STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/9/24 through 6/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VNX311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 6/9/24 through 6/12/24. Event ID# VNX311. The following intakes were investigated NC00215933, NC00215916, NC00214732, NC00214538, NC00211349, NC00211131, NC00211058, NC00217967, NC00215177. Three of the 31 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to keep the call light within reach for 1 of 1 resident (Resident #54) reviewed for accommodation of needs. Findings included: Resident #54 was admitted to the facility on 4/17/19 with a diagnosis of intracerebral	F 558	1. Resident #54 had her call bell assessed by the maintenance director on 6-28-24 to ensure it was long enough to reach across the bed in the event she is sitting in her chair. The call bell was able to reach across residents bed to the chair that she sits in on the left side of her bed. 2. All residents / resident rooms were audited by the licensed nurses on 6-28-	7/10/24

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

Electronically Signed | 07/03/2024

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F 558	Continued From page 1 hemorrhage (bleeding in the brain). A review of Resident #54's care plan revealed in part a focus area initiated on 5/7/2019 of at risk for falls. The goal, last revised on 3/15/24, was for Resident #54 not to sustain any injuries related to falls through the next review. An intervention was to be sure Resident #54's call light was within reach and encourage Resident #54 to use it for assistance as needed as Resident #54 required prompt response to all requests for assistance. A review of Resident #54's quarterly Minimum Data Set (MDS) assessment dated 6/1/24 revealed she was moderately cognitively impaired. She had functional limitation in range of motion of her upper extremities on one side. On 6/10/24 at 1:22 PM Resident #54 was observed in her room seated in her recliner chair on the left side of her bed. Her call light was observed on the right side of her bed hanging from the headboard of her bed. Resident #54 was not able to reach her call light. An interview with Resident #54 at that time indicated she needed some assistance. Resident #54 stated she could not reach her call light, and she couldn't yell for help because her voice was not loud enough. She reported there had been other times when her call bell was left where she couldn't reach it, and she just had to wait for someone to come into her room to help her. She went on to say this was frustrating. On 6/10/24 at 1:55 PM Resident #54 was observed to be asleep in her recliner chair. Her call light was still observed to be out of reach. On 6/10/24 at 2:08 PM Resident #54 was	F 558	24, to see if call bells could reach the bed and /or chair if resident was out of bed. No residents were identified as needing longer cords and their call lights were in reach. 3. On 6/29/24 Facility staff were educated by the Staff development, director of nursing, unit managers, and/or department manager to have call bells within reach when residents are in their rooms in bed/or chair and that longer cords are available if needed. This was added to the orientation of new facility staff on 6/29/24 by the administrator. 4. DON, ADON and Unit managers will audit call bell placement on 5 residents/day x 5 days x 4 weeks then 5 residents /day 3 days x 4 weeks. Referred to QAPI committee for additional recommendations. 5. Completion date July 10,2024	

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F 558	Continued From page 2 observed to be asleep in her recliner chair. Her call light was still observed to be out of reach. On 6/10/24 at 2:47 PM an observation of Resident #54 with Nurse Aide (NA) #6 revealed Resident #54 was seated in her recliner chair with her call light out of her reach hanging on the right side of her bed from the headboard. An interview with NA #6 at that time indicated she was assigned to Resident #54. NA #6 reported Resident #54 could not reach her call light where it was now. She stated she had last been in Resident #54's room between 1:00 PM and 1:30 PM that day picking up lunch meal trays. She reported she had not made sure Resident #54 had her call bell in reach when she left Resident #54's room. NA #6 went on to say residents should have their call lights within reach at all times. She confirmed Resident #54 was able to use her call light. On 6/12/24 at 10:59 AM an interview with the Director of Nursing indicated Resident #54 was able to use her call light to obtain assistance. She reported residents should have their call light within their reach at all times. She stated when any staff member left a resident's room, they should always make sure the resident had their call light within their reach. On 6/12/24 at 11:13 AM an interview with the Administrator indicated the facility had longer call light cords if needed. She stated residents should have their call light within reach at all times. She went on to say before any staff member left a residents room, they should make sure that resident had their call light within reach.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		7/10/24

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F 578	Continued From page 3 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 4 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the opportunity to establish advanced directives and document this in the medical record for 1 of 2 residents (Resident #100) reviewed for advanced directives. Findings included: A review of the facility's policy titled "Advanced Directives" dated last revised September 2022 revealed, in part, the following: "1. If the resident or resident representative indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. A. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. B. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance." Resident #100 was admitted to the facility on 9/9/22 with a diagnosis of stroke (disrupted blood supply to the brain). A review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated 5/9/24 revealed she was cognitively intact. On 6/9/24 at 4:05 PM an interview with Resident #100 indicated she understood that advanced directives included a living will and a power of	F 578	1. Social worker met with resident #100 on 7-2-24 to discuss advanced directives. The resident was asked if she wanted information on establishing advanced directives. Information and assistance was offered on establishing advanced directives during this meeting. 2. 2.All Residents/ Resident representatives were asked if they had an advanced directive and/or wanted assistance with establishing an advanced directive. This was completed by the IDT members starting 7-2-24. Information and assistance was provided upon request. 3. The interdisciplinary team was educated on the advanced directive policy on 7-2-24 by the administrator. On 7/2/24 this education was added to the orientation of any new IDT team members by administrator. 4. The LNHA and/or designee will audit all new admissions for documentation of the Advanced directive conversation on admission. Audits of admission records will be completed weekly x 8 weeks. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Completion date 7/10/2024	

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F 578	Continued From page 5	F 578		

attorney. She stated she did not have either of these things. She went on to say she did not recall ever being offered the opportunity or assistance with establishing them. Resident #100 stated she would like more information.

