STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265794	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heisinger Bluffs Rehab and Healthcare Center	1002 West Main Street Jefferson City, MO 65109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide the appropriate Center for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC) for three residents (Residents #1, #60, and #61) out of three sampled residents whom the facility-initiated discharge from Medicare Part A Services when benefit days were not exhausted. The facility census was 55. 1. Review of the facility's policy titled Transfer/Discharge Notice Appeal, dated 11/24/24, showed residents have the right to appeal transfer or discharge notices. Should the resident who received a notice of transfer or discharge disagree with the reasons for the transfer or discharge, the resident and/or their representative my file an appeal. When a resident exercises their right to appeal they will not be transferred or discharged while the appeal is pending unless failure to do so with endanger the health or safety of the resident or other individuals in the facility. 2. Review of Resident #1's medical record showed: -Medicare Part A skilled services started on 02/03/25; -Last covered day of Medicare Part A skilled services on 03/05/25; -Facility initiated discharge from Medicare Part A services; -Resident remained in the facility; -Did not contain a NOMNC. During an interview on 03/26/25 at 11:25 A.M., the Interim Administrator said the resident used 29 Medicare Part A days with 71 remaining. 3. Review of Resident #60's medical record showed: -Medicare Part A skilled services started on 11/19/24; -Last covered day of Medicare Part A skilled services on 12/27/24; -Facility initiated discharge from Medicare Part A services; (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-discharged to home on [DATE]; -Did not contain a NOMNC. During an interview on 03/26/25 at 11:25 A.M., the Interim Administrator said the resident used 38 Medicare Part A days with 62 remaining. 4. Review of Resident #61's medical record showed: -Medicare Part A skilled services started on 08/02/24; -Last covered day of Medicare Part A skilled services on 09/11/24; -Facility initiated discharge from Medicare Part A services; -discharged to home on [DATE]; -Did not contain a NOMNC. During an interview on 03/26/25 at 11:25 A.M., the Interim Administrator said the resident used 39 Medicare Part A days with 61 remaining. 5. During an interview on 03/26/25 at 10:40 A.M., the Social Services Director (SSD) said he/she is responsible to ensure the NOMNC forms are completed timely. The SSD said he/she did not complete any NOMNC forms for Medicare A residents since the Advance Beneficiary Notice (ABN) form came out last year. The SSD said he/she thought the new ABN form replaced both the old ABN form and the NOMNC form, so he/she did not complete the NOMNC for the resident's discharged from Medicare Part A services since last year. The SSD said he/she did not know he/she still needed to ensure the NOMNC form was completed when a Medicare Part A resident discharged from skilled services. During an interview on 03/26/25 at 1:10 P.M., the Interim Administrator said he/she has been the Administrator about a month, and he/she did not know NOMNCs were not being completed when a resident discharged from Medicare Part A services. The Interim Administrator said it is the SSD's responsibility to ensure these are completed prior to the last date of Medicare A coverage. The Interim Administrator said the NOMNC should be issued and signed by the resident or the responsible party at least 48 hours prior to discharge from the Medicare Part A last covered date.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility staff failed to serve food in accordance with the nutritionally calculated menus to 33 of 55 residents (Residents #3, #4, #5, #6, #7, #8, 10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #22, #23, #28, #29, #30, #32, #34, #36, #37, #40, #42, #45, #46, #48, #51 and #58). The facility census was 55. 1. Review of the facility's Food and Nutrition Services Policy, dated 04/30/24, showed: -Each resident is provided with a nourishing, palatable, well-balance diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident; -The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical , functional, and psychosocial factor that affect eating and nutritional intake and utilization; -A resident-centered diet and nutrition plan will be based on the assessment; -Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. Review of the facility's Therapeutic Diets Policy, dated 04/2024, showed: -Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes; -A therapeutic diet will be prescribed by the resident's physician (or non-physician provider). The physician may delegate this task to a registered or licensed dietitian as permitted by state law; -All menus will be approved by a registered dietitian and food will be prepared according to approved recipes and instructions;; -Diet order should match the terminology use by the food and nutrition services department; -If a mechanically altered diet is ordered, the provider will specify the texture modification. 