STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhaven Manor	5460 Delmar Blvd Saint Louis, MO 63112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three of three sampled residents who expired and had money in their accounts longer than 30 days (Residents #314, #315 and #316). The census was 60. 1. Review of Resident #314's financial records, showed: -Expired on [DATE]; -Ending balance of $390.49; -TPL form sent on [DATE]. 2. Review of Resident #315's financial records, showed: -Expired on [DATE]; -Ending balance of $29.04; -TPL form sent on [DATE]. 3. Review of Resident #316's financial records, showed: -Expired on [DATE]; -Ending balance of $20.04; -TPL form sent on [DATE]. 4. During an interview on [DATE] at 3:42 P.M., the Business Office Manager (BOM) said the facility was supposed to send the TPL form within 30 days. The BOM started working at the facility in June of last year and realized TPLs were not sent. It was not acceptable to send the funds later than 30 days.

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

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

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to maintain a surety bond sufficient to ensure the protection of resident funds. This deficiency had the potential to affect all residents who have money in the resident trust fund. The census was 60. Review of the facility's Surety Bond Invoice, dated 12/28/23, showed a bond amount of $75000. Review of the facility's average resident trust fund balance for the previous twelve months, showed: -A monthly average of $52,000.00; -For this amount, the bond amount should have been $78,000. During an interview on 11/12/24 at 2:00 P.M., the Business Office Manager said she was not aware the amount was not sufficient and would request an increase immediately. The bond amount should have been sufficient. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he was unaware the bond amount was not sufficient. The bond should be sufficient and he had the bond amount increased immediately.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation and interview, the facility failed to provide accessible information on the location of the State Survey Agency hotline number that was readily available to residents in the facility without assistance. The census was 60. Observations throughout the survey on 11/ 7/24, 11/8/24 and 11/12/24 showed, the State Survey Agency number not posted in the facility. During a group interview on 11/8/24 at 9:55 A.M., seven residents, whom the facility identified as alert and oriented, attended the group meeting and said they did not know where the State Survey Agency hotline number was posted. During an interview on 11/12/24 at 3:17 P.M., the Director of Nursing said the State contact information was not posted. The facility has ordered a new poster and frame. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for the State Survey Agency hotline number to be posted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure the residents' Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflect the residents' status for two of 26 sampled residents (Resident #57 and #60). The census was 60. 1. Review of Resident #57's significant change MDS, dated [DATE], showed: -admitted to the facility: [DATE]; -Diagnoses included high blood pressure, aphasia (language disorder that affects a person's ability to understand, speak, read and write), and depression; -Special services received while a resident: Hospice Care; -Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No; -Staff failed to accurately document the resident's condition resulted in a life expectancy of less than six months necessitating hospice services. Review of the resident's physician order sheet, dated [DATE], showed an order dated [DATE], for Hospice care. Review of the resident's care plan in use during the survey, showed: -Problem: Resident has been admitted to Hospice related to diagnosis of senile degeneration of the brain; -Goal: Resident will have his/her needs met thru the next review date; -Interventions included: Facility and Hospice to coordinate for continuity of care. Follow up with Physician and Hospice as needed. Medication provided as prescribed. Monitor for a decline in functions. Provide spiritual and emotional support as needed. 2. Review of Resident #60's admission MDS, dated [DATE], showed: -admitted to the facility: [DATE]. -Diagnoses included cancer, asthma, malnutrition, and Parkinson's Disease; -Special services received while a resident: Hospice Care; -Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No; -Staff failed to accurately document the resident's condition resulted in a life expectancy of less than six months necessitating hospice services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician order sheet, dated [DATE], showed an order dated [DATE], for Hospice care. Review of the resident's medical record showed he/she expired at the facility on [DATE]. Review of the resident's care plan, showed: -Problem: Resident has been admitted to Hospice related to diagnosis of metastatic lung cancer; -Goal: Resident will have his/her needs met thru the next review date; -Interventions included: Follow up with Hospice as needed. Follow up with Physician as needed. Medication provided as prescribed. Monitor for a decline in functions. Provide medication as prescribed. 