STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205064	A. BUILDING _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS MANOR	758 BROADWAY BANGOR, ME 04401

(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 From 5/13/24 through 5/16/24, on-site visits were conducted at Ross Manor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00047390, #ME00047255, #ME00046156, #ME00045848, #ME00045287, and #ME00043846. It was determined that Ross Manor is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	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.	F 550		

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

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F 550	Continued From page 1	F 550		

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.

§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:
Based on observations and interviews, the facility failed to ensure that a resident requiring feeding assistance was done in a dignified manner for 1 of 2 residents observed requiring feeding assistance (Resident #28 [R28]).

Finding:

On 5/16/24 between 8:28 a.m. through 8:35 a.m., a surveyor observed Certified Nursing Assistant #2 (CNA2) feeding R28 while standing at the side of the table, facing away from R28, talking to another staff. CNA2 used a spoon to pick up food, looked at R28 briefly to find placement of food in R28's mouth, then looked away and continued conversation with another staff.

On 5/16/24 at 8:40 a.m., in an interview with CNA2, a surveyor confirmed the above finding.

On 5/16/24 at 8:56 a.m. in an interview with Registered Nurse #2, a surveyor confirmed the

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F 550	Continued From page 2 above finding that CNA2 was not feeding R28 in a dignified manner.	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests	F 551		

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F 551	Continued From page 3	F 551		

of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to review an Advance Beneficiary Notice with a resident's legal guardian for 1 of 4 residents reviewed for beneficiary notices (Resident #147 [R147]). This had the potential to prevent R147's right to appeal discharge.

Findings:

On 05/15/24, record review indicated R147's admitting diagnosis included bimalleolar fracture of right ankle and intellectual disability. Therapy

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F 551	Continued From page 4 documentation dated 11/4/23 indicated R147 "is intellectually challenged and functions at a 5 year old level." The record identified a legal guardian as the responsible party for medical and financial decisions. However, the record revealed that on 12/16/23 the Advance Beneficiary Notice was signed by R147, not the legal guardian. On 5/15/24 at 11:40 a.m., in an interview with a surveyor, the Licensed Social Worker stated R147 should not have signed, R147 was not able to. On 05/15/24 at 12:16 p.m., in an interview with a surveyor, the Program Director of Therapy stated the notice should have been signed by the legal guardian. At this time a surveyor confirmed the Advance Beneficiary Notice was not reviewed with the legal guardian.	F 551		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		

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residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was accurate in the electronic record for 2 of 6 residents reviewed for advanced directives (Resident #53 [R53] and Resident #68 [R68]).

Findings:

1. On 05/13/24 at 2:05 p.m., review of R53's electronic record revealed a face sheet and provider order indicated under the advanced directive heading, "CPR, Full Code". Review of

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F 578	Continued From page 6 R53's paper chart revealed a form signed by the R53's power of attorney on 1/12/24 indicating the code status of do not resuscitate (DNR). On 05/14/24 at 10:34 a.m., in an interview with a surveyor, the Director of Nursing reviewed R53's electronic and paper record and confirmed that R53's clinical record contained two different directions for code status. 2. On 05/14/24 at 10:16 a.m., review of R68's electronic record revealed a face sheet which indicated under the advanced directive heading, "CPR". The provider order reflected full code status. Review of R68's paper chart revealed a form signed by the R68 on 2/17/24 indicating the code status of do not resuscitate (DNR). On 05/14/24 at 10:34 a.m., in an interview with a surveyor, the Director of Nursing reviewed R68's electronic and paper record and confirmed that R68's clinical record contained two different directions for code status.	F 578		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		

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F 640	Continued From page 7 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to transmit a quarterly and annual	F 640		

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F 640	Continued From page 8 Minimum Data Set 3.0 (MDS) electronically to the State MDS database within 14 days of completion for 2 of 2 sampled residents reviewed for Resident Assessment (Resident#3 [R3], Resident#4 [R4]). Findings: On 5/15/24 at 1:52 p.m., during an interview with a surveyor, the MDS Registered Nurse (RN) and a surveyor reviewed the following: 1. R3's annual MDS was completed on 4/2/24. The clinical record lacked evidence of this being transmitted to the State MDS database. 2. R4's quarterly MDS was completed on 4/2/24. The clinical record lacked evidence of this being transmitted to the State MDS database. During this interview, the MDS RN submitted the above MDS and they were accepted.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		

