STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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 A recertification survey was conducted by Healthcare Licensing and Surveys from 1/29/24 to 2/1/24. Also reviewed in the course of the survey was complaint intake WY00003756. The following common abbreviations are used throughout this document: MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse QA: Quality Assurance DON: Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and	F 576		2/23/24

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

Electronically Signed | 02/20/2024

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 576	Continued From page 1 the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure elders' right to receive mail delivery including Saturdays. The census was 37. The findings were: 1. Interviews with the resident council president of Founders Cottage on 1/30/24 at 1:44 PM revealed the facility did not distribute mail on Saturdays. 2. Interview with the resident council president of Watt Cottage on 1/30/24 at 2:09 PM revealed the facility did not distribute mail on Saturdays. 3. Interview with the resident council president of	F 576	1. We have identified that all elders were at risk for lack of mail delivery on Saturdays. All elders, including those identified in the deficiency, now receive mail daily, including Saturdays. Green House has arranged with the local post service to ensure Saturday delivery, designating Founders Cottage for mail and package delivery on Saturdays and Founders staff to deliver the mail and packages to the elders. Mail throughout the rest of the week will be delivered to the administration building with administrative staff delivering to the cottages daily.	

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F 576	Continued From page 2 Whitney cottage on 1/30/24 at 2:17 PM revealed the facility did not distribute mail on Saturdays. 4. Interview with 3 residents, including the resident council president, of Scott cottage on 1/30/24 at 2:58 PM revealed the facility did not distribute mail on Saturdays. 5. Interview with Shahbaz #5 on 1/30/24 at 2:18 PM revealed staff obtained elders' mail once per week when soomeone from the administration delivered it to the cottages. 6. Interview with the administrator on 1/31/24 at 4:53 PM revealed the mail service delivers the mail to the administration building where it was sorted by cottage and someone would deliver the mail to the individual cottages. 7. Interview with the administrative coordinator on 2/1/24 at 8:21 AM revealed mail was delivered to the administrative building and she sorted it to deliver to the individual cottages. Further interview revealed she only worked Monday through Friday and on Saturday the mail stayed locked in the mailbox until she returned on Monday.	F 576	2. Changes to prevent reoccurrence will include review of the current mail delivery policy to ensure it includes a Saturday delivery plan and staff reeducation of the policy and procedure with verbal and written attestation that the Founders Cottage staff is responsible for Saturday mail delivery and administrative staff responsible for delivery during the week. This retraining will reoccur within 2 weeks. The mail delivery carrier was educated and a sign is posted for other carrier's awareness of the procedure. 3. Monitoring of compliance will include a mail logbook that Founders staff fill out for the reception and delivery of Saturday mail/packages that will be monitored by the Quality Assurance committee weekly for the first month, then monthly for the next 2 months with 100% compliance through a 3 month period required to close the PIP.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		2/23/24

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F 610	Continued From page 3 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and facility investigation review, the facility failed to ensure a thorough investigation of injuries of unknown source for 1 of 1 sample elder (#90). The findings were: 1. According to the Centers for Medicare and Medicaid Services State Operations Manual Appendix PP last revised on 2/3/23 "...An Injury should be classified as an "injury of unknown source" when all of the following criteria are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time...Initiate an investigation of an alleged violation of abuse, neglect, exploitation, and mistreatment, including injuries of unknown source..." 2. Review of the significant change MDS assessment dated 12/27/23 showed elder #90 had short-term and long-term memory problems	F 610	1. Immediate actions: Elder #90 longer resides at our facility. Each nurse has already received individualized training on wound care policies and procedures. New hires will receive this same training and training will re-occur as needed if a deficit is identified. Training will emphasize the importance of timely reporting, thorough investigation and documentation of new wounds. 2. GH will identify if any other elders are at risk of being impacted by conducting an audit of all elders with current wounds within 14 days. This report will be performed by the QA and/or wound nurse and shared with the DON and Administrator upon completion and with the QA team at the next QA meeting. 3. The QA nurse and/or the Wound nurse will monitor new wounds for the proper reporting, investigation, and documentation of all new wounds with audits completed weekly the first month and monthly for 2 months to ensure proper documentation exists and investigations are initiated and completed as required. Findings will be shared with	

