water or alcohol-based hand rub: before and after handling clean or soiled dressings, before performing resident care procedures, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, when during resident care, moving from a contaminated body site to a clean body site, after	F 880	equipment (PPE) use was not followed when providing wound care and incontinence care to Resident #31 and #3. On 7/26/24, reeducation was provided to Nurse #1 when proper hand hygiene was not maintained during wound care for Resident #10. Skills competencies for Hand Hygiene and PPE were completed by the treatment NA and Nurse #1 with return demonstration validated by the ADON. Resident #31, #3 and #10 did not experience an adverse outcome as a result of noncompliance. 2) On 8/1/24, the Director of Nursing (DON) completed a rounding observation of licensed nurses and nurse aides performing wound care, incontinence care and other direct care tasks to ensure proper infection prevention practices including hand hygiene and PPE use. No additional concerns observed. An audit of residents with wounds and other devices requiring Enhanced Barrier Precautions was completed and appropriate isolation signage posted at resident door. 3) Effective 8/9/2024, the Assistant Director of Nursing (ADON) or Unit Manager (UM) provided education on the Hand Hygiene, PPE and Enhanced Barrier Precautions policies to all current facility and agency staff. Education included appropriate hand hygiene practices, PPE usage including proper donning and doffing and on criteria for Enhanced Barrier Precautions and required isolation signage. The license	

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F 880	Continued From page 101 assistance with personal body functions (e.g., elimination). Review of the facility's policy and procedure revised on 3/29/24, entitled "Enhanced Barrier Precautions" read in part: "It is the policy of this facility to implement enhanced barrier precautions for preventing the transmission of novel or targeted multidrug-resistant organisms." "Enhanced Barrier Precautions (EBP) refer to the use of gown and gloves for certain residents during specific high-contact care activities that have been found to increase risk for transmission of multidrug-resistant organisms (MDROs). "Prompt recognition of need- Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves." "Initiation of EBP- An order for EBP will be obtained for residents with any of the following: wounds and/or indwelling medical devices regardless of MDRO colonization status." "Implementation of EBP- Make gowns and gloves available immediately outside of the residents room." "High-contact resident care activities include- Dressing, Bathing, Transferring, Providing hygiene, Changing Linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator, Wound care: any skin	F 880	receiving isolation orders for residents will be responsible for placement of appropriate signage on resident door. The Infection Preventionist will monitor signage placement during routine infection prevention rounds. A Hand Hygiene and PPE skills competency was also completed with return demonstration validated by the ADON. Newly hired facility and agency staff not receiving education or skills competency validations by 8/9/24 will receive education and validation of competencies prior to first worked shift. The DON will monitor and track education and competency completion. 4) The DON, ADON or UM will complete rounding observations of staff performing wound care or incontinence care for three (3) residents to ensure appropriate hand hygiene and PPE practices including adherence to enhanced barrier precautions and posted isolation signage where applicable. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, the once weekly for four (4) weeks. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with infection prevention and control practices. Completion Date: 8/10/2024	

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opening requiring a dressing."

The findings included:

1a. A continuous wound care observation was conducted on 7/24/24 from 1:35 PM to 2:22 PM of the Treatment Nurse Aide (NA) completing wound care for Resident # 31.

The Treatment NA did not perform hand hygiene before collecting supplies from the treatment cart, before entering Resident #31's room, or prior to donning gloves for wound care.

The Treatment NA placed new gloves on both her hands at Resident #31's bedside and proceeded to remove his left foot dressing.

Wearing the same gloves, the Treatment NA performed the wound care to his left foot and applied the new dressing on Resident #31's left foot.

Wearing the same gloves, the Treatment NA removed the dressing from Resident #31's right foot.

Wearing the same gloves, the Treatment NA performed the wound care to Resident #31's right foot and applied the new dressing on his right foot. She reapplied Resident #31's left and right off-loading boots.

