STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 03/14/2025

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/11/25 through 03/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XAXI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/11/25 through 03/14/25. Event ID# XAXI11. The following intakes were investigated: NC00227509, NC00227358, NC00215703, NC00214629 and NC00214372. 2 of the 14 complaint allegations resulted in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		4/10/25

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

Electronically Signed | 04/07/2025

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain repair or replace damaged bed power cord for 2 of 12 (Room#101 and Room#103) resident rooms on 1 of 4 resident halls reviewed for maintaining a safe, clean, and homelike environment. The findings included: a.On 3/11/25 at 11:16 AM an observation of room 101 b bed revealed the bed remote and power cord lying on top of the bed. Electrical tape was wrapped around multiple areas of the bed's power cord. Further observation revealed the outer protective wire coating was broken, torn, or	F 584	1.The Bed remote and power cords in Rooms 101 and Room 103 were immediately removed from service on 3/14/2025 by Maintenance Director. 2. A quality review of all bed controllers was conducted through observation by the Maintenance Director to ensure no other area of concerns on 3/14/2025. 3. On 3/14/2025 the Executive Director educated the Maintenance Director to maintain, repair or replace damaged bed power cords in resident rooms to maintain a safe, clean, and homelike. The Executive Director educated all staff on completing a work order for the maintenance director of any broken or	

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F 584	Continued From page 2 missing exposing 3 inner color-coded wires spanning the length of the visible portion of the power cord as it attached under the bed. The resident in room 101 was interviewed on 3/11/25 at 3:30 PM. She stated the bed power cord wire had been damaged and wrapped with electrical tape for as long as she had been in the room. A follow-up observation of room 101 b bed on 3/14/25 at 11:30 AM found the bed cord unchanged. b.On 3/11/25 at 3:42 PM an observation of room 103 b bed revealed the bed remote and the power cord laying on top of the bed. Black electrical tape was wrapped around the cord in 5 locations. Upon closer observation, the power cord's outer wire covering was missing sections of the protective covering. The inner color-coded wires were exposed and visible without electrical tape covering the inner wires. The resident stated during the observation that the bed remote power cord had been damaged for 2 years without repair. On 3/14/25 at 11:30 AM an observation of room 101 b bed and 103 b bed with the Maintenance Director revealed the bed cords to be unchanged. The Maintenance Director stated the bed power cords were damaged and replacement power cords had been ordered 2-3 weeks prior. A follow-up interview with the Maintenance Director was conducted on 3/14/25 at 11:51 AM. He stated a replacement cord for a bed was ordered 2-3 weeks prior when he was made aware of the damaged cord by an administrative	F 584	dysfunctional equipment by 04/07/2025. Newly hired staff will be educated during orientation. The Executive Director or designee will conduct audits related to equipment repair in timely manner and proper functioning of all medical equipment 5x week for 4 weeks, then 3x week for 4 weeks, 1x week for 4 weeks, and PRN and or until substantial compliance is achieved. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 03/31/25. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The ED will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. 5. 04/10/25	

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F 584	Continued From page 3 staff who was conducting a round in room #101 room. The Maintenance Director presented an invoice dated 2/17/25 for one replacement bed power cord. The ordered cord was delivered to the facility earlier in the week and the replacement cord did not fit the bed in room 101 and another power cord needed to be ordered. He stated the cord had not been reordered, and he would place an order on the current day (3/14/25). The Maintenance Director said he would replace room 101 b bed with a manually operated bed until the correct cord had arrived. The Maintenance Director went on to state he was unaware how many of the bed power cords needed to be replaced in the facility, and he would conduct an audit, he was not aware of room 103 b bed's damaged bed cord. The Maintenance Director stated room 101 b bed and 103 b bed's damaged power cords did not have frayed or exposed inner wires, the outside coating of the power cords was cracked and missing in some places and he felt the damaged cords did not pose an electric shock hazard. He reported he had placed electrical tape around the damaged cords at some point and could not recall how long it had been. Additionally, the Maintenance Director reported he did not have a specific routine audit of the bed cords but did monthly checks of the mattresses that would include looking at the bed power cords. The Administrator was interviewed on 3/14/25 at 12:17 PM and stated the damaged bed cords should have been repaired or replaced when they were identified.	F 584		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		4/10/25