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F 610	Continued From page 4 and diagnoses which included Parkinson's disease with dyskinesia, pain, and a personal history of diseases of the skin and subcutaneous tissue. The elder had a functional limitation in range of motion on one side of lower extremities, required substantial/maximal assistance for rolling left and right, moving from sitting to lying, moving from lying to sitting, moving from sitting to standing, and transfers. Further review showed the elder was at risk for pressure injury development and was marked as having no skin issues. Review of the care plan last revised on 1/9/24 showed the resident had potential for impaired skin integrity related to Parkinson's disease, impaired mobility, and a "Braden" score of 15, which indicated a mild risk for skin breakdown. Further review showed the resident had a "Large hematoma L [left] shin" The following concerns were identified: a. Review of a "Late Entry" progress note dated 11/23/23 and timed 3:30 AM showed "...This nurse and Shahbaz went in to do rounds on elder...As Shahbaz was drying off the elder I noticed a bruise to left lower leg. Upon assessment of the area it was fluid filled, was cool to the touch and elder denied pain to area. Wound measured 4.5 cm [centimeters] by 3 cm. Applied a dressing to the area at time of assessment to protect area if blisterpops [sic] open. Wound care nurse informed family of wound and treatment plan." b. Review of a progress note dated 11/23/23 and timed 5:38 AM showed "Elder has fluid filled area to upper leg. Has bruising in area the fluid sits. Covered with foam dressing to protect if opens up..." c. Review of a progress note dated 12/11/23 and timed 4:31 AM showed "...[S/he] is incredibly uncomfortable and every time you move [his/her]	F 610	QA monthly. Reeducation will occur if deficiencies are noted. Furthermore, the wound nurse and/or QA nurse will conduct a thorough investigation of any new wounds of 'unknown origin' on an ongoing basis. Reports will be reviewed by IDT weekly and shared with QA monthly. 4. All wound care policies and procedures including significant change of condition will be reviewed with necessary updates made within 14 days by the DON, QA and/or Wound Nurse. Any updated policies will be reviewed by the Administrator and QA team at the next QA meeting.	

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F 610	Continued From page 5 leg or touch around the burn or inflammation [s/he] yelps out in pain. This is becoming increasingly concerning and the redness continues to creep down to [his/her] ankle & toes..." d. Review of a progress note dated 12/11/23 and timed 4:32 AM showed "...Elders burn on [his/her] left leg seems to be increasingly getting worse. [His/Her] shin to ankle is incredibly inflamed and is double the size of [his/her] other leg. The inflammation and burn is hot to the touch and very red..." d. Review of a progress note dated 12/15/23 and timed 9:41 AM showed "...Large hematoma to lower left leg, Black Escar [sic] with moderate purulent drainage. Pt [patient] shows signs of pain such as moaning and pulling back when area is touched. Sent to hospital for assessment, currently following wound care orders, advanced wound care to evaluate and treat on 12/18/23..." e. Review of the progress notes from 11/23/23 through 12/27/23 showed no evidence the source of the injury was identified or an investigation for origin was initiated. 3. Review of the facility's investigation showed it was initiated on 12/13/23, 20 days after the first documented wound note. Further review showed the investigation was completed related to the wound deterioration and change of condition resulting in hospitaliztion, from 12/8/23 through 12/11/23. There was no evidence the wound source was investigated or identified. 4. Interview with Shahbaz #1 on 1/31/24 at 2:53 PM revealed elder #90 developed a wound after s/he was assisted to bed and his/her leg was positioned against the heater; however, she was not aware when the incident had occurred. The	F 610		

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F 610	Continued From page 6 Shahbaz revealed the resident developed a wound in the area where his/her leg was positioned against the heater; however, some nurses indicated it was a hematoma and others indicated it was a burn. 5. Interview with LPN #1 on 1/31/24 at 7:17 PM revealed resident #90 had received a burn to his/her shin when the elder's leg had been hanging off the bed and positioned on the heater vent; however, he was not on shift when it was discovered. The LPN revealed the facility had been performing dressing changes for "a week or two;" however, the wound had deteriorated from what originally appeared as blistering with discoloration to the presence of eschar (dead tissue that forms over healthy skin and then, over time, falls off). 6. Interview with Shahbaz #2 on 1/31/24 at 7:40 PM revealed she was caring for the elder on the day s/he obtained the wound; however, she did not recall the date. The Shahbaz revealed she attempted to get the nurse on shift to assess the elder's leg as the Shahbaz had found the elder with his/her leg wrapped in a blanket and positioned up against the heater. The Shahbaz revealed the blanket and the elder's leg were both hot to the touch and the elder developed a blister in the area. The Shahbaz revealed the nurse observed the area twice; however, there was no documentation in the record on the date the incident occurred. The Shahbaz revealed she was told the wound being caused by a burn was speculation. 7. Interview with the wound care nurse on 2/1/24 at 8:33 AM revealed elder #90's wound was first identified on a night shift; however, she did not	F 610		

