STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415082	A. BUILDING _____ B. WING _____	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE COMMUNITY	546 MAIN STREET COVENTRY, RI 02816

(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 000	INITIAL COMMENTS A recertification and complaint survey, ACTS reference numbers 98910 and 98882, were conducted at Riverview Healthcare Community Nursing Home on 12/30/2024 through 1/3/2025 to determine compliance with 42 C.F.R. Part 483, requirements for Long Term Care Facilities. State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified as a result of this survey.	F 000	Riverview Nursing and Rehabilitation provides this plan of correction without admitting or denying the validity of or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. Received JAN 2 2 2025 Facilities Regulation	1/22/25
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice for 2 of 2 residents observed for wound care, Resident ID #s 33 and 77, 1 of 2 residents reviewed for the utilization of a Freestyle Libre sensor (a continuous glucose monitoring system that is designed to replace finger sticks and lessen the need for test strips for people with diabetes), Resident ID #20, 1 of 1 resident reviewed for hand splints, Resident ID #33, and 1 of 1 resident reviewed for the use of a hot pack (a pack that delivers heat to relax the muscle), Resident ID #103.	F 658	F 658 – Services provided meet professional Standards Resident # 77 MD was immediately notified, wound assessed and order was changed to 1 x daily. Resident ID # 33 MD was immediately notified of time discrepancy. After wound review order was changed wash with Vashe to be soaked for 1 minute. DON/ Designee conducted 14 day look back of current residents with dressing change orders to ensure that dressings were being done per MD orders. SDC/ designee reeducated all nursing staff on Policies for Dressing changes and wound care, following MD orders, documentation and notification of MD if order not followed.	1/2/2025 1/2/2025 1/3/2025 1/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen M Sechio, MHA	Administrator	1/22/2025

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.

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F 658	Continued From page 1 Findings are as follows: 1. Record review for Resident ID #77 revealed that s/he was readmitted to the facility in December of 2024 with diagnoses including, but not limited to, Methicillin Resistant Staphylococcus Aureus (MRSA, an antibiotic resistant infection) and type 2 diabetes mellitus. Review of the care plan revealed that the resident has bilateral foot wounds with an intervention to administer treatments, as ordered. Record review revealed that Resident ID #77 had increased drainage to his/her left foot on 12/23/2024 and the physician was contacted. Additionally, an order was obtained to complete the wound dressing to the resident's left foot wounds twice a day. Review of the resident's Minimum Data Set Assessment dated 11/6/2024 revealed a Brief Mental Status score of 15 out of 15, indicating intact cognition. Review of the December 2024 Treatment Administration Record (TAR) revealed the wound dressing was not changed twice a day per the physician's order on 12/24/2024, 12/29/2024 and 12/30/2024. During a surveyor observation and interview on 12/31/2024 at approximately 11:00 AM with Licensed Practical Nurse (LPN), Staff C and Unit Manager, Staff D, the left foot dressing was dated 12/30/2024 with the initials of LPN, Staff U. Staff C and D revealed, Staff U worked the first shift on 12/30/2024, indicating that this dressing was not changed on 12/30/2024 on the second shift, as	F 658	F 658 continued Unit managers will conduct a weekly audit of residents with orders for dressing changes to ensure compliance. Audit will be reviewed by DON/ADON and will randomly, in person, audit 2 residents weekly. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained. Resident ID # 20 MD was immediately notified and gave orders for Freestyle Libre System , for sensor to be changed Q 2 weeks and PRN. Orders also placed for observation of signs and symptoms of infection at sight of sensor, and to check to ensure device was working properly. DON/ Designees conducted a 14 day look back of all diabetic residents to ensure that if they had a Freestyle Libre sensor there were orders for the device, when to change sensor, checking for signs and symptoms of infection and to ensure device is working properly. SDC/ Designee re-educated all current nurses on order transcription and documentation to ensure accuracy. Education also included Freestyle Libre device information on when to change, looking for signs and symptoms of infection and what to do if device isn't working properly. Completed	1/2/2025 1/3/2025 1/10/2025