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F 684	Continued From page 4 § 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 record review, staff, resident and Medical Director interviews, the facility failed to follow physician orders for checking a diabetic resident's blood glucose levels twice daily for 2 of 2 residents with physician orders for blood sugar monitoring (Resident #23 and Resident #17). The findings included: 1. Resident #23 was admitted to the facility on 2/17/25. His medical diagnoses included: Diabetes Mellitus Type-2. The admission Minimum Data Set (MDS) assessment dated 2/24/25 revealed Resident #23 was cognitively intact. Resident #23 had a care plan for Diabetes Mellitus type-2 dated 2/28/25. The care plan interventions read, fasting serum blood sugar as ordered by doctor. Review of Resident #23's active physician orders for March 2025 revealed the following orders: - An order dated 2/17/25 that read, Lantus (long-acting insulin)100 unit/ milliliter (ml), inject 20 units subcutaneously at bedtime.	F 684	1.The Licensed Nurse obtained blood glucose twice daily for Resident #23 as indicated per physician□s order. Resident #23 was affected related to this citation. The Licensed Nurse obtained blood glucose twice daily for Resident #17 as indicated per physicians order. Resident #17 was affected related to this citation. 2.The Director of Nursing and or Nurse Managers completed a quality review audit for resident identified as having orders to obtain blood glucose checks as indicated per physicians□ orders by 04/07/25. No concerns identified. 3.The Regional Director of Clinical Services educated the Director of Clinical Services on obtaining blood glucose levels per physicians orders by 04/04/25. The Director of Clinical Services and or Nurse Managers to educate Licensed Nurses by 4/7/25 on obtaining blood glucose checks per physician orders. Newly hired staff educated upon hire during orientation. The Director of Clinical Service and or designee will perform quality improvement monitoring for five diabetic residents with blood glucose checks 5x week for 4 weeks, then 3x	

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F 684	Continued From page 5 - An order dated 2/21/25 entered by the Medical Director that read, blood glucose (BG) twice daily. Review of the electronic medical record revealed the following blood glucose results: - A result of 125 obtained on 2/20/25 - A result of 193 obtained on 2/25/25 There were no other blood glucose results documented in the electronic medical record An interview was conducted with Resident #23 on 3/12/25 at 2:04 PM. He said it had been a while since his blood glucose had been checked at the facility. Resident #23 said he felt like he had not experienced any symptoms of high or low blood sugar. An interview was conducted with Nurse #1 on 3/12/25 at 2:20 PM. Nurse #1 stated Resident #23 did not get blood glucose checks and he did not have an order to check them. After she reviewed his active physician order, Nurse #1 verbalized Resident #23 did have an active order for blood glucose checks twice a day. She opened the blood glucose order entry details and reviewed the order. After reviewing the order entry details, Nurse #1 explained the order had been entered in by the Medical Director. She further explained the order did not show up on Resident #23's Medication Administration Record (MAR) because the order had been entered incorrectly. Nurse #1 stated she did not know to check Resident #23's blood glucose because the order did not pull to the MAR to let her know to check it. Nurse #1 reported there was not a process she was aware of for checking orders entered by providers to ensure they were entered correctly.	F 684	week for 4 weeks, 1x week for 4 weeks, and PRN to ensure substantial compliance is achieved. 4.The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 03/31/25. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The ED will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan Date of Compliance 4/10/25	

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F 684	Continued From page 6	F 684		

An interview was conducted with the Medical Director on 3/13/25 at 1:37 PM. The Medical Director reported she had been notified about Resident #23's blood glucose order being entered She said the staff did not know to check Resident #23's blood glucose because she had not entered the order correctly to pull to the MAR.

An interview was conducted with the Director of Nursing (DON) 3/14/25 at 4:44 PM. The DON explained the order for Resident #23's blood glucose checks had been entered by the Medical Director incorrectly and did not pull to the MAR to for the nurses to see. The DON stated the nurses did not know to check his blood glucose because it was not on the MAR. The DON explained orders were reviewed during the morning clinical meeting. She reported an orders report from the prior day was pulled and the orders were reviewed from the printed report. The DON stated order entry was not checked for the orders when they were reviewed during the morning meeting. The DON said there was not a current process for a second check of orders entered by providers to ensure they had been entered correctly.

An interview was conducted with the Administrator on 3/14/25 at 4:50 PM. The Administrator said staff had not known to check Resident #23's blood glucose because the order had been entered incorrectly by the Medical Director. The Administrator said there should be a process for checking orders entered by providers to ensure they were entered correctly.

2. Resident #17 was admitted on 6/25/24 with diagnoses that included type 2 diabetes mellitus. Resident #17 had a care plan dated 6/25/24 for

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F 684	Continued From page 7	F 684		

type 2 diabetes dated 6/25/24 with interventions that included to monitor blood glucose checks as ordered.

Resident #17 had a physician's order dated 12/14/24 for dulaglutide pen-injector 1.5 milligrams to inject 3 milligrams subcutaneously weekly every Saturday. (Dulaglutide is a once-a-week injection drug prescribed to treat type 2 diabetes mellitus.)

Resident #17 had a physician order dated with a start date 1/10/25 and end date 1/20/25 for fingerstick glucose (blood sugar check) two times daily (BID) before meals.

A review of Resident #17's Medication Administration Record (MAR) for January 2025 found blood glucose checks were not initialed as completed on 1/10/25 through 1/18/25 at 6:00 AM and 4:30PM. On 1/19/25 Nurse #2 had initialed blood glucose check was completed at 4:30 PM and the blood sugar level was not documented on the MAR.