2. Review of the facility menus dated 03/25/25 (Week 3, Tuesday), showed the menus directed staff to provide the residents on regular diets with one cup of chicken spinach alfredo. Review of Residents #3, #6, #8, #10, #11, #14, #15, #18, #19, #22, #32, #34, #36, #40, #45, #46, #48 and #51 Physician Order Sheets (POS), dated March 2024, showed the residents' physicians directed staff to provide the residents with regular diets. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/25/25 at 11:53 A.M., showed staff served Residents #3, #6, #8, #10, #11, #14, #15, #18, #19, #22, #32, #34, #36, #40, #45, #46, #48 and #51, a #6 (5.3 ounce) scoop of chicken spinach alfredo (2.7 ounces less than directed by the menus). 3. Review of the facility menus dated 03/25/25 (Week 3, Tuesday), showed the menus directed staff to provide the residents on soft and bite-sized textured diets with one cup of chicken spinach alfredo or a #10 scoop of minced and moist textured beef brisket, a #10 (3.2 ounce) scoop of minced and moist textured hominy and one half cup of fruits of the forest pureed pie. Review of Residents #4, #5, #17, #20 and #42 POS, dated March 2024, showed physicians directed staff to provide the resident with soft and bite-sized textured diets. Observation on 03/25/25 at 11:53 A.M., showed staff served Residents #17, #20 and #42, a #6 scoop of chicken and spinach alfredo (2.7 ounces less than directed by the menus), a two ounce scoop of coarsely chopped hominy (1.2 ounces less than directed by the menus) and a slice of regular fruits of the forest pie. Observation showed staff served Residents #4 and #5 a #20 (1.6 ounce) scoop of minced and moist textured beef brisket (half the amount directed by the menus), a two ounce scoop of coarsely chopped hominy (1.2 ounces less than directed by the menus) and a slice of regular fruits of the forest pie. 4. Review of the facility menus dated 03/25/25 (Week 3, Tuesday), showed the menus directed staff to provide the residents on minced and moist textured diets with a #10 scoop of minced and moist textured beef brisket, a #10 scoop of minced and moist textured hominy, a #10 scoop of pureed wheat roll and a half cup of pureed fruits of the forest pie. Review of Resident #29's POS, dated March 2024, showed the resident's physician directed staff to provide the resident with a minced and moist textured diet. Review of Residents #37 and #58 POS, dated March 2024, showed the residents' physicians directed staff to provide the residents with mechanical soft textured diets. Observation on 03/25/25 at 11:53 A.M., showed staff served Residents #29, #37 and #58, a #20 scoop of minced and moist textured beef brisket (half the amount directed by the menus), a two ounce scoop of coarsely chopped hominy (1.2 ounces less than directed by the menus), a two ounce scoop of pureed pie (half the amount directed pie the menus) and a regular dinner roll. 5. Review of the facility menus dated 03/25/25 (Week 3, Tuesday), showed the menus directed staff to provide the residents on pureed textured diets with #10 scoops of pureed beef brisket and pureed hominy, and one half cup of pureed fruits of the forest pie. Review of Residents #7, #12, #13, #16, #23, #28 and #30 POS, dated March 2024, showed the residents' physicians directed staff to provide the residents with pureed textured diets. Observation on 03/25/25 at 11:53 A.M., showed staff served Residents #7, #12, #13, #16, #23, #28 and #30, a #20 scoop of pureed beef brisket (half the amount directed by the menus), a #20 scoop of pureed hominy (half the amount directed by the menus), and two ounces of pureed pie (half the amount directed by the menus). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/25 at 10:11 A.M., the Dining Service Director (DSD) said staff diet order should match the diets used on the menus and the facility did not have a menu for mechanical soft textured diets. The DSD said he/she tries to review the diet orders ever six months and whenever nursing brings him/her a diet communication form to ensure the physician ordered diets match those diets used by the facility, but he/she does not always catch them all. The DSD said staff should served the minced and moist textured menus to resident with physician orders for mechanical soft textured diets. 