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F 658	Continued From page 2 ordered. Additionally, during this observation, the dressing had dried drainage on the outside of the dressing. During a surveyor interview on 12/31/2024 at approximately 11:00 AM during the dressing change with Resident ID #77, the resident revealed to the surveyor that his/her dressing should be changed twice a day and that it has not been. During a surveyor interview on 1/2/2025 at 1:21 PM with Nurse Practitioner, Staff B, she revealed that she would expect the dressing to be changed twice a day, per the physician's order. During a surveyor interview on 1/2/2025 at 1:31 PM with the Director of Nursing Services (DNS), she revealed that she would expect the dressing to have been completed twice a day, per the physician's order. Additionally, she was unable to provide evidence that the physician's order was followed on 12/24/2024, 12/29/2024 and 12/30/2024. 2. Record review revealed Resident ID #33 was admitted to the facility in November of 2012 with a diagnosis including, but not limited to, persistent vegetative state. Review of the care plan revealed that the resident has a stage 4 pressure ulcer (the most severe stage, with full-thickness tissue loss and exposed bone or muscle) to his/her coccyx (tailbone) with an intervention to administer treatments, as ordered. Review of a physician's order dated 12/19/2024 revealed to wash his/her coccyx wound with	F 658	F 658 Continued Unit managers will Conduct a weekly audit of all diabetic Residents with a Free Style libre device to ensure the Resident has the correct order, that the skin is being checked for S/S of infection and it is being changed Q 14 days per orders. DON/ Designee will conduct random audits of residents on Freestyle Libre device to ensure there are orders in place, For a minimum of 3 months or longer until sufficient compliance is achieved. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained . Resident ID # 33 Staff ID F Resting hand splints immediately applied. MD notified. DON/Designee conducted a 14 day look back of all residents identified with having orders/care plans for splints to ensure that staff were following orders for splints to be on/off per MD orders. SDC/Designee reeducated all nursing staff on the importance of splints, following MD orders and the use of therapy for splint evaluation.	1/2/2025 1/3/2025 1/10/2025

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F 658	Continued From page 3 vashe (wound cleanser) and allow it to soak for 5 minutes, followed by silvagel and calcium alginate with silver (wound treatments) followed by a silicone bordered gauze (wound dressing), twice daily. During a surveyor observation of the resident's wound treatment on 12/31/2024 at 11:38 AM, with LPN, Staff A, she was observed to soak the wound with vashe for approximately 2 minutes, instead of allowing the vashe to soak for 5 minutes, as ordered. During a surveyor interview following the above-observation with Staff A, she would not acknowledge that did she not follow the order. Further record review revealed that the resident is followed by a wound physician for his/her coccyx wound. Additionally, the wound was reevaluated on 1/1/2025 with recommendations to continue with the 5-minute soak of vashe. During a surveyor interview on 1/2/2025 at 1:10 PM with the Nurse Practitioner, Staff B, she indicated that she would expect that staff would follow the physician order and allow the wound to soak with vashe for the full 5 minutes. During a surveyor interview on 1/2/2025 at 1:21 PM with the DNS, she indicated that she would expect the staff to follow the physician's order. 3. Record review revealed Resident ID #20 was readmitted to the facility in November of 2024 with diagnoses including, but not limited to, type 2 diabetes, and chronic kidney disease. During a surveyor observation and interview on	F 658	F 658 Continued Unit Managers will conduct a daily audit of residents that are utilizing splints to ensure that they are on/off the residents at the correct time. DON/Designee will conduct a weekly random audit of at least 2 residents with orders for splints for a minimum of 3 months to ensure compliance. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained. Resident ID # 103 Staff G CMT, Staff G, was immediately reeducated regarding applying hot packs and following MD orders. A Rhode Island state approved CMT evaluation was performed with staff G on 1/13/2025. A skin evaluation was performed on resident revealing no redness or injuries. DON/Designee conducted an audit of all residents with orders for Hot Packs. All hot packs will now be administered by licensed nurses only. SDC/Designee reeducated licensed nurses and CMT's regarding new change on who will be administering Hot Packs. Unit Managers will conduct weekly random audits of residents with Hot Pack orders to ensure treatment orders are followed within the indicated order times.	12/31/2024 1/3/2025. 1/15/2025

