STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135137	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Promontory Point Rehabilitation	3909 South 25th East Ammon, ID 83406

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, observation, record review, and, resident and staff interview, it was determined the facility failed to ensure a resident was assessed for safety to self-administer medication. This was true for 1 of 1 resident (Resident # 2) reviewed for self-administration of medications. This failure created the potential for adverse outcomes if Resident #2 received too much or too little of the medication. Findings include: The facility's Self- Administration of Medication policy, revised 10/12/22, stated the interdisciplinary team will determine which medication may be self-administered. The results of the interdisciplinary team assessment will be recorded on the Medication Self-Administration Assessment in the patient ' s medical record. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including Hypertension and removal of her pancreas. On 3/4/24 at 1:42 PM, Fluticasone Propionate nasal spray (nasal spray used to treat allergies) was observed on Resident #2's bedside table. Resident #2's care plan, dated 2/12/24, had no documentation Resident # was able to self-medicate. There was no Medicatioon Self-Adminisration Assessment in Resident #2's record. On 3/4/24 at 1:45 PM, Resident # 2 stated the medication on her bedside table was a nasal spray that she used for her allergies. On 3/5/24 at 9:06 AM, RN # 1 stated medications were not allowed to remain at a resident's bedside unless the resident was persistent on taking their own medication then an assessment was completed.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48989 Based on policy review, record review, and resident, and staff interview, it was determined the facility failed to ensure a residents' advance directive or POST were obtained and documented in their record. This was true for 4 of 12 residents (Resident #1, 130, #7, and #182) whose advance directives were reviewed. This deficient practice created the potential for harm or adverse outcomes if the residents' wishes regarding their advanced care plans were not followed or documented. Findings include: The facility's Residents' Rights Regarding Treatment and Advanced Directives policy, undated, stated: It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. 'Advance directive' is a written instruction such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when an individual is incapacitated (unable to speak for themselves). 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident's representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to the staff. 4. Any decision-making regarding resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. The State Operation Manual Appendix PP defined an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law [whether statutory or as recognized by the courts or the State], relating to the provision of healthcare when the individual is incapacitated. Physician Order for Life-Sustaining Treatment, [POST], paradigm form is a portable form designed to improve patient treatments the patient wants in the event of a medical emergency, taking the patient ' s current medical condition into consideration. A POST is not an advance directive. 1. Resident #1 was admitted to the facility on [DATE] with diagnoses including surgical aftercare following placement of drain tubes post gallbladder surgery for blockage due to gallstones. An MDS assessment, dated 2/14/24, documented Resident #1 was cognitively intact. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's record did not include a copy of an advance directive, or documentation he was offered assistance to formulate an advance directive. On 3/7/24, at 10 AM, the SW confirmed Resident #1 was not offered assistance to formulate an advance directive and his record did not include documentation of further requests or follow up regarding an advance directive. 2. Resident #130 was admitted to the facility on [DATE], with multiple diagnoses including sepsis (when your immune system has a dangerous reaction to an infection). and chronic pressure ulcers of the buttocks. Resident #130's record did not include a copy of an advance directive, or documentation he was offered assistance to formulate an advance directive. On 3/5/24 at 11:34 AM, Resident #130 and his spouse stated they were interested in Resident #130 having an advance directive. Resident #130 and his spouse both stated they had not received information regarding advance directives since admission. On 3/7/24 at 10 AM, Resident #130's record was reviewed with the SW. The SW confirmed there was no documentation Resident #130 had an advance directive or that he was offered assistance in formulating one. 49552 3. Resident #7 was admitted on [DATE], with multiple diagnosis including respiratory failure and hypertension. An MDS admission assessment, dated 1/31/24, documented Resident #7 was cognitively intact. Resident #7's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her. 4. Resident #182 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and sepsis (when your immune system has a dangerous reaction to an infection). A MDS admission assessment, dated 3/1/24, documented Resident #182 was cognitively intact. Resident #182's record did not include an advanced directive or documentation information about an advanced directive was provided and discussed with her. On 3/6/24 at 11:38 AM, the SW stated he asked residents if they have had an advanced directive on admission and if they had one, he asked for a copy. If the resident did not have an advanced directive, he offered to help the resident formulate one or find a lawyer to help them formulate an advanced directive. The SW stated he did not document in the resident's chart if they had an advanced directive or if he offered to help them formulate one.