Nurse #2 was interviewed on 4/14/25 at 12:53 PM. She stated she was assigned to Resident #17 on some of the days the blood glucose checks were not completed. Nurse #2 said she was not aware Resident #17 had an order blood glucose checks two times daily before meals from 1/10/25 through 1/18/25. Nurse #2 confirmed that Resident #17 did have an order for blood glucose checks beginning on 1/10/25 and was not able to explain why the blood sugar checks were not completed, and confirmed Resident #17 had a current order to check blood sugars. Nurse #2 stated she always followed physician orders and completed all blood sugar checks.

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F 684	Continued From page 8	F 684		

The Medical Director was interviewed on 3/14/25 at 1:38 PM. She stated the order for Resident #17 to receive blood sugar checks was written on 1/10/25 by the Nurse Practitioner. The Medical Director stated the Nurse Practitioner did not correctly enter the order into the electronic chart and it was not visible for the nurses to see. The Medical Director stated the NP and herself had not received much training for entering orders in the electronic medical chart and did not enter the orders correctly.

An interview was conducted with the Director of Nursing (DON) 3/14/25 at 4:44 PM. The DON explained the order for Resident #17's blood glucose checks had been entered by the Nurse Practitioner incorrectly and did not pull to the MAR to for the nurses to see. The DON stated the nurses did not know to check his blood glucose because it was not on the MAR. The DON explained orders were reviewed during the morning clinical meeting. She reported an orders report from the prior day was pulled and the orders were reviewed from the printed report. The DON stated order entries were not reviewed to ensure they had been made visible for nurses to see on the MAR. The DON said there was not a current process for a second check of orders entered by providers to ensure they had been entered correctly.

An interview was conducted with the Administrator on 3/14/25 at 4:53 PM. The Administrator said staff had not known to check Resident #17's blood glucose because the order had been entered incorrectly by the Nurse Practitioner. The Administrator said there should be a process for checking orders entered by

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F 684	Continued From page 9 providers to ensure they were entered correctly.	F 684		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		4/7/25

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F 756	Continued From page 10 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Medical Director, and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendations to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident (Resident #46) who received an antipsychotic medication. In addition, the facility failed to follow pharmacy recommendations that had been signed by the physician to add a 14-day stop date for a prn (as needed) psychotropic medication for a Resident #17. This deficient practice occurred for 2 of 5 residents reviewed for pharmacy recommendations (Resident #46 and Resident #17). The findings included: 1. Resident #46 was admitted to the facility on 5/12/21 with diagnoses that included paranoid schizophrenia, anxiety disorder, and major depressive disorder. A review of Resident #46's active physician's orders revealed the following orders: -An order dated 7/10/24 that read, olanzapine (antipsychotic medication) 2.5 milligrams (mg) give one tablet by mouth one time a day every Tuesday, Thursday, and Saturday for schizophrenia. -An order dated 12/24/24 that read, olanzapine 5 mg by mouth daily for schizophrenia.	F 756	1. Resident #46 AIMS was completed on 03/13/25. Resident #17's "as Needed" anti drepressent Medication was discountinued 11/25/24. 2.On 04/7/2025 the Director of Nursing/Designee completed an audit on pharmacy recommendations for as needed antipsychotic medications to ensure recommendations are followed as ordered. 3.The Regional Director of Clinical Services provided education to the Executive Director and the Director of Clinical Services on pharmacy recommendations within 21 days on 03/12/2025. The education was provided to license staff by the Director of clinical Services on 4/7/25 and will be included in new hire orientation. Pharmacy recommendations will be audited 5x week for 4 weeks, then 3x week for 4 weeks, 1x week for 4 weeks, and PRN. The audits will be presented to the Quality Assurance Committee each month. 4.The Director of Nursing/Designee will present the monitoring plan to the Quality Assurance Committee. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit	

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F 756	Continued From page 11 A quarterly Minimum Data Set (MDS) assessment dated 12/24/24 revealed Resident #46 was cognitively intact. He was not documented for behaviors or rejection of care. The MDS documented that he received antipsychotic medication. Review of the Consultant Pharmacist's pharmacy consultation reports revealed an AIMS assessment was recommended on 10/12/24, 12/7/24, and on 2/9/25. (Abnormal Involuntary Movement Scale is a scale to measure abnormal involuntary movements in patients taking antipsychotic medications). The pharmacy recommendations dated 10/12/24, 12/7/24, and 2/9/25 read, "please monitor for involuntary movements now and at least every 6 months or per facility protocol. It is recommended that monitoring frequency increase following does adjustments." The comments read, "[Resident #46] receives olanzapine which may cause involuntary movements, including tardive dyskinesia (abnormal involuntary movements caused by medications), but an abnormal involuntary movement scale (AIMS), or other appropriate assessment was not documented in the medical record within the previous 6 months." -The pharmacy recommendation dated 10/12/24 was signed by the Director of Nursing (DON) on 10/24/24. Under DON comments it read, "recommendations added to orders." -The pharmacy recommendation dated 12/7/24 was signed by the Director of Nursing on 12/23/24. Under DON comments it read, "order updated with recommendation."	F 756	Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. 4/7/25	

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F 756	Continued From page 12	F 756		

-The pharmacy recommendation dated 2/9/25 was signed by the Director of Nursing on 2/19/25. Under DON comments it read, "followed recommendation".