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F 658	Continued From page 4 1/2/2025 at approximately 12:00 PM, the resident was observed to have a freestyle libre2 system placed on his/her upper posterior (back) left arm. The resident indicated that it is used daily to check his/her blood glucose. Record review of the physician's orders failed to reveal an order for the freestyle libre2, how often to change the device, or to monitor for any complications such as, infection or if the device is not working. Record review of the care plan failed to reveal the use of the freestyle libre2 as the method of glucose (blood sugar) monitoring or any interventions to mitigate risk. During a surveyor interview on 1/2/2025 at approximately 3:00 PM with the Assistant Director of Nursing Services, she acknowledged that the resident was utilizing a freestyle libre2 sensor for glucose monitoring and that there was no physician's order or a care plan in place. 4. Record review revealed Resident ID #33 was admitted to the facility in November of 2012 with a diagnosis including, but not limited to, persistent vegetative state. Review of a physician's order dated 8/14/2024 revealed an order to apply resting hand splints to both hands with morning care and remove them during evening care, daily. Surveyor observations revealed the resident was without either hand splint in place on the following dates and times: -12/30/2024 at 11:10 AM	F 658	F 658 Conitnued DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained.	

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F 658	Continued From page 5 -12/31/2024 at 11:38 AM -1/2/2025 at 9:11 AM and 11:34 AM During a surveyor interview following the above observation on 1/2/2025 at 11:34 AM with Nursing Assistant (NA), Staff F, he acknowledged that the resident was not wearing either hand splint. He revealed that he was the NA assigned to his/her care that morning and revealed that he had already completed his/her morning care. Further, he acknowledged that both hand splints were observed on the nightstand and revealed that he was unsure if the resident utilizes them. During a surveyor interview on 1/2/2025 at 11:37 AM with the LPN, Staff A, she revealed that the resident wears hand splints daily and that they should be on. During a surveyor interview on 1/2/2025 at 1:21 PM with the DNS, she revealed that she would expect the staff to follow the physician's order. 5. Record review revealed Resident ID #103 was admitted to the facility in February of 2021 with diagnoses including, but not limited to, type 2 diabetes and pain. Record review of a physician's order dated 12/10/2024 revealed to apply a hot pack for 15 minutes, as needed every 8 hours, for back pain. During the Medication Administration Task on 1/2/2025 at 10:20 AM with the Certified Medication Technician, Staff G, she was observed applying the hot pack to the resident's back. During further observation on 1/2/2025 at 12:07	F 658		

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F 658	Continued From page 6 PM, Staff G was observed entering the resident's room where she removed the hot pack from the resident's back, which was approximately two hours later. During a surveyor interview with Staff G following the removal of the hot pack, she indicated that she placed the hot pack on the resident's back at 10:20 AM and that she does not know how long the hot pack was supposed to be applied for. During a surveyor interview on 1/3/2025 at approximately 11:00 AM with the Director of Nursing Services, she indicated that she would expect the staff to follow the physician's order.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the facility failed to ensure that a resident is provided assistive devices to prevent accidents relative to smoking for 1 of 1 resident reviewed, Resident ID #41. Findings are as follows: Review of a facility policy revealed that a smoking	F 689	F 689 accidents and incidents Resident ID # 41 Order placed for resident to use Smoking Apron during all smoking breaks. Resident educated to smoking policy and use of smoking apron during smoking breaks. Quarterly smoking evaluation completed on 1/14/2025 DON/Designee conducted an audit of current smokers in the building to ensure that the orders and care plans were updated to include recommendations per smoking evaluation and to ensure resident and staff have access to any accessories needed per smoking evaluation. SDC/Designee reeducated all staff that are involved in resident smoke breaks on compliance with safety for smokers during smoke breaks and the use of smoking accessories per specific resident smoking evaluation/CP.	1/3/2025 1/10/2025

