STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. Building B. Wing	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Ridge Retirement Community	4851 Harvard Road Lawrence, KS 66049

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 41037 The facility identified a census of 58 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to document a recapitulation of the facility stay upon discharge from the facility for Resident (R) 54, who was sampled for discharge. Findings included: - R54's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Minimum Data Set (MDS) was not completed during stay. R54's Baseline Care Plan dated 10/18/21, under Initial Admission/Discharge Goals, documented R54 intended to return to the community. Review of the EMR under Progress Notes dated 10/20/21 at 03:23 PM titled Discharge Note family had decided to transfer R54 to another facility. R54 left the facility in a private vehicle accompanied by family. The EMR lacked a recapitulation of R54's stay. The facility was unable to provide the recapitulation of R54's stay. On 11/17/21 at 03:28 PM in an interview, Licensed Nurse (LN) G stated the nurse on duty prepared the discharge summary and documented in the progress note. LN G stated she was not on duty when R54 was discharged . On 11/17/21 at 04:24 PM in an interview, Administrative Nurse D stated the nurse on duty at the time of the discharge was responsible for completing the discharge summary form which included the recapitulation. The facility Discharge Criteria policy date 11/28/17 lacked instructions of recapitulation of stay. (continued on next page)

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to document a recapitulation for R54's stay at the facility after her discharge to another facility. This placed her at risk for an interruption in the continuity of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42966 The facility identified a census of 58 residents. The sample included 16 residents; nine residents reviewed for bathing. Based on observations, record reviews, and interviews, the facility failed to provide consistent bathing for Resident (R) 17, R51, R154, R27, R32, R33, and R41. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity for the affected residents. Findings included: - The Diagnoses tab of R17's Electronic Medical Record (EMR) documented diagnoses of displaced fracture of lower end of left femur (thigh bone) and essential hypertension (high blood pressure). The Admission Minimum Data Set (MDS) dated [DATE], documented R17 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R17 required extensive physical assistance with two staff for bed mobility, transfers, dressing, toileting, bathing, and personal hygiene. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 09/09/21, documented R17 required assistance with two staff with ADLs due to non-weight bearing status (NWB). The ADL Care Plan dated 09/20/21, documented R17 needed help arranging her bathing and preferred showers in the evening on Wednesday and Saturdays and wanted to bathe two times a week. The ADL Care Plan documented R17 needed assistance with washing legs, feet, and back but assisted with washing in the shower if she was handed a soapy washcloth. Review of the Lookback Report between 09/03/21 and 11/17/21 (75 days) revealed R17 received nine showers/baths (09/14/21, 09/19/21, 09/25/21, 10/03/21, 10/12/21, 10/16/21, 10/23/21, 11/02/21, 11/14/21) and refused once (09/11/21). Bathing task was documented Not Applicable on 12 occasions on the following dates: 09/07/21, 09/08/21, 09/21/21, 09/22/21, 09/28/21, 09/29/21, 10/05/21, 10/19/21, 10/26/21, 11/03/21, 11/09/21, and 11/10/21. Upon request, the facility provided a Rapid Recovery Bathing Schedule which did not reflect bathing days for R17. On 11/17/21 at 08:56 AM, R17 sat up in bed and ate breakfast independently. She appeared comfortable, no signs of distress or discomfort. On 11/17/21 at 12:50 PM, R17 stated she did not get showers/baths regularly, maybe once a week. She stated when she did not get baths regularly, it made her feel like she was not important enough. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. She stated refusals were also documented in POC. She stated R17 did not refuse bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touchscreen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R17. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - The Diagnoses tab of R51's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and psychosis (any major mental disorder characterized by a gross impairment in reality testing) not due to a substance or known physiological condition. The Admission Minimum Data Set (MDS) dated [DATE], documented R51 had a Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. R51 required limited physical assistance with one staff for bed mobility, transfers, dressing, toileting, and personal hygiene and extensive physical assistance with one staff for bathing. The Quarterly MDS dated [DATE], documented R51 had a BIMS score of 10 which indicated moderate cognitive impairment. R51 required supervision with one staff for bed mobility, toileting, and personal hygiene; limited physical assistance with one staff for transfers; and extensive physical assistance with one staff for bathing. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 05/06/21, documented R51 was alert and oriented to self and was able to make her needs and wants known. Her BIMS assessment indicated severe cognitive impairment. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA dated 05/06/21, documented R51 needed supervision assistance with bathing. The ADL Care Plan dated 05/27/21, documented staff helped R51 arrange bathing and she preferred showers in the evenings three times a week on Monday, Wednesday, and Saturday. The Care Plan documented R51 did most of her own washing in the shower with a soapy washcloth but needed staff to assist with washing feet and back. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon request, the facility provided the bathing schedule which documented R51 had scheduled bathing on Monday, Wednesday, and Saturday. Review of the Lookback Report between 08/01/21 and 11/17/21 (108 days) revealed R51 received five showers/baths (08/08/21, 08/11/21, 08/18/21, 10/28/21, and 10/30/21) and refused bathing on ten occasions (08/15/21, 08/16/21, 09/06/21, 09/19/21, 10/10/21, 10/27/21, 11/01/21, 11/06/21, 11/08/21, and 11/13/21). Bathing task was documented Not Applicable on 31 occasions (08/01/21, 08/02/21, 08/03/21, 08/04/21, 08/09/21, 08/22/21, 08/23/21, 08/25/21, 08/29/21, 08/30/21, 09/01/21, 09/05/21, 09/08/21, 09/13/21, 09/15/21, 09/20/21, 09/22/21, 09/26/21, 09/29/21, 10/03/21, 10/04/21, 10/06/21, 10/11/21, 10/13/21, 10/17/21, 10/18/21, 10/20/21, 10/24/21, 10/31/21, 11/10/21, and 11/15/21). On 11/16/21 at 08:32 AM, R51 ambulated independently with walker in the hallway. She appeared comfortable and without signs of distress or discomfort. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. She stated refusals were also documented in POC. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touchscreen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R51. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - The Diagnoses tab of R154's Electronic Medical Record (EMR) documented diagnoses of metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood) and dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance. The Admission Minimum Data Set (MDS) dated [DATE], documented R154 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. R154 required limited physical assistance with one staff for bed mobility, transfers, walking, and dressing; extensive physical assistance with one staff for toileting, bathing, and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/08/21, documented R154 had a BIMS score of 12 which indicated she was moderately impaired and she required assist of a staff member for bed mobility, transfers, dressing, toilet use, and personal hygiene. The ADL Care Plan dated 11/16/21, documented staff helped R154 arrange bathing and she preferred showers in the evening two times a week on Wednesday and Saturday. R154 assisted with washing in the shower with a soapy washcloth but needed assistance with washing legs, feet, and back. Upon request, the facility provided a Rapid Recovery Bathing Schedule that documented R154 was scheduled for bathing on evening shift Wednesdays and Saturdays. The Lookback Report reviewed since R154's admission on 11/02/21 to present revealed Not Applicable documented on 11/03/21, 11/09/21, 11/10/21, and 11/16/21. The facility provided a Bathing Refusal Sheet dated 11/06/21 that documented R154 refused bathing because she thought she was going home the next day. On 11/16/21 at 10:54 AM, R154 sat in recliner and applied her makeup. She appeared comfortable and without signs of distress. On 11/17/21 at 12:52 PM, R154 stated she had not received bathing regularly and had not received a shower since she admitted . She stated not getting bathed made her feel not quite right. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. She stated refusals were also documented in POC. CNA M stated R154 refused showers a lot depending on her mood. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touchscreen which ensured documentation was included in the resident's electronic medical record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide consistent bathing for R154. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. 41037 - R27's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition for R27. The MDS documented that R27 required extensive assistance of two staff members for activities of daily living (ADL's). The MDS documented R27 was dependent with bathing of two staff member during look back period. The Quarterly MDS dated [DATE] documented a BIMS score of nine which indicated moderately impaired cognition for R27. The MDS documented that R27 required extensive assistance of two staff members for ADL's. The MDS documented R27 was dependent on one staff member for bathing during the look back period. R27's Activities of Daily Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 04/13/21 documented she required assistance of one staff member for bathing. R27's Care Plan dated 04/20/21 documented she required assistance with bathing. The Care Plan with revision date of 11/02/21 documented her bath/shower days were on Monday, Wednesday and Friday day shift. Review of the Lookback Report between 08/01/21 and 11/15/21 (106 days) revealed R8 received 22 showers/baths (08/02/21, 08/04/21, 08/09/21, 08/13/21, 08/18/21, 08/20/21, 08/25/2, 08/30/21, 09/01/21, 09/06/21, 09/17/21, 1, 09/20/21, 09/29/21, 10/01/21, 10/11/21, 10/13/21, 10/20/21, 10/22/21, 10/25/21, 10/27/21, 11/08/21 and 11/12/21). Bathing task was documented Not Applicable on the following 25 occasions; 08/06/21, 08/11/21, 08/16/21, 08/23/21, 08/27/21, 09/08/21,09/03/21, 09/08/21, 09/10/21, 09/13/21, 09/15/21, 09/22/21, 09/24/21, 09/27/21, 10/04/21, 10/06/21, 10/08/21, 10/15/21, 10/18/21, 10/29/21, 11/01/21, 11/03/21 11/05/21, 11/10/21, and 11/15/21. On 11/16/21 at 11:10 AM R27 sat in her wheelchair next to her bed, her right arm hung over the side of the wheelchair, her eyes were closed and her hair uncombed. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. She stated R27 did refuse bathing at times. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touch screen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R27. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - R32's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hemiplegia (paralysis of one side of the body), hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented that R32 required limited assistance of one staff member activities of daily living (ADL's). The MDS documented R32 required assistance of one staff member for bathing during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R32 required limited assistance of one staff member assistance of for ADL's. The MDS documented R32 required assistance of one staff member for bathing during the look back period R32's Activities of Daily Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 04/17/21 documented he was independent with bed mobility, required assistance of one staff member for transfer, bathing and dressing. R32's Care Plan with revision date of 11/02/21 documented he preferred to shower two times weekly on Tuesday and Saturday on evening shift. Review of the Lookback Report between 08/01/21 and 11/16/21 (107 days) revealed R32 received 10 baths/showers (08/03/21, 08/10/21,08/14/21, 08/31/21, 09/11/21, 09/25/21, 10/02/21, 10/05/21, 10/09/21, and 11/09/21) and refused 11 times (08/17/21, 08/21/21, 08/24/21, 08/28/21, 09/03/21, 09/07/21, 09/14/21, 09/21/21, 09/28/21, 10/19/21, and 11/16/21). Bathing task was documented Not Applicable on eight occasions: 09/18/21, 10/12/21, 10/16/21, 10/23/21, 10/30/21, 11/02/21, 11/06/21, and 11/13/21. On 11/17/21 at 08:31 AM R32 propelled himself in the wheelchair from the dining room to his room with his left hand and his right foot was bent under the wheelchair. Nursing staff stopped to direct him to the right side of the hallway so they could pass by him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/21 at 11:09 AM, during an interview with R32, he stated he does not refuse his shower/bath and always wanted his bath/shower two times a week at least. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. He stated R32 did not refuse bathing. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touch screen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R32. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - R33's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS documented that R33 required assistance of one staff member for bathing during look back period. R33's Activities of Daily Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 10/22/21 documented she required assistance of one staff member for ADL's. R33's Care Plan dated 10/25/21 documented she preferred to take a shower in the evening two times a week on Sunday and Thursday. Review of the Lookback Report between 10/01/21 and 11/14/21 (32 days) revealed R33 received two baths/showers (10/21/21 and 10/28/21). No refusals were recorded. Bathing task was documented Not Applicable on two occasions: 11/04/21, and 11/07/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/16/21 at 02:18 PM R33 stood next to the nurses station, hair greasy and uncombed. R33's skirt slid down and she held the skirt up as she ambulated. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. LN G stated that she was not sure if R33 refused her shower/bath. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touch screen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R33. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity. - R41's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented that R41 required assistance of one staff member for bathing during the look back period. R41's Activities of Daily Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 11/02/21 documented he required assistance of two staff member for bathing. R41's Care Plan dated 08/06/19 documented he preferred to take a shower anytime in the evening on Tuesday, Thursday and Sunday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR under Look Back Report from 08/01/21 to 11/16/21 (108 days) revealed R41 received 18 bath/showers (08/03/21, 08/08/21, 08/17/21, 08/19/21, 08/22/21, 08/26/21, 08/29/21, 08/31/21, 09/12/21, 09/14/21, 09/19/21, 09/26/21, 10/05/21, 10/10/21, 11/01/21, 11/09/21. 11/11/21 and 11/14/21) and refused on three occasions (08/15/21, 10/03/21, and 10/19/21). Bathing task was documented Not Applicable on 21 occasions (08/01/21, 08/10/21, 08/24/21, 09/02/21, 09/05/21, 09/07/21, 09/09/21, 09/10/21, 09/16/21, 09/21/21, 09/23/21, 09/28/21, 10/12/21, 10/14/21, 10/17/21,10/21/21, 10/24/21, 10/31/21, 11/04/21, 11/07/21, and 11/16/21). 11/16/21 at 09:26 AM R41 propelled himself in the wheelchair down the hallway from the dining room. The wheelchair lacked anti roll back brakes (a device placed on wheelchair wheel that are weight sensitive braking mechanism). On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were busy. She stated R41 did not refuse bathing, the staff would just take him into the shower room. On 11/17/21 at 03:22 PM, Licensed Nurse (LN) G stated the charge nurse was responsible for making sure bathing was completed by the aides as assigned. She stated bathing was documented in POC and on a bath sheet and should have been documented as given or refused, Not Applicable made her wonder if bathing got done or not. On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated she assumed Not Applicable was documented when it was not the resident's shower day. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there have been issues getting bathing done, sometimes the resident refused, sometimes staffing was a reason. The facility's Bath and Shower policy, dated 11/28/17, directed residents' baths and showers were performed and documented as scheduled according to resident preference to maintain each resident's hygiene and dignity. The policy directed the person that gave the resident his/her bath documented on the touch screen which ensured documentation was included in the resident's electronic medical record. The facility failed to provide consistent bathing for R41. This deficient practice had the risk for poor hygiene and decreased self-esteem and dignity.

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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** 41037 The facility identified a census of 58 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to ensure restorative care (care provided to maintain a person's highest level of physical, mental, and psychosocial function in order to prevent declines that impact quality of life) was performed for Resident (R) 32. This deficient practice placed R32 at increased risk for possible development of contractures and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension), which could effect his ability provide self-care and cause decreased self-esteem. Findings included: - R32's electronic medical record (EMR) from the Diagnoses tab documented diagnoses of hemiplegia (paralysis of one side of the body), hypertension (elevated blood pressure), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented that R32 required limited assistance of one staff member activities of daily living (ADL's). The MDS documented R32 had not received restorative nursing services during the look back period. The Quarterly MDS dated [DATE] documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R32 required limited assistance of one staff member assistance of for ADL's. The MDS documented R32 had not received nursing restorative services during the look back period R32's Activities of Daily Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 04/17/21 documented he was independent with bed mobility, required assistance of one staff member for transfer, bathing and dressing. R32's Care Plan dated 09/30/21 documented restorative programs were resolved. Review of the EMR under Reports tab Look Back- Clinical Assessments for Restorative Nursing: nursing program of ambulation three times weekly with rolled walker, gait belt (belt used to help transfer a person from one place to another) and side by assistance. Remind R32 to shift his weight to left if his right foot was drug behind during ambulation. Document if R32 chose not to participate with the ambulation program but with the NuStep for 15 minutes. ROM and stretching program, staff to remind R32 to place right leg on a chair. Reviewed from August 1, 2021 to November 15, 2021. August 2021 documented R32 had not received restorative nursing services. September 2021 documented he received restorative services on 09/27/21. October 2021 documented he received restorative services on 10/18/21; 10/20/21 and 10/25/21. November 2021 documented he received restorative nursing services on 11/04/21 and 11/10/21. Review of the EMR under Progress Notes tab documented: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/01/21 at 11:13 AM R32 continued restorative program of walking 300 feet using his walker and wheelchair following along behind him three/five times a week. When R32 refused to walk he was able to use the Nu-Step/Sci-fi (a medical device that combines lower and upper body movement for a full body work out) for 15 minutes, he had participated in the restorative program and would continue the current program 10/01/21 at 12:56 PM documented R32 had decided not to participate in the ambulation restorative program but continued to use the Nu-step three/five times a week. R32 also had a stretching/ROM program. R32 participated with the current restorative programs and would continue current programs. 11/01/21 at 12:22 PM R32 decided not to participate in the ambulation restorative program but continue to use the Nu-step three/five times a week. R32 also had a stretching/ROM program. R32 had participated with the current restorative programs and would continue current programs. On 11/15/21 at 08:03 AM in an interview R32 stated he would like to maintain his ability to do things. On 11/16/21 at 11:13 AM R32 propelled himself in the wheelchair from the dining room to his room with his left hand. His right foot was bent under the wheelchair. On 11/17/21 at 08:31 AM R32 propelled himself in the wheelchair from the dining room to his room with his left hand and his right foot was bent under the wheelchair. Nursing staff stopped to direct him to the right side of the hallway so they could pass by him. On 11/17/21 at 02:33 PM in an interview, Certified Nurse's Aide (CNA) G stated she did not know much about the nursing restorative programs. On 11/17/21 at 03:28 PM in an interview, Licensed Nurse (LN) G stated she knew that some residents had restorative programs. LN G stated she sis not know if R32 had a nursing restorative program. On 11/17/21 at 04:12 PM in an interview, Administrative Nurse E stated she was in charge of the nursing restorative programs at the facility. Administrative Nurse E stated that R32 was currently on a restorative program. Administrative Nurse E stated that the restorative aide, therapy and herself met monthly to discuss the residents on restorative programs and review their participation. The facility Restorative Nursing policy with revision date 11/28/17 documented a restorative nursing program would be utilized to maintain and/or improve ROM, mobility and ADL's. The facility failed to provide restorative care for R32 which had the risk for a decline in functional mobility and ability to perform ADLs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42966 The facility identified a census of 58 residents. The sample included 16 residents; nine residents reviewed for bathing. Based on observations, record reviews, and interviews, the facility failed to have sufficient staffing available to meet the bathing needs of the residents in a manner that promoted each resident's physical, mental, and psychosocial well-being. This deficient practice had the risk for poor hygiene and low self-esteem and dignity for affected residents. Findings included: - The facility failed to ensure sufficient staffing was available to provide consistent bathing for affected residents. (Reference F677) On 11/16/21 at 02:20 PM, Resident (R) 40 stated she was angry that she could never get a bath when she wanted one and she felt that she was not being bathed enough throughout the week. She stated she felt that the facility did not have enough staff and that she had to go without baths some days. She stated she asked for a bath the night before and was told that that did not have enough staff to help but a student assisted her with her bath. She stated the student did the best they could but the Certified Nurse Aide (CNA) should have completed the bath. R40 appeared visibly upset during the interview. On 11/16/21 at 02:20 PM, R10 stated even though she completed her own bathing, she felt like the facility could have done better with assisting residents with baths. She felt that the facility is so short on staffing that most of the residents had to wait and miss showers. On 11/16/21 at 02:34 PM, during Resident Council meeting with surveyors, residents voiced concerns with facility not having enough staff for proper bathing when requested. On 11/16/21 at 02:34 PM, R24 stated she was not receiving baths when requested, she requested a bath the previous night and staff would not give her one. On 11/16/21 at 03:30 PM, R33 wore a baggy skirt that appeared too large for her frame. R33's hair appeared to be greasy and unwashed. On 11/17/21 at 12:50 PM, R17 stated she did not get showers/baths regularly, maybe once a week. She stated when she did not get baths regularly, it made her feel like she was not important enough. On 11/17/21 at 12:52 PM, R154 stated she had not received bathing regularly and had not received a shower since she admitted . She stated not getting bathed made her feel not quite right. On 11/17/21 at 02:32 PM, Certified Nurse Aide (CNA) M stated the aides were assigned showers and they were documented in Point of Care (POC- EMR charting system) and on a shower sheet. She stated there were new aides in the facility who documented Not Applicable and it could have meant they were unable to give the shower, or they were too busy to get showers done that shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/21 at 04:24 PM, Administrative Nurse D stated aides were responsible for bathing and it was documented in POC if it was given or refused. She stated there was a bathing schedule that was updated if residents changed when they preferred their shower along with type of bathing provided. She stated there had been issues getting bathing done. she stated the reason was occassionaly the resident refused, but sometimes staffing was the reason baths/showers were not completed. The facility's Nursing Services policy, last revised 04/27/18, directed nursing services were provided to maintain resident safety and attained or maintained the highest practicable physical, mental, and psychosocial well-bring of each resident. The policy directed the facility provided sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services. The facility failed to provide sufficient staffing to meet the bathing needs of residents in a manner that promoted each resident's physical, mental, and psychosocial well-being. This deficient practice had the risk of poor hygiene and low self-esteem and dignity for affected residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42966 The facility identified a census of 58 residents; two medication rooms and four medication carts. Based on observations, record review, and interviews, the facility failed to discard expired suppository medications; failed to properly store and date insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) vials and pens; and failed to properly store medications. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents. Findings included: - On 11/16/21 at 09:01 AM, the Healthcare medication room revealed the following expired acetaminophen (analgesic- medication used to treat pain and inflammation) suppositories mixed in a bag with non-expired acetaminophen suppositories: Eight suppositories with expiration of October 2021 Five suppositories with expiration of August 2021 Two suppositories with expiration of January 2021 One suppository with expiration of September 2020 One suppository with expiration of April 2020 On 11/16/21 at 11:20 AM, the Rapid Recovery medication cart revealed the following: One Novolin R insulin vial, opened and not dated One Lantus insulin vial, opened and not dated One Insulin Aspart vial, opened and not dated One Humulin N vial, opened and not dated One Lantus insulin pen, open date 10/16/21 One Lantus insulin pen, opened and not dated On 11/16/21 at 03:28 PM, the Red Hall medication cart revealed four unidentified white round pills in a medication cup, not labeled, in the top drawer of the cart. On 11/16/21 at 03:34 PM, the Red Hall treatment cart revealed four Novolog insulin pens opened and not dated; and one Tresiba insulin pen, opened and not dated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the manufacturer's instructions for Novolin R directed opened vials of Novolin R were discarded after 42 days. A review of the manufacturer's instructions for Lantus vials and pens directed opened Lantus vials and pens were discarded after 28 days. A review of the manufacturer's instructions for Insulin Aspart vials directed opened Insulin Aspart vials were discarded after 28 days. A review of the manufacturer's instructions for Humulin N vials directed opened vials of Humulin N were discarded after 31 days. A review of the manufacturer's instructions for Tresiba insulin pens directed opened Tresiba pens were discarded after 56 days. On 11/16/21 at 09:01 AM, Licensed Nurse (LN) I stated the pharmacy was responsible for disposing of medications that were expired and came into the facility monthly. On 11/17/21 at 03:22 PM, LN G stated the pharmacy came into facility monthly to check for expired medication and the nurse also checked for outdated medications. LN G stated when insulin was opened, it was dated and labeled with the resident's name. She stated most insulins were good for less than 30 days once opened, there was a reference guide in the medication room. LN G stated no medications were stored loose in medication cups, medications were given as soon as they were popped into the cup. On 11/17/21 at 04:24 PM, Administrative Nurse D stated the pharmacy came in monthly to check the medication cart and rooms and nurses checked for expired medications. She stated new vials/pens of insulin were dated and placed in a bag with the resident's name; loose medications were not stored in medication cup in the medication cart and expired medications were not stored with non-expired medications. The facility's Medication Storage policy, January 2021, directed medications and biologicals were stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The policy directed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure were removed from stock and disposed of according to procedures for medication disposal. The facility failed to discard expired medicated suppositories, failed to properly store and date multiple insulin vials/pens, and failed to properly store medications. This deficient practice had the risk for unwarranted physical complications and ineffective treatment for affected residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45668 The facility had a census of 58 residents with one kitchen and one main dining room. Based on observation, and interview, and record review, the facility failed to ensure sanitary food storage. This deficient practice placed residents at risk for foodborne illness and contamination. Findings include: - During an observation on 11/15/2021 at 07:37 AM the main walk-in freezer in the kitchen had a significant water leak on the unit compressor/blower unit hanging on the ceiling of the freezer unit. Ice build-up located around the compressor unit was leaking down onto the rack underneath the compressor. Metal sheet pans were placed underneath the leak to catch the leaking water. Boxes stored underneath the sheet pans contained open packages of cinnamon rolls and southern biscuits with direct exposure to the leaking water. The thermometer temperature for the walk-in freezer unit read -10 degrees Fahrenheit. While observing the walk-in refrigerator unit, an inspection of the refrigerator compressor/blower unit located on the ceiling revealed debris covering a hose. A large tray of uncovered Jell-O bowls being prepared for lunch service were stored directly below the hose with the hanging debris. In an interview on 11/17/2021 at 01:30 PM Dietary Staff DD stated that if equipment was broken maintenance would be notified by a service ticket and a sign would be placed over the item. Dietary Staff DD reported that food suspected to be contaminated would be immediately thrown out and an investigation of the cause would be completed. In an interview on 11/17/2021 at 01:45 PM Dietary Staff BB stated that contaminated food should be thrown out if suspected. Food should be stored in a sanitary manner when not being served. A review of the Facilities Food Storage policy revised 04/06/2020 noted that food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Under Frozen Storage Guidelines of the Food Storage policy revealed the freezer should be defrosted on a regular basis and not to overload the freezer unit. The policy stated that overloading the unit makes it work harder, reduces cold air circulation, and makes it difficult to store and rotate food properly. Under Refrigerated Storage Guidelines of the Food Storage policy stated to wrap food properly and never leave any food items uncovered. The facility failed to ensure sanitary food storage by allowing food to be stored directly underneath contaminant sources within the storage unit and not properly covering food items. This deficient practice placed residents at risk for food borne illnesses and food safety concerns.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 58 residents. The sample included 16 residents and two residents were reviewed for therapy services. Based on observation, interview, and record review, the facility failed to provide physical and occupational therapy services for Resident (R)204. This deficient practice placed the resident at increased risk for physical impairment and decreased mobility. Findings included: A review of R204's Electronic Health Record (EHR) under Medical Diagnosis indicated the resident had hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left non-dominant side. Other listed diagnoses were primary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), oropharyngeal dysphagia (swallowing difficulty), and polyneuropathy (weakness, numbness, and pain in multiple areas of the body). The Admission Minimum Data Set (MDS) dated [DATE] was not completed at the time of the survey. The baseline Care Plan dated 11/08/21 documented R204 planned to stay in long term care and directed staff to follow the care plan. The baseline Care Plan lacked directions regarding physical mobility and activities of daily living (ADL's). A review of R204's EHR under Physician's Progress Note dated 11/5/2021 noted orders for a physical and occupational therapy evaluation. R204's EHR dated 11/5/2021 noted an active order dated 11/05/21 for Physical Therapy: Evaluate and treat as indicated. R204 had a speech therapy consult order placed on 11/08/21. A review of the clinical records from 11/5/2021 through 11/15/2021 for R204 lacked documentation showing that a physical therapy evaluation had been completed. An Occupational Therapy Plan of Care (POC) dated 11/15/2021 recorded therapy was necessary for contracture (inability to move a joint) management and splint trial and carryover. The POC documented that without therapy, R204 was at risk for further contracture, wounds, and hospitalization s. The document noted the start date of care for R204's hand contractures began on 11/15/2021 Observation on 11/16/20212 at 08:30 AM R204 sat in the dining area and ate his breakfast. He wore prescribed supportive braces. On 11/16/2012 at 01:26 PM R204 sat in his room and watched television. He reported that occupational therapy finally came by to see him and change out the type of supportive braces he needed. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/15/2021 at 09:00 AM R204 stated that the doctor told him that he would continue his occupational therapy that he started at his previous facility. R204 stated that he has not heard anything about this since his admission. He stated that he only has two working fingers on his right hand, and he can barely move his left arm or hand. Interview on 11/17/2021 at 04:15 PM Administrative Nurse D stated that she was the one who notified the therapy department on 11/15/2021 of the consult. She was not sure why the delay occurred but thought maybe it was due to not enough therapy staff available. Interview on 11/17/2021 at 10:49 AM Therapy Consultant HH stated that he had been informed about the consult of Monday (11/15/2021) by the Director of Nursing. He was not sure of any reason for the delay of the therapy evaluation and reported he evaluated and staretd therapy services as soon as he was informed of the order. Review of the facility policy Specialized Rehabilitative Services revised April 2018 noted: The facility will provide or obtain from an outside resource specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability based on the individual resident needs as identified by the comprehensive assessment and individualized plan of care. Specialized therapy services, including physical therapy, occupational therapy, speech-language pathology, are provided for the facility by the corporate therapy team. The facility failed to provide the physician ordered therapy services to R204 in a timely manner.The resident did not receive therapy services until 10 days after his admission and the date of the therapy order. This deficient practice placed the patient at increased risk for physical impairment and decreased mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. Building B. Wing	11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Ridge Retirement Community	4851 Harvard Road Lawrence, KS 66049

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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. 42966 The facility identified a census of 58 resident. Based on observations, record reviews, and interviews, the facility failed to ensure proper hand hygiene during meal service and failed to ensure appropriate hand hygiene and glove usage during wound care and peri-care (involves washing the genital and rectal areas of the body or peri-area) for Resident (R) 29. This deficient practice had the risk for cross-contamination and increased risk for infection for all residents. Findings included: - On 11/15/21 at 07:37 AM, Dietary BB wore gloves and served food onto a plate in the serving window then left through the kitchen door to deliver the plate to a resident's table. She returned to the kitchen, touched the doorknob and keys to enter the kitchen, and began serving another plate. She left kitchen again by opening kitchen door and delivered breakfast plate to a female resident. Dietary BB returned to the kitchen door, used her keys to unlock the door, and enter the kitchen. She continued to wear the same gloves and proceeded with breakfast serving. On 11/15/21 at 11:25 AM, Dietary CC brought extra cups out of the kitchen for resident use, picked up multiple cups, touched the outside of straws after removing the paper, touched table and silverware for a resident. He grabbed inside his pocket for his keys to unlock kitchen door. He delivered two drinks to resident, placed clothing protector on resident, then poured chocolate milk from carton into cup and dropped a straw onto the ground. He performed hand hygiene after placing straw into trash. Dietary CC grabbed two drinks, delivered to residents, grabbed two more drinks and delivered to another resident, placed his hands on his hips. Dietary CC assisted a resident with clothing protector, reached into pocket to grab keys to unlock kitchen door for entry, no hand hygiene observed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/21 at 09:45 AM, LN H set up wound supplies for R29's dressing change on a table with a clean barrier and left the room to get assistance. At 09:51 AM, LN H and Administrative Nurse K entered R29's room, performed hand hygiene, and donned gloves. LN H removed R29's left sock then cleansed top and side of R29's left food with wound cleanser and gauze. Wearing the same gloves, she opened a packet of skin prep and applied to both areas, then left open to air. Administrative Nurse K removed R29's right sock. LN H cleansed right shin with wound cleanser and gauze, doffed (remove) gloves and performed hand hygiene then donned new gloves. Administrative Nurse K used wound cleanser and gauze to cleanse right shin again then doffed gloves, performed hand hygiene, and donned new gloves. LN H applied skin prep to right shin and left open to air, doffed gloves, performed hand hygiene, and donned new gloves. Administrative Nurse K removed blanket and unfastened brief then raised the bed. Certified Nurse Aide (CNA) N donned gloves and assisted in rolling R29 over in bed, then removing brief to expose buttocks. LN H cleansed right buttock with wound cleanser. Administrative Nurse K grabbed wipes for CNA N and LN H then doffed gloves, performed hand hygiene, and donned new gloves. LN H cleansed barrier cream and bowel movement off buttocks/anal region then used the wound cleanser again to clean the buttocks wound wearing the same gloves. LN H used another wipe to clean bowel movement off anal region, doffed gloves, performed hand hygiene, then donned new gloves. LN H applied skin prep to bilateral buttocks, placed dressings to open areas on buttocks, doffed gloves, performed hand hygiene, then donned new gloves to help reposition R29 in bed. CNA N removed soiled draw sheet and pad then placed soiled linen on floor. Administrative Nurse K doffed gloves, performed hand hygiene, and exited room. CNA N tucked new draw sheet and pad under R29 and R29 rolled onto her back. LN H cleaned R29's peri-area from the front. LN H doffed gloves, performed hand hygiene, then donned new gloves. CNA N fastened brief, pulled R29 up in bed with LN H, touched her pillow and R29's head then pulled blanket on R29's body. LN H elevated R29's head of bed to assist her with changing shirts. LN H assisted R29 with removing soiled shirt. LN H placed soiled shirt on floor with other soiled linens, LN H doffed gloves and performed hand hygiene. Both LN H and CNA N helped R29 put a clean shirt on, CNA N touched R29's arm during dressing assistance. LN H lowered head of bed to position R29 on her left side. CNA N placed pillow under right side then placed pillows under R29's feet then doffed gloves. CNA N grabbed a trash bag for soiled linen, attempted to pick soiled linen up using the bag but was unable to grab it all so she picked soiled linen up without gloves, touched her mask on her way to sink, washed hands in sink. LN H returned R29's table and items within her reach then performed hand hygiene before exiting room. CNA N brought soiled linen bag and trash bag to soiled linen room down the hallway, no hand hygiene observed. CNA N then went to clean storage to grab new wipes and pillowcases and returned to R29's room. CNA N exited R29's room with more soiled linen, outside of a bag, and placed in soiled utility, no hand hygiene observed. On 11/17/21 at 01:24 PM, Dietary BB stated all employees were required to perform hand hygiene in between touching any dirty area and after taking off gloves. She stated that employees were required to wash hands before and after shift, hand hygiene after touching counters, tables, and any surfaces that may have been dirty. She stated gloves were changed in between serving residents food and when preparing food. On 11/17/21 at 02:32 PM, CNA M stated hand hygiene was performed before and after cares and after doffing gloves and before donning new gloves. She stated gloves were doffed with hand hygiene and donning new gloves when moving from a dirty area during cares to a clean area and she did not touch any clean surfaces with the same gloves worn during peri-care. CNA M stated soiled linen was placed in a trash bag and put in soiled utility room and were not to be carried loosely outside of a bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/21 at 03:22 PM, LN M stated hand hygiene was performed when she entered rooms, hand hygiene between glove changes. She stated she removed gloves after peri-care before touching clean areas or putting on a new brief. LN M stated soiled linens were transported in a bag to soiled utility, gloves were worn for transportation. LN M stated IV medication balls were carried in her hand, not inside a scrub pocket. On 11/17/21 at 04:24 PM, Administrative Nurse D stated hand hygiene was performed before and after cares and after removing gloves. She stated gloves were changed during wound care after removing soiled dressing and new gloves donned before clean dressing change. Gloves were doffed after peri-care and new gloves donned before moving to clean surfaces. Administrative Nurse D stated soiled linen were transported in a trash bag and taken to soiled utility. She stated hand hygiene was performed after touching anything during meal service. The facility's Guidelines for Dining Services Staff Fundamentals to Prevent Food Borne Illness, last revised 04/27/20, directed dirty hands or gloves spread germs/bacteria and hands/fingernails were washed thoroughly using correct procedure that included soap and water before work, anytime they are soiled, after handling raw foods, between work tasks, and anytime the employee leaves and re-enters the kitchen. Gloves were used only one time and were changed anytime they became soiled and between tasks and were treated like a food contact surface. Gloves were changed if they encountered an unclean surface, door, or piece of equipment. Proper handwashing occurred prior to putting on and after removing gloves. The facility's Hand Hygiene policy, dated 11/28/17, directed hand hygiene was performed before and after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the resident's environment and after removing gloves. The facility's Linen Transportation policy, revised 11/28/17, directed soiled linens were placed in bags for transportation to the soiled utility rooms or to the laundry. The facility failed to ensure proper hand hygiene during meal service and failed to ensure appropriate hand hygiene and glove usage during wound care and peri-care for R29. This deficient practice had the risk for cross-contamination and increased risk for infection for all residents.