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F 610	Continued From page 7 know the date. She confirmed it was reported the elder's leg was wrapped in a blanket, against the heater, and the blanket was warm to the touch. The wound care nurse revealed initially the area appeared to be a blister with the peri area intact; however, it then began to drain the fluid. She revealed the facility was observing the area daily and during the weekend of 12/8/23 through 12/11/23 the nurse reported the area was redder and more inflamed. The wound nurse revealed she classified the wound as unstageable and the hospital called it a hematoma; however, the facility was unable to identify an origin. She confirmed one thought was the wound could have been a burn; however, physical therapy did not believe it was and the hospital did not classify it as a burn. 8. Interview with the RN QA/Educator on 1/31/24 at 5:42 PM revealed the facility identified concerns with elder #90's wound deterioration and change of condition which resulted in hospitalizaltion, and as a result, initiated an investigation on 12/13/23, 20 days after the first wound note was documented. She revealed during the investigation, the facility was unable to identify a wound origin and she revealed she did not observe the wound until after the investigation was initiated, following the elder's return from the hospital.	F 610		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

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F 658	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility investigation review, performance improvement plan review, professional standard review, and policy review, the facility failed to ensure timely care and treatment was provided for 1 of 5 sample elders (#90) reviewed for skin conditions. This failure resulted in actual harm to elder #90 who developed a wound infection and had delayed hospitalization. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 1/5/24. The findings were: 1. Review of the significant change MDS assessment dated 12/27/23 showed elder #90 had short-term and long-term memory problems and diagnoses which included Parkinson's disease with dyskinesia, pain, and a personal history of diseases of the skin and subcutaneous tissue. The elder had a functional limitation in range of motion on one side of lower extremities, required substantial/maximal assistance for rolling left and right, moving from sitting to lying, moving from lying to sitting, moving from sitting to standing, and transfers. Further review showed the elder was at risk for pressure injury development and was marked as having no skin issues. Review of the care plan last revised on 1/9/24 showed the resident had potential for impaired skin integrity related to Parkinson's disease, impaired mobility, and a "Braden" score of 15, which indicated a mild risk for skin breakdown. Further review showed the resident had a "Large hematoma L [left] shin" The following concerns were identified: a. Review of a "Late Entry" progress note dated 11/23/23 and timed 3:30 AM showed	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 9 "...This nurse and Shahbaz went in to do rounds on elder...As Shahbaz was drying off the elder I noticed a bruise to left lower leg. Upon assessment of the area it was fluid filled, was cool to the touch and elder denied pain to area. Wound measured 4.5 cm [centimeters] by 3 cm. Applied a dressing to the area at time of assessment to protect area if blisterpops [sic] open. Wound care nurse informed family of wound and treatment plan." b. Review of a "Late Entry" progress note dated 12/9/23 and timed 2:10 AM showed "...wound nurse contacted via email regard L lower shin wound. Read as follows: Hi [wound nurse name], [room number]'s wound looks fairly concerning. The bottom part of the wound is open and red. There's a fair amount of edema in [his/her] ankle and feet, and when you handle the dressing, you can tell it's pretty painful for [him/her]. In the middle of this wound it also feels unnaturally warm, almost hot. I had to get the last allevyn dressing changed tonight, but I didn't see where there were anymore, so I applied an ABD [abdominal] pad held in place with kerlix wrap. Sorry! That's really all I had. Thought you should know. Wound nurse replied at 1049 [10:49 AM] as follows: Hi [nurse name], I sent an email to purpose [sic] to hopefully be available to take a look Monday, however I'd [sic] it continues to get worse please send a cerner [email] and escalate the problem. If [s/he] is showing signs of infection I think it best if [s/he] is evaluated by a provider. Please monitor closely. Thank you, [wound nurse name]. On shift nurse replied once more at 2344 [11:44 PM] stating: Will do [wound nurse name]. I had to change the dressing again tonight, it doesn't look quite as bad as yesterday night. The wound appears pretty much the same, but the pain was a little less when handling [his/her] leg,	F 658		