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure pertinent health information was provided to the receiving hospital. This was true for 1 of 2 residents (Resident #8) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include: The facility's policy, Bed Hold Notice Before/Upon Transfer, revised 12/1/22, stated, Promontory Point Rehabilitation will provide the receiving provider the following: - Contact information of the practitioner responsible for the care of the patient. - Patient representative information, including contact information. - Advance Directive information. - All special instructions or precautions for ongoing care, as appropriate. - Comprehensive care plan goals. - All other necessary information including a copy of the patient ' s discharge summary, as applicable, and any other documentation to ensure a safe and effective transition of care. Resident # 8 was admitted to the facility on [DATE]. with multiple diagnoses including dementia and hypertension. A nurse's note dated 3/6/24 at 8:14 PM, documented Resident #8 was sent to the hospital earlier that day. The note documented there was no update and Resident #8 had not yet returned and his family and provider were aware. On 3/7/24 at 8:38 AM, RN #2 stated a transfer sheet and a medication list were sent with residents when they transferred to the hospital and the provider, family, and EMS were called. RN #2 stated this should have been documented in the progress note. On 3/7/24 at 8:48 AM, the DON and the ADON stated when a resident transferred to the hospital, the nurse notified and gave the physician a report, then made a progress note. They stated the facility sent a medication list, labs, and face sheet with the resident to the hospital. They further stated report was called to the hospital and family and should be documented in a progress note. Resident #8's record did not include documentation pertinent medical information was provided to the receiving hospital.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48989 Based on record review, policy review and resident staff interview, it was determined the facility failed to ensure a baseline care plan was reviewed and provided to residents' and their representative. This was true for 5 of 12 residents (#7, #16, #130, #181, and #184) whose records were reviewed. This failure placed residents at risk of not having their goals for care and services met. Findings include: A facility policy titled, Baseline Care Plan, undated, documented the facility would develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care that met professional standards of quality care. The guidelines stated the baseline care plan was developed within 48 hours of admission and included a minimum of healthcare information necessary to care for the patient and included the following: -initial goals based on admission orders -physician orders -dietary orders -therapy services -social services -PASARR [Preadmission Assessment and Resident Review) recommendation, if applicable -initial goals of resident -special needs, services, health or safety risk, wound care The guidelines further stated all care should be summarized and reviewed and signed by the patient and patient representative if applicable. a. Resident #16 was admitted to the facility 2/15/24, with multiple diagnoses including stroke and a post-surgical head wound. Resident #16's record did not include documentation a baseline care plan was provided and discussed with her. On 3/6/24, at 10:30 AM, Resident #16 stated she was uncertain of her plan of care. She stated she did not believe she had papers telling her what her care needs were at the facility. b. Resident #130 was admitted to the facility on [DATE], with multiple diagnoses including sepsis (when your immune system has a serious reaction to an infection) and chronic pressure ulcers of his buttocks. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #130'ss record did not include documentation a baseline care plan was provided and discussed with him. On 3/5/24, at 11:34 AM, Resident #130 and his spouse stated they remembered signing papers when he was admitted but did not remember what those papers stated. 49552 c. Resident #7 was admitted on [DATE], with multiple diagnosis including respiratory failure and hypertension. Resident #7 's record did not include documentation a baseline care plan was provided and discussed with her. d. Resident #181 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and thyroid cancer. Resident #181's record did not include documentation a baseline care plan was provided and discussed with him or his wife. On 3/4/24 at 4:24 PM, Resident #181 stated no one had discussed the plan for his care and he did not remember signing a paper about it. e. Resident #184 was admitted on [DATE], with multiple diagnosis including respiratory failure, renal (kidney) failure, and congestive heart failure. Resident #184's record did not include documentation a baseline care plan was provided and discussed with him. On 3/4/24 at 4:59 PM, Resident #184 stated he did not receive papers about how the facility planned on caring for him. During an interview on 3/6/24 at 11:18 AM, the DON stated the baseline care plan was initiated when the patient was admitted . She stated there was no documentation the baseline care plan was reviewed with the above residents or their representative and there was no documentation one was signed by the residents' or their representative.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure there was an on-going activity program designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident. This was true for 2 of 12 residents (#8 and #180) reviewed for activities. This failure created the potential for harm if residents experienced boredom and lack meaningful activities throughout the day. Findings include: The facility's Activities policy, revised 10/25/22, documented Promontory Point will provide an ongoing program to support patients in their choice of activities based on their preferences and include the following:. -Scheduled activities will be posted throughout the facility. - Special considerations will be made for developing meaningful activities for patients with dementia and/or special needs. - All staff will assist patients in and from activities when necessary. 1. Resident #180 was admitted to the facility on [DATE], with multiple diagnosis including fracture of the left tibia (the larger of the two bones in the lower leg) and hypertension. A care plan created on 2/21/24, documented Resident #180 was to be invited to scheduled activities, she was to be provided with an activities calendar, and she was to be assisted/escorted to activity functions. On 3/4/24 at 3:15 PM, Resident #180 was observed sitting in her wheelchair in her room. There was no activity calendar observed in her room. On 3/4/24 at 3:21 PM, Resident #180 stated she was not offered activities except therapy. She stated she had not received a calendar of the activities that were offered in the facility. 2. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. Resident #8's care plan, revised 2/6/24,documented he liked to watch TV. The care plan documented Resident #8 was to be provided with simple, short activities, an activity calendar and reminded of upcoming activities. On 3/4/24 at 4:44 PM, Resident #8 was observed awake and sitting in his room. The TV was not on. On 3/4/24 at 4:50 PM, Resident # 8's wife stated he did not like activities other than watching TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/24 at 1:16 PM, the Administrator stated the activity director was let go, so activitties were not being offered according to resident care plans/preferences. He stated staff were going room to room offering activities. He stated Bingo wass offered at 2:00 PM in the dining room and there were no activity calendars in the Resident's rooms.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' dressing care was provided according to professional standards of nursing practice for 2 of 2 residents (#181 and #182) reviewed for quality of care. This failed practice had the potential to create infection in wounds or to Intravenous line sites. Findings include: The facility's Clean Dressing Change policy, revised 11/2/22, stated after securing a resident's dressing, staff were to mark the dressing with their initials and date. Dressing were to be changed per physician's order. The facility's PICC/Midline/CVAD (intravenous[IV] lines) Dressing Change policy revised 5/14/22, stated after the transparent semipermeable dressing was applied to the insertion site, staff were to label the dressing with the date and time the dressing was changed and their initials. 1. Resident #181 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and thyroid cancer. On 3/4/24 at 4:34 PM, Resident #181 was observed lying in bed with an IV dressing on his left upper arm without a date or initials. The edges of the dressing were loose and light brown in color. On 3/4/24 at 4:40 PM, Resident #181 stated he could not remember the last time the dressing was changed. 2. Resident #182 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and sepsis (when your immune system has a dangerous reaction to an infection). a. On 3/4/24 at 2:51 PM, Resident #181 was observed sitting in a chair in his room. The dressing to his left elbow did not have a date, time or initials. His IV site dressing on his left forearm did not have a date, time, or initials. b. On 3/6/24 at 9:42 AM, Resident # 182's IV site dressing on right hand was observed without date, time, or initials. On 3/6/24 at 12:09 PM, RN #2 stated all IV and wound dressings should be dated and initialed by the nurse, when they were changed. On 3/7/24 at 1:16 PM, the ADON stated all IV dressings and wound dressings should be dated and initialed when changed.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49552 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 resident (Resident #181) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practice. Finding include: The facility's Verifying Placement of feeding tube (a flexible plastic tube placed into the stomach to provide nutrition) policy, revised 6/14/21, directed staff to verify tube placement by gently tugging on the tube and taking note of the marking on the tube. A physician's order, dated 2/20/24, directed staff to change, date, and initial Resident #181's feeding bag and tubing every night shift. On 3/6/24 at 12:05, Resident #181 was observed in his room receiving Jevity 1.5 (a type of feeding formula that provides complete, balanced nutrition) via his feeding tube. The bottle of Jevity 1.5 was not labeled with Resident #181's name, start date or time, or rate of feeding to be delivered per hour. On 3/6/24 at 12:08 PM, RN #2 stated the bottle of Jevity 1.5 should have been labeled with Resident #181's name, the date it was started, along with the time and the rate it should be flowing at. On 3/6/24 at 12:11 PM, Resident #181 was lying in bed, with the head of the bed elevated. RN #2 was observed giving Resident #181's medication through his feeding tube. The feeding tube placement was not checked prior to giving the medication. On 3/6/24 at 12:17 PM, RN #2 stated she should have checked for tube placement.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, observation, record review, and staff interview, it was determined the facility failed to follow physician orders for the maintenance of supplemental oxygen This was true for 3 of 4 residents (#7, #181, and #182) reviewed for supplemental oxygen use. This placed residents at risk for respiratory infections when the supplemental oxygen and nebulizer tubing and humidifier bottle were not dated when changed. Findings include: The facility's Oxygen Concentrator policy revised 5/1/22, documented it was the nurse's responsibility to change the oxygen tubing weekly and as needed if it became soiled or contaminated. a. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure. A physician's order, dated 1/28/24, documented to change Resident #7's oxygen tubing and bag, clean the filter, and change the water (humidifier) bottle weekly. The order stated the staff were to initial and date the tubing when they were changed. A physician's order, dated 1/28/24, documented to change Resident #7's nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) tubing weekly and as needed and initial and date the tubing every day shift, every Sunday. On 3/4/24 at 3:02 PM, Resident #7's oxygen concentrator tubing, water bottle, and nebulizer tubing were observed without dates. b. Resident # 81 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and thyroid cancer. A physician's order, dated 2/20/24, documented to change Resident #182's oxygen tubing and bag, clean the filter, and change the water bottle weekly. The order directed staff to initial and date the tubing. On 3/4/24 at 4:28 PM, Resident #181 was observed lying in bed with his oxygen mask on. The oxygen mask and tubing were not dated. c. Resident #182 was admitted to the facility on [DATE], with multiple diagnosis including respiratory failure and sepsis (when your immune system has a dangerous reaction to an infection). A physician's order, dated 2/26/24, documented to change Resident #182's oxygen tubing and bag, clean the filter, and change the water bottle weekly. The order directed staff to initial and date the tubing. A physician's order, dated 2/26/24, documented to change Resident #182's nebulizer tubing set weekly and as needed and to initial and date the tubing every day shift, every Sunday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/24 at 4:01 PM, Resident #182 was observed sitting in a chair with oxygen on. The oxygen tubing was not dated. The nebulizer set and tubing in his room were also not dated. On 3/5/24 at 12:54 PM RN #1 stated the oxygen tubing should be changed once a week and tubing is to be dated.