On 6/11/24 a review of Resident 100's record did not reveal any evidence Resident #100 wanted to establish advanced directives or refused.

On 6/11/24 at 2:31 PM an interview with Social Worker (SW) #2 indicated she was currently Resident #100's SW. She stated she started in this role in May 2023. She further indicated Resident #100 was her own representative. SW #2 reported she did not recall ever having a conversation with Resident #100 about whether or not she would like to establish advanced directives.

On 6/11/24 at 3:23 PM an interview with the Admissions Director indicated she assisted residents with completing the admission paperwork. She reported she had been doing this when Resident #100 was first admitted to the facility. She stated she spoke with residents and/or their representatives regarding code status and asked if they had a living will and/or a power or attorney on admission. She went on to say if a resident had either of these things, a copy was requested to place in the resident's record. The Admissions Director reported if residents did not have these things, she did not ask if they would like to establish them or offer any assistance with doing this.

On 6/12/24 at 8:42 AM an interview with SW #1 indicated he had been the SW at the facility from September 2022 through September of 2023. He

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F 578	Continued From page 6 stated he did not recall ever having a conversation with Resident #100 about whether or not she would like to establish advanced directives. On 6/12/24 at 10:00AM an interview with the Assistant Director of Nursing indicated there was no documentation in Resident #100's record that Resident #100 wanted to establish advanced directives or refused. On 6/12/24 at 10:59 AM an interview with the Director of Nursing indicated the Admissions Director asked residents whether or not they had advanced directives in a verbal conversation on admission. She reported regarding whether or not a resident or representative wished to establish advanced directives, there had not been any documentation of this in the record. On 6/12/24 at 11:13 AM an interview with the Administrator indicated she did not know why there was no documentation in Resident #100's record regarding whether or not she wanted to establish advanced directives.	F 578		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for oxygen for 4 of 28 residents reviewed for MDS assessments (Resident #3, Resident #75, Resident #121, and Resident	F 641	1 The MDS assessments for Residents #3, #75, #121, and #328 were modified, submitted, and accepted by 7-9-24 by minimum data set nurse. 2 The MDS assessments for all	7/10/24

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F 641	Continued From page 7 #328). Findings include: a.Resident #3 was admitted on 7/25/2018 and readmitted on 10/12/23 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, oxygen dependence, and hypoxemia (low levels of oxygen in body tissues). Review of physician orders dated 5/5/22 revealed an order for Resident #3 to receive continuous oxygen three liters per minute via nasal cannula (oxygen delivery method) to maintain oxygen saturation (measurement of oxygen in the blood.) above 90%. Review of the annual MDS assessment dated 5/6/24 for Resident #3 revealed she was cognitively intact. Resident #3 had not been coded for oxygen use on the assessment. Review of Resident #3's June 2024 Medication Administration Record (MAR) revealed that she received continuous oxygen via nasal cannula delivered at 3 liters per minute. b.Resident #75 was admitted on 6/29/23 with diagnoses that included chronic obstructive pulmonary disease, and diabetes. Review of physician orders dated 2/20/24 revealed an order for Resident #75 to receive oxygen two liters per minute via nasal cannula (oxygen delivery method) every bedtime and while napping to maintain oxygen saturation (measurement of oxygen in the blood.) above 90%.	F 641	residents on O2 were audited by the District Director of Operations by 6-14-24. Four other resident assessments were modified/corrected/submitted/accepted by 6/18/24.MDS nurse and regional director of clinical reimbursement to reflect accurate o2 coding. 3 MDS coordinators were educated on coding Section -O special treatments, procedures, and programs per RAI guidelines with an emphasis on oxygen Delivery, by the Regional Director of Clinical Reimbursement on 6-12-24. This education was added to newly hired MDS nurses on 6/13/24 by administrator. 4 Director of nursing, and/or administrator will audit section O for all completed MDS each week x 8 weeks for accurate coding of o2 therapy. Results of the audits will be referred to QAPI committee for additional recommendations. 5 Completion date 7/10/24	

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F 641	Continued From page 8	F 641		

Review of the annual MDS assessment dated 5/28/24 for Resident #75 revealed she was cognitively intact. Resident #75 had not been coded for oxygen use on the assessment.