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F 689	Continued From page 7 assessment will be completed upon admission, quarterly, and when a resident chooses to change their smoking decision. Additionally, it reveals that the resident must be dressed appropriately per the care plan. Record review revealed that the resident was admitted to the facility in April of 2023 with diagnoses including, but not limited to, traumatic brain injury, schizoaffective disorder, and epilepsy. Review of a Smoking Evaluation dated 10/15/2024 revealed that the resident utilizes a smoking apron. Review of a care plan dated 10/14/2024 revealed that the resident is a smoker with an intervention including, but not limited to, s/he is able to smoke safely with a smoking apron in place at times. Further review failed to reveal evidence when a smoking apron would need to be applied. During a surveyor observation on 1/2/2025 at 10:38 AM in the presence of Registered Nurse (RN), Staff H, of the resident smoking, s/he was not wearing a smoking apron. During the observation the ashes from the resident's cigarette were observed to be landing on his/her pajama pants. During a surveyor interview immediately following the above observation with Staff H, he acknowledged that the resident was not wearing a smoking apron and that the ashes had been landing on his/her pajama pants. Additionally, Staff H acknowledged that the resident's care plan revealed s/he is able to smoke safely with a smoking apron at times. Staff H, indicated they	F 689	F 689 Continued DON/Designee will conduct random audits of current smokers at smoke breaks to ensure compliance with smoking evaluation, orders and Care plans, for a minimum of 3 months to ensure compliance. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained	

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F 689	Continued From page 8 were not aware of when the resident should wear a smoking apron. During a surveyor interview on 1/2/2025 at 11:06 AM with the Assistant Director of Nursing she acknowledged that the resident's smoking assessment revealed that s/he should be utilizing a smoking apron. Record review revealed an order was put in place on 1/2/2025 to utilize a smoking apron with all smoking breaks after it was brought to the facility's attention by the surveyor. During a surveyor interview on 1/2/2025 at 11:20 AM with the Director of Nursing Services (DNS) she acknowledged that the care plan and the most recent smoking assessment revealed the resident should be utilizing a smoking apron. The DNS further revealed that the resident refuses use of the smoking apron at times but was unable to provide evidence of the refusals.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812	F 812 On 12/30/25 Dietary Aide #I and Cook #J were educated on the spot when Surveyor identified non-compliance with Food Code 2-402.11 resulting in donning a beard guard immediately following. All dietary employees have since been educated and a monitoring system is in place to be discussed at Qapi meeting. As well, the Air Gap on 1NS was identified on 1/2/25 and immediately r ectified. All employees were educated about the airgap regulation. Both of these areas have been added to auditing system and being reported upon by the Food Service Director or Designee during Qapi meetings.	

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F 812	Continued From page 9 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety relative to the main kitchen and 1 of 2 ice machines observed without an air gap (gap between the water supply inlet and the flood level rim of the plumbing fixture). Findings are as follows: 1. Review of the Rhode Island Food Code 2018 Edition 2-402.11, states in part,"...food employees shall wear hair restraints, beard restraints that are designed and worn to effectively keep their hair from contacting exposed food..." During a surveyor observation of the main kitchen on 12/30/2024 at approximately 8:25 AM, Dietary Aide, Staff I, and Cook, Staff J, were observed with full facial hair and not wearing a beard restraint while in the main kitchen. Additionally, Staff J was observed plating the breakfast meal for the residents. During a surveyor interview following the above observation on 12/30/2024 with the Food Service Director (FSD), she acknowledged that Staff I and J were not wearing a beard restraint, as required.	F 812		

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F 812	Continued From page 10 2. Review of the Rhode Island Food Code 2018 Edition 5-202.13 states in part, "...An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or non FOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25mm [millimeter] (1 inch)..." During a surveyor observation of the first-floor kitchenette on 1/2/2025 at 11:08 AM with the Director of Maintenance in the presence of the FSD, revealed an ice machine without an air gap. During a surveyor interview directly following the above observation with the FSD, she acknowledged that the ice machine failed to have an air gap as outlined in the Rhode Island Food Code.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	F 880 Infection Prevention and Control Resident ID # 77 Staff P was immediately reeducated regarding IPC Precautions guidelines. 12/30/2024 Resident ID # 153 Staff C was immediately reeducated regarding ICP Precautions guidelines. 12/30/2024 Resident ID #330 Staff Q was immediately reeducated regarding ICP Precautions guidelines. 12/30/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415082	A. BUILDING _____ B. WING _____	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE COMMUNITY	546 MAIN STREET COVENTRY, RI 02816

