STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Rehab & Care Center	1308 Game Farm Road Yorkville, IL 60560

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review, the facility failed to ensure the quarterly MDS (Minimum Data Set) assessments were completed in the required time. This applies to 5 of 5 residents (R14, R20, R21, R34, R39) reviewed in the sample of 14. The findings included: 1. R14's EMR (Electronic Medical Record) showed R14 was admitted to the facility on [DATE]. R14's MDS (Minimum Data Set) showed her ARD (Assessment Reference Date) was March 1, 2024. R14's quarterly MDS was transmitted on April 12, 2024, making it 132 days late. 2. R20's EMR showed R20 was admitted to the facility on [DATE]. R20's MDS showed her ARD was March 13, 2024. R20's MDS was transmitted on April 15, 2024, making it 123 days late. 3. R21's EMR showed R21 was admitted to the facility on [DATE]. R21's MDS showed his ARD was February 22, 2024. R21's quarterly MDS was transmitted on April 12, 2024, making it 140 days late. 4. R34's EMR showed R34 was admitted to the facility on [DATE]. R34's MDS showed his ARD was March 11, 2024. R34's quarterly MDS was transmitted on April 15, 2024, making it 125 days late. 5. R39's EMR showed R39 was admitted to the facility on [DATE]. R39's MDS showed her ARD as March 1, 2024. R39's quarterly MDS was transmitted on April 12, 2024, making it 132 days late. On April 15, 2024, V3 (MDS Coordinator) said she has been a little behind because she has been helping out the acting DON (Director of Nursing) with her responsibilities. V3 said she knows these quarterly MDS assessments were all late and should have been submitted in timely manner. V3 confirmed the transmission date of all five residents' quarterly MDS assessments. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provide policy their titled, Resident Assessment Schedule with a date of May 2022. Their policy showed, the purpose of the policy: Assessment schedule presented below is to be followed by the facility. The policy showed the assessments to be done on admission and when those assessments were to be completed. The policy then showed the assessments were to be completed again in 90 days.

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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** 43389 Based on observation, interview, and record review the facility failed to notify the physician of new skin wound, obtain orders for treatment, and update the care plan. This applies to 1 of 1 residents (R34) reviewed for skin assessment in the sample of 14. The findings include: R34 is an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that include cerebrovascular disease, vascular dementia, atrial fibrillation, and anxiety. Per the MDS (Minimum Data Set) Assessment of March 11, 2024, R34 is severely cognitively impaired and requires substantial to maximal assistance with bed mobility and movement. On April 15, 2024, 11:47 AM, R34 was sleeping with left arm side against his left bed rail. On, April 16, 2024, at 9:00 AM, R34 was observed with V7 (Hospice Certified Nurse Aide). R34 was lying in bed wearing only an incontinence brief and was noted with a bruise to his forearm (lower left arm), and a deep red, open, and bleeding wound to his upper left arm. V7 stated that there was no dressing on the wound today. V7 stated the wound to the left upper arm was there last Friday when she saw R34, but it was a little smaller and not open. V7 stated that she doesn't know how R34 got the bruise to his left upper arm, but he is always lying against the railing on his left side, and she assumed that is how he got it. Later at 9:08 AM, V7 stated that she wrote a note in the book at the front desk about R34's wound. V7 also stated that V12 (RN-Registered Nurse) was notified about the wound. On April 17, 2024, at 8:28 AM, V12 stated that he was not informed of the bruising or wound to R34's upper left arm. On April 16, 2024, at 10:11 AM, CNA's V10 and V11 stated the R34 is always lying against his bed railing on the left side. On April 16, 2024, at 10:30 AM, V9 (Hospice Nurse) today is the first time she has seen the left upper arm bruising and skin tear. V9 stated no one contacted her Friday or any other day before today to report R34's bruising or a skin tear to his left upper arm. V9 stated if there is any change with the resident the CNA should contact her and tell the facility nurse about the bruising. V9 stated R34 is always on the railing. V9 nurse stated she believes the upper left forearm bruising