Review of Resident #75's June 2024 Medication Administration Record (MAR) revealed that she received oxygen via nasal cannula delivered at 2 liters per minute at bedtime and when she napped.

c. Resident #121 was admitted on 4/24/24 with diagnoses that included chronic obstructive pulmonary disease.

Review of Resident #121's physician orders dated 4/28/24 revealed an order for oxygen at two liters per minute via nasal cannula (oxygen delivery method).

Review of the five-day MDS assessment dated 4/30/24 for Resident #121 revealed he was moderately cognitively impaired. The Resident had not been coded for oxygen use on the assessment.

Review of Resident #121's Medication Administration Record (MAR) dated June 2024 revealed he received continuous oxygen delivered at two liters per minute via nasal cannula.

d. Resident #328 was admitted to the facility on 5/22/24 with diagnoses that included fracture of the right femur and asthma.

Review of physician orders dated 5/22/24 revealed an order for Resident #328 to receive continuous oxygen at four liters per minute via

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F 641	Continued From page 9 nasal cannula (oxygen delivery). Review of the five-day MDS assessment dated 5/28/24 for Resident #328 revealed she was mildly cognitively impaired. Resident #328 had not been coded for oxygen use on the assessment. Review of Resident #328's Medication Administration Record (MAR) dated June 2024 revealed she received oxygen via nasal cannula delivered at four liters per minute continuously. In interviews with the MDS coordinator on 6/11/24 at 9:38 AM and 12:59 PM she stated that Resident #121, Resident #328, Resident #3, and Resident #75 were not coded for oxygen use because she did not code a resident for oxygen use unless the physician used the word "hypoxia" (low levels of oxygen in the blood) in the physician's order for oxygen. An interview with the Director of Nursing on 6/11/24 at 1:45 PM revealed all physician orders were reviewed by the MDS Coordinator and she coded based on the physician order. She stated that Resident #121, Resident #328, Resident #3, and Resident #75 should have been coded for oxygen by the MDS nurse. In interviews with the Administrator and the Director of Operations on 6/11/24 at 2:00 PM and 2:40 PM they stated that the MDS for Resident #121, Resident #328, Resident #3, and Resident #75 should have been coded for oxygen.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		7/10/24

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F 657	Continued From page 10 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to have a quarterly interdisciplinary care plan meeting for 1 of 6 residents reviewed for care planning. (Resident #8) Findings included: Resident #8 was admitted to the facility on	F 657	1.Resident #8 had a care plan conference held on 6-25-24 with members of the interdisciplinary team and resident. 2. On 6/27/24 Social work completed an audit of care plan meetings held for all long-term residents to ensure quarterly care plan meetings were held. Results of the audit noted 8 Residents were due for	

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F 657	Continued From page 11 11/18/22. Her active diagnoses included hemiplegia affecting left nondominant side, diabetes mellitus, unsteadiness on feet, cerebrovascular disease, muscle weakness, hyperlipidemia, and hypertension. Review of Resident #8's minimum data set assessment dated 5/15/24 revealed she was assessed as cognitively intact. Review of Resident #8's medical record revealed her last care plan meeting was held on 2/13/24. During an interview on 6/9/24 at 10:37 AM Resident #8 stated she had not had a care plan meeting in a long time and could not remember the date of her last care plan meeting. During an interview on 6/11/24 at 9:28 AM Social Worker #2 stated the last care plan meeting for Resident #8 was on 2/13/24. She stated care plan meetings were supposed to be completed quarterly. She concluded she did not have a reason Resident #8 had not had another care plan meeting since 2/13/24. During an interview on 6/11/24 at 9:37 AM the Administrator stated care plan meetings were to be held quarterly for residents.	F 657	a care plan review. Care plan conferences for residents identified will be held prior to July 10,2024. 3. IDT team was educated by the administrator on 7-2-23 on the care plan policy/process. On 7/2/24 the administrator added this education to the orientation for newly hired IDT team members. 4. The administrator/director of nursing will audit the MDS schedule weekly to ensure care plan meetings are scheduled and occurring with documentation. Audits will be completed weekly x 8 weeks. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Completion date 7/10/24	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		7/10/24

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RIDGEWOOD LIVING & REHAB CENTER	1624 HIGHLAND DRIVE WASHINGTON, NC 27889

(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
F 688	Continued From page 12 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to apply a hand splint to a resident as ordered for 1 of 4 residents reviewed for positioning and mobility. (Resident #51) Findings included: Resident #51 was admitted to the facility on 8/9/17. His active diagnoses included muscle weakness, unspecified sequelae (an aftereffect of a disease, condition, or injury) of cerebral infarction, pain in left shoulder, and flaccid hemiplegia affecting left nondominant side. Review of Resident #51's Minimum Data Set assessment dated 3/7/24 revealed he was assessed as moderately cognitively impaired. He was documented to have no rejection of evaluation or care. He had impairment on one side of his upper extremities. He required set-up or clean-up assistance with eating and was dependent on staff for oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.	F 688	1. Resident #51 had splint applied as ordered upon identification by facility nurse. 2. Assistant director of nursing completed an audit of all residents with splints by 6-14-24. All splints were applied as ordered. 3. On 6/24/24 All nursing staff were educated on the use of splints to prevent contractures by Staff development, director of nursing, ADON and/or Unit Coordinators. On 6/24/24 this education was added to the orientation of new nursing staff by administrator. 4. DON and/or ADON will audit 5 splints weekly x week x 4 weeks then 3 splints x week x 4 week. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Completion date 7/10/24	

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Review of an order dated 3/27/23 revealed Resident #51 was ordered for staff to apply left hand splint after breakfast and remove after supper for contracture prevention.