(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 880	Continued From page 11 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident, including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	F 880 Continued Resident ID # 330 Staff R was immediately reeducated regarding ICP Precautions Guidelines. Resident ID # 330 Staff S was immediately reeducated regarding ICP Precautions Guidelines. Resident ID# 332 Staff T was immediately reeducated regarding ICP Precautions Guidelines. SDC/IPC Reeducated all staff on Enhanced, Contact, Droplet and airborne precautions DON/Designee will conduct weekly random audits, on the floors, of staff using PPE to ensure continued compliance. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained.	12/31/2024 12/31/2024 12/31/2024 1/15/2025

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F 880	Continued From page 12 §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 surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to contact precautions (a type of precaution utilized when a resident is known or suspected to be infected with a Multidrug Resistant Organism, MDRO, that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces in the resident's room) for 4 of 4 residents observed for contact precautions, Resident ID #s 77, 153, 330, and 332. Findings are as follows: Review of a facility policy titled "Isolation-Categories of Transmission-Based Precautions" revealed in part, "Contact precautions...staff and visitors wear gloves (clean, non-sterile) when entering the room...Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potential contaminated surfaces with clothing after gown removed..." 1. Record review for Resident ID #77 revealed that s/he was readmitted to the facility in	F 880		

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F 880	Continued From page 13 December of 2024 with diagnoses including, but not limited to, Methicillin Resistant Staphylococcus Aureus (MRSA, an MDRO) and type 2 diabetes mellitus. Record review revealed that the resident has wounds to his/her bilateral feet. Record review revealed a physician's order dated 12/12/2024 for contact precautions for MRSA in the wounds. Review of the signage posted outside of the resident's room on 12/30/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to room entry. During a surveyor observation on 12/30/2024 at 12:04 PM revealed Nursing Assistant, Staff P, enter Resident ID #77's room without wearing a gown and gloves prior to entering the room. During a surveyor interview immediately following the above mentioned observation, Staff P acknowledged the signage outside of Resident ID #77's room and that she failed to wear a gown and gloves prior to entering the room. 2. Record review for Resident ID #153 revealed that s/he was admitted to the facility in June of 2024 with a diagnosis including, but not limited to, MRSA. Record review revealed a physician's order dated 12/5/2024 for contact precautions for MRSA in the resident's urine. Review of signage posted outside of the	F 880	F 658 continued Unit managers will conduct a weekly audit of residents with orders for dressing changes to ensure compliance. Audit will be reviewed by DON/ADON and will randomly, in person, audit 2 residents weekly. DON/ Designee will submit audit findings to QAPI committee for review monthly for a minimum of 3 months. The QAPI committee will make recommendations for resolution of audits once consistent compliance has been achieved and maintained. Resident ID # 20 MD was immediately notified and gave orders for Freestyle Libre System , for sensor to be changed Q 2 weeks and PRN. Orders also placed for observation of signs and symptoms of infection at sight of sensor, and to check to ensure device was working properly. DON/ Designees conducted a 14 day look back of all diabetic residents to ensure that if they had a Freestyle Libre sensor there were orders for the device, when to change sensor, checking for signs and symptoms of infection and to ensure device is working properly. SDC/ Designee re-educated all current nurses on order transcription and documentation to ensure accuracy. Education also included Freestyle Libre device information on when to change, looking for signs and symptoms of infection and what to do if device isn't working properly. Completed	1/2/2025 1/2/2025 1/3/2025