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F 658	Continued From page 10 and there wasn't the localized warmth that I noticed last night. There was I would say a moderate amount of serous drainage on the old pad. When applying the ABD pad, I applied a generous amount of TAO [triple antibiotic ointment], if that'll help..." c. Review of a progress note dated 12/11/23 and timed 4:31 AM showed "...[S/he] is incredibly uncomfortable and every time you move [his/her] leg or touch around the burn or inflammation [s/he] yelps out in pain. This is becoming increasingly concerning and the redness continues to creep down to [his/her] ankle & toes..." d. Review of a progress note dated 12/11/23 and timed 4:32 AM showed "...Swelling in left leg diminished, there still is edema right near the edges of wound. Appearance of wound has not changed. No localized warmth noted, and when elder turned in bed [s/he] did not yell out "ow!" like [s/he has been doing the past couple of nights. Silicone hyrcocellular [sic] dressings remain. Previous dressing that was applied Saturday night had gotten frazzled and needed to be replaced. Only a moderate amount of serous drainage noted. Will report to wound nurse..." e. Review of a progress note dated 12/11/23 and timed 4:32 AM showed "...Elders burn on [his/her] left leg seems to be increasingly getting worse. [His/Her] shin to ankle is incredibly inflamed and is double the size of [his/her] other leg. The inflammation and burn is hot to the touch and very red..." f. Review of a progress note dated 12/11/23 and timed 12:49 PM showed "Advance wound care was with nurse to assess the wound. When bandage was taken off wound bed was red, inflamed and had moderate purulent drainage. Wound bed also had areas of necrotic skin and a	F 658		

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F 658	Continued From page 11 black whole [sic] to what advanced wound care noted as bone. Dispatch was called right away and elder was sent to ER [emergency room]. POA [Power of Attorney] was notified and incident protocol was initiated..." g. Review of a progress note dated 12/13/23 and timed 3:42 PM showed the elder returned from the hospital and an advanced wound care referral request was initiated. h. Review of a progress note dated 12/15/23 and timed 9:41 AM showed "...Large hematoma to lower left leg, Black Escar [sic] with moderate purulent drainage. Pt [patient] shows signs of pain such as moaning and pulling back when area is touched. Sent to hospital for assessment, currently following wound care orders, advanced wound care to evaluate and treat on 12/18/23 [5 days after the elder's return to the facility]..." 2. Interview with Shahbaz #1 on 1/31/24 at 2:53 PM revealed elder #90 had and area which developed into a wound, became infected, and resulted in the elder's hospitalization. The Shahbaz revealed when the elder returned from the hospital, his/her family initiated comfort care and the elder passed away. 3. Interview with LPN #1 on 1/31/24 at 7:17 PM confirmed he was the night nurse on 12/8/23 through 12/11/23 who was assigned care to elder #90. The LPN revealed the resident had received a burn to his/her shin when the elder's leg had been hanging off the bed and positioned on the heater vent; however, he was not on shift when it was discovered. The LPN revealed the facility had been performing dressing changes for "a week or two;" however, the wound had deteriorated from what originally appeared as blistering with discoloration to the presence of	F 658		

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F 658	Continued From page 12 eschar (dead tissue that forms over healthy skin and then, over time, falls off). The LPN revealed when he was caring for the resident from the evening of 12/8/23 through the morning of 12/9/23, he notified the wound care nurse of an increase in the elder's pain, a fair amount of drainage, and localized warmth to the wound, and was told to monitor the wound and notify the provider if it worsened. The LPN revealed on the Saturday (12/9/23) evening through Sunday 12/10/23 morning shift, the localized warmth was not as severe and the elder's wound continued to have drainage. The LPN revealed on 12/10/23 he did not observe signs of deterioration; however, he confirmed on 12/11/23 the elder was transferred to the hospital after he left the facility. The LPN confirmed he did not call the physician and was unable to say why he notified the wound nurse instead. He stated he may have "messaged" the physician at that time; however, he could not remember. The LPN revealed the facility policy was to notify the physician if an elder had a need for immediate medical treatment and he confirmed the resident was diagnosed with and infection resulting in treatment while at the hospital. The LPN revealed the elder's wound improved when s/he returned; however, s/he was placed on comfort measures and passed away. Further interview revealed the elder was gradually declining and the wound made day-to-day living more difficult. 4. Interview with Shahbaz #2 on 1/31/24 at 7:40 PM revealed elder #90 had an area with a blister on his/her leg and after the "blister popped," the elder developed an infection and was sent to the hospital for treatment. The Shahbaz stated the elder was in a lot of pain and would cry, as a result of the wound. The Shahbaz confirmed the	F 658		