Review of Resident #51's care plan dated 4/12/24 revealed he was care planned for activities of daily living self-care performance deficit related to flaccid hemiplegia of the left side, generalized weakness, and immobility. The interventions included applying his left-hand splint as directed for contracture prevention and left hemiplegia.

During an interview on 6/9/24 at 11:38 AM Resident #51 stated he was supposed to get his splint applied to his left hand daily, but it was not on his left hand today. He concluded sometimes staff do not put his splint on him.

During observation on 6/9/24 at 11:39 AM Resident #51 was observed to not have his splint on his left hand.

During an interview on 6/10/24 at 8:54 AM Resident #51 stated he finished breakfast but had no one had put his left-hand splint on that morning.

During observation on 6/10/24 at 8:54 AM Resident #51 was observed to not have his splint on his left hand.

During an interview on 6/10/24 at 12:13 PM Resident #51 stated no staff had placed his splint on his left hand yet.

During observation on 6/10/24 at 12:13 PM Resident #51 was observed to not have his splint

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F 688	Continued From page 14 on his left hand. During an interview on 6/10/24 at 12:56 PM Nurse #5 stated the nurse aides should place Resident #51's splint to his left hand in the mornings. Upon observing the resident, she concluded the splint was not placed on Resident #51's left hand and it should have been. Nurse #5 then retrieved the splint from Resident #51's dresser and placed it on the resident. During an interview on 6/10/24 at 12:59 PM Nurse Aide #4 stated she forgot to place Resident #51's splint on his left hand that morning. She stated she knew he was to get his splint on in the morning because the information was on the resident's care guide at the nurse aide's kiosk. During an interview on 6/10/24 at 1:18 PM the Director of Nursing stated if a resident is ordered to have a splint placed then staff should have put the splint on as ordered or documented a refusal.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		7/10/24

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F 692	Continued From page 15 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide a nutritional supplement as ordered by the physician. This was for 1 of 1 residents (Resident #25) reviewed for nutrition. Findings included: Resident #25 was admitted to the facility on 10/30/23 with a diagnosis of diabetes mellitus. A care plan focus area initiated on 11/3/23 was at risk for nutritional problems related to poor oral intake. The goal, last revised on 4/22/24, was for Resident #25 to maintain stable weight through the next review. An intervention was to provide nutritional supplements as needed. A review of Resident #25's weight record revealed in part on 2/13/24 he weighed 188 pounds. On 6/11/24 Resident #25 weighed 196.4 pounds. A current active physician's order with a start date of 2/13/24 was for a nutritional shake three times a day with meals for weight loss prevention. A review of Resident #25's quarterly Minimum Data Set (MDS) assessment dated 5/3/24	F 692	1. On 6/12/24 Resident #25□s supplement was provided as ordered by dietary and verified by facility nurse. 2. An Audit of all ordered supplements was completed by the dietary manager on 7-2-24 to ensure supplements that were ordered were noted on the resident□s tray card. One resident tray card needed updating. 3. All dietary personnel were educated by the dietary manager on reading tray cards and ensuring supplements are sent from the kitchen on the meal tray as ordered on 7-2-24. On 7/2/24 the dietary manager added this to orientation for newly hired dietary staff. All nursing staff were educated on 06/24/24 by SDC, DON, ADON and UC to look at meal tray tickets when serving resident meals. If supplements are missing, they are to notify the dietary department. On 6/24/24 the administrator added this education to orientation for newly nursing staff. 4. The dietary manager and/or Assistant Dietary manager will audit 5 trays 3 times week x 4 weeks then 5 trays weekly x 4 weeks for supplements as ordered. Results of the audits will be referred to	

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F 692	Continued From page 16	F 692		

revealed he was severely cognitively impaired. He rejected care on 4 to 6 days of the look back period for the assessment. He was 71 inches tall. Resident #25 weighed 191 pounds. He had no or unknown weight loss of 5 percent or more in one month or 10 percent or more in 6 months.

On 6/11/24 at 8:53 AM the Unit Manager was observed to deliver Resident #25's breakfast meal tray to him and leave his room. Resident #25 began eating his toast. His meal tray ticket was observed to list a nutritional shake; however, no nutritional shake was present on his tray.

On 6/11/24 at 9:09 AM Nurse Aide (NA) #5 was observed to remove Resident #25's breakfast tray. An interview with NA #5 at that time indicated Resident #25 did not receive a nutritional shake on his breakfast tray. She stated he was getting nutritional shakes at one time, but he had been refusing them. NA #5 reported she thought these had been discontinued.