6. During an interview on 03/25/25 at 11:53 A.M., [NAME] B said he/she did not review the menus prior to service in their entirety, because staff trained him/her to always use a #6 scoop for casseroles and #20 scoops for pureed and mechanically altered textured food items despite what the menus says to use. During an interview on 03/28/25 at 10:11 A.M., the DSD said staff are expected to serve meals in accordance with the menus, which would include the portion sizes listed on the menus, unless the resident requests other wise and staff are trained on this requirement. The DSD said he/she never directed staff to always use the same size scoops for different foods, but he/she is not always the person who trains the new staff and [NAME] B is a new employee. During an interview on 03/28/25 at 11:23 A.M., the interim administrator said staff should serve the menus as planned, which would include the specific portion sizes and food items listed for the various diets, and staff have been trained on this requirement. The interim administrator said the menus should be available in the service station and staff should review the menus prior to service. The interim administrator said the DSD is responsible to ensure physician ordered diets match the diets used by the facility and that staff follow the menus.

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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, interview and record review, the facility staff failed to store food in a manner to prevent potential contamination and out-dated use. Facility staff also failed to properly wash, sanitize and air-dry mechanically washed dishes to prevent cross-contamination and the growth of foodborne pathogens. This has the potential to affect all residents. The facility census was 55. 1. Review of the facility's Receiving and Storage of Food Policy, dated 10/2023, showed: -Foods shall be received and stored in a manner that complies with safe food handling practices; -Food in designated dry storage areas shall be kept off the floor (at least 18 inches); -Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in-first out system; -Refrigerated foods will be stored in such a way that promotes adequate air circulation around food storage containers; -All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date); -Pesticides and other toxic substances and drugs will not be stored in the kitchen area or in storerooms for food or food preparation equipment and utensils; -Soaps, detergents, cleaning compounds or similar substances will be stored in separate storage areas from food storage and labeled clearly. Review of the facility's Refrigerators and Freezers Policy, dated 11/2024, showed: -All food will be appropriately dated to ensure proper rotation by expiration dates; -Use by dates may be completed with expiration dates on all prepared food in refrigerators; -Supervisors/designee will be responsible for ensuring food items in pantries, refrigerators, and freezers are not expired or past perish dates. Observations on 03/25/25 at 9:06 A.M., showed the baker's station contained: -Opened and undated 11 pound containers of chocolate fudge and cream cheese frostings stored under stand mixer; -An undated bulk container which contained sugar removed from the original packaging; -An opened and undated one gallon bottle of apple cider vinegar; -An opened and undated one gallon bottle of white vinegar stored next to a 32 ounce (oz. unlabeled spray bottle of blue liquid; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A can of vegetable oil pan release spray without it's nozzle cover cap, stored next to 23 oz. bottle of multi-surface cleaner. During an interview on 03/25/25 at 9:12 A.M., [NAME] B said the unlabeled spray bottle with blue liquid is diluted multi-surface cleaner. The cook said food items should not be stored next to chemicals. Observations on 03/25/25 at 9:23 A.M., showed walk-in refrigerator #2 contained: -A sign on the door to the walk-in that read Items in the fridge and/or freezer must be labeled, dated (mm/dd/yy) & properly stored. Label/date MUST be facing outward.; -Opened and undated one gallon containers of mayonnaise, mild cocktail sauce and dijon honey mustard; -Two opened and undated containers of [NAME] Caesar Dressing; -Two opened and undated containers of sweet pickle relish; -An opened and undated bag of cut broccoli; -An undated plastic resealable bag of boiled eggs; -11 uncovered and undated baked pies stacked on top of each other in multiple areas of the walk-in. Observations on 03/25/25 at 9:34 A.M., showed the walk-in freezer contained: -A sign on the door to the walk-in that read Items in the fridge and/or freezer must be labeled, dated (mm/dd/yy) & properly stored. Label/date MUST be facing outward.; -Cases of waffles and buttermilk pancakes stored on the floor; -An undated bag of chicken breast opened to the air; -Two sheets of puff pastry dough removed from original package stored in an undated plastic resealable bag; -Four unlabeled and undated styrofoam bowls which contained and unidentifiable brown substance. During an interview on 03/25/25 at 9:40 A.M., [NAME] B said the stryofoam bowls contained ice cream, but they should be labeled with what they are and dated when they were made. The cook said the pies in the walk-in refrigerator were made on 03/24/25 for use at dinner on 03/25/25, they should be covered, and he/she did not know why the baker did not cover them. The cook said opened food items, like the gallon containers, should be dated when opened so staff know when to discard them and staff should use all of one food item before they open another unless the food has gone bad or expired. The cook said he/she did not know why there were multiple containers of salad dressing and pickle relish open in the walk-in. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on 03/25/25 at 10:28 A.M., showed walk-in refrigerator #1 contained: -A sign on the door to the walk-in that read Items in the fridge and/or freezer must be labeled, dated (mm/dd/yy) & properly stored. Label/date MUST be facing outward.; -Cases of shelled eggs and raw chicken stored on the floor; -Opened and undated one gallon bottles of Worcestershire sauce, soy sauce, barbeque sauce, hot sauce and salsa; -An opened and undated half gallon bottle of sweet and sour sauce; -An opened and undated 48 oz. jar of dijon mustard; -An opened and undated 32 oz. container of chopped garlic. During an interview on 03/25/25 at 10:35 A.M., Dietary Aide (DA) A said the food trucks deliver on Mondays and Tuesdays, but the truck had not arrived for the day so the food stored on the floor would be from the previous day. The DA said food should not be stored on floor, but he/she thought the food was stored on the floor because the Dining Service Director (DSD) over ordered on the food supply due to going on vacation, and they did not have enough room to put everything away properly. The DA said he/she believed there was probably enough room now to store the food off of the floor and he/she did not know why staff continued to store food on the floor. During an interview on 03/25/25 at 10:37 A.M., [NAME] B said the food trucks deliver on Mondays and Tuesdays, but the truck had not arrived for the day so the food stored on the floor would be from the previous day. The cook said food should not be stored on floor and he/she did not know why staff stored food on the floor as he/she did not work the previous day. Observations on 03/27/25 at 12:10 P.M., showed walk-in refrigerator #1 contained: -A sign on the door to the walk-in that read Items in the fridge and/or freezer must be labeled, dated (mm/dd/yy) & properly stored. Label/date MUST be facing outward.; -Opened and undated one gallon bottles of Worcestershire sauce, soy sauce, barbeque sauce, hot sauce and salsa; -An opened and undated half gallon bottle of sweet and sour sauce; -An opened and undated 48 oz. jar of dijon mustard; -An opened and undated 32 oz. container of chopped garlic. Observations on 03/27/25 at 12:10 P.M., showed walk-in refrigerator #2 contained: -A sign on the door to the walk-in that read Items in the fridge and/or freezer must be labeled, dated (mm/dd/yy) & properly stored. Label/date MUST be facing outward.; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Opened and undated one gallon containers of mayonnaise, mild cocktail sauce and dijon honey mustard; -Two opened and undated containers of [NAME] Caesar Dressing; -Two opened and undated containers of sweet pickle relish; -An opened and undated bag of cut broccoli. During an interview on 03/27/25 at 12:20 P.M., the DSD said staff should date, label and cover opened and prepared food items and foods should not be stored on the floor or next to chemicals. The DSD said staff are expected to use all of one food item before they open another of the same thing unless the items has gone bad or expired. The DSD said he/she is responsible to monitor the food storage multiple times a day and the cooks are also responsible to monitor the food storage multiple times a day to ensure food is stored appropriately. The DSD said he/she had not looked at the food storage that day. The DSD said staff are trained on proper food storage requirements and should make corrections as needed. During an interview on 03/28/25 at 11:05 A.M., the administrator said staff should date, label and cover opened and prepared food items and foods should not be stored on the floor or next to chemicals. The administrator said staff are expected to use all of one food item before they open another of the same thing. The administrator said the DSD is responsible to monitor the food storage at least weekly and designate someone to be in charge of that in his/her absence. The administrator said he/she did not know if the DSD appointed anyone specifically to monitor food storage while during his/her recent absence, but the cooks should also routinely monitor it during their shift and when they put the truck away. The administrator said staff are trained on proper food storage requirements and if they identify an issue with food storage, they should dispose of the items not stored properly. 