Wearing the same gloves, the Treatment NA unfastened Resident #31's brief to check the scrotum and groin area for wounds and then turned Resident #31 onto his side to check his buttocks for a wound that needed cream application. Resident #31 had bowel

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incontinence. She repositioned him onto his back again.

Wearing the same gloves, the Treatment NA went into Resident #3's bathroom and obtained a wet washcloth. She went back to Resident #31's bedside and positioned him onto his side. She proceeded to provide bowel incontinence care. After providing incontinence care she removed her left-hand glove, she continued to wear the same glove on her right hand. She did not perform hand hygiene after removing her left-hand glove.

Wearing the glove on her right hand and with her ungloved left hand the Treatment NA repositioned a brief under Resident #31. She turned and repositioned Resident #31 to fasten the new brief.

Wearing the glove on her right hand and with her left hand ungloved the Treatment NA went back to the treatment cart located in the hall outside Resident #31's door to obtain a tube of cream from the treatment cart. She did not remove the right-hand glove or perform hand hygiene.

Wearing the same glove on her right hand, the Treatment NA re-entered Resident #31's room. She repositioned him onto his side, unfastened his brief and applied the cream to his buttocks with her gloved right hand. She did not remove the glove from her right hand or perform hand hygiene after applying the cream.

The Treatment NA placed a new glove onto her left hand. She continued to wear the same glove on her right hand. She removed the offloading boot from Resident #31's right foot and unwrapped the outer dressing layer of Resident

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#31's right foot dressing to loosen the dressing. Using her right hand, she attempted to smooth out and remove the folds and wrinkles from the outer dressing layer and then rewrapped it around his right foot.

The Treatment NA exited Resident #31's room and went back to the treatment cart, she removed her gloves, and used alcohol-based hand rub to clean her hands.

An interview was performed with the Treatment NA on 7/25/24 at 2:24 PM. The Treatment NA stated that if she was doing wound care on the same part of the body, she did not need to change her gloves. The Treatment NA said she thought it was okay for her to wear the same pair of gloves to do the wound care on both of Resident #31's feet. She explained that included removing the old dressings on his feet, performing the wound care, and putting on the new dressings to both his feet. The Treatment NA said if she moved to a different area of the body to do a treatment or dressing then she would need to change her gloves or if there was blood or body fluids she would need to change her gloves. The Treatment NA said she had not thought about the drainage from Resident #31's wounds being body fluids. The Treatment NA said that since Resident #31 had drainage from his foot wound and that was considered body fluids, then she should have changed her gloves. The Treatment NA said she was supposed to perform hand-hygiene when she removed her gloves and before she put clean gloves on. The Treatment NA said she had forgotten to perform hand hygiene. She stated that after she had performed bowel incontinent care for Resident #31, she should have changed her gloves and performed

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hand hygiene. She could not say why she did not change her gloves after providing incontinence care except that she forgot.

An interview was conducted on 7/26/24 at 2:25 PM with the Assistant Director of Nursing (ADON). The ADON stated she was the facility infection preventionist and did staff education. The ADON said the Treatment NA should have performed hand-hygiene and changed her gloves when providing wound care. She said the Treatment NA had received training on hand hygiene and infection control practices for wound care. The ADON stated she expected the Treatment NA to know she needed to perform hand hygiene anytime she removed her gloves and before putting on new gloves. The ADON indicated the Treatment NA should know to change her gloves between dirty and clean wound care procedures. She said the Treatment NA was nervous and thought that was why mistakes were made and the Treatment NA had forgotten to change her gloves and perform hand hygiene.

An interview was conducted on 7/26/24 at 4:34 PM with the Director of Nursing (DON). The DON stated that the Treatment NA should have changed her gloves between dirty and clean procedures. She said the Treatment NA should have performed hand-hygiene before providing wound care, after removing gloves, and before putting on new gloves. The DON stated that the Treatment NA had received training on infection control practices for wound care including hand hygiene and changing gloves.

An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The

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Administrator stated that all protocols, process, and procedures should be followed when the Treatment NA provided wound care. She said that the Treatment NA should have performed hand hygiene and changed her gloves.