On 6/11/24 at 10:33 a review of Resident #25's Medication Administration Record (MAR) revealed in part documentation by Nurse #4 that Resident #25 took 50 percent of his nutritional shake with his breakfast meal.

On 6/11/24 at 10:50 AM an interview with Nurse #4 indicated she was caring for Resident #25 on 6/11/24. She stated Resident #25 drank 50 percent of his nutritional shake this morning with his breakfast on 6/11/24. She reported she had not seen the shake, it came from the kitchen with his breakfast tray, but she asked NA #5 how much of it Resident #25 drank.

On 6/11/24 at 1:09 PM in a follow-up interview NA

QAPI committee for additional recommendations.
5. Completion date 7/10/24

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#5 confirmed Resident #25 had not received a nutritional shake with his breakfast on 6/11/24. She stated she had not realized it was still listed on his meal ticket. She reported she was supposed to look at meal tickets and compare what was on the tray to what was on the meal ticket. NA #5 went on to say if an item was missing, she was supposed to call to the kitchen and get a replacement. She reported she had not done this for Resident #25's nutritional shake. NA #5 further indicated Nurse #4 had not asked her how much nutritional shake Resident #25 drank.

On 6/11/24 at 1:29 PM an interview with the Unit Manager indicated she delivered Resident #25's breakfast meal tray on 6/11/24. She stated she had not seen a nutritional shake on Resident #25's breakfast tray, but she had not looked at the meal ticket either. She reported after she delivered Resident #25's breakfast, NA #5 had taken over.

On 6/11/24 at 4:16 PM an interview with the Dietary Manager indicated the kitchen was not perfect. She stated Resident #25's nutritional shake was missing from his breakfast tray on 6/11/24. She reported as a safeguard the person who delivered Resident #25's breakfast tray should be calling the kitchen to obtain a replacement.

On 6/12/24 at 10:59 AM an interview with the Director of Nursing (DON) indicated if a resident had a physician's order for a nutritional supplement, then the nurse should ensure that the resident received this as this was something the nurse needed to document on the MAR. The DON went on to say whoever delivered a resident's meal tray should be checking the tray

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F 692	Continued From page 18 to ensure all items listed on the meal ticket were present. She stated if an item was missing, a replacement should be obtained. On 6/12/24 at 11:13 AM an interview with the Administrator indicated the kitchen should be making sure that nutritional shakes were present on the meal tray for residents who had them listed on their meal tray tickets. She went on to say if the shake is missing from the tray, whoever delivered the tray should contact the kitchen for a replacement.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		7/10/24

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F 693	Continued From page 19 by: Based on observation, staff interviews, and record review the facility failed to clean and store a syringe for enteral feeding with the plunger separately to dry for 1 of 1 resident reviewed for tube feeding. (Resident #57) Findings included: Resident #57 was admitted to the facility on 8/6/18. His active diagnoses included muscle weakness, persistent vegetative state, and anoxic brain damage. Review of Resident #57's Minimum Data Det assessment dated 4/4/24 revealed he was assessed as having a persistent vegetative state/no discernible consciousness. He was assessed to have a feeding tube in place and 51% or more of total calories the resident received through parenteral or tube feeding, and 501 cubic centimeters or more of fluid intake per day by IV or tube feeding. Review of Resident #57's care plan dated 4/8/24 revealed he was care planned to require tube feeding related to persistent vegetative state. The interventions included to keep the head of the bed elevated 45 degrees during and thirty minutes after tube feed, follow physician's orders for current feeding orders, check for tube placement and gastric contents/residual volume per facility protocol, and record, monitor, document, and report as needed any signs or symptoms of aspiration fever, shortness of breath, tube dislodged, infection at tube site, tube dysfunction or malfunction. During observation on 6/9/24 at 10:45 AM the	F 693	1. The syringe observed for Resident #57 was discarded upon identification, on 6-10-24, and a new syringe was provided by facility nurse. 2. There are no other residents receiving Enteral nutrition. 3. On 6/24/24 Facility nurses were educated on cleaning/drying process of piston syringes used with enteral feedings education was provided by Staff development director of nursing, assistant director of nursing, and Unit managers. On 6/24/24 the education was added to the orientation of newly hired nurses by the administrator. 4. DON and/or ADON will audit all tube feeding syringes 3 x week x 4 weeks then weekly x 4 weeks for compliance with the cleaning process. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Completion date 7/10/24	

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enteral feeding syringe for Resident #57 was observed with the plunger stored in syringe and was in a plastic bag hanging beside the resident's bed and dated 6/9/24. White debris and liquid were observed at the base of plunger, inside of the syringe.

During an interview on 6/9/24 at 10:46 AM Nurse #6 stated she stored the enteral feeding syringe for Resident #57 the way it was observed by the surveyor and reused it for medication pass. She further stated the white debris was left over medication and water from this morning when she gave his medication via feeding tube.