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F 880	Continued From page 14 resident's room on 12/30/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to entering the room. During a surveyor observation on 12/30/2024 at 10:34 AM revealed Licensed Practical Nurse, Staff C, enter Resident ID #153's room without wearing a gown or gloves prior to entering the room. During a surveyor interview immediately following the above mentioned observation, Staff C, acknowledged the signage posted outside of Resident ID #153's room and that she failed to wear a gown and gloves prior to entering the room. 3. Record review for Resident ID #330 revealed that s/he was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, Extended-spectrum beta-lactamases (ESBL, an MDRO). Record review revealed a physician's order dated 12/30/2024 for contact precautions for ESBL in the resident's urine. Review of the signage posted outside of the resident's room on 12/30/2024 and 12/31/2024 revealed the resident was on contact precautions and indicated to wear a gown and gloves prior to entering the room. During a surveyor observation on 12/30/2024 at 12:06 PM revealed Maintenance Staff, Staff Q, enter Resident ID #330's room without wearing a gown prior to entering the room and removed the resident's mattress from his/her bed.	F 880		

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F 880	Continued From page 15 During a surveyor interview immediately following the above mentioned observation, Staff Q acknowledged the signage posted outside of Resident ID #330's room and that he failed to wear a gown prior to entering the room. During a surveyor observation on 12/31/2024 at 10:45 AM revealed an Occupational Therapist, Staff R, enter Resident ID #330's room without wearing gown or gloves prior to entering the room and placed her laptop on the resident's dresser in his/her room. During a surveyor interview immediately following the above mentioned observation, Staff R acknowledged the signage posted outside of Resident ID #330's room but thought that it was only for direct contact and not upon room entry. During a surveyor observation on 12/31/2024 at 11:00 AM revealed Activity Aide, Staff S, enter Resident ID #330's room without wearing a gown or gloves prior to entering the room. During a surveyor interview immediately following the above mentioned observation, Staff S acknowledged the signage posted outside of Resident ID #330's room and that she failed to wear a gown and gloves prior to entering the room. 4. Record review for Resident ID #332 revealed that s/he was admitted to the facility in December of 2024 with a diagnosis including, but not limited to, MRSA. Record review revealed a physician's order dated 12/24/2024 for contact precautions for MRSA in	F 880		

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F 880	Continued From page 16 the resident's nares. Review of signage posted outside of the resident's room on 12/30/2024 and 12/31/2024 revealed the resident was on contact precautions and indicated to wear gloves and a gown prior to entering the room. During a surveyor observation on 12/31/2024 at 10:48 AM revealed Certified Occupational Therapy Assistant, Staff T, enter Resident ID #332's room without wearing a gown or gloves prior to entering the room. During a surveyor interview immediately following the above mentioned observation, Staff T acknowledged the signage posted outside of Resident ID #332's room but thought that it was only for direct contact and not upon room entry. During a surveyor interview with the Infection Preventionist on 1/2/2025 at 9:55 AM, she revealed that she would expect staff to put on a gown and gloves prior to entering a resident's room who is on contact precautions. During a surveyor interview on 12/31/2024 at 2:24 PM with the Director of Nursing Services and the Administrator, they revealed they would expect staff to put on a gown and gloves prior to entering a resident's room who is on contact precautions.	F 880		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call	F 919	F 919 There were no noted ill effects to any of the residents as a result of the current system.	

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F 919	Continued From page 17 directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, staff and resident interview, it has been determined that the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 3 of 3 floors observed. Findings are as follows: During the resident council task completed on 12/31/2024 at approximately 1:00 PM multiple residents complained of waiting for long periods of time for their call lights to be answered due to the staff no longer carrying walkie talkies. During surveyor observations of all the units from 12/30/2024 to 1/3/2025, revealed that not all resident rooms' call lights are visible from the nurse's station. During a surveyor observation of the first floor on 1/3/2025 at approximately 10:20 AM, revealed lights above the resident doors signaling a call light had been engaged. Further observation failed to reveal that the call light relayed the call directly to staff members or to a centralized staff work area. During a surveyor interview on 1/3/2025 at 10:29 AM with Licensed Practical Nurse (LPN), Staff K,	F 919	F 919 All Residents were assessed for their ability to use the call light system. Those that were able to demonstrate this ability were given handbells. All employees were educated about the need to respond to handbells, continuously round on residents who do not have the ability to utilize any form of notification system. This is being documented for all those unable to utilize handbells. ANYTECH has been contracted to install a building wide system that will both directly notify direct care workers as well as have a centralized notification response area. During the most recent Resident Council there were no concerns relayed related to call lights or response times. Monitoring via random audits will be done weekly by Administrator of Designee with results reported during QAPI meetings until 3 or more months of successful completion.	