2. Review of the facility's Dishwashing Machine Use Policy, dated 11/2024, showed: -Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspect of proper use and sanitation; -Dishwashing machines that use hot water to sanitize will maintain the following wash solution temperatures: b. 160 dF for single tank, conveyor, dual temperature machines; -Dishwashing machine hot water sanitation rinse temperatures may not be fore than 194 dF, or less than: a. 165 dF for stationary rack, single temperature machines; b. 180 dF for all other machines; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately; -If hot water temperatures do not meet requirements, cease use of the dishwashing machine immediately until temperatures are adjusted. Observations on 03/25/25 at 8:48 A.M., showed DA C washed soiled dishes in the heat sanitizing conveyor mechanical dishwasher. Observations during two cycles of the dishwasher showed the machine's gauges measured the temperature of the wash cycle water at 153 dF and the temperature of the rinse cycle water at 169 dF. Observation during a third cycle of the dishwasher showed the machine's gauges measured the temperature of the wash cycle water at 158 dF and and the temperature of the rinse cycle water at 175 dF. Observation showed the DA did not look at the gauges on the dishwasher during the three cycles. Observation showed the area did not contain any visible information related to the proper temperatures for the machine's wash and rinse cycles. During an interview on 03/25/25 at 8:55 A.M., DA C said he/she forgot what the wash and rinse temperature of the dishwasher is suppose to be and he/she does not look at the machine gauges very often. During an interview on 03/27/25 at 12:20 P.M., the DSD said the wash temperature of the dishwasher should be 160 dF and the rinse temperature should be 180 dF. The DSD said staff are expected to check the temperature of the dishwasher before they wash dishes and multiple times a day and they should not wash dishes in it until it reaches the proper temperature. The DSD said staff, including DA C who had worked at the facility for multiple years, have been trained on the proper temperatures for the dishwasher and to not use the dishwasher if it is not at the proper temperature. During an interview on 03/28/25 at 11:10 A.M., the interim administrator said the wash and rinse temperatures of the dishwasher should be in accordance with the facility policy and staff should verify the dishwasher has met the required temperatures before they use it to wash dishes. The interim administrator said staff should monitor the dishwasher temperatures each time they are going to use the dishwasher and staff are trained on proper dishwasher temperatures and procedures. 3. Review of the facility's Dishwashing Machine Use Policy, dated 11/2024, showed the policy directed staff to all items washed in the dishwashing machine to air-dry after they are ran through an entire cycle. Observations on 03/25/25 at 8:48 A.M., showed DA C washed soiled dishes in the mechanical dishwashing station. Observations showed the DA then removed wet dishes from the clean side of the station and stacked them together the on utility carts. Observation on 03/25/25 at 9:05 A.M., showed five metal pans of various sizes stacked together wet on the storage rack in the kitchen. Observation on 03/25/25 at 10:44 A.M., showed the dining room service station contained nine service trays and seven insulated plate covers stacked together wet in storage. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/27/25 at 12:20 P.M., the DSD said staff should allow cleansed dishes to air-dry before they are put away and staff, including DA C who had worked at the facility for multiple years, have been trained on that requirement. During an interview on 03/28/25 at 11:10 A.M., the interim administrator staff should allow dishes to air-dry before they are put away and staff are trained on that requirement.

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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, facility staff failed to use enhanced barrier precautions (EBP) (an infection control practice that requires staff to wear personal protective equipment (PPE) (protective equipment such as gowns, gloves, goggles, and masks used to prevent or minimize exposure to hazards) for the care of residents) for four residents (Resident #59, #7, #33 and #13) of seven sampled residents and failed to ensure two residents' catheter (indwelling tube placed directly in the bladder to drain urine) bags did not touch the floor for two residents (Resident #48 and #7) out of three sampled residents. The facility census was 55. 1. Review of the facility policy titled Enhanced Barrier Precautions, undated, showed EBP that employs targeted gown and glove use during high contact resident care activities. The facility will ensure staff are trained in EBP and will maintain sufficient supplies to support implementation of EBP. EBP expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDRO) (bacteria or fungi that have developed resistance to one or more classes of antimicrobial agents, making them difficult to treat) to staff's hands and clothing. EBP are indicated for residents with any of the following: wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheostomies. EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheter), and wound care. The resident's care plan will address the need for EBP and will be communicated to the caregivers. Facility staff will be trained in enhanced barrier precautions. 