During observation on 6/10/24 at 12:03 PM the enteral feeding syringe for Resident #57 was observed with the plunger stored in syringe and was in a plastic bag hanging beside the resident's bed and dated 6/10/24. White debris and liquid were observed at the base of plunger, inside of the syringe.

During an interview on 6/10/24 at 12:08 PM Nurse #5 stated she used the enteral feeding syringe to check residual as well as provide medications that morning to Resident #57. The nurse stated after using it, she rinsed the syringe and plunger and then placed the plunger in the syringe and placed them in a bag hung next to the bed to dry and to be reused. Upon observing the syringe, she stated there was white debris and water must have been crushed medication remnants and water from the morning medication pass.

During an interview on 6/11/24 at 7:58 AM the Director of Nursing stated the syringe, and the plunger were to be cleaned with soap and water

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F 693	Continued From page 21 and dried with a paper towel and then the plunger and the syringe were to remain separate as they dry hanging in the bag next to the resident's bed.	F 693		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to honor residents' food preferences for 2 of 2 residents reviewed for food preferences (Resident #27, and Resident	F 803	1. The facility Dietary manager met with resident #27 and resident #117 on 6-10-24 to review their dietary preferences with no change in plan of care. The dietary	7/10/24

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F 803	Continued From page 22 #117). Findings include: a.Resident #27 was admitted on 5/17/24 and readmitted on 6/7/24. Review of the admission MDS assessment dated 5/17/24 for Resident #27 revealed she was cognitively intact. During an interview with Resident #27 on 6/9/24 at 11:39 am she stated that she did not like green beans or carrots but had been served green beans and carrots up to three times a week since her admission on 5/17/24. During an interview with Resident #27 on 6/9/24 at 12:21 pm she stated that she was served mixed vegetables that included large amounts of green beans and carrots. She indicated that she did not like carrots and green beans, and she wished the kitchen would stop sending them. Observation of Resident #27's meal tray on 6/9/24 at 12:21 pm a bowl of mixed vegetables that included green beans and carrots had been served to Resident #27. Review of Resident #27's meal ticket on her meal tray revealed that green beans and carrots were listed as disliked foods. During an interview on 6/10/24 at 12:57 pm Resident #27 stated that she got a bowl of carrots on her lunch tray. She further indicated that she was served a bowl of green beans with her dinner on 6/9/24. She stated that she had not spoken to anyone from the dietary department since she was readmitted on 6/7/24 because the dietary staff already had her dislikes from her prior	F 803	manager observed meal trays on 13 occasions and found no dislikes served. 2. The Dietary manager reviewed all residents admitted in the last 30 days to ensure likes and dislikes had been reviewed with the residents and tray cards accurately reflect likes and dislikes on 7-2 -24. All dislikes are reflected accurately on the tray cards. 3. Dietary staff were educated on Honoring dislikes on 6-10-24. The education was provided by the dietary manager. The dietary manager added this education to the orientation for newly hired dietary staff on 6/10/24. 4. Dietary manager / Assistant dietary manager will audit 5 trays 3 x week x 4 weeks, then 5 trays weekly x 4 weeks to ensure dislikes are being honored. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Completion date 7/10/24	

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admission on 5/17/24. She stated that her dislikes were listed on her meal ticket and the kitchen staff should honor what was on her meal ticket.

Observation of Resident #27's meal tray on 6/10/24 at 12:57 pm a bowl of carrots had been served to Resident #27.

Review of Resident #27's tray meal ticket dated 6/10/24 revealed her dislikes were listed. Her dislikes included carrots and green beans.

b.Resident #117 was admitted on 5/7/24 with diagnoses that included heart failure and diabetes.

Review of the annual MDS assessment dated 5/13/24 for Resident #117 revealed she was moderately cognitively impaired.

In an interview with Resident #117 on 6/9/24 at 1:48 pm she stated that she did not like milk, eggs, or fish but was served eggs every few weeks, fish every Friday, and milk about once a month. Review of Resident #117's meal ticket on her tray revealed that her dislikes listed on the meal ticket included milk, scrambled eggs, and fish.

Observation of Resident #117's meal tray on 6/10/24 at 7:45 am scrambled eggs had been served to Resident #117. Review of Resident #117's meal ticket on her tray revealed that her dislikes listed on the meal ticket included scrambled eggs.

In an interview with Resident #117 on 6/11/24 at 9:30 am she stated that she received milk on her breakfast meal tray and before she could tell

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F 803	Continued From page 24	F 803		

someone that she did not like or want milk it that it was opened, so it was wasted.

During an interview with the Certified Dietary Manager (CDM) on 6/10/24 at 01:04 pm she stated that she meets with all residents after they were admitted and asked them about their food likes and dislikes and recorded the information in the computer system and when she printed out tray meal tickets dislikes were listed on the ticket. She stated that if a resident had a dislike that an alternative would have been provided to that resident and the disliked food would not have been placed on the meal tray to be served to the resident. The interview further revealed that the dietary aide viewed the meal tickets when meal plates were prepared and called out any disliked foods to the cook before the food was plated so the disliked food would not be placed on the resident's plate. The CDM stated that residents should not get food on their plate that was listed as a dislike on their meal ticket. She indicated that dietary staff were educated that diets must be followed and if there was a dislike listed on the meal ticket that the food should not be served to the resident. The CDM did not know why Resident #27 and #117 received disliked foods on their meal trays.