1b. An observation was performed on 7/22/21 at 2:20 PM of Resident #31's room and hallway. There was no EBP signage present on the door or in his room. No personal protective gowns were observed in his room or stored outside in the hallway.

An observation was performed on 7/23/24 at 1:57 PM of Resident #31's room. There was no EBP signage observed on the door or in his room. There was a clear plastic personal protective equipment cart located outside the door of the room across the hall, but there were no gowns seen in the cart.

An observation was completed on 7/24/24 at 1:16 PM of Resident #31's room and hallway revealed there was no EBP sign on the door or in his room. There was a clear plastic PPE cart located on the hallway at the door across from Resident #31's room

An observation was completed on 7/24/24 at 1:35 PM of the Treatment NA performing personal care and wound care to Resident #31's diabetic foot ulcers. The Treatment NA did not wear a gown while performing Resident #31's wound care. The Treatment NA was observed repositioning Resident #31 in bed and adjusting his bed linens without wearing gloves or a gown. The Treatment NA was also observed performing incontinent care for Resident #31 and did not wear a gown. During parts of the incontinent care

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the Treatment NA was also observed not wearing a glove on her left hand.

An interview was conducted on 7/24/24 2:24 PM with the Treatment NA. She stated residents with wounds should have EBP in place. The Treatment NA said she was supposed to wear a gown and gloves when doing wound care for residents with EBP in place. The Treatment NA explained she thought if a resident needed EBP that there would be a sign on the door and PPE cart outside the door. She explained that since he did not have a sign for EBP on his door or a PPE cart outside his door she had not thought she needed to wear a gown. The Treatment NA said that since Resident #31 had wounds that he probably should have EBP in place and that she should have worn a gown and gloves.

An interview was conducted on 7/26/24 at 2:25 PM with the Assistant Director of Nursing (ADON). The ADON stated she was the facility infection preventionist and did staff education. The ADON stated that enhance barrier precautions (EBP) should be in place for residents with wounds or devices. She stated that Resident #31 had previously had a sign for EBP on his door. The ADON stated she did not know what happened to Resident #31's EBP door sign that maybe it had fallen off the door. The ADON stated that the Treatment NA should have worn gown and gloves when she provided wound care for resident #31, provided incontinent care or repositioned him in bed. The ADON stated that the Treatment NA had received training on EBP and that she should have known to wear a gown and gloves.

An interview was conducted on 7/26/24 at 4:34

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PM with the Director of Nursing (DON). The DON stated that Resident #31 should have an order for EBP and that he should have a sign on his door for EBP because he has chronic wounds. The DON said that the Treatment NA should have worn a gown and gloves when providing care and doing wound care.

An interview was conducted with the Administrator on 7/26/24 at 5:23 PM. The Administrator stated that residents who had wounds should have EBP in place, they should have an order in place for EBP, and that EBP should be followed for wound care. The Administrator said the Treatment NA should have worn a gown and gloves when she provided care and wound care for Resident #31.

2. The facility's policy entitled Hand Hygiene last revised on 01/11/23 read in part:

"Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.

Policy Explanation and Compliance Guidelines:

2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.

3. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.

Hand Hygiene Table - Either use soap and water or alcohol-based hand rub (ABHR is preferred) under these conditions:

- After handling contaminated objects

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F 880	Continued From page 109 - Before applying and after removing personal protective equipment (PPE), including gloves - Before performing resident care procedures - Before and after providing care to residents in isolation - After handling items potentially contaminated with blood, body fluids, secretions or excretions - When, during resident care, moving from a contaminated body site to a clean body site - After assistance with personal body functions (e.g., elimination, hair grooming, smoking) A wound observation was made on 07/24/24 at 10:10 AM on Resident #3 with the Treatment Nurse Aide (NA). The Treatment NA was observed standing in the resident's room with her cart in the doorway, placing her clean wound supplies directly onto the resident's overbed table which had not been cleaned. There were visible food particles and liquid spills that had dried on the table. She finished getting the supplies from her cart and pushed it into the hall to the other side of the doorway. The Treatment NA donned a clean gown and pulled the curtain around the resident but left the door open at the request of the resident's roommate. She donned clean gloves without sanitizing her hands and placed her clean barrier pad on the resident's bed and began with the resident's left below the knee stump wound. The Treatment NA removed the old dressing from the stump wound and with the same gloves on cleaned the wound with wound cleanser and then realized she didn't have the calcium alginate to place on the wound bed, so she doffed her gown and gloves and without sanitizing her hands, went out to her cart and obtained the calcium alginate. After obtaining the calcium alginate, she donned a clean gown but did not tie it around it and without sanitizing her	F 880		