3. During an interview on [DATE] at approximately 2:00 P.M., the MDS Coordinator said she updates the MDS. She is responsible for the MDS. Under Section J, and answer of yes would be noted under if the person is actively dying, and there has to be a physician documentation that they are dying. If the resident is on hospice, it should be noted on the MDS under section O. 4. During an interview on [DATE] at 11:45 A.M., the Administrator said he would expect for the residents' MDS to be accurately coded. The MDS should be accurate and should reflect the residents' current condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to ensure residents who received dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) had documented assessments and monitoring related to dialysis and ongoing documented communication with the dialysis center. The facility identified two residents who received dialysis, and one resident was sampled (Resident #53). In addition, the facility failed to have a copy of the dialysis contract. The sample was 18. The census was 60. Review of the facility's Care of a Resident with End-Stage Renal Disease Policy, dated reviewed 10/12/24, showed: -Policy statement: residents with end stage renal disease (ESRD, chronic irreversible kidney failure) will be cared for according to currently recognized standards of care; -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents; -Education and training of staff includes, specially: -The nature and clinical management of ESRD (including infection prevention and nutritional needs); -The type of assessments data that is to be gathered about the resident's condition on a daily or per shift basis; -Signs and symptoms of worsening condition and/or complications of ESRD; -How to recognize and intervene in medical emergencies such as hemorrhage (bleeding) and septic infections (serious condition in which the body responds improperly to an infection); -Care of the grafts (arteriovenous graft (AVG), is a surgical procedure that connects an artery and vein using a synthetic tube to create a vascular access point for hemodialysis (a medical treatment that removes waste and excess water from the blood when the kidneys can no longer do so)), and fistulas (access made by joining an artery and vein in the arm); -Agreements between the facility and the contracted ESRD facility include all aspects of how the residents care will be managed, including: -How the care plan will be developed and implemented; -How information will be exchanged between the facilities. Review of Resident #53's medical record, showed: -Cognitively intact; -Diagnoses included: ESRD and dependence on renal dialysis. Review of the care plan, in use at the time of survey, showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: is at risk for fluid imbalance and decreased physical mobility related to diagnosis of ESRD. Dependent on dialysis Monday (M), Wednesday (W) and Friday (F); -Goal: will remain free of complications related to diagnoses of ESRD now through next review; -Interventions: ensure to attend dialysis appointments as scheduled, monitor for infections and monitor shunt site (a surgically created connection between an artery and vein) for bruit and thrill (sound and sensation that indicate a good blood flow in a dialysis fistula or graft). Review of the order summary, dated active orders as of 11/6/24, showed an order to check every shift for monitoring dialysis access. Report absence or weak thrill or bruit to dialysis provider and primary medical doctor, start date 8/29/24. Review of the Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated 10/1/24 through 10/31/24. showed no documentation to show staff checked every shift for monitoring dialysis access or report the absence or weak thrill or bruit to the dialysis provider and primary medical doctor. Review of the progress notes dated 10/1/24 through 10/31/24, showed: -On 10/9/24 at 1:14 P.M., 10/18/24 at 7:55 A.M., 10/21/24 at 1:35 P.M., and on 10/30/24 at 6:42 P.M., staff documented dialysis assessments; -Staff did not document any other dialysis assessments. Review of the Dialysis Communication Records, provided by the facility, dated 10/1/24 through 10/31/24, showed four out of 13 assessments were completed. Review of the MAR/TAR, dated 11/1/24 through 11/6/24, showed no documentation to show staff checked every shift for monitoring dialysis access or report the absence or weak thrill or bruit to the dialysis provider and primary medical doctor. Review of the progress notes, dated 11/1/24 through 11/6/24, showed staff did not document any dialysis assessments. Review of the dialysis communication records, provided by the facility, showed no assessments were completed from 11/1/24 through 11/6/24. During an interview on 11/12/24 at 11:40 A.M., Licensed Practical Nurse (LPN) A said residents who received dialysis services had their vital signs and weights completed before going to dialysis. This information was documented on the dialysis communication form along with the medications given to the resident. The form was sent with the resident to dialysis. He/She also called dialysis to give them a report and he/she would document that the resident went out to dialysis in the electronic medical record. When the resident returned home, the nurse should reassess the resident by taking their resident's vital signs and checking the access site. The only place the weight and vital signs are documented was on the dialysis communication form. During an interview on 11/12/24 at 12:43 P.M., LPN E said residents who received dialysis services had a communication form that was completed when they went to dialysis which included the resident's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vital signs, the location of the dialysis access site and the medications the resident received. The form was sent to dialysis with the resident. Dialysis was pretty good at sending the forms back to the facility. During an interview on 11/13/24 at 8:15 A.M. and 11:35 A.M., the Director of Nursing (DON) said the facility did not have a copy of the dialysis contract. The facility reached out to the dialysis company to try to obtain a copy but was told the contract was at a different location. She would expect the facility to have a copy of the dialysis contract. Staff should check the resident's vital signs and weight before going to dialysis and document them on the communication form. The form is sent to dialysis with the residents. Sometimes the facility got the form back and sometimes dialysis did not send the form back. If the resident returned home and there was no weight or vitals completed by dialysis, the nurse should complete it. The nurse should monitor the access site for bleeding, bruit and thrill every shift and document it on the TAR. The DON would expect for dialysis monitoring to be documented. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for dialysis monitoring to be documented. During an interview on 11/13/24 at 8:15 A.M. and 11:35 A.M., the DON said the facility did not have a copy of the dialysis contract. The facility reached out to the dialysis company to try to obtain a copy but was told the contract was at a different location. She would expect the facility to have a copy of the dialysis contract During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for the facility to have a copy of the dialysis contract on premises

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 37 opportunities observed, three errors occurred resulting in an 8.11% error rate (Resident #50). The census was 60. Review of the facility's Medication Administration Policy, undated, showed: -Only licensed personnel or certified medical technicians (CMT) are assigned responsibility of preparing, administering, and recording medication or permitted access to drug storage areas; -Medication may be administered to a resident only if ordered by a practitioner licensed to prescribe medication in that location. Review of the facility's Administering Medications through a Metered Dose Inhaler Policy, dated reviewed 10/1/24, showed: -Purpose: The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications; -Allow at least one minute between inhalations of the same medication and at least two minutes between inhalations of different medications. 1. Review of Resident #50's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/2/24, showed: -Cognitively intact; -Diagnoses included: high blood pressure and chronic obstructive pulmonary disease (COPD, chronic lung disease). Review of the resident's Order Summary Report, active orders as of 11/8/24, showed: -An order for: Spironolactone (used to treat fluid retention) 25 milligram (mg), give one tablet once time daily for diuretic (water pill); -An order for: Spiriva Respimat (used to treat COPD) Inhalation (Inhaler) 1.25 microgram (mcg), give two puff inhale one time daily for COPD; -An order for: Combivent Respimat (Ipratropium-Albuterol, medication used to treat lung disease) inhalation 20-100 mcg, give two puff inhale one time daily for COPD. Observation on 11/8/24 at 9:10 A.M., showed CMT D administered one tablet of Spironolactone-Hydrochlorothiazide (a combination of two different diuretic medications) 25-25, then administered Combivent Respimat inhaler one puff and Spiriva Respimat inhaler one puff, without waiting at least 2 minutes between the different types of inhalers. At 9:40 A.M., CMT D administered Spiriva Respimat inhaler one puff and Combivent inhaler one puff without waiting at least 2 minutes between the different types of inhalers. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/24 at 11:20 A.M., the pharmacist said Spironolactone and Spironolactone HCTZ were not the same medication, and the medications are not interchangeable. During an interview on 11/8/24 at 11:39 A.M., the Director of Nursing (DON) said when staff administer medication, she would expect for staff to follow the five rights of medication administration (right resident, right medication, right dose, right time, and right route). Spironolactone and Spironolactone HCTZ were not the same medication. If the card of medication did not match the Medication Administration Record (MAR) she would expect for CMTs to notify the nurse and the nurse to verify the order. She would expect for staff to administered one inhaler, both two puffs, then wait a few minutes and administer the second inhaler, two puffs. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect staff to follow physician orders and to follow the facility's policies and procedures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to label, date, and cover food in the kitchen. In addition, the facility failed to ensure that kitchen equipment was clean and was in proper working order. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 60. 1. Observations of the kitchen dry storage room, showed: -On 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M.,: -A package of opened mostaccioli noodles wrapped in plastic without a date; -A package of opened cheese flakes wrapped in plastic without a date; -On 11/6/24 at 11:14 A.M. and 11/7/24 at 4:14 P.M., a package of opened stuffing mix wrapped in plastic without a date. 2. Observation on 11/6/24 at 11:14 A.M. and 11/7/24 at 4:14 P.M., showed: -Walk in cooler: -Tortilla shells opened, wrapped in plastic, and without a date; -A salad mix opened, wrapped in plastic, and without a date; -Walk in freezer: -A box of cookies opened, undated, and exposed to the air; -Catch all freezer: -French toast in a plastic bag with a knot tied at end, without a date; -Biscuits in a plastic bag with a knot tied at end, with a hole in the bag, opened, and exposed to air; -A package of hot dogs opened, wrapped in plastic, and without a date; -An unidentified food item in an aluminum container, wrapped in plastic, and without a date. 3. Observations on 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M. in the kitchen, showed: -The deep fryer: -Old grease sat in the fryer; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Caked on grease and batter along the inside of the fryer; -Two straining baskets with caked on grease; -The stove: -Heavy caked on stains on the stove burners; -Old food particles inside the stove burners. 4. Observations of the walk-in cooler on 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M., showed a fan in the ceiling leaked water into a metal pan that sat on the top shelf in the cooler. 5. During interviews on 11/13/24 at 2:23 P.M., the Director of Dietary Services said it is her expectation that all food items should be properly labeled, dated, and stored. Everyone is responsible for labeling and dating food. She does not have a designated sanitation staff person. Staff clean every day in the kitchen, but deep cleaning is done on Sundays because their stock comes in on Mondays. She does not fry a lot in the deep fryer. She changes the grease one time a week. She had not used the deep fryer since last week on Thursday. She is responsible for cleaning the stove. The stove should be getting cleaned every two weeks. Regarding the fan in the cooler, they have someone coming out to look at it on Monday. She expects for the fan as well as all the equipment in the kitchen to be in proper working order. Maintenance is aware of the issue and have called someone out to fix it. 6. During interviews 11/13/24 2:35 P.M. and 11/18/24 at 11:45 A.M., the Administrator said he would have expected for all food to be properly labeled, dated, and stored. He also expected for all equipment in the kitchen to be clean and in proper working order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to place signage and follow indications for enhanced barrier precautions (EBP, an infection control intervention that utilizes personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs)) for two residents who had pressure ulcers (open wounds that occur when skin and tissue are damaged by prolonged pressure), and an indwelling urinary catheter (a flexible tube that drains urine from the bladder into a collection bag) (Residents #42 and #38). In addition, the facility failed to ensure the indwelling urinary catheter bag was off the floor for one resident (Resident #38). Furthermore, the facility failed to ensure the nebulizer mask was stored in bag or clean container when not in use for one resident (Resident #45). The sample was 18. The census was 60. Review of the Centers for Disease Control and Prevention's (CDCs) Implementation of PPE Use in Nursing Homes to Prevent Spread of MDRO guidelines, dated 4/2/2024, showed: -Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization; -Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: -Dressing; -Bathing/showering; -Transferring; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter, feeding tube, tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe (trachea) to help a person breathe)/ventilator (type of breathing aparatus); -Wound care: any skin opening requiring a dressing; -In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier (continued on next page)

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	265392	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhaven Manor	5460 Delmar Blvd Saint Louis, MO 63112

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Precautions do not impose the same activity and room placement restrictions as Contact Precautions (Steps taken to prevent the spread of germs), they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk; -When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (such as, gown and gloves); -Signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves; -Make PPE, including gowns and gloves, available immediately outside of the resident room; -Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room); -Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room; -Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; -Provide education to residents and visitors. Review of the facility's Enhanced Barrier Precautions Policy, revised on 10/12/24, showed: -Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms; -Prompt recognition of need: -All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; -All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities; -Initiation of Enhanced Barrier Precautions: -The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC; -Enhanced barrier precautions will be initiated for residents with any of the following: -Wounds (such as, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling/implanted medical devices (such as, central lines, ports, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO; -Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. The facility did not have policies to address process and procedure for infection control related to oxygen tubing and nebulizer mask storage. 1. Review of Resident #42's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/21/24, showed: -Both short term and long-term memory loss; -Resident had an indwelling catheter; -Two Stage III pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling); -Two Stage IV pressure ulcers (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling); -One Unstageable (slough and/or eschar known but not stageable due to coverage of wound bed by slough and/or eschar); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One unstageable (deep tissue suspected deep tissue injury in evolution); -Diagnoses included: cancer, heart failure, benign prostatic hyperplasia (BPH, enlarged prostate), stroke and aphasia (a language disorder that makes it difficult to communicate due to damage to the brain's language center). Observation on 11/8/24 at 7:40 A.M., showed no sign on the door to indicate the resident was on EBP. The resident sat in his/her chair with the covered catheter drainage tube draining to gravity. Certified Nurse Aide (CNA) C and Certified Medication Technician (CMT) D entered the resident's room, performed hand hygiene and put on gloves. CNA C and CMT D transferred the resident from the chair to the bed using a mechanical lift. After the resident was in bed, CNA C and CMT D rolled the resident side to side to remove his/her pants and brief. The resident had a dressing on his/her left buttocks dated 11/5/24. The CMT provided personal hygiene to the resident while CNA C held the resident over on his/her side. There were two superficial open areas on the sacrococcygeal area (pertaining to both the sacrum and coccyx (the tailbone)) which were not covered. After the CMT finished cleaning the resident, he/she applied a barrier cream to the buttocks and removed his/her gloves and left the room. A few minutes later, CMT D and the Assistant Director of Nursing (ADON) entered the room, performed hand hygiene and put gloves on. The ADON observed the open areas on the sacrococcygeal area, removed her gloves and left the room to go get supplies to clean the wounds. CMT D emptied 600 milliliters (mL) from the resident's catheter. The ADON returned to the room, performed hand hygiene, put gloves on, then provided wound care to the resident. Staff failed to wear a gown while providing high-contact resident care. 2. Review of Resident #38's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included traumatic spinal cord dysfunction (a condition where the spinal cord is damaged due to trauma), hypotension (low blood pressure), and quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down); -Resident had indwelling catheter; -One Stage II pressure ulcer; -One Stage III pressure ulcer; -One Stage IV pressure ulcer. Observation on 11/8/24 at 10:28 A.M., showed no EBP sign on the door. The resident's indwelling catheter bag did not have a barrier cover on it and hung on the side of the lowered bed. Part of the bag lay on the floor. CNA C entered the room, performed hand hygiene and applied gloves. CNA C did not adjust or pick up the catheter bag. At approximately 10:35 A.M., the ADON entered the room, performed hand hygiene and applied gloves. The ADON provided wound care while CNA C assisted in turning the resident from side to side. Both staff failed to wear a gown while providing high-contact resident care. During an interview on 11/8/24 at 11:39 A.M., the Director of Nursing (DON) and ADON said they had not heard of EBP, and they did not recall hearing about it. (continued on next page)

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