An interview was conducted on 3/14/25 at 11:15 AM with the Consultant Pharmacist. The consultation report recommendations for Resident #46 from 10/24/24, 12/23/24, and 2/19/24 were for an AIMS assessment to be completed due to Resident #46 receiving an antipsychotic medication. The Consultant Pharmacist stated he kept sending the recommendation because he did not see an AIMS assessment that had been done.

An interview was conducted with the Director of Nursing on 3/14/25 at 10:14 AM. She reported she was responsible for reviewing and ensuring pharmacy recommendations were completed. The DON explained she had misunderstood what the pharmacy recommendations for Resident #46 were asking for. The DON explained she had added to "monitor for involuntary movements now and at least every 6 months" as an order and added it to the olanzapine medication order for Resident #46. The DON reported she had not realized the pharmacy recommendations indicated an AIMS assessment needed to be completed for Resident #46.

An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director stated the facility should follow pharmacy recommendations.

An interview was conducted with the Administrator on 3/14/25 at 4:44 PM. The Administrator said Resident #46 should have had

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F 756	Continued From page 13	F 756		

an AIMS completed and the pharmacy recommendations should have been followed. The Administrator stated she was not sure why the DON missed the recommendation to do an AIMS.

2. Resident #17 was admitted on 6/25/24 with diagnoses that included type 2 diabetes mellitus, depression, and anxiety.

Resident #17's quarterly Minimum Data Set (MDS) dated 12/9/24 coded her as severely cognitively impaired. She was coded for taking an antidepressant.

Resident #17 had a physician's order dated 7/23/24 for trazadone Hcl oral tablet 50 milligrams give one tablet by mouth as needed (PRN) for insomnia at bedtime. The physician's order was discontinued on 11/25/24.

Pharmacy recommendations from July 2024 through February 2025 for Resident #17 were reviewed:
A recommendation dated 7/26/24 read in part Resident #17 had a PRN antidepressant trazadone without a stop date. The physician's response was to add a 14-day stop date and was signed dated 8/14/24. The pharmacy recommendation dated 9/9/24 repeated the recommendation, with the same physician response.

A pharmacy recommendation dated 11/13/24 read in part Resident #17's prescriber accepted a pharmacy recommendation to add a stop date to PRN trazadone on 8/15/24, but the order has not been processed. The pharmacy recommendation was signed by the Director of Nursing on 11/25/24

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F 756	Continued From page 14 and noted the order for trazadone PRN was discontinued 11/25/24. The DON stated on 3/14/25 at 10:25 AM the pharmacy recommendation to place a stop date on the PRN trazadone was overlooked by her in the August 2024 pharmacy review and she did not discontinue the medication until 11/24/24 pharmacy recommendation found it. The DON stated until recently, she was not retaining or scanning the pharmacy recommendations into the electronic charting when she received them from the consulting pharmacist. The DON said she was faxing the physician responses to the pharmacy recommendations to the pharmacy, and she thought the pharmacy was changing the orders. The Consultant Pharmacist was interviewed on 3/14/25 at 11:15 AM and stated PRN psychoactive medications should have a 14-day stop date. He said he had made recommendations for a 14-day stop date for any PRN psychoactive medications a resident received that did not include a stop date and they were sent to the DON monthly. The Medical Director was interviewed on 3/14/25 at 1:37 PM. She stated her orders should be followed to add a 14-day stop date to the antipsychotic medication. The Administrator stated on 3/14/25 at 4:53 PM the DON was faxing signed physician pharmacy recommendations to the pharmacy. The DON did not know she needed to make the changes in Resident #17's orders.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use	F 758		4/7/25

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F 758	Continued From page 15 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 16 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Director, and Consultant Pharmacist interviews, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) assessment for a resident who received an antipsychotic medication (Resident #46). In addition, the facility failed to ensure a physician order for an as needed (prn) psychotropic medication was limited to 14 days (Resident #17). This deficient practice occurred for 2 of 5 residents reviewed for unnecessary psychotropic medications (Resident #46 and Resident #17). The findings included: 1. Resident #46 was admitted to the facility on 5/12/21 with diagnoses that included paranoid schizophrenia, anxiety disorder, and major depressive disorder. A review of the electronic medical record revealed Resident #46's last AIMs was completed on 10/5/23. (Abnormal Involuntary Movement Scale is a scale to measure abnormal involuntary movements in patients taking antipsychotic medications).	F 758	1. Resident #46 AIMS was completed on 03/13/25. Resident #17's "as Needed" anti drepressent Medication was discountinued 11/25/24. Resident #46 Resident pharmacy consultation reports revealed a missing AIMS assessment was recommended on 10/12/24, 12/7/24, and 2/9/25. Resident #17 physician order for antidepressant PRN without a stop date. Pharmacy consultation report dated 7/23/24 recommended a stop date. 2. On 03/12/2025 Pharmacy consultation report and PRN psychotropic medication orders were reviewed by the Director of Clinical Services/Designee to ensure the orders were written correctly and the order included a stop date of no more than fourteen (14) days and all necessary assessments (AIMs) were completed. 3. The Regional Director of Clinical services provided education to the Executive Director and the Director of Clinical Services on 3/12/25. The Director of Nursing/Designee provided education to the nurses and medical staff regarding the correct format to order PRN (as	