2. Review of Resident #59's Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/16/25, showed staff assessed the resident as: -Unable to assess cognitive status; -Short and long term memory problems; -Dependent on staff for toileting and lower body dressing; -Required substantial/maximal assistance from staff for shower/bathe self and upper body dressing; -Had one venous/arterial ulcer (painful skin wounds caused by poor blood circulation in the lower extremities); -Diagnosis of peripheral vascular disease (PVD) (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the Physician's Order Sheet (POS), dated March 2025, showed: -Arterial spot left inner foot: cleanse with wound cleanser, pat dry, apply skin prep daily; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Arterial spot on left heel: cleanse with wound cleanser, pat dry, apply skin prep daily; -Arterial wound left shin: cleanse with wound cleanser, pat dry, apply medihoney (used to treat or prevent wounds) to wound bed, cover with calcium alginate (a treatment that helps promote wound healing), and cover with 2 x 2 boarder gauze daily. Observation on 03/25/25 at 10:15 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/27/25 at 9:37 A.M., showed Licensed Practical Nurse (LPN) K performed wound care to all wounds on resident's left leg arterial ulcer. LPN K did not wear a gown while he/she completed the wound care. During an interview on 03/27/25 at 2:21 P.M., LPN K said EBP is used for residents that have feeding tubes, catheters, and tracheostomies (a surgical opening in the windpipe with a tube to provide an airway). LPN K did not know if EBP is required for wounds, but using EBP is extra precautions to prevent residents from getting an infection. LPN K said there are not any residents on EBP, or at least there are no signs, but there should be. LPN K said he/she did not know why it was not being done at the facility, but he/she did ask management about it and had not received an answer. LPN K said he/she did not receive instruction on how or when to use EBP, and that not using PPE can potentially spread infection to the resident. 3. Review of Resident #7's Annual MDS, dated [DATE], showed staff assessed resident as follows: -Severe cognitive impairment; -Indwelling urinary catheter; -Hospice care; -Diagnoses of Stroke, Neurogenic Bladder (a condition where the nerves that control bladder function are damaged, leading to abnormal bladder control), and Dementia. Review of the resident's POS, dated March 2025, showed staff to provide urinary catheter care every shift. Observation on 03/26/25 at 8:58 A.M., showed Certified Nurse Aide (CNA) F and CNA H entered the resident's room with a mechanical lift. CNA F washed hands his/her hands applied gloves and provided catheter care to the resident. CNA H washed hands and applied gloves before he/she emptied the resident's catheter bag. CNA F and CNA H rolled the resident from side to side in bed, as they changed the resident's clothing and placed a mechanical lift sling under the resident. CNA F and CNA H did not wear a gown during catheter care, dressing the resident or during the transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/25 at 2:31 P.M., CNA F said he/she had heard of EBP and it is used for resident's anytime they have a feeding tube, catheter, or if the staff comes in contact with body fluids. CNA F said if a resident requires EBP there should be signs posted on the door. The CNA said he/she does not know why the resident does not have an EBP sign posted at the door, because he/she should. The CNA said the charge nurse is responsible for posting the signs as soon as the resident requires EBP. The CNA said he/she is supposed to wear a gown and gloves for a resident on EBP. The CNA said the facility does not have any gowns in any of the residents' rooms, and they should. The CNA said he/she did not wear a gown during the residents care because he/she did not know he/she needed to. During an interview on 03/27/25 at 2:38 P.M., CNA H said he/she does not know what EBP is. The CNA said he/she did not wear a gown during the resident's care because he/she did not know he/she had to. During an interview on 03/28/25 at 9:16 A.M., Registered Nurse (RN) I said staff are supposed to wear a gown when providing contact care or catheter care for residents with catheters. The RN said he/she doesn't know why the aides are not wearing gowns. The RN said he/she would think the charge nurse is responsible for making sure the aides are wearing gowns and the Infection Preventionist (IP) should probably be auditing. 