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F 658	Continued From page 13 elder was placed on comfort care and passed away after s/he returned from the hospital. 5. Interview with the wound care nurse on 2/1/24 at 8:33 AM revealed elder #90's wound was first identified on a night shift; however, she did not know the date. She revealed initially the area appeared to be a blister with the peri area intact; however, it then began to drain the fluid. She revealed the facility was observing the area daily and during the weekend of 12/8/23 through 12/11/23 the nurse reported the area was more red and more inflamed. She revealed she recommended the nurse escalate it to the provider if it worsened. The wound nurse revealed when she returned on Monday, the area had hardened and deteriorated and the elder was admitted to the hospital. Further interview revealed triple antibiotic ointment and an abdominal pad were not an appropriate treatment for the wound and she would expect the nurses to send an elder out for treatment based on what the nurse had reported to her about the wound's condition and what she observed the following Monday. 6. Interview with the RN QA/Educator on 1/31/24 at 5:42 PM revealed the facility identified concerns with elder #90's wound deterioration and change of condition and as a result initiated an investigation on 12/13/23. She revealed when the investigation was complete, education was provided to all nurses related to wound assessment, wound care, and change of condition. She revealed during the investigation, the facility was unable to identify a wound origin and she revealed she did not observe the wound until after the investigation was initiated, following the elder's return from the hospital. She revealed	F 658		

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F 658	Continued From page 14 the expectation was for nurses to notify the physician and family any time there was a change of condition. She revealed LPN #1 notified the physician via cerner, which was an email system; however, in this situation the physician should have been notified via telephone or sent to the ER. She revealed the LPN should not have delayed the resident's treatment and confirmed the elder's treatment was delayed as a result of the nurse's failure to notify the physician or transport to the ER. She revealed corrective action included education and disciplinary action for the LPN. She revealed the facility identified all residents were potentially at risk and as a result the entire staff was educated as part of the facility's system changes. She revealed additional system changes included hiring another nurse to create a wound team. She revealed the facility was monitoring for compliance through weekly audits for wound care, change of condition, and physician notification and were reviewing audits in QA. Further interview revealed the facility's plan was implemented on 1/5/24. 7. Review of the "Change in Elder Condition" policy last updated 12/14/23 showed "...1. The Nurse will notify the elder's Attending Physician or On-Call Physician when there has been: ...d. A significant change in the elder's physical/emotional/mental condition. e. A need to alter the elder's medical treatment significantly...g. A need to transfer the elder to a hospital/treatment center..." 8. According to Perry, Potter, Ostendorf in "Nursing Interventions & Clinical Skills", 7th edition, 2020, page 654: "Wound Care and Irrigation...Safe Patient Care...Compare the wound assessment to previous assessment and	F 658		

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F 658	Continued From page 15 determine progress toward healing. If there is no movement toward healing or if you notice deterioration, consider a wound care consultation. Lack of wound healing is often related to infection. Notify health care provider and wound, ostomy, continence nurse or wound care team..." 9. Review of the facility's investigation showed it was initiated on 12/13/23. The following interventions were implemented: a. LPN #1 received disciplinary action. In addition, the nurse received individual training and signed off on understanding on 1/5/24. b. Quality performance audits were initiated on 1/1/24 to review family/power of attorney notification, physician notification, elder change of condition and transfer, and wound nurse notification. Review of the Facility QAPI meeting minutes performance improvement plan discussed on 1/10/24 confirmed the audits were implemented. c. All nurses were educated on 1/5/24. d. Facility wound care policy updated on 1/5/24. e. Facility compliance was determined to be met on 1/5/24 when all nurses were educated, including LPN #1 and the wound care policy was updated. All other interventions were implemented prior to 1/5/24.	F 658		
F 684 SS=G	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	F 684		