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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. 49552 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents were free from medication errors. This was true for 2 of 2 residents (#11 and #132) whose medication administration were observed. This failure created the potential for harm to residents who receive insulin using an insulin pen to experience low or high blood sugars when they received an incorrect amount of insulin. Findings include: The facility's Insulin Pen policy revised 10/12/22, documented the insulin pen is to be primed with 2 units of insulin after attaching the pen needle. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. When injecting the insulin, while pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. On 3/5/24 at 7:41 AM, RN #2 was observed placing the insulin pen needle on the insulin pen and dialed the pen to the order dose of 14 units of Tresiba (long acting insulin) insulin. RN #2 injected the insulin and held the needle in Resident # 11's skin for 3 seconds. On 3/5/24 at 7:53 AM, RN #2 was observed placing the pen needle on the insulin pen and dialed the pen to the order dose of 4 units of Lispro (rapid acting insulin) insulin. RN #2 injected the insulin and held the needle in Resident #132's skin for 4 seconds. On 3/5/24 at 8:00 AM, RN #2 stated she primed the insulin pen needle with 1 unit of insulin and when injecting usually held the insulin pen in the resident's skin for 4 seconds. On 3/6/24 at 10:53 AM, the DON stated the insulin pen should be primed with 2 units of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135137	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Promontory Point Rehabilitation	3909 South 25th East Ammon, ID 83406

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 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** 48989 Based on policy review, observation, and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented and maintained to provide a safe and sanitary environment. This was true for 2 of 4 residents (#116 and #133) observed for infection control. This failure created the potential for harm by placing residents at risk for cross-contamination and infection. Findings include: 1. Resident #133 was admitted on [DATE], with multiple diagnoses including aftercare following total knee replacement. The facility's Personal Protective Equipment Policy (PPE), dated, 7/8/23, stated personal protective equipment appropriate to specific task requirements would be utilized per CDC guidelines. The policy stated equipment included but was not limited to: -gowns -gloves -masks -eyewear (googles and/or face shields The CDC website for isolation and standard precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last reviewed 7/11/23, and accessed 3/14/24, states: Handwashing should be performed before having direct contact with patients; after contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings; after contact with a patient's intact skin; if hands will be moving from a contaminated-body site to a clean-body site during patient care; after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; after removing gloves. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated. Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 3/4/24 At 5:35 PM, LPN #1 placed unopened testing supplies for admission testing of COVID-19, influenza, and PPD (purified protein derivative - skin injection to test for silent tuberculosis infection) on Resident #133's overbed table in front of her. LPN #1 then administered a nasal COVID-19 testing swab, a nasal influenza swab, and a PPD test to Resident #133. LPN #1 did not perform hand hygiene or wear PPE prior to administering the admission tests to Resident #133. On 3/4/24 at 5:55 PM, LPN #1 confirmed she did not perform hand hygiene or put on PPE during admission testing for COVID-19, influenza, and PPD. On 3/7/24 at 10:32 AM, the IP stated the facility policy was staff should be gowning and using PPE prior to completion of COVID-19 tests for all new admissions of unknown COVID-19 status. The IP further stated it was the facility's policy to use PPE for all new admissions. 2. On 3/4/24 at 5:35 PM, meal tray passes were observed in the facility's North Hall. a. LPN #1 entered Resident #133's room and placed a meal tray on her overbed table in front of her. LPN #1 did not perform hand hygiene prior to delivering Resident #133's meal. On 3/4/24 at 5:55 PM, LPN #1 confirmed she did not perform hand hygiene prior to delivering Resident #133's meal tray b. The Administrator delivered a meal tray to Resident #116. Resident #116 was not offered hand hygiene prior to receiving his meal tray. On 3/7/24 at 4:24 PM, the Administrator was asked if all residents should have hand hygiene offered prior to receiving their meal tray. The Administrator stated all residents should be offered hand hygiene prior to receiving their meal tray. The Administrator was asked if he offered hand hygiene to Resident #116 for his evening meal on 3/4/24. The Administrator stated he did not. 49552