During an interview with the Cook Aide on 6/10/24 at 1:15 pm she stated that she read the disliked foods listed on the meal ticket to the cook who plated the meal, and the cook would substitute the disliked food with an alternate food of the same food group. She further indicated that Resident #27 had a dislike of the alternate vegetable on 6/10/24 so she did not read the dislikes to the cook because she thought that a vegetable had to be served with the meal. She

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F 803	Continued From page 25 further indicated that she did not know why Resident #27 and Resident #112 received food that was listed on their meal ticket as disliked food on the other dates. In an interview with the Evening Cook on 6/10/24 at 1:22 pm she stated that she served the lunch meal every day after the morning cook prepared the food. She stated that the Cook Aide read the meal ticket to her and told her if a resident had a dislike and if they did, she would not put that food on the plate. She stated that if a resident had a dislike that she would serve an alternate food item and if a resident disliked the main and alternative food that she prepared and served a third option. The interview further revealed that the Cook did not look at the meal ticket and if the Cook Aide did not tell her of a disliked foods that she served the food that was on the menu. In an interview with the Director of Nursing on 6/10/24 at 1:53 pm she stated that if residents received food that was listed as disliked on their meal ticket that someone did not pay attention. She further stated that Resident #27 and #117 should not have received food that they disliked. In an interview with the Administrator on 6/10/24 at 3:36 pm she stated that Resident #27 and Resident # 117 should not have been served food that they disliked if it was marked on the meal ticket as disliked.	F 803		
F 842 SS=D	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.	F 842		7/10/24

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(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 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

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F 842	Continued From page 27 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- (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 observation, staff interviews, and record review the facility failed to accurately document the use of splints on a resident's Treatment Administration Record (TAR) for 1 of 3 residents reviewed for positioning and mobility and failed to accurately document nutrition supplement intake on the Medication Administration Record (MAR) for 1 of 1 resident reviewed for nutrition. (Resident #51 Resident #25) Findings included: 1. Review of an order dated 3/27/23 revealed Resident #51 was ordered for staff to apply left	F 842	1. The Splint was placed on the hand of resident # 51 upon identification with correct documentation. Upon identification the facility nurse corrected documentation for resident #25. 2. On 7/2/24 the director of nursing and/or assistant director of nursing audited splints and supplements to verify documentation accuracy. 3. All RN/LPN were educated on Documentation guidelines, specifically accurate documentation of splint application and nutritional supplement intake by the Staff development, DON, and/or unit coordinator on 06/24/24. On	

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hand splint after breakfast and remove after supper for contracture prevention.

Review of Resident #51's treatment administration record for June 2024 revealed it was documented by the nurse that the resident's left-hand splint had been applied at 8 AM on 6/10/24.

During an interview on 6/10/24 at 8:54 AM Resident #51 stated he finished breakfast but had no one had put his left-hand splint on that morning.

During observation on 6/10/24 at 8:54 AM Resident #51 was observed to not have his splint on his left hand.

During an interview on 6/10/24 at 12:13 PM Resident #51 stated no staff had placed his splint on his left hand yet.

During observation on 6/10/24 at 12:13 PM Resident #51 was observed to not have his splint on his left hand.

During an interview on 6/10/24 at 12:56 PM Nurse #5 stated she did not check this morning to see if Resident #51's left-hand splint was on. She further stated she documented the splint as applied in his treatment administration record at 8 AM that morning. She concluded she should have checked to ensure it was put on him, but usually staff placed it on him so she documented it as on and should not have.

During an interview on 6/10/24 at 1:18 PM the Director of Nursing stated the nurse should not document an intervention or treatment as

6/24/24 the education was added to the orientation of newly hired nurses by the administrator.
4. DON/ADON will audit 5 residents with orders for splints and/or supplements to ensure documentation is accurate 3 x week x 4 weeks then weekly x 4 weeks. Results of the audits will be referred to QAPI committee for additional recommendations.
5. Completion date 7/10/24

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completed without first checking that the treatment was in place to have accurate medical records.
2. A physician's order with a start date of 2/13/24 was for a nutritional shake three times a day with meals for weight loss prevention.

On 6/11/24 at 8:53 AM the Unit Manager was observed to deliver Resident #25's breakfast meal tray to him and leave his room. His meal tray ticket was observed to list a nutritional shake; however, no nutritional shake was present on his tray.

On 6/11/24 at 10:33 a review of Resident #25's Medication Administration Record (MAR) revealed in part documentation by Nurse #4 that Resident #25 drank 50 percent of his nutritional shake with his breakfast meal.