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F 684	Continued From page 16 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 medical record review, staff interview, facility investigation review, performance improvement plan review, and policy review, the facility failed to implement interventions and treatment to prevent the deterioration of wounds for 1 of 5 sample elders (#90) reviewed for skin conditions. This failure resulted in actual harm to elder #90 who developed a wound infection and had delayed hospitalization. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 1/5/24. The findings were: 1. Review of the significant change MDS assessment dated 12/27/23 showed elder #90 had short-term and long-term memory problems and diagnoses which included Parkinson's disease with dyskinesia, pain, and a personal history of diseases of the skin and subcutaneous tissue. The elder had a functional limitation in range of motion on one side of lower extremities, required substantial/maximal assistance for rolling left and right, moving from sitting to lying, moving from lying to sitting, moving from sitting to standing, and transfers. Further review showed the elder was at risk for pressure injury development and was marked as having no skin issues. Review of the care plan last revised on 1/9/24 showed the resident had potential for impaired skin integrity related to Parkinson's disease, impaired mobility, and a "Braden" score of 15, which indicate a mild risk for skin breakdown. Further review showed the resident had a "Large hematoma L [left] shin" The	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 17 following concerns were identified: a. Review of a "Late Entry" progress note dated 11/23/23 and timed 3:30 AM showed "...This nurse and Shahbaz went in to do rounds on elder...As Shahbaz was drying off the elder I noticed a bruise to left lower leg. Upon assessment of the area it was fluid filled, was cool to the touch and elder denied pain to area. Wound measured 4.5 cm [centimeters] by 3 cm. Applied a dressing to the area at time of assessment to protect area if blisterpops [sic] open. Wound care nurse informed family of wound and treatment plan." b. Review of a progress note dated 11/23/23 and timed 5:38 AM showed "Elder has fluid filled area to upper leg. Has bruising in area the fluid sits. Covered with foam dressing to protect if opens up. c. Review of a progress note dated 11/23/23 and timed 1:37 PM showed "Skin Condition Observed via Shahbaz-Nursing to observe and document observation for new skin observations. Nurse observed left shin. Area is fluid filled and tender to touch. Area is covered with bandage for protection. Compression socks not applied." d. Review of a progress note dated 11/25/23 and timed 11:03 AM showed "L [left} lateral shin with dk [dark] purple bruising. Fluid noted to epidermal layer. Approximated edges with erythema/warmth 15x6cm [sic]. Tagederm [sic] in place per/noc [per night] shift. Elder to state discomfort when gently pressed. PRN Tylenol administered. This was stated byelder [sic] to be effective. Fluids encouraged." e. Review of a progress note dated 11/26/23 and timed 2:45 PM showed "Large bruise noted on L lower extremity with fluid filled blister on top. Slight clear drainage noted during dressing change. Wound in tact [sic] and cool to touch, pt	F 684		

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F 684	Continued From page 18 [patient] states wound only hurts when touched. See PCC [point click care] picture for measurement, Standing orders initiated." f. Review of the "Point Click Care Wound Evaluation" dated 11/26/23 and timed 2:20 PM showed the elder appeared to have a discolored area to the lower left leg which started just below the knee. The area had red and purple discoloration on the upper portion and what appeared to be a fluid filled area toward the bottom. Further review showed the area measured 12.57 cm by 5.27 cm. g. Review of a "Point Click Care Wound Evaluation" dated 11/30/23 and timed 3:39 PM showed the elder appeared to have a discolored area to the lower left leg which started just below the knee. The area had red and purple discoloration throughout and what appeared to be an open area toward the bottom. Further review showed the area measured 15.81 cm by 6.39 cm. h. Review of a progress note dated 12/1/23 and timed 1:42 PM showed "...large bruise on L shin with popped blister on top. Pictures in PCC. Scant drainage no s/s [signs or symptoms] of infection. Provider notified..." i. Review of a "Point Click Care Wound Evaluation" dated 12/4/23 and timed 3:42 PM showed the elder appeared to have a discolored area to the lower left leg which started just below the knee. The area had red and purple discoloration throughout with a larger open area toward the bottom. Further review showed the area measured 19.34 cm by 6.55 cm. j. Review of a progress note dated 12/7/23 and timed 1:01 PM showed "Large bruising on L shin with popped blister on top. Bottom of blister is open. Scant drainage still occurring. Red and inflamed. Not hot to touch, pt has no fever. Pt reports pain on [his/her] leg. Provider notified..."	F 684		