is probably from leaning on the railing. On April 17, 2024, at 2:08 PM, V13 (Regional Director/Registered Nurse) stated, if someone identifies a wound whether it is a facility employee or contract staff, they should let the nurse at the facility know. V13 stated the nurse should then assesses it, notify doctor, and put interventions in place. V13 stated that the hospice CNA should have notified the facility's nurse at the time she first found the bruising to R34's left upper arm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 16, 2024, at 1:34 PM, V6 (Primary Physician/Medical Director) stated it is possible that bruising to R34's left upper arm came from leaning against the bed rail. V6 stated he was not aware of the bruising or skin tear. V7 stated had he known about the bruising, he would have wanted R34 repositioned more often, and the wound covered to prevent further damage. On April 16, 2024, at 4:24 PM, R34 was observed in the bedroom with V2 (Director of Nursing), R34's left upper arm was observed with a bloody area about the size of a quarter. The left upper arm wound measured 4.5 cm (centimeters) by 6.6 cm by 1.3 x1.5 cm. The bruising to R34's left forearm was noted to measure 2.8 cm x 5.5 cm. Skin assessments from 4/1/2024 through 4/15/2024 did not mention the left upper arm bruise/wound. As of April 18, 2024, at 9:00 AM, R34 did not have a skin-care care plan. There is no documentation in R34's progress notes of the left upper arm wound until April 16, 2024, at 1:50 PM. The Facility's wound care policy dated January 20, 2023, shows the following: It is the policy of [the facility] to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions. 5. The facility will assess residents weekly for current skin conditions. c. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it, Skin Tear Protocol (NUR1225) or New Skin Condition Protocol (NUR1230). Assessments for EHR are assigned. f. The nurse will measure the area; call physician to obtain appropriate treatment order, call the guardian/family member to inform him/her, document the area on the T.A.R. (Treatment Administration Records), and initiate the treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview and record review the facility failed to assess and provide proper adaptive device to resident, to prevent further reduction in ROM (range of motion). This applies to 1 of 2 residents (R30) reviewed for range of motions in the sample of 14. The findings include: R30 is [AGE] years-old who has multiple medical diagnoses which include non-traumatic intracerebral hemorrhage, multiple localized, altered mental status, cognitive communication deficit, lack of coordination, and aphasia. R30's MDS (minimum data set) dated February 19, 2024, showed that the resident was severely impaired with cognition. R30's MDS showed that she has functional limitation in ROM on both side of both upper and lower extremities. The same MDS showed that R30 required maximum to total assistance from the staff with most of her ADLs (activities of daily living). R30 was observed multiple times from April 15, 2024, through April 17, 2024 and during these observations, R30 was observed in bed with both hands tightly clenched. Hand rolls were noted lying on each side of her arms, but they were not placed inside R30's hands. The hands rolls were noted to be too large for R30. On April 16, 2024, at 10:15 AM R30 was lying in bed. There were hand rolls lying on each side of her hands which were not in placed. Both of R30's hands were clenched tightly. On April 16, 2024, at 12:11 PM, V16 (Rehab Director) stated that she will refer R30 to the evaluator. V16 stated that the hand roll was too big for R30's hands and R30 needed a smaller size. On April 16, 2024, at 12:25 PM. V16 stated that they saw R30 and just put a smaller hand roll in place that fit R30. V16 also stated that she could not locate a documented rehab evaluation for R30 and there was nothing done by the occupational therapist. On April 16, 2024, at 12:29 PM, V17 (Husband) stated that R30 has never been assessed or evaluated by rehab for potential use of splint and prevention of contracture. V17 was observed giving passive range of motion (PROM) exercises to R30. R30's was observed opening at times when V17 was massaging it. V17 was worried that hand contracture will fully develop if he does not continue to give PROM. V17's friend who was a therapist recommended the hand roll splint because he noticed that when he visited R30, there was no splints on her hands and informed V17 that contracture will develop if there is nothing on her hands. On April 16, 2024, at 2:36 PM, V3 (Nurse) stated that they don't have admission therapy assessment/evaluation for R30. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 17, 2024, at 11:55 AM, V13 (Regional Director/RN) stated that during admission, it is part of the routine that the resident should be evaluated by the therapist to determine if the resident requires physical/occupational therapy or restorative. When they determine what is needed, they would refer it to the physician for order. This is for the resident who needs extensive assistance or totally dependent to staff for care. It is done to maintain and improve mobility or prevent decline.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to provide peri-care in a manner that would prevent urinary tract infection (UTI). The facility also failed to ensure that an indwelling urinary catheter was secured to the resident who was wearing it. This applies to 6 of 7 residents (R1, R9, R14, R26, R30, R38) reviewed for perineum and catheter care in the sample of 14. The findings include: 1. Face sheet shows that R26 is [AGE] years-old who has multiple medical diagnoses which include, irritable bowel syndrome, end stage renal disease and urinary tract infection (UTI). Minimum Data Set (MDS) dated [DATE], shows that R26 requires extensive assistance for toileting care. On April 16, 2024, at 9:44 AM, V14 (Certified Nursing Assistant/CNA) rendered incontinence care to R26 who was wet with urine. V14 cleaned R26 with a wet washcloth from front to back. V14 cleaned the pubic area, however, she did not separate the labia to clean its inner corners and the urethra. V14 proceeded to wipe the back peri-area with a wet washcloth from inner to outer area (starting from rectal going outward to the buttocks). 2. Face sheet shows that R30 is [AGE] years-old who has multiple medical diagnoses which include non-traumatic intracerebral hemorrhage, multiple localized, and neuromuscular dysfunction of the bladder, acute cystitis without hematuria, urinary tract infection, and presence of urogenital implants. MDS dated [DATE], shows that she is totally dependent from others for toileting hygiene. On April 15, 2024, 10:24 AM, R30 was resting in bed, she was non-verbal. R30 has an indwelling urinary catheter, with the catheter tubing not secured to R30. On April 16, 2024, at 10:27 AM, R30 was transferred from bed to shower chair. The indwelling urinary catheter remained unsecured; it was pulling during transfer. On April 16, 2024, at 12:29 PM V17 (R30's Husband) stated that R30 used to have a leg strap to secure her catheter but the facility lost it. On April 17, 2024, at 12:52 PM, V13 (Regional Director/RN) stated that an indwelling urinary catheter should be secured or anchored to the resident to prevent from getting pulled or cause trauma. 3. Face sheet shows that R1 is [AGE] years-old who has multiple medical diagnoses which include unspecified acute kidney failure and acute pyelonephritis. MDS dated [DATE], shows that R1 requires extensive assistance with toileting hygiene. On April 16, 2024, at 12:45 PM, V14 (CNA) rendered incontinence care to R1 who was wet with urine and had a bowel movement. V14 wiped R1 from front to back. However, V14 did not clean the inner labia and the groins. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Face sheet shows that R38 is [AGE] years-old who has multiple medical diagnoses which include Diabetes Mellitus. On April 17, 2024, at 10:55 AM, V18 and V19 (Both CNA) assisted R38 to the bathroom for toileting. R38's incontinence pad was heavily saturated with urine. V18 and V19 assisted R38 to stand up, while V18 cleaned R38 from behind, wiping and/or reaching under from front to back. However, V18 did not clean the pubic area, groins and was not able to clean the inner labia of R38. On April 17, 2024, at 12:00 PM, V13 (Regional Director/RN) stated that when staff provide incontinence care the staff must clean perineal area from front to back. For female, they should clean inner labia, groins, pubic area, the whole perineum to prevent infection. 41855 5. R9's EMR (Electronic Medical Record) showed she was admitted to the facility on [DATE], with diagnoses that included Cerebral palsy, dementia, anxiety, deaf, rheumatoid arthritis, and major depression. R9's MDS (Minimum Data Set) dated February 23, 2024, showed R9 had severely impaired cognitive skills for daily decision making. R9 was dependent on staff for toileting hygiene and all ADLs (Activities of Daily Living). R9's Care plan showed the facility identified the following for R9. She was at risk for skin breakdown or pressure ulcers/pressure injury related to decreased mobility, at risk for UTI's (urinary tract infections) related to history if UTIs and alteration in elimination of bladder and bowel incontinence. Interventions included keeping her skin clean and dry, providing incontinence care for episodes of incontinence, and assisting/providing perineal care as needed by applying facility approved cleaning and perineal care products after each incontinence episode. On April 17, 2024, at 12:45 PM, V14 (CNA/Certified Nurse Assistant) and V11 (CNA) used hand sanitizer and put on gloves before using a mechanical lift to transfer R9 from her wheelchair into her bed. Wearing the same gloves, V14 pulled down R9's pants and opened her incontinence brief which was saturated with urine and appeared to have some brown stool on it when she pulled it through her legs. V14 used a wet rag she put soap on and wiped the inner thigh area and then the outer labia going from both front to back and back to front. V14 did not spread the labia to clean in-between. V14 used a wet rag and wiped down the inner thighs and outer labia. R9 was turned onto her left side. Wearing the same gloves, R9 wiped between her buttocks and then around on her butt cheeks. Wearing the same gloves she placed a new incontinence brief under resident, fastened it, and while wearing same gloves pulled her pants back up. 6. R14's EMR showed she was admitted to the facility June 20, 2019 and her diagnoses included cerebral infarction, transient ischemic attack, hypothyroidism, altered mental status and multiple wounds. R14's MDS dated [DATE] showed R14 had severe cognitive impairment and was dependent on staff for all ADLs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14's care plan showed R14 was at risk for skin breakdown or pressure ulcers related to decreased mobility and R14 has incontinence of both bowel and bladder. Interventions included keeping skin clean and dry, and provide incontinence care for episodes of incontinence. On April 17, 2024, at 1:04 PM, V14 removed gloves after cleaning R14's roommate (R9) and put on new gloves without using hand sanitizer. V14 opened up R14's incontinence brief, it was wet with urine. Wound care physician was present for wound rounds. R14 had several wounds to be looked at. Incontinence brief was pulled out and away from resident by V14. Wound care physician asked V14 to help hold resident during wound care. After wound care was completed, V14 left the room and did not return. Surveyor asked V2 if anyone was going to provide incontinence now that wound care was completed and V2 (DON/Director of Nursing) said yes, and she went and got V18 (CNA). V2 and V18 used hand sanitizer and put on gloves. No one provided incontinence/perineal care. V2 used a protective ointment and applied it to R9's inner thighs and then applied ointment on her vaginal area by going back and forth from front to back and back to front. Facility provided policy titled, Perineal Care and dated July 2017. The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition .Steps in procedure 9. For a female resident: (1) separate the labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down and the catheter about 3 inches. Gently rinse and dry the area.) (2) Continue to wash the perineum moving from the inside outward to and including the thighs, alternating from side to side and using downward strokes.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to document the reason for the use of an antipsychotic medication and develop interventions for dose reduction for this medication. This applies to 1 of 5 residents (R38) reviewed for unnecessary medications in the sample of 14. The findings include: Face sheet shows that R38 is [AGE] years-old who has multiple medical diagnoses which include unspecified psychosis not due to substance or known physiological condition, and depression unspecified. R38 was admitted from home on February 24, 2024. R38's Census record shows that R38 was initially admitted to the facility on [DATE], for a short-term rehab and was discharged home on May 23, 2023. R38 was readmitted to the facility on [DATE]. On April 17, 2024, at 1:29 PM, V1 (Administrator) stated that R38 was readmitted to the facility for a long-term care because her husband could not take care of her anymore. On April 16, 2024, at 3:25 PM, R38 was resting on her recliner. R38 was alert and oriented and stated that sometimes she forgets recent events. R38's active Physician Order Summary (POS) shows multiple medications including Risperidone 0.5 milligrams (mg) tablet at bedtime. This medication indicates that it was ordered on April 5, 2023. Review of the physician notes from February 2024 to present does not have documentation addressing the use of Risperidone. There was no psychiatric evaluation. Facility presented a psychotropic care plan which was dated April 6, 2023, and in this care plan there was no targeted behavior which addressed the use of the Risperidone (anti-psychotic) medication. On April 16, 2024, at 3:33 PM, V22 (Social Service Director) stated that R38 has periods of forgetfulness. She (R38) does not have any aggressive behavior or unusual behavior such as auditory/visual hallucinations or paranoia. On April 17, 2024, at 10:25 AM, V18 (Certified Nursing Assistant/CNA) stated that she is familiar with R38. R38 frequently gets confused especially when she's tired. She's a very nice lady. V18 has never seen R38 displayed hallucinations and delusions. There was never an acting out behavior. She is a high risk for fall, sometimes she loses her balance. On April 17, 2024, at 12:04 PM, V13 (Regional Director/RN) stated that R38 should be seen by a psychiatrist for the appropriateness of the medication. Care plan should be done within 21 days. They should have reviewed the care plan and adjusted the time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 36567 Based on observation, interview and record review, the facility failed to follow recipe for butternut squash during pureed meal preparation. This applies to 2 of 2 residents (R14 and R34) reviewed for pureed diets in the sample of 14. The findings include: On April 15, 2024 at 11:08 AM, V4 (Dietary Manager) stated that the facility currently only have R14 and R34 on pureed diets. On April 15, 2024, at 11:09 AM, the pureed lunch meal prep of Roasted Squash Butternut by V5 (Cook) was observed in the facility kitchen. V5 had a recipe in front of him that showed serving portion for one serving and V5 stated that he is preparing for 2 residents. V5 measured two #8 scoops (4 ounce/scoop) of cooked butternut squash into a blender and added three ladles (2 ounce/ladle) of broth into the same blender and pureed the mixture. This showed that V5 used total of 6 oz of broth to prepare 2 servings of roasted butternut squash. When V5 opened the lid of the blender the product appeared to be a watery loose consistency. V5 added 1 tablespoon of thickener to this mixture and blended it again to form a more cohesive form and poured the mixture into two bowls and placed it on the steam table. Production recipe for Squash Butternut Roasted Pureed Thick per serving listed ingredients as 1 (one) #8 scoop of roasted butternut squash, 1/8 teaspoon of low sodium chicken base and 1 tablespoon of hot water, 3/8 teaspoon of food thickener. Instructions for the recipe included as follows: 1. Remove portions required from regular prepared roasted butternut squash recipe. 2. Add to a food processor and process until fine consistency. 3. Combine base and hot water and gradually add hot broth to mixture while processing to a smooth homogeneous consistency. All liquids may not be required. 4. Add food thickener and process briefly until mixed On April 17, 2024 at 01:11 PM, V21(Dietitian) stated that the recipe should be followed during meal preparation in order the nutrient values are not compromised. Facility diet manual (undated) for pureed diets included that if liquids and other items are added during pureeing, a standardized recipe should be used. Facility scoop size equivalent chart showed that #8 scoop = 4 ounces (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14 and R34's meal ticket showed that they were on pureed diets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Rehab & Care Center	1308 Game Farm Road Yorkville, IL 60560

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 36567 Based on observation, interview and record review, the facility failed to serve pureed braised beef in desired consistency for pureed diets. This applies to 2 of 2 residents (R14 and R34) reviewed for pureed diets in the sample of 14. The findings include: On April 15, 2024 at 11:08 AM, V4 (Dietary Manager) stated that the facility currently only have R14 and R34 on pureed diets. On April 15, 2024 at 11:13 AM, the pureed lunch meal prep of Braised Beef done by V5 (Cook) was observed in the facility kitchen. V5 stated that he is preparing the pureed beef for two residents. V5 placed two 6 oz/ounce scoops of cooked braised beef into the blender along with 1 oz of beef broth and pureed the mixture for about a minute. V5 opened the container and stated that the mixture was ready to be served. The pureed product had shreds of beef at the side of the blender and the contents of the blender appeared granular. V4, who was in the vicinity, was seen scraping down the shreds of beef from the sides of the blender into the pureed mixture before platting it into bowls. When taste tested , the pureed beef had shreds of beef that needed to be chewed. V4 and V5 were notified that the pureed beef was not safe to be served due to the irregular consistency. V4 agreed and pointing to another blender, stated that the other blender pureed food better. Recipe titled Beef Tips Braised Pureed Thick included as follows: 1. Place prepared Braised Beef Tips in the food processor and process until smooth in texture. 2. Add thickener and process briefly until mixed. Scrape down sides with spatula and reprocess . On April 17, 2024 at 01:11 PM, V21(Dietitian) stated that the consistency of pureed products should be smooth and close to pudding consistency to be easily swallowed without chewing. Facility directives (undated) listed under titles Basis of a Therapeutic diet and Review of Pureed diet included as follows: The pureed diet changes the regular diet to a soft pudding-like consistency and is for patients or residents with chewing or swallowing difficulties or with a condition of dysphagia. This diet consists of food which may be swallowed without chewing . R14 and R34's meal ticket showed that they were on pureed diets.

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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** 29562 Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and gloving during provisions of perineum and catheter care. This applies to 5 of the 14 residents (R1, R9, R14, R26, R30) reviewed for infection control in the sample of 14. The findings include: 1. On April 16, 2024, at 9:44 AM, V14 (Certified Nursing Assistant/CNA) rendered incontinence care to R26 who was wet with urine. V14 wiped R26 from front to back using a wet towel and a peri-care cleansing spray. After V14 wiped the back peri-area, V14 changed gloves without hand hygiene, she applied barrier cream, clean incontinence brief, and she assisted to dressed R26. V14 removed her gloves and left the room to get the mechanical lift for transfer. V14 completed the care without hand hygiene and without sanitizing the peri-care cleansing spray after she used it. On April 16, 2024, at 10:01 AM, V14 and V15 (CNA) transferred R26 from bed to wheelchair via mechanical lift. V14 and V15 were not wearing gloves. After they transferred R26 to the wheelchair, V15 stripped the old bed sheet, he left the bedroom and carried the old linens in his arms to the hallway without a plastic bag and without hand hygiene. V15 came back to the room to place new set of linens on the bed, then V15 picked the soiled linen and incontinence brief from the garbage bin, he placed a new plastic lining bag inside the garbage bin, he left the bedroom and carried the soiled items to the hallway without hand hygiene. 2. On April 16, 2024, at 10:27 AM, V14 emptied the indwelling urinary catheter bag of R30. V14 flushed the urine in the toilet bowl, she changed her gloves without hand hygiene and helped reposition R30. Then V14 left the bedroom without hand hygiene. 3. On April 16, 2024, at 12:45 PM, V14 rendered incontinence care to R1 who was wet with urine and had a bowel movement. V14 wiped R1 from front to back, applied barrier cream, clean incontinence brief, and straightened R1's clothing. V14 changed her gloves in between dirty to clean tasks without hand hygiene all throughout the care. On April 17, 2024, at 11:52 AM, V13 (Regional Director/RN) stated that when staff provided care or any procedure to the resident, the staff must wash hands, wear gloves, change gloves when soiled or when they are working from dirty to clean tasks. The staff should also wash hands or sanitize hands in between changes of gloves and perform hand hygiene before leaving the room. When staff use an item during care and they touched it with soiled gloves, the staff should disinfect it after using it. These are to be done to prevent spread of infection. 