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F 644	Continued From page 9 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to incorporate recommendations from the Preadmission Screening Resident Review (PASARR) level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 1 sampled resident (Resident #77 [R77]). Finding: On 05/14/24 at 8:25 a.m., during a record review of R77's record, the PASARR II dated 3/7/24 has the PASRR determination explanation the R77 met the State of Maine's definition for serious mental illness due to a diagnosis of schizoaffective disorder, anxiety disorder and major depressive disorder, these diagnosis has led to intermittent functional limitations in interpersonal functioning, concentration or adaptation to change causing significant distress and impairment in R77's ability to function independently. R77's PASRR recommended: "Specialized services for ongoing service or support with ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. Rehabilitative services: Service or Support for socialization/leisure/recreation activities, family involvement in R77's care and	F 644		

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F 644	Continued From page 10 supportive counseling from nursing facility staff. On 05/16/24 at 9:11 a.m., in an interview with the Licensed Social Worker conditional (LSW), She stated that she was new to working with PASRR level II's, she was used to the level II's having to do with therapy and not psychiatry. She stated because she was unfamiliar with what she had to do, and confirmed she hadn't done anything. As of 5/16/24, an order was received for a referral to a local psychiatrist for geriatric psych services and psych evaluations and to treat as appropriate.	F 644		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		

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F 676	Continued From page 11 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide services to maintain and/or improve residents' highest level of functional mobility. The facility failed to provide Resident Restorative Nursing as outlined in care plan for 1 of 1 sampled resident (Resident #87 [R87]). Finding: Resident #87's care plan for need/preference, approach, goal dated 3/28/24 that directs staff to "establish a restorative nursing program for me". R87's Restorative charting has an order for "Nursing Rehab/Functional Maintenance Plan: PASSIVE RANGE OF MOTION DATE: 5/2/24 PROBLEM: Decreased range of motion/functional mobility r/t (related to): Disease process, GOAL: Resident will have no further loss of ROM (range of motion)/functional mobility x 3 months INTERVENTIONS: Perform PROM (passive range of motion) to LE (lower extremities) for 15 minutes QD (every day).	F 676		

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F 676	Continued From page 12 The facility was not able to provide any documented evidence that R87 received his/her PROM as directed by his/her Restorative plan on 4/1/24, 4/2/24, 4/4/24 through 4/7/24, 4/9/24 through 4/16/24, 4/20/24, 4/21/24, 4/24/24, 4/25/24, 4/27/24, 4/28/24, 4/30/23, 5/2/24 through 5/5/24, and from 5/8/24 through 5/15/24, 34 of 45 days. On 5/16/24 at 9:21 a.m., during an interview with the Director of Nursing a surveyor confirmed the above finding.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure physicians orders were followed for the use of sliding scale insulin order for 1 of 5 residents reviewed for unnecessary medications. (Resident#19 [R19], Resident #51 [R51]). Findings: 1. R19's clinical record contained a physician order to check blood sugar levels 4 times a day	F 684		

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and a physician order to use sliding scale Insulin Aspart for Blood Glucose (BS) readings of 201-250 give 4 units, 251 - 300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, greater than 400 call physician for administration instructions.

A review of R19's Task Med Tech Medication Administration Record, (MAR) for May 2024 has the following documented:

On 5/3/24 at 11:00 a.m., documentation showed that R19's BS was 254; documentation shows that R19 received 4 units of Aspart Insulin. The sliding scale indicates that for a BS of 254 he/she should have received 6 units of Aspart Insulin for coverage at that time.

On 5/4/24 at 8:00 a.m., documentation showed that R19's BS was 90; documentation shows that R19 received 4 units of Aspart Insulin. The sliding scale indicates that R19 should not have received any Aspart Insulin coverage at that time.

On 5/5/24 at 11:00 a.m., documentation showed that R19's BS was 276; documentation shows that R19 received 4 units of Aspart Insulin. The sliding scale indicates that R19 should have received 6 units of Aspart Insulin for coverage at that time.

On 5/12/24 at 4:00 p.m., documentation showed that R19's BS was 266; documentation shows that R19 did not receive any Aspart Insulin. The sliding scale indicates that R19 should have received 6 units of Aspart Insulin for coverage at that time.