4. Review of Resident #33's Quarterly MDS, dated [DATE], showed staff assessed the resident with mild cognitive impairment, PVD, and diabetes mellitus. Review of the resident's POS, dated March 2025, showed; -Unstageable (a wound with full thickness loss where the base is obscured by injured tissue) left heel: cleanse with wound cleanser, pat dry and paint with betadine; -Unstageable right heel: cleanse with wound cleanser, pat dry and paint with betadine. Observation on 03/26/2025 at 1:27 P.M., showed outside the resident's room did not have an EBP sign or PPE station. CNA/Certified Medication Technician (CMT) M and CNA/CMT N provided perineal care to the resident and did not wear a gown. During an interview on 03/28/25 at 11:44 A.M., the Director Of Nursing (DON) said the resident should be on EBP. 5. Review of Resident 13's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows; -Severe cognitive impairment; -Dependent on staff members for assistance with all Activities of Daily Living (ADL)s; -Hospice care; -Wheelchair; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of Dementia. Review of the resident's POS, dated March 2025, showed arterial wound: Left 1st toe, cleanse with wound cleanser, pat dry, cover with Xeroform (wound care gauze), wrap with kerlix, and secure with tape daily. Observation on 03/27/25 at 10:06 A.M., showed there is not an EBP sign posed outside the resident's room and PPE is not observed in the room or in the hallway. RN I and LPN L provided wound care to the resident and did not wear a gown. The LPN without gloves or a gown on begun to hold the resident's hand and hugged the resident during wound care. During an interview on 03/27/25 at 2:41 P.M., LPN L said staff are supposed to wear gloves and a gown during care with any residents who have catheters or indwelling medical devices. The LPN said EBP signs should be posted outside the rooms so staff know to use the PPE. The LPN said the PPE should be readily available to the staff. The LPN said he/she doesn't know who is responsible for posting the EBP signs but the charge nurses should put the PPE out for staff. The LPN said he/she doesn't know why the PPE is not out. The LPN said he/she should have worn a gown and gloves during wound care for the resident but he/she didn't because, he/she was there for resident comfort. During an interview on 03/28/25 at 9:16 A.M., RN I said EBP is used to prevent the spread of MDROs. The RN said he/she questioned during wound care whether or not he/she should have had a gown on. The RN said the resident should be on EBP and there should be EBP signs posted outside the resident's room and he/she does not know why there isn't any signs posted. The RN said he/she would not know where to go to get a gown. During an interview on 03/27/25 at 2:40 P.M., the infection preventionalist said EBP is the protocol that requires a gown and gloves to be worn for close proximity care provided for an extended period of time for a resident deemed necessary to be on EBP. The infection preventionalist said residents are deemed necessary for EBP at the facilities discretion and if the resident is colonized, has a wound, feeding tube, tracheostomy, or catheter. The infection preventionalist said there are some residents with active pressure wounds and catheters that would require the EBP protocol. The infection preventionalist said implementing EBP has been in process for a while and items have been purchased for the implementation. It has not been fully implemented because staff have not found a way that works to maintain a home-like environment for the residents. The infection preventionalist said staff have been educated on the EBP protocol and the IP and other department heads have attended meetings and webinars about the process. During an interview on 03/28/25 at 11:40 A.M., The DON said the purpose of EBP is to prevent spread of MDROs from the residents to staff. The DON said residents who have indwelling medical devices, including catheters, and chronic wounds should be on EBP. The DON said EBP would includes wounds and surgical wounds. The DON said he/she does not know why residents with catheters and wounds are not on EBP and he/she is responsible. The DON said EBP signage should be posted and he/she doesn't know why the signs are not posted. The DON said gowns can be stored in the residents' rooms and he/she does not know why the gowns are not in the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/25 at 12:32 P.M., the administrator said anyone with an indwelling medical device, or open wound should be on EBP. The administrator said the IP and nursing staff are responsible for placing residents on EBP, and determining what PPE is required and what precautions should be posted outside the rooms. The administrator said the facility has struggled with finding what the facility could use for storage of the PPE that is homelike. The administrator said, We just haven't figured out our process for EBP yet. 6. Review of the facility policy titled Urinary Catheter Care, undated, directed staff to be sure the catheter tubing and drainage bag is kept off the floor. 7. Review of Resident #48's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -Indwelling urinary catheter; -Wheelchair; -Diagnosis of Neurogenic Bladder. Review of the resident's care plan, dated 02/26/2025, showed staff documented the resident used an indwelling urinary catheter. Review of the resident's POS, dated March 2025, showed orders for catheter care every shift and to change the catheter bag and tubing monthly. Observation on 03/25/25 at 11:21 A.M., showed the resident in a wheelchair in his/her room with his/her catheter bag hung under the wheelchair. The catheter bag rested on the floor. Observation on 03/25/25 at 3:27 P.M., showed the resident in a wheelchair in his/her room with his/her catheter bag hung under the wheelchair. The catheter bag rested on the floor. Observation on 03/26/25 at 9:34 A.M., showed resident in a wheelchair in his/her room with his/her catheter bag hung under the wheelchair. The catheter bag rested on the floor. During an interview 03/26/25 at 9:34 A.M., the resident said staff put his/her catheter bag under his/her wheelchair after they dress him/her and transfer him/her. Observation on 03/27/25 at 2:11 P.M., showed the resident sat in his/her wheelchair. The resident's catheter bag rested on the floor under his/her wheelchair. Observation on 03/28/25 at 9:32 A.M., the resident sat in his/her wheelchair, in his/her room, and looked at a newspaper. The resident's catheter bag rested on floor under his/her wheelchair. The resident propelled his/her wheelchair across his/her room and down hallway. The resident's catheter bag slid on the floor, under his/her wheelchair. CNA F approached the resident, said hello and walked away. The CNA did not fix the catheter bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/25 at 9:41 A.M., CNA J said he/she got the resident up this morning and hung the resident's catheter bag on the wheelchair. The CNA said he/she can see the resident's catheter bag sliding on the floor. The CNA said the resident's catheter bag is not supposed to touch the floor, because of germs, bacteria and it can cause Urinary Tract Infections. The CNA walked away and started care for other residents and did not fix the catheter bag on the floor. During an interview on 03/28/25 at 9:44 A.M., RN P said he/she sees the resident's catheter bag sliding on the floor. The RN said the aides should hang catheter bags under the wheelchairs, and off the floor. The RN said the charge nurse is responsible to ensure aides are doing that. The RN said staff doesn't want the catheter bag to touch the floor, because there is all kinds of organisms on the floor, that can cause infection. 8. Review of Resident #7's Annual MDS, dated [DATE], showed staff assessed resident as: -Severe cognitive impairment; -Indwelling urinary catheter; -Wheelchair. Review of the resident's POS, dated March 2025, showed urinary catheter care every shift. on Review of the resident's care plan, 03/05/2025, showed staff documented the resident had an indwelling urinary catheter. Observation on 03/25/25 at 10:06 A.M., showed the resident sat in wheelchair, in his/her room. The resident's catheter bag hung under his/her wheelchair and rested on the floor. Observation on 03/25/25 at 3:39 P.M., showed the resident sat in wheelchair, in his/her room. The resident's catheter bag hung under his/her wheelchair and rested on the floor. Observation on 03/27/25 at 2:31 P.M., showed the resident sat in wheelchair, in his/her room. The resident's catheter bag hung under his/her wheelchair and rested on the floor. During an interview on 03/27/25 at 2:31 P.M., CNA F said the resident's catheter bag is touching the floor. The CNA said the resident's catheter bag is not supposed to touch the floor as it can cause infections such as a UTI. The catheter bag can get caught on something, there is a lot of reasons it can't be on the floor. 9. During an interview on 03/28/25 at 9:16 A.M., RN I said when aides hang catheter bags under the residents wheelchairs, the tubing and bag should not touch the ground because of infection concerns. During an interview on 03/28/25 at 11:40 A.M., the DON said staff should put catheter bags in slings and secure them to the wheelchairs so they do not touch the floor. The DON said it is an infection control concern for a catheter bag to be on the floor, and he/she doesn't know why staff are not keeping the bags off the floor. The DON said him/her, the ADON and the charge nurses should identify catheter bags on the floor, and take the time to educate staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/28/25 at 12:32 P.M., the administrator said he/she expects staff to hang catheter bags under wheelchairs, where it is not touching the ground. The administrator said staff doesn't want it to touch the ground, because of infection control. The administrator said nurses are responsible to ensure aides keep the catheter bags off the ground, it should be a standard of practice. The administrator said if staff see a catheter bag on the ground they should change the catheter bag.