On 6/11/24 at 10:50 AM an interview with Nurse #4 indicated she was caring for Resident #25 on 6/11/24. She stated Resident #25 drank 50 percent of his nutritional shake this morning with his breakfast on 6/11/24. She reported she asked NA #5 how much of it Resident #25 drank.

On 6/11/24 at 1:09 PM in an interview NA #5 confirmed Resident #25 had not received a nutritional shake with his breakfast on 6/11/24. NA #5 further indicated Nurse #4 had not asked her how much nutritional shake Resident #25 drank.

On 6/11/24 at 1:19 PM a follow-up interview with Nurse #4 indicated she realized that Resident #25 did not receive a nutritional shake on his breakfast tray on 6/11/24, and her documentation that he consumed 50 percent of it was not

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F 842	Continued From page 30 accurate. She stated she had not seen the shake on Resident #25's breakfast tray, but thought she asked Nurse Aide (NA) #5 how much of the shake Resident #25 drank. Nurse #4 reported there must have been a miscommunication with NA #5 about which resident she was asking about. She went on to say she would correct her documentation now. On 6/12/24 at 10:59 AM an interview with the Director of Nursing (DON) indicated Nurse #4 should have made sure Resident #25 received his nutritional shake before she documented how much he drank on the MAR. The DON went on to say documentation in residents records should be accurate. On 6/12/24 at 11:13 AM an interview with the Administrator indicated documentation in resident's records should be accurate.	F 842		
F 880 SS=D	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,	F 880		7/10/24

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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;
(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

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F 880	Continued From page 32 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 and staff interviews, the facility failed to handle soiled linen in a manner to prevent the spread of infection for 1 of 1 resident reviewed for infection control and prevention (Resident #44). Findings included: Review of facility policy entitled "Laundry and Bedding, Soiled" read in part "soiled laundry/bedding shall be handled according to best practices for infection prevention and control". "Contaminated laundry is placed in a bag or container at the location where it is used". During an observation of incontinence care for Resident #44 on 6/10/24 at 2:11 pm NA #1 laid soiled bath cloths and towels directly on the floor. She then removed her soiled gloves, placed them in the trash receptacle, washed her hands, and left the room. She returned with plastic bags. NA#1 then put on clean gloves and picked the soiled towels and wash cloths up off the floor and placed them in a plastic bag and tied the bag closed, removed her soiled gloves, placed them in the trash receptacle in the room, washed her hands, and disposed the soiled items in a dirty	F 880	1. Resident #44 has not been negatively affected by the deficient practice. Nurse aid #1 has was provided 1-1 education by the DON on 7-2-24. 2. All residents have the potential to be affected by this practice. On 7/2/24 and 7/3/24 infection control rounds were completed by infection control nurse with no concerns noted regarding linen handling. 3. On 6/24/24 facility nursing staff were educated on Linen handling by staff development, director of nursing, assistant director of nursing, and/or unit coordinator. Education was initiated on 6/24/24. This education was added to the orientation for newly hired nursing staff on 6/24/24 by the administrator. 4. The DON, ADON, and/or UC will observe linen handling 5 events of linen handling 3 times weekly x 4 weeks then 5 linen handling events weekly x 4 weeks. Results of the audits will be referred to QAPI committee for additional recommendations. 5. Date of compliance 7/10/24	

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laundry hamper outside of the resident's room.

In an interview with NA #1 on 6/10/24 at 2:30 pm she stated that she should have put the soiled towels and cloths in a plastic bag and should not have put it on the floor, but she forgot to bring a plastic bag with her that time. She further indicated that the soiled towels and wash cloths were dirty, and the floor was dirty and that increased the risk for the spread of infection. She stated that the facility protocol was to place the soiled linen directly into a plastic bag after use.

In an interview with Nurse #1 on 6/10/24 at 2:36 pm she stated dirty linens to include towels and wash cloths should not have been placed directly on the floor after it had been used. She stated it should have been placed directly into a plastic bag, tied closed, and removed from the room. The interview further revealed that soiled linens placed directly on the floor created a concern of cross contamination because the linen could transfer germs to the floor and staff walked on it and spread germs to other areas of the building. She further indicated that the floor was considered dirty, and germs could have contaminated the linen on the floor and when handled by staff germs could be spread.

In an interview with the Staff Development Coordinator/Infection Control Nurse on 6/10/24 at 3:51 pm she stated that after incontinence care was provided for Resident #44 that disposable items should have been placed in the trash and reusable wash cloths and towels should have been placed in a plastic bag and taken to the dirty hamper. She further indicated that was not appropriate to put the soiled towels and wash cloths directly on the floor before it had been

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F 880	Continued From page 34 placed into a plastic bag because that created infection control concerns and that germs could have been spread throughout the building on peoples' shoes. In an interview with the Director of Nursing on 06/11/24 at 10:37 am she stated soiled towels and cloths should not have been placed on the floor without a barrier and should have been placed directly into a plastic bag. She further indicated that staff had been educated in infection control to include how to handle soiled linen.	F 880		