On 5/15/24 at 8:15 a.m., during an interview with

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	205064	A. BUILDING _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS MANOR	758 BROADWAY BANGOR, ME 04401

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F 684	Continued From page 14 the Director of Nursing (DON), R19's MAR was reviewed, and the above findings were confirmed by the surveyor. 2. R51's clinical record contained a physician order to check blood sugar (BS) levels 4 times a day and a physician order to use Insulin Lispro for BS readings greater than 300. If BS is greater that 300 give 5 units of Lispro. A review of R51's MAR for May 2024 has the following documented: On 5/11/24 at 4:00 p.m., documentation showed that R51's BS was 165; documentation shows that R51 received 5 units of Lispro. R51 should not have received Lispro 5 units for coverage at that time because BS was below 300. On 5/16/24 at 10:44 a.m., during an interview with the DON, a surveyor reviewed the MAR for R51 with the DON and confirmed the above finding.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide supervision for resident safety when they sent a resident out to an	F 689		

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F 689	Continued From page 15 appointment in the community independently for 1 of 1 residents reviewed (Resident # 147 [R147]). Findings: On 5/15/24, record review indicated R147's admitting diagnosis included bimalleolar fracture of right ankle and intellectual disability. Therapy documentation dated 11/2/23, indicated R147's baseline needs include assistance from a caregiver 24 hours a day, 7 days a week for cognitive deficits, and safety awareness deficits. The record identified a legal guardian for decision making. A physician order indicated R147 was to be accompanied by a staff member for the scheduled follow up appointment on 12/14/23. On 5/15/24 at 10:40 a.m., in an interview with a surveyor, the Unit Manager stated staff did not accompany R147 to the appointment due to a miscommunication, as the facility thought a member from R147's group home would be there instead. On 5/15/24 at 10:50 a.m., in an interview with a surveyor, the Certified Nursing Assistant (CNA) stated R147 was transported to the appointment by Capitol's wheelchair van service. CNA did not accompany R147 until after the facility received phone calls of complaint for not sending staff to supervise the resident. At this time the surveyor confirmed the resident was not accompanied by a staff member to the appointment for safety and supervision.	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711		

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F 711	Continued From page 16 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 6 sampled residents (Residents #13 [R13]). Finding: Documentation in Resident #13's clinical record stated the Physician signed Physician Orders (block orders) on 2/16/24. These orders were in effect for 60 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 4/26/24. The medical record lacked evidence that the Physician reviewed and signed orders on or around 4/26/24. On 5/16/24 at 9:00 a.m. in an interview with the	F 711		

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F 711	Continued From page 17 Director of Nursing, a surveyor confirmed that the Physician Orders (block orders) were late and they are unable to find another one that was reviewed and signed as of 5/16/24.	F 711		
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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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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.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, Wound Care Policy and Procedure review, observation and interview, the facility failed to ensure that the infection control practices according to the facility's Wound Policy and Procedure during a pressure ulcer dressing

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change was followed for 1 of 2 sampled residents with a Stage 3 or higher pressure ulcer (Resident #83 [R83]).

Finding:

On 5/15/24, a review of R83's clinical record was completed. R83 is diagnosed with insulin dependent diabetes, obesity, status/post acute respiratory failure with hypoxia, kidney failure, hypotension, deep vein thrombosis, and a healing Stage 4 pressure ulcer on the sacrum.
In the physician order section, the pressure ulcer treatment is to cleanse with Normal Saline and pat dry. Apply Lotrisone cream (antifungal antibiotic and topical steroid cream) around pressure ulcer wound, pack wound with Aquacel with Silver and cover the wound with Mepilex (absorbent foam dressing). Change daily and as needed.

A review of the Wound Care Policy and Procedure indicated under the 'Steps in the Procedure', number 1, "Use disposable cloth (paper towel is adequate) to establish a clean field on the resident's overbed table. Place all items to be used during procedure on the clean field."

On 5/16/24 at 9:45 a.m., an observation of R83's dressing change, performed by Registered Nurse #1 (RN1) was done. RN1 used R83's overbed table to place her treatment supplies on. On the overbed table was a cellphone, a book, mug of water and a wash basin with used bath water. RN1 removed the washbasin. A ring of dirty wash water was left on bedside table and RN1 placed the sterile packages of sponges and Aquacel on the standing water and placed the cap to the

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F 880	Continued From page 20 Normal Saline spray bottle open side down on the soiled table. RN1 did not make a clean field on the overbed table prior to placing the treatment supplies on the table. On 5/16/24, at approximately 10:15 a.m., the surveyor discussed the lack of a clean field with RN1. RN1 confirmed she did not place a clean field on the overbed table prior to placing her treatment supplies on the table.	F 880		