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F 919	Continued From page 18 she revealed that previously the call lights would communicate with walkie talkies carried by the Nursing Assistants (NA) but that they no longer work. Additionally, she acknowledged that the call lights do not call directly to a staff member or to a centralized staff work area. During a surveyor interview on 1/3/2025 at 10:33 AM with Unit Manager, Staff D, she revealed that the NA's carry walkie talkies that the call lights communicate directly with. However, Staff D was unable to locate an NA that was carrying a walkie talkie and was unable to provide a functioning walkie talkie. During a surveyor observation on 1/3/2025 at approximately 10:40 AM of the second floor, revealed a call light above room 211 engaged. Further surveyor observation of the unit failed to reveal an NA in the hallway at the time the light was engaged. During a surveyor interview on 1/3/2025 at 10:42 AM with LPN, Staff A, she revealed that the NA's carry walkie talkies to alert them when a call light is engaged. During a follow up interview at approximately 10:50 AM Staff A, acknowledged that the staff no longer carry walkie talkies. During a surveyor interview on 1/3/2025 at 10:45 AM with NA, Staff L, he revealed that he does not carry a walkie talkie and the only way he is aware a call light is engaged is by the light above the door. During a surveyor interview on 1/3/2025 at 10:51 AM with NA, Staff M, she revealed that the staff do not utilize walkie talkies and there is no centralized staff area that the call lights alert to.	F 919		

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F 919	Continued From page 19 During a surveyor interview on 1/3/2025 at 11:09 AM with LPN, Staff N, she revealed that the staff on the third floor do not use walkie talkies and the call lights do not alert to a centralized location. During a surveyor interview on 1/3/2025 at 11:10 AM with NA, Staff O, she acknowledged that the only way she is aware a call light is engaged is by the light above the door. During a surveyor interview on 1/3/2025 at 12:33 PM with the Administrator, she acknowledged that the call lights in the facility do not communicate the call directly to a staff member or to a centralized staff work area.	F 919		

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Center for Health Facilities and Regulation on 1/3/2025. The facility was found to be in compliance with 42 CFR §483.73 related to Emergency Preparedness. Census: 173 Capacity: 190	E 000		

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

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.

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K 000	INITIAL COMMENTS The annual Federal Life Safety Code survey was conducted by the State Survey Agency. The facility was surveyed pursuant to the National Fire Protection Association 101 Life safety Code, 2012 Edition as referenced in 42 CFR 483.90 (a - d) - Physical Environment. A deficiency was identified as a result of the survey. Census: 173 Capacity: 190	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain their emergency lighting system in accordance with the National Fire Protection Association (NFPA) 101, 2012 Edition, and NFPA 110, 2010 Edition. This deficient practice has the potential to impact 173 of 173 residents, as well as an indeterminable number of staff and visitors. Findings are as follows: Review of the NFPA 101, 2012 Edition, states in part,	K 291	K291 There were no ill effects noted due to lack of emergency lighting for the generator transfer switch. It was immediately rectified with the installation of the transfer generator lighting by Eastland Electric on January 20, 2024. This will be checked weekly and will be r eported upon at Qapi meeting by Director of Maintenance or Designee for 3 months or more of 100% compliance and added to Tels Checklist for ongoing monitoring. EM 1/23/25	

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K 291	Continued From page 1 "...9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems [EPS]..." Review of NFPA 110, 2010 Edition states in part, "...7.3 Lighting...7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting..." Surveyor observation made during the Life Safety Code Tour in the presence of the Maintenance Director and the Regional Plant Operational Manager on 1/2/2025, failed to reveal evidence that the facility installed a battery-powered backup emergency lighting unit in the electrical room, where the generator transfer switch is located. During a surveyor interview with the Maintenance Director following the above observation, he acknowledged that the electrical room where the generator transfer switch is located failed to have a battery-powered backup emergency lighting unit, as required.	K 291		