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F 684	Continued From page 19 k. Review of a "Late Entry" progress note dated 12/9/23 and timed 2:10 AM showed "...wound nurse contacted via email regard L lower shin wound. Read as follows: Hi [wound nurse name], [room number]'s wound looks fairly concerning. The bottom part of the wound is open and red. There's a fair amount of edema in [his/her] ankle and feet, and when you handle the dressing, you can tell it's pretty painful for [him/her]. In the middle of this wound it also feels unnaturally warm, almost hot. I had to get the last allevyn dressing changed tonight, but I didn't see where there were anymore, so I applied an ABD [abdominal] pad held in place with kerlix wrap. Sorry! That's really all I had. Thought you should know. Wound nurse replied at 1049 [10:49 AM] as follows: Hi [nurse name], I sent an email to purpose [sic] to hopefully be available to take a look Monday, however I'd [sic] it continues to get worse please send a cerner [email] and escalate the problem. If [s/he] is showing signs of infection I think it best if [s/he] is evaluated by a provider. Please monitor closely. Thank you, [wound nurse name]. On shift nurse replied once more at 2344 [11:44 PM] stating: Will do [wound nurse name]. I had to change the dressing again tonight, it doesn't look quite as bad as yesterday night. The wound appears pretty much the same, but the pain was a little less when handling [his/her] leg, and there wasn't the localized warmth that I noticed last night. There was I would say a moderate amount of serous drainage on the old pad. When applying the ABD pad, I applied a generous amount of TAO [triple antibiotic ointment], if that'll help..." l. Review of a progress note dated 12/11/23 and timed 4:31 AM showed "...[S/he] is incredibly uncomfortable and every time you move [his/her] leg or touch around the burn or inflammation	F 684		

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F 684	Continued From page 20 [s/he] yelps out in pain. This is becoming increasingly concerning and the redness continues to creep down to [his/her] ankle & toes..." m. Review of a progress note dated 12/11/23 and timed 4:32 AM showed "...Swelling in left leg diminished, there still is edema right near the edges of wound. Appearance of wound has not changed. No localized warmth noted, and when elder turned in bed [s/he] did not yell out "ow!" like [s/he has been doing the past couple of nights. Silicone hyrcocellular [sic] dressings remain. Previous dressing that was applied Saturday night had gotten frazzled and needed to be replaced. Only a moderate amount of serous drainage noted. Will report to wound nurse..." n. Review of a progress note dated 12/11/23 and timed 4:32 AM showed "...Elders burn on [his/her] left leg seems to be increasingly getting worse. [His/Her] shin to ankle is incredibly inflamed and is double the size of [his/her] other leg. The inflammation and burn is hot to the touch and very red..." o. Review of a progress note dated 12/11/23 and timed 12:49 PM showed "Advance wound care was with nurse to assess the wound. When bandage was taken off wound bed was red, inflamed and had moderate purulent drainage. Wound bed also had areas of necrotic skin and a black whole [sic] to what advanced wound care noted as bone. Dispatch was called right away and elder was sent to ER [emergency room]. POA [Power of Attorney] was notified and incident protocol was initiated..." p. Review of a progress note dated 12/13/23 and timed 3:42 PM showed the elder returned from the hospital and an advanced wound care referral request was initiated. q. Review of a progress note dated 12/15/23	F 684		

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F 684	Continued From page 21 and timed 9:41 AM showed "...Large hematoma to lower left leg, Black Escar [sic] with moderate purulent drainage. Pt [patient] shows signs of pain such as moaning and pulling back when area is touched. Sent to hospital for assessment, currently following wound care orders, advanced wound care to evaluate and treat on 12/18/23 [5 days after the elder's return to the facility]..." r. Review of a progress note dated 12/17/23 and timed 6:33 AM showed "...At 4am rounds this nurse noticed that the elder's dressing had moved and needed to be changed. Elder complained of pain while this writer removed the old dressing. Upon removal this writer noticed the wound bed was black in color and around 6 inches long. Attempted to clean the wound with wound wash per wound nurