

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

PRINTED: 10/07/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175100		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2024	
NAME OF PROVIDER OR SUPPLIER VIA CHRISTI VILLAGE MANHATTAN, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2800 WILLOW GROVE ROAD MANHATTAN, KS 66502			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint investigation #KS00189423.			F 000			
F 550 SS=D	The 2567 was sent electronically on 10/07/24. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.			F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/07/2024

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

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. The sample included 20 residents, with two reviewed for dignity. Based on observation, record review, and interview, the facility failed to provide dignity and quality of life for Resident (R)187 and R133, by having an uncovered urinary collection bag visible to guests and other residents. This placed the residents at risk of embarrassment and an undignified living environment. Findings included: - R187's Electronic Medical Record (EMR) recorded diagnoses of heart failure (a condition when the heart does not pump blood for the body's needs), kidney failure (the kidneys are no longer able to function effectively and are unable to filter waste), and compression fracture of the lumbar spine (a break in a lower bone in the spine.) R187's EMR documented the resident was admitted to the facility on 09/28/24. R187s "Care Plan" dated 10/02/24, documented the resident had an indwelling urinary catheter (a	F 550			

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F 550	Continued From page 2 flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) due to urinary retention. R187's EMR recorded "Physician Order" dated 10/01/24 for a Foley catheter at all times due to urinary retention. On 09/30/24 at 09:30 AM, observation revealed R187 rested in bed, with the uncovered urinary catheter bag hanging on the right side of the bed frame, visible from the door. On 10/01/24 at 08:00 AM, observation revealed R187 rested in bed, with the uncovered urinary catheter bag hanging on the right side of the bed frame, visible from the door. On 10/01/24 at 04:00, Administrative Nurse D stated the resident's urinary catheter bag should always be covered. The facility's "Quality of Life-Dignity " policy, dated 01/2024, documented each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. The policy documented demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed including helping the resident keep urinary catheter bags covered. The facility failed to cover R187's urinary catheter	F 550			

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F 550	Continued From page 3 bag, placing the resident at risk for embarrassment and an undignified living environment. - R133's Electronic Medical Record documented diagnoses of UTI (an infection in any part of the urinary system), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and traumatic brain injury (TBI-an injury to the brain caused by external forces). The "Admission Minimum Data Set" (MDS), dated 09/10/24, documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. The MDS documented R133 was dependent on staff for toileting hygiene, lower body dressing, and mobility. The MDS documented R133 had an indwelling urinary catheter and received antibiotics (medication used to treat infections). R133's "Care Plan," dated 09/04/24, stated R133 had an indwelling suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion) tube. The care plan directed staff to ensure the drainage bag was below the level of the bladder at all times and ensure the catheter bag was covered for dignity concerns. On 10/01/24 at 07:40 AM, observation revealed R133 lying on a mattress on the floor in his room with his urinary catheter bag on the bare floor. At 07:55 AM, R133 hollered out for help and Certified Nurse Aide (CNA) M came in, and	F 550			

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F 550	Continued From page 4 offered to assist him to get dressed. CNA M changed R133's brief and provided incontinent care. After staff dressed R133, they assisted him into his wheelchair and took him to the dining room. Observation revealed no privacy bag or cover over the catheter collection bag and yellow urine was visible to other residents in the dining room. On 10/01/24 at 03:42 PM, Administrative Nurse D verified a privacy bag or cover should be used to cover the catheter bag so the urine was not visible. The facility's "Quality of Life, Dignity" policy, dated 01/2024, stated each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Associates shall promote, maintain, and protect resident privacy, including bodily privacy and helping to keep urinary catheter bags covered. The facility failed to ensure dignity for R133 when they took him to the dining room with the catheter bag uncovered and urine visible to other residents. This placed the resident at risk for impaired dignity and decreased quality of life.	F 550			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657			

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F 657	Continued From page 5 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. The sample included 20 residents with four residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review the facility failed to revise the care plan for Resident (R) 5 who was on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). This deficient practice placed R5 at risk for impaired care due to uncommunicated care needs. Findings included:	F 657			

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F 657	Continued From page 6 - R5's Electronic Medical Record (EMR) documented diagnoses of cerebrovascular accident (CVA-stroke- 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 the right side, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin,), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk.) The "Significant Change Minimum Data Set (MDS)," dated 08/23/24, documented the resident had severely impaired cognition. The MDS documented R5 was dependent on staff for all activities of daily living (ADLs). The MDS documented R5 had one Stage 2 (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) pressure ulcer. R5's "Care Plan," dated 07/07/24, directed staff to maintain the resident's skin integrity without new skin-related injuries over the next review period. Staff would assist the resident with repositioning as indicated and when they noticed signs and symptoms of discomfort. Staff would observe the resident for verbal and non-verbal signs or symptoms of discomfort. Staff would maintain the resident's skin integrity with the management of her mobility and assist with repositioning. The care plan documented the resident had impaired skin integrity and to provide treatment and dressing changes and the resident would be free from signs and symptoms of infection. The care plan lacked any direction for the staff regarding the EBP care and precautions.	F 657			

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F 657	Continued From page 7 On 10/01/24 at 12:10 PM observation revealed License Nurse (LN) G entered the room of R5, who was on enhanced barrier precautions. A sign was posted on the wall of the resident's room giving instructions on personal protection equipment (PPE-gown and gloves). The room had a metal storage bin affixed to the wall upon entrance to the resident's room with PPE supplies. Continued observation revealed LN G entered the resident's room and donned gloves. LN G elevated the resident's right leg off the pillow and removed part of the dressing to reveal the resident's open draining wound on her calf with serosanguineous (semi-thick blood-tinged drainage) noted onto the pillow. LN G stated she would return later to replace the dressing after she administered pain medication to the resident and the resident shook her head yes. LN G verified they had not worn full PPE in the isolation room and were not aware she had to. On 10/01/24 at 04:00 PM interview with Administrative Nurse D verified the care plan lacked documentation the resident required EBP. The facility's "Care Plan -Comprehensive Person-Centered" policy, dated 09/2023, stated the facility would develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs, that are identified through evaluation and assessment, is developed and implemented for each resident. The care plan would describe the services that are to be provided for the resident and would update the care plan when there has been a significant in the resident's condition.	F 657			

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F 657	Continued From page 8	F 657			
F 661 SS=D	The facility failed to revise R5's "Care Plan" to include EBP. This placed R5 at risk for impaired care due to uncommunicated care needs. Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. The	F 661			

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F 661	Continued From page 9 sample included 20 residents of which one was reviewed for discharge. Based on record review and interview, the facility failed to provide a resident-specific detailed discharge summary and complete a recapitulation (summary) of stay for Resident (R) 233. This placed the resident at risk for unidentified and unmet care needs. Findings included: - R233's Electronic Medical Record (EMR) documented diagnoses of a nondisplaced fracture of left posterior (back) column acetabulum (part of the hip), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with other circulatory complications, peripheral vascular disease (PVD-slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), end-stage renal (pertaining to kidneys) disease (ESRD-a terminal disease of the kidneys) dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), right below knee amputation, reduced mobility and a need for assistance with personal care. R233's "Admission Minimum Data Set" (MDS), dated 05/06/24, documented that R233 had moderately impaired cognition, exhibited physical, and verbal behaviors directed toward others, and rejected care which significantly interfered with the resident's care, participation in activities and social interactions and disrupted care or living environment. R233 was dependent on staff with toileting hygiene, upper and lower body dressing, and bathing. The MDS further documented R233 required partial/moderate assistance with rolling in bed, sitting to lying, lying to sitting, sitting to	F 661			

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F 661	Continued From page 10 standing, and used a wheelchair for mobility. R233 had severe pain, had fallen before admission, and had two unstageable deep tissue deep tissue injury (DTI- purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) injuries which were present on admission. R233's "Care Plan" dated 04/29/24, documented R233 was at risk for pressure injuries and other skin-related injuries. The care plan directed staff to observe skin for redness and breakdown during routine care, keep bed linens wrinkle-free and not use excess pads, and have pressure relieving cushions on the wheelchair, and mattress on the bed. The plan directed to offload heels as much as possible and provide treatments as indicated. The "Interdisciplinary Team Note" dated 04/29/24 at 07:23 PM, documented R233 admitted to long-term care for a pelvic fracture after falling at home. R233's skin was not intact and he required the use of a heel protector on the left foot. The "Interdisciplinary Team Note" dated 05/02/24 at 03:55 PM, documented a reabsorbed ruptured blister to the heel. The note documented he had orders for heel protectors on admission and a small dressing post-cleaning. The "Interdisciplinary Team Note", dated 05/05/24, documented R233 yelled at staff and refused care. Staff provided education on the importance of personal hygiene. The intervention outcome was effective. R233's EMR documented on 05/22/24 that R233	F 661			

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F 661	Continued From page 11 received wound care and was discharged home. The record lacked evidence of a recapitulation of R233's stay in the facility. On 10/02/24 at 02:37 PM Administrative Nurse D reported on the day R233 had been discharged, the nurse responsible for completing the discharge instruction had gotten another discharge that day mixed up and had not included a full discharge summary due to the facility not having electronic records related to a cyber-attack on their main company. Administrative Nurse D verified an incomplete discharge instruction was given to R233's representative and a recapitulation should also have been completed. The facility's "Discharge Summary and Plan" policy, dated 01/2022, documented that when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident in adjusting to his/her new living environment. The discharge summary will include a recapitulation of the resident's stay at this community and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing the release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's current diagnosis, medical history, course of illness, treatment and/or therapy since entering the community, physical and mental functions, current lab, radiology, consultation, and diagnostic test results, ability to perform activities of daily living, sensory and physical impairments, nutritional status and requirements, special treatments or procedures, mental and psychosocial status, discharge potential, dental	F 661			

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F 661	Continued From page 12 condition, rehabilitation, cognitive status, and medication therapy. The facility failed to provide a resident-specific detailed discharge summary and complete a recapitulation of stay for R233. This placed the resident at risk for unidentified and unmet care needs.	F 661			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690			

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F 690	Continued From page 13 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. The sample included 20 residents with three reviewed for urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Based on observation, interview, and record review the facility failed to provide catheter care and services consistent with the standards of practice for Resident (R) 133 when staff failed to monitor urine output, failed to ensure the tubing was anchored appropriately, and failed to manage the tubing and urine collection bag in a sanitary and dignified manner. This placed the resident at risk for catheter-related complications including dislodgement and urinary tract infections (UTI). Findings included: - R133's Electronic Medical Record documented diagnoses of UTI (an infection in any part of the urinary system), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), and traumatic brain injury (TBI-an injury to the brain caused by external forces). The "Admission Minimum Data Set" (MDS), dated 09/10/24, documented a Brief Interview for Mental Status (BIMS) score of eight, indicating	F 690			

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F 690	Continued From page 14 moderately impaired cognition. The MDS documented R133 was dependent on staff for toileting hygiene, lower body dressing, and mobility. The MDS documented R133 had an indwelling urinary catheter and received antibiotics (medication used to treat infections). R133's "Care Plan," dated 09/04/24, stated R133 had an indwelling suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion) tube. The care plan directed staff to monitor for signs and symptoms of UTI, provide catheter care per facility policy, and maintain a closed drainage system. Change the catheter every 30 days and as needed (PRN). Ensure the drainage bag was below the level of the bladder at all times and ensure the catheter bag was covered for dignity concerns. The care plan directed staff to secure the catheter tubing to a leg to avoid tension on the urinary insertion site and ensure enough slack in the tubing so it does not get pulled on during care. R133's EMR under the daily "Task" documentation lacked catheter output for 31 of 75 shifts from 09/05/24 through 09/30/24. The "Physician Order," dated 09/10/24, directed staff to administer Cipro (antibiotic) 500 milligrams (mg), three times per day (TID), for five days for a diagnosis of UTI. On 10/01/24 at 07:40 AM, observation revealed R133 lying on a mattress on the floor in his room with his urinary catheter bag on the bare floor. At 07:55 AM, R133 hollered out for help and	F 690			

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F 690	Continued From page 15 Certified Nurse Aide (CNA) M came in, and offered to assist him to get dressed. CNA M donned personal protective equipment (PPE). CNA M changed R133's brief and provided incontinent care. The urinary catheter tubing was secured to R133's right leg. CNA N assisted with using the full lift to transfer R133 to the toilet. CNA M stepped on the catheter tubing during the transfer and set the catheter bag on the floor in the bathroom. After staff dressed R133, they assisted him into his wheelchair and took him to the dining room. Observation revealed no privacy bag or cover over the catheter collection bag and yellow urine was visible to other residents in the dining room. On 10/01/24 at 03:42 PM, Administrative Nurse D verified staff were not to allow the catheter bag or tubing to lie on the floor and a privacy bag or cover should be used to cover the catheter bag so the urine was not visible. The facility's "Urinary Tract Infections (Catheter-Associated)e Guidelines for Prevention," dated 01/2024, directed staff to always practice vigilant hand hygiene and standard precautions when handling catheter systems. Keep the drainage bag below the level of the bladder at all times and do not place the drainage bag on the floor. The facility failed to provide catheter care consistent with the standards of practice when staff failed to monitor urine output, failed to ensure the tubing was anchored appropriately, and failed to manage the tubing and urine collection bag in a sanitary and dignified manner. This placed the resident at risk for catheter-related complications including	F 690			

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F 690	Continued From page 16 dislodgement and UTI.	F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. The sample included 20 residents with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to monitor Resident (R) 57's physician-ordered fluid restriction. This placed R57 at risk of complications related to fluid overload. Findings included: - R57's Electronic Medical Record (EMR)	F 692			

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F 692	Continued From page 17 documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), pulmonary hypertension high blood pressure that affects the lungs), hypernatremia (greater than normal concentration of sodium in the blood), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, major depressive disorder (major mood disorder that causes persistent feelings of sadness), and need for assistance with personal care. The "Quarterly Minimum Data Set" (MDS), dated 08/16/24, documented R57 had intact cognition, used a wheelchair, and required partial/moderate assistance with oral and toileting hygiene, upper body dressing, and mobility. R57 received an antidepressant (a class of medications used to treat mood disorders), a diuretic (a medication to promote the formation and excretion of urine), and an opioid (a class of drugs to treat pain). The MDS further documented R57 received oxygen therapy. R57's "Care Plan," dated 08/13/24, documented that R57 was at risk for impaired nutrition. The care plan instructed staff R57 would follow a 2000 milliliter (ml) fluid restriction. The plan documented half of the fluid restriction (1000 ml) to be given by nursing staff and the other half (1000 ml) would be provided by dietary staff. The care plan further documented R57 took a diuretic which put him at risk for dehydration and weight fluctuations due to fluid shifts. The plan recorded	F 692			