41855 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R9's EMR (Electronic Medical Record) showed she was admitted to the facility on [DATE], with diagnoses that included Cerebral palsy, dementia, anxiety, deaf, rheumatoid arthritis, and major depression. R9's MDS (Minimum Data Set) dated February 23, 2024, showed R9 had severely impaired cognitive skills for daily decision making. R9 was dependent on staff for toileting hygiene and all ADLs (Activities of Daily Living). R9's Care plan showed the facility identified the following for R9. She was at risk for skin breakdown or pressure ulcers/pressure injury related to decreased mobility, at risk for UTI's (urinary tract infections) related to history if UTIs and alteration in elimination of bladder and bowel incontinence. Interventions included keeping her skin clean and dry, providing incontinence care for episodes of incontinence, and assisting/providing perineal care as needed by applying facility approved cleaning and perineal care products after each incontinence episode. On April 17, 2024, at 12:45 PM, V14 (CNA/Certified Nurse Assistant) and V11 (CNA) used hand sanitizer and put on gloves before using a mechanical lift to transfer R9 from her wheelchair into her bed. Wearing the same gloves, V14 pulled down R9's pants and opened her incontinence brief which was saturated with urine and cleaned R9's perineal area. Wearing the same gloves, R9 was turned onto her left side and V14 wiped R9 between her buttocks and then around on her butt cheeks. Wearing the same gloves she placed a new incontinence brief under resident, fastened it, and while wearing same gloves pulled her pants back up. 5. R14's EMR showed she was admitted to the facility June 20, 2019 and her diagnoses included cerebral infarction, transient ischemic attack, hypothyroidism, altered mental status and multiple wounds. R14's MDS dated [DATE], showed R14 had severe cognitive impairment and was dependent on staff for all ADLs. R14's care plan showed R14 was at risk for skin breakdown or pressure ulcers related to decreased mobility and R14 has incontinence of both bowel and bladder. Interventions included keeping skin clean and dry and provide incontinence care for episodes of incontinence. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 17, 2024, at 1:04 PM, V14 (CNA) removed her gloves after providing incontinence care to R14's roommate (R9) and put on new gloves without using hand sanitizer. V14 opened up R14's incontinence brief, it was wet with urine. V20 (Wound Care Physician) was present for wound rounds. V2 (DON/Director of Nursing) was providing the wound care. R14 had several wounds to be looked at. V2 removed a dressing from R14's sacral area and stepped out of the way so V20 could measure the wound. Without changing gloves, V2 picked up her pen and clipboard and wrote the measurements down. V20 said she was documenting, V2 said she would like to document for her records. After writing down measurements, with the same gloves on, V2 started to grab supplies that were laid out on the over the bed tray table. V20 (Physician) reminded V2 she needed to remove her gloves and use hand sanitizer before moving on. V2 did as V20 asked and then put on a new pair of gloves. Wound care continued. V2 removed her gloves and hand sanitized after cleaning and applying treatment to foot wounds and put on new gloves. V2 picked up her pen that she used earlier without changing her gloves and wrote down measurements. After V2 removed the dressing to the left heel wound, and while V20 was measuring the wound, V2 pulled off old gloves and without hand sanitizer, V2 put on new gloves. V2 cleaned R14's right heel and was told by V20, she wanted a different treatment and dressing applied to this wound. V2 said she needed to go get the supplies needed. V2 removed her gloves, left the room, and returned with more dressing supplies. Facility provided policy titled, Infection Control: Nursing Services, dated April 2015 showed, Emptying urinary catheter bags .wear gloves to empty a catheter bag because it is to avoid getting urine on your hands. Facility provided policy titled, Infection Prevention and Control Program Policies and Procedures: General Statement, dated August 2018 showed Hand Hygiene General Statement. Good hand hygiene is a requirement of standard precautions. Wash or sanitize your hands before and after each care contact for which hand hygiene is indicated by acceptable professional practice, utilizing designated time frames and products. Hands should be washed with soap and water when they are visibly soiled, or if they have come in contact with blood or other body fluids, before or after eating or handling food, and times specified by other applicable regulations.