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F 758	Continued From page 17 A review of Resident #46's active physician's orders revealed the following orders: -An order dated 7/10/24 that read, olanzapine (antipsychotic medication) 2.5 milligrams (mg) give one tablet by mouth one time a day every Tuesday, Thursday, and Saturday for schizophrenia. -An order dated 12/24/24 that read, olanzapine 5 mg by mouth daily for schizophrenia. A quarterly Minimum Data Set (MDS) assessment dated 12/24/24 revealed Resident #46 was cognitively intact. He was not documented for behaviors or rejection of care. The MDS documented that he received antipsychotic medication. An interview was conducted on 3/14/25 at 11:15 AM with the Consultant Pharmacist. He explained what he was looking for when he did the pharmacy medical record review for Resident #46 was a documented AIMS assessment with a date on it and he had not seen that completed. An interview was conducted with the Director of Nursing on 3/14/25 at 10:14 AM. She explained the MDS nurse was historically responsible for completing the AIMS assessments. The DON reported the facility had changed MDS nurses several times in the last couple of years. She stated the current MDS nurse was new in the position and was not aware it was something she needed to do. The DON said she was not entirely sure on how often AIMS assessments needed to be completed until she looked up the policy today (3/14/25), she reported she kind of new but was not entirely sure. The DON stated after checking the policy, AIMS assessments should be completed on admission, when there were	F 758	needed) psychotropic medications. The medical staff was instructed to include a stop date of 14 days for PRN (as needed) medications; nursing staff was instructed to complete all necessary assessments (AIMS). The education will be included in new hire orientation. New PRN (as needed) psychotropic medication orders and the AIMS assessment will be reviewed 5X per week for 4 weeks; then 3x per week for 4 weeks, and 1x a week for 4 weeks. The Director of Clinical Services will be presented to the Quality Assurance Committee each month. 4.The Director of Nursing/designee will present the monitoring plan to the Quality Assurance Committee. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. 4/7/25	

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changes in the antipsychotic medication, and quarterly.

An interview was conducted with the MDS Nurse on 3/14/25 at 4:11 PM. The MDS Nurse reported she had worked at the facility since August 2024. She explained she had not been told she was supposed to do the AIMS assessments or was supposed to look and make sure they were done. She further explained she had not been told AIMS were part of her role, she said if it was, she was unaware. The MDS Nurse stated she did not know who was supposed to do the AIMS assessments or was responsible for them.

An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director stated the facility should complete AIMS assessments to monitor residents for side effects of antipsychotic medications.

An interview was conducted with the Administrator on 3/14/25 at 4:44 PM. The Administrator said AIMS assessments should be completed for residents who received antipsychotic medication. The Administrator said AIMS assessments should be done every three months, when a new medication was added, or if requested by pharmacy or a provider.

2.Resident #17 was admitted on 6/25/24 with diagnoses that included type 2 diabetes mellitus, depression, and anxiety.

Resident #17's quarterly Minimum Data Set (MDS) dated 12/9/24 coded her as severely cognitively impaired. She was coded for taking an antidepressant

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F 758	Continued From page 19	F 758		

Resident #17 had a physician's order dated 7/23/24 for trazadone Hcl oral tablet 50 milligrams give one tablet by mouth as needed (PRN) for insomnia at bedtime. The physician's order was discontinued on 11/25/24.

Pharmacy recommendations from July 2024 - February 2025 for Resident #17 were reviewed. A recommendation dated 7/26/24 read in part Resident #17 had a PRN antidepressant trazadone without a stop date. The physician's response was to add a 14-day stop date and was signed dated 8/14/24.

A recommendation dated 11/13/24 read in part Resident #17's prescriber accepted a pharmacy recommendation to add a stop date to PRN trazadone on 8/15/24, but the order has not been processed. The pharmacy recommendation was signed by the Director of Nursing on 11/25/24 and noted the order for trazadone PRN was discontinued 11/25/24.

The DON stated on 3/14/25 at 10:25 AM the pharmacy recommendation to place a stop date on the PRN trazadone was overlooked by her in the August 2024 pharmacy review and she did not discontinue the medication until 11/24/24 pharmacy recommendation found it. The DON stated until recently, she was not retaining or scanning the pharmacy recommendations into the electronic charting when she received them from the consulting pharmacist. The DON said she was faxing the physician responses to the pharmacy recommendations to the pharmacy, and she thought the pharmacy was changing the orders.

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F 758	Continued From page 20 The consultant pharmacist was interviewed on 3/14/25 at 11:15 AM and stated PRN psychoactive medications should have a 14-day stop date. He said he had made recommendations for a 14-day stop date for any PRN psychoactive medications a resident received that did not include a stop date and they were sent to the DON monthly. The Medical Director was interviewed on 3/14/25 at 1:37 PM. She stated her orders should be followed to add a 14-day stop date to the antipsychotic medication. The Administrator stated on 3/14/25 at 4:53 PM the DON was faxing signed physician pharmacy recommendations to the pharmacy. The DON did not know she needed to make the changes in Resident #17's orders.	F 758		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F 791		4/7/25

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F 791	Continued From page 21 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide dental services for 1 of 1 (Resident #17) residents reviewed for providing emergency dental services. The findings included: Resident #17 was admitted on 6/25/24 with diagnoses that included type 2 diabetes mellitus and heart failure. Resident #17 was care planned for oral and	F 791	F791 Resident #17 was seen on 03/14/25 via telehealth/ triage appointment that is available with current in-house Dental provider. Recommendation was made and shared with the MD. MD addressed Residents oral needs with her own treatment plan, with the intent for Resident to see a Dental provider as soon available. Resident #17 will be seen on April 16th, 2025, by the dental provider that comes onsite to the facility. Provider will screen resident at that time and make	

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F 791	Continued From page 22 dental health problems on 06/25/24 with interventions that included monitor document and report any signs or symptoms of oral problems needing attention and provide mouth care. Resident #17 had a physician order dated 7/23/24 for dental consultation as needed. A provider progress note dated 11/25/24 read in part the resident had a lesion in the left lower buccal (cheek) fold along the edge of the left lower denture. The resident is agreeable to an alteration to the lower denture area. The provider wrote that a dental consult would be beneficial to make some alterations along the lower edge of the left lower denture. Resident #17 had a physician order dated 11/25/24 that read; dental referral to evaluate lower full denture which is causing recurrent buccal trauma. Resident #17's quarterly Minimum Data Set (MDS) assessment dated 12/9/24 coded her as severely cognitively impaired. She was coded for loose or broken dentures and yes for difficulty, pain with swallowing chewing. She required a therapeutic and mechanically altered diet and needed set-up assistance with eating. A Provider Progress Note dated 2/3/25 read in part, Resident #17 was seen for sore area on the left side of her mouth and jaw. The resident had issues with her denture causing recurrent trauma to her inner left mouth area in the last few months. The denture needed to be modified, and the dental consultation was not completed. Resident #17 had an approximately .5 to 1 centimeter laceration and the left lower buccal	F 791	recommendations. As a precautionary measure, Resident #17 has an additional appointment in the community on May 29th, 2025, at a Dentist office if the April 15th visit does not take place. On March 12th, 2025, a quality review was completed by Clinical Services and Unit Managers on to ensure all orders and referrals related to residents oral health and dental needs were properly processed and carried out. Any concerns noted were addressed as identified. 03/31/25-04/07/25 Director of Nursing and/or designee re-educated current Licensed Nursing staff regarding process and policy for Residents with oral and dental needs and how referrals and orders should be processed. ED educated the IDT team 03/31/2025 on the process for Residents oral and Dental needs (both onsite and offsite providers). Also, following physicians orders, making referrals and the roles of Social Worker, Business office, Nursing Admin team and Transportation/appointment coordinator. ED reviewed the CMS-2567, F#791, in Resident Council meeting 04/03/25 and explained to group what services are available at the facility currently and in the community. No needs expressed by the group. All newly hired nursing staff will receive this education during orientation. Starting on 04/07/25 the Social Worker and/or designee will conduct random Quality Reviews to ensure residents are receiving oral and Dental care Referrals	

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F 791	Continued From page 23 fold that was adjacent to the sharp edge of her lower denture. The provider note wrote Resident #17 had an appointment in-house for a dental consultation on 2/5/25. A nursing progress note dated 2/8/25 written by Nurse #1 read Resident #17 had a sore area on her left inner cheek. The resident stated it was very sore, and magic mouthwash did not help much. The resident's bottom denture was very loose, and the resident's family was concerned. A note was left for the Physician to evaluate and advise. Attempts to interview Nurse #1 were unsuccessful. A progress note written by a provider dated 2/11/25 read in part the resident was seen at the request of Resident #17's family for a follow-up concern regarding a mouth lesion. The resident had been seen for this concern numerous times starting in the fall of 2024 when a dental consult was placed. The progress note wrote, it was determined the lesion was caused by the lower denture defect and required an alteration. The family did not want to take the resident out for dental care and the request was put in for residency care by the traveling dentist. She was scheduled to see the dentist at this location and was postponed until later in the week of 2/10/25 -2/14/25. The provider wrote the resident did not wear her bottom dentures that caused difficulty when eating. The progress note went on to say the provider had confirmed the dentist was coming to the facility later in the week of 2/10/25-2/14/25. The provider requested special attention that the resident was seen and if for some reason the resident was not seen by the	F 791	and visits as ordered. Social Worker and/or designee will review 3 random residents per week/4 weeks and 3 Random Residents per month/2 months and then prn. ED introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 03/31/25. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Social Worker will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Date of Compliance 04/07/25	

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dentist, the resident needed to be seen as soon as possible.