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F 692	Continued From page 18 R57 was to be weighed daily. The "Physician Order," dated 06/12/24, recorded a fluid restriction of 2000 ml per 24-hour period. R57's clinical record lacked evidence staff monitored and recorded his fluid intake. On 10/01/24 at 12:51 PM, observation revealed R57 sat at a dining room table with a cup of coffee and a thermal cup with his meal. On 10/01/24 at 01:00 PM, Certified Nurse Aide (CNA) N reported staff kept track of meal intake and the fluids R57 drank and recorded this in the EMR. On 10/01/24 at 03:22 PM, Licensed Nurse (LN) I stated the nurse aides would typically enter information on fluid intake into the EMR and she was unsure how to look the information up. LN I said she was unsure who monitored R57's fluid intake and did not know what the breakdown of fluid provided to R57 by nursing and dietary staff. LN I reported R57 was weighed daily to monitor fluid shifts. On 10/01/24 at 04:04 PM, Dietary Staff CC reported that she was unaware of R57 fluid restrictions and said the specifics of any restrictions would be on the resident's meal tickets. A review of R57's meal ticket lacked information related to a fluid restriction. On 10/01/24 at 04:51 PM, Administrative Nurse D reported R57 had a physician-ordered fluid restriction and somehow was overlooked. The facility's "Fluid Restriction" policy, dated	F 692			

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F 692	Continued From page 19 06/2019, documents that when a fluid restriction is ordered by the physician for a resident, the nursing associate shall be responsible for assuring that the Nutrition and Dining Services department receives a written notice of the fluid restriction amount for 24 hours using a Die Order Form. Responsibility for fluid allotment shall be divided between the Nutrition and Dining service and Nursing departments. The facility failed to monitor R57's physician-ordered fluid restriction. This placed R57 at risk of complications related to fluid overload.	F 692			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880			

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F 880	Continued From page 20 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

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F 880	Continued From page 21 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility had a census of 86 residents. Based on observation, record review, and interview the facility failed to adhere to infection control for enhanced barrier precautions (EBP -an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities), for Resident (R)5, who had an open wound on her right calf. This placed the resident at risk for infection. Findings included: - On 10/01/24 at 12:10 PM observation revealed License Nurse (LN) G entered the room of R5, who was on enhanced barrier precautions. A sign was posted on the wall of the resident's room giving instructions on personal protection equipment (PPE-gown and gloves). The room had a metal storage bin affixed to the wall upon entrance to the resident's room with PPE supplies. Continued observation revealed LN G entered the resident's room and donned gloves. LN G elevated the resident's right leg off the pillow and removed part of the dressing to reveal the resident's open draining wound on her calf with serosanguineous (semi-thick blood-tinged)-drainage) noted onto the pillow. LN G stated she would return later to replace the dressing after she administered pain medication to the resident and the resident shook her head yes. LN G verified she had not worn full PPE in the EBP room and was not aware she had to.	F 880			

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F 880	Continued From page 22 On 10/01/24 at 12:30 PM interview with LN G verified R5's entrance door had an "Enhanced Barrier Isolation" sign with the initials "EBP" posted on the door frame, R5's room had instructions on the wall for wearing appropriate PPE. LN G verified staff should wear appropriate PPE when providing care for the resident. On 10/01/24 at 04:00 PM interview with Administrative Nurse D verified the staff should wear PPE when providing care for R5 and verified they would immediately go and do some education with the staff in regard to the EBP and wearing PPE for the resident care. The facility's "Enhanced Barrier Precautions in Skilled Nursing Communities" policy, dated 03/2024, documented the facility would fully implement EBP in accordance with CMS regulatory requirements for F880. EBP in addition to "Standards and Contact Precautions," shall be implemented during high contact resident care activities when caring for residents that have an increased risk for acquiring and/or transmitting a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices and residents with colonization with n MDRO. The purpose is to prevent opportunities for the transfer of MDROs to associate's hands and clothing during care. EBP expands the use of PPE and refers to the use of gowns and gloves during high-contact resident care activities that provide an opportunity for transfer of MDROs to staff hands and clothing. The facility failed to adhere to infection control standards and policies for R5 who required enhanced barrier precautions. This placed the	F 880			

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F 880	Continued From page 23 resident at risk for infection.	F 880			