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hands, donned clean gloves and forgot her scissors. With the same gloves on she reached into her pocket and got out her keys and gave them to another Nurse Aide (NA) in the hallway and asked her to get her scissors out of her cart. The hall NA handed the scissors and keys to the Treatment NA, and she placed her keys back in her pocket and took the scissors and cut the calcium alginate to fit the wound bed on Resident #3's left below the knee stump wound and with the same gloves covered the wound with a border gauze dressing. The Treatment NA then took her black marker out of her pant pocket and marked the dressing with her initials and the date. She then moved to the gastrostomy tube (g-tube) site and with the same gloves on and not sanitizing her hands and changing her gloves, removed the dressing from the g-tube site. With the same gloves on, she cleansed the site with wound cleanser and placed a clean dressing around the g-tube site and taped it in place and used her marker to initial and date the dressing. Without sanitizing her hands and with the same gloves on, she unfastened the resident's brief and removed it and the brief had smears of dried bloody drainage from the sacral wound and dried smears of stool both on the brief and on the resident's buttocks in between his cheeks. The Treatment NA next moved to the sacral wound which did not have a dressing on it and said the old dressing must have come off. Without sanitizing her hands or changing gloves, she proceeded with the same gloves and cleansed the sacral wound with wound cleanser, opened and applied collagen powder to the wound and applied a bordered foam dressing over the wound and used the same marker to initial and date the sacral dressing. The Treatment NA then moved to the lower back wound and without sanitizing her

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hands or changing her gloves and using the same gloves, removed the old dressing on the resident's back wound. She cleansed the wound with wound cleanser, opened the border gauze dressing and realized she had forgotten the Medi-honey to be applied to the back wound. The Treatment NA doffed her gown and gloves and without sanitizing her hands went out to her cart in the hallway and obtained a packet of Medi-honey from her cart and put it in her pant pocket. She then donned a clean gown but did not tie it in the back and without sanitizing her hands donned a clean pair of gloves, reached into her pocket with the gloves on and retrieved the packet and applied the Medi-honey to the gauze dressing and covered the wound with a border gauze dressing. The Treatment NA then doffed her gown and gloves and without sanitizing her hands, went out to her cart again to get xeroform for the new open area between the resident's left thumb and index finger. She donned a clean gown and without sanitizing her hands donned clean gloves and used the same scissors to cut the xeroform to fit the area on his left hand. The Treatment NA cleansed the area with wound cleanser, and without sanitizing her hands or changing her gloves applied the xeroform to the area and covered it with a bordered gauze dressing. Without sanitizing her hands and using the same gloves she rubbed silver alginate cream to his right arm with her gloved hands and with a tongue blade applied the silver alginate cream to his left and right upper legs and scrotum. She reached inside his bedside table drawer and obtained wipes and without sanitizing her hands or changing her gloves proceeded to wipe the stool smears from his buttocks and with the same gloves turned him on his back and fastened his clean brief on both

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sides. The Treatment NA then doffed her gloves and without sanitizing her hands donned clean gloves and applied silver alginate cream to his left hand and applied a clean sleeve on his left arm. The Treatment NA doffed her gown and gloves and without sanitizing her hands gathered all her supplies and her trash and left the room.