A note written on 3/6/25 by the Transportation Driver read Resident #17 will be seen by the dentist on 5/29/25 at 11:00 AM.

Resident #17 had a physician order dated 03/09/25 that read; lidocaine viscous (used to numb red, swollen, and painful sores in mouth) mouth and throat solution 2% with direction to place and dissolve 15 milliliters buccally before meals for left lower buccal lesion for 14 days and discontinue if lesion is healed.

A review of Resident #17's March 2025 Medication Administration Record (MAR) found the resident received the lidocaine viscous as ordered.

A review of the in-house dentist and dental hygienist visits and notes dated 10/30/24 through 3/10/25 was completed. Resident #17 was not seen by the hygienist or the dentist.

The business office manager (BOM) was interviewed on 3/13/25 at 3:28 PM. The BOM stated Resident #17's family initially did not want to enroll the resident into the dental program because they thought the resident was going to be a short-term resident. The family later decided the Resident #17 was going to be a long-term resident, and she was enrolled in the dental program on 1/27/25 by the resident's family. The residents' information along with physician order was sent to the in-house dental provider on 2/10/25. The BOM said the facility was unaware the resident was not seen on 3/10/25 and would be seen on the next visit to the facility on 4/16/25

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F 791	Continued From page 25 and was unsure if the dental provider did emergent visits. A follow-up interview with the BOM on 3/13/25 at 3:56 PM was conducted. The BOM stated the dental provider was called and asked if Resident #17 could be seen emergently. The dental provider told the BOM a triage form could be filled out and sent to the dental provider and a regional dentist would review and develop a plan of care for the resident. The BOM stated the facility was unaware of the triage form and the form would be completed on 3/13/25 and sent to the dental provider for Resident #17. Furthermore, the BOM said the dental provider told her the dentist needed to see Resident #17 for an evaluation prior to the dental hygienist providing any oral care. On 3/10/25 the dental hygienist was at the facility and Resident #17 had not been evaluated by a dentist and was not included on the list to be seen. The Administrator was interviewed on 3/14/25 at 4:53 PM. She stated the facility did attempt to schedule Resident #17 a dentist appointment when the referral was written but was unable to find a dentist to accept the residents insurance. The Administrator said if the facility was aware of the triage option for the resident, it should have been completed and submitted soon after the resident was signed up with the in-house dentist. The resident was not included on the dental provider list to be seen on 3/10/25 because the dentist had not evaluated Resident #17. The Administrator said Resident #17 should have been seen on 3/10/25.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/7/25

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F 880	Continued From page 26 §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 §483.71 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; (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:	F 880		

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F 880	Continued From page 27 (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 observations, record review, and staff and Medical Director interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) for a resident (Resident #23) with a feeding tube and a resident with a wound (Resident #32) when Nurse #1 failed to wear a gown while administering a tube feeding for Resident #23 and the Wound Care Nurse failed to wear a gown while performing wound care for Resident #32. This deficiency occurred for 2 of 2 staff members	F 880	1.Resident #23 and Resident #32 were identified as needing Enhanced Barrier Precautions. On 03/12/25 and 03/13/25 when the deficient practice was identified, the Director of Nursing re-educated Nurse #1 and wound nurse on proper PPE as required per Enhanced Barrier Precautions during high contact resident care activity specifically as it relates to accessing feeding tube and wound care. 2.A quality review was completed on	

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reviewed for infection control practices (Nurse #1 and the Wound Care Nurse).

The findings included:

Review of the facility's policy and procedure dated August 2022 entitled "Enhanced Barrier Precautions" read in part:
"Enhanced Barrier Precautions (EBP) are used as an infection control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. EBP's employ targeted gown, and glove use during high-contact resident care activities when contact precautions do not otherwise apply.
"Examples of high-contact care activities requiring the use of gown and glove for EBP include: Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator; wound care (any skin opening requiring a dressing)."
"EBPs are indicated for residents with wounds and/or indwelling medical devices, regardless of MDRO colonization."

1. An observation was completed on 3/12/25 at 2:20 PM of Nurse #1 accessing Resident #23's gastrostomy feeding tube and administering his tube feeding. The nurse performed hand hygiene using hand sanitizer and donned clean gloves. She did not don a gown. Nurse #1 checked placement of the feeding tube, flushed the tube with water, administered a bolus tube feeding through the tube, flushed the tube with water, and replaced the stopper at the end of the tube. She disposed of the trash, removed her gloves, and performed hand hygiene using hand sanitizer.