An interview on 07/24/24 at 3:07 PM with Treatment NA revealed she had been doing treatments on wounds for about a month. She stated she had received training from the previous Treatment Nurse who was now a Unit Manager and she referred to her when she needed assistance or guidance with wound treatments. The Treatment NA indicated she realized she had not sanitized her hands and changed her gloves like she should have during the wound care for Resident #3. She further indicated she was overwhelmed and nervous about being watched during wound care and had just forgotten a lot during the wound treatments. The Treatment NA explained that she felt like she had received the proper training that she needed to perform wound treatments and said she needed to center herself, slow down, and put her training into effect.

An interview on 07/24/24 at 4:11 PM with Unit Manager #1 revealed that she had previously done wound care at the facility for a couple of months before changing roles to the Unit Manager. She stated the Treatment NA still utilized her for a resource.

An interview on 07/26/24 at 2:25 PM with the Assistant Director of Nursing (ADON) who also serves as Staff Development Coordinator (SDC) and Infection Preventionist (IP) revealed she was

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aware of the concerns about the Treatment NA's wound care and had done one on one education with her regarding handwashing on 07/24/24. The ADON stated the Treatment NA should have known to sanitize her hands anytime she took off her gloves and should have known to sanitize her hands and change gloves when moving from a dirty to clean procedure and when moving from one wound to another.

An interview on 07/26/24 at 4:36 PM with the Director of Nursing (DON) revealed it was her expectation that when a resident was on Enhanced Barrier Precautions (EBP) that all staff don and doff Personal Protective Equipment (PPE) appropriately when providing care to any resident but especially wound care and that they sanitize their hands according to the infection control policies and procedures. She stated the Treatment NA had received additional training on donning and doffing PPE and handwashing.

An interview on 07/26/24 at 5:07 PM with the Administrator revealed it was her expectation that all staff follow all procedures and protocols when providing wound treatments.

3. The facility's policy entitled, "Hand Hygiene," revised on 1/11/23 indicated under 6. Additional considerations:
a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.
Under Hand Hygiene Table, either soap and water or alcohol based hand rub were to be used when performing the following tasks: before and after handling clean or soiled dressings, linens, etc., after handling items potentially contaminated

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with blood, body fluids, secretions, or excretions, when, during resident care, and moving from a contaminated body site to a clean body site.

An observation of wound care by Nurse #1 was made on 7/26/24 at 2:24 PM. Nurse #1 applied hand sanitizer to both hands and put on a gown and gloves prior to entering Resident #10's room. She removed the old dressing on Resident #10's wound to her sacrum. The old dressing had moderate amount of serous (having to do with serum, the clear liquid part of blood) drainage. She proceeded to clean the wound with normal saline-soaked gauze. Nurse #1 removed her gloves and without doing hand hygiene, she put on a new pair of gloves to both hands. Nurse #1 applied medical honey to Resident #10's sacral ulcer, and removed her gloves from both hands. Without performing hand hygiene, she put on a new pair of gloves and covered Resident #10's sacral wound with a bordered foam dressing. She removed her gown and gloves, and washed both hands in the sink.

An interview with Nurse #1 on 7/26/24 at 2:36 PM revealed she was an agency nurse who was asked to do wound care for the day. Nurse #1 stated that she had received education in the past regarding hand hygiene during wound care. Nurse #1 stated that she knew hand hygiene should be done before and after wound care, and whenever her gloves became soiled. Nurse #1 said that the reason why she did not do hand hygiene after removing her gloves during the wound care observation was because her gloves did not become visibly soiled. She further stated that she didn't know she was supposed to perform hand hygiene whenever removing gloves even though they did not look soiled.

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F 880	Continued From page 115 An interview with the Infection Preventionist (IP) on 7/26/24 at 2:46 PM revealed Nurse #1 had been educated before on hand hygiene after removing gloves. The IP stated that Nurse #1 should have followed the infection control policy and performed hand hygiene whenever she removed her gloves during wound care. An interview with the Director of Nursing (DON) on 7/26/24 at 4:35 PM revealed hand hygiene should be done whenever gloves were removed and changed.	F 880		