An interview was conducted with Nurse #1 on

current residents as indicated as requiring Enhanced Barrier Precautions to ensure physicians order, care plan and residents room indicated Enhanced Barrier Precaution by the Director of Clinical Services and the Assistant Director of Nursing on 03/13/25 when the deficient practice was identified. Additionally, The Director of Nursing, and Nurse Managers completed a quality review on current residents as indicated as requiring Enhanced Barrier Precautions to ensure physicians order, care plan and residents room indicated Enhanced Barrier Precaution by 03/13/25.
3.The Regional Director of Clinical services re-educated the Director of Nursing and Executive Director on proper PPE as required per Enhanced Barrier Precautions during high-contact residents care activity initially on 03/13/25. The DCS and or Nurse Managers re-educated current licensed nurses, certified nurse aides, therapy on the Enhanced Barrier Precautions policy to include proper PPE required during high-contact resident care activity on 03/13/25 through 04/07/25. The DCS and or Nurse Manager re-educated licensed nurses, certified nurse aide, therapy staff, and non-direct care staff on Donning / Doffing with verbal and or return demonstration of understanding 03/13/25 through 04/07/25. Newly hired staff will be educated on Enhanced Barrier Precautions policy and Donning/Doffing during orientation. The DON and or Unit Manager will conduct Quality Improvement Monitoring 5x per week for 4 weeks, then 3x per week for 4

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F 880	Continued From page 29 3/12/25 at 2:30 PM. Nurse #1 said the EBP sign on the outside of Resident #23's room door was for Resident #23's roommate. She explained the EBP sign was hung above or below the name on the door to identify who in the room the EBP were for. She reported she had received education on EBP and that residents with indwelling devices and wounds should have EBP. She said she should have known Resident #23 needed EBP since he had a feeding tube, but said she did not think about it. Nurse #1 reported she should have worn a gown and gloves when she did Resident #23's tube feeding. An interview was conducted with the Infection Preventionist (IP) on 3/14/25 at 9:39 AM. She explained residents with indwelling devices and chronic wounds should have EBP in place. She said Nurse #1 should have worn a gown and gloves when administering Resident #23's tube feeding. The IP said she thought Nurse #1 may have been nervous and just forgot. She said Nurse #1 had received education on EBP and should have known Resident #23 needed EBP since he had a feeding tube. An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director reported she was familiar with EBP. She stated the facility should use and follow EBP for residents with feeding tubes. An interview was conducted with the Director of Nursing (DON) and Administrator on 3/14/25 at 4:44 PM. The DON said residents with wounds and indwelling devices should have EBP in place. She explained nurses should follow EBP and should wear a gown and gloves for residents who require EBP. The DON reported Nurse #1 should	F 880	weeks, then 1x week for 4 weeks, and PRN. 4.The Director of Nursing/designee will present the monitoring plan to the Quality Assurance Committee. The Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. 4/7/25	

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have worn a gown when administering Resident #23's tube feeding. The Administrator added the facility has plenty of personal protective equipment (PPE) and that it was just human error.

2. An observation and interview was completed on 3/13/25 at 12:37 PM with the Wound Care Nurse. The Wound Care Nurse was observed performing wound care to Resident #32's right foot wound. The Wound Care Nurse said the wound was classified as a vascular wound and betadine was being applied to the wound because of maceration around the wound. She performed hand hygiene using hand sanitizer, donned gloves, and removed the dressing from the bottom of Resident #32's right foot and placed the dressing in the trash. She removed her gloves, performed hand hygiene using hand sanitizer, and donned new gloves. She cleaned the wound with normal saline, she removed her gloves and performed hand hygiene using hand sanitizer. She donned new gloves, applied betadine to the wound, and covered the wound with a foam dressing. She removed her gloves and performed hand hygiene using hand sanitizer.

An additional interview was conducted with the Wound Care Nurse on 3/14/25 at 8:52 AM. She reported she had not worn a gown when performing Resident #32's wound care because she was not on EBP. The Wound Care Nurse reported EBP were used if a resident grew out an organism on a wound culture, but that EBP was not used for other wounds. The Wound Care Nurse stated she was not sure if residents with wounds should have EBP. She said she thought chronic wounds may need EBP but that she

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would check and let the surveyor know. The Wound Care Nurse returned after a few minutes and said she checked with the Infection Preventionist (IP) and was told anyone with chronic wounds needed EBP. She reported she was not aware Resident #32 needed EBP and that was why she did not use EBP and wear a gown when she did her wound care. The Wound Care Nurse said she had received education on EBP.

An interview was conducted with the IP on 3/14/25 at 9:39 AM. She explained residents with indwelling devices and chronic wounds should have EBP in place. The IP reported gown and gloves should be worn when performing wound care. The IP said Resident #32 had not had EBP in place because the IP was not aware of her wound. She reported there should be better communication between herself and the Wound Care Nurse about wounds. The IP said the Wound Care Nurse had received education on EBP, she said she was not sure why the Wound Care Nurse did not remember Residents with wounds needed EBP.

An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director reported she was familiar with EBP. She stated the facility should use and follow EBP for residents with wounds.

An interview was conducted with the Director of Nursing (DON) and Administrator on 3/14/25 at 4:44 PM. The DON said residents with wounds and indwelling devices should have EBP in place. She said there was miscommunication between the IP and Wound Care Nurse and that was why Resident #32 did not have EBP in place. She

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F 880	Continued From page 32 explained nurses should follow EBP and wear gown and gloves for resident who required EBP. The Administrator added the facility has plenty of personal protective equipment (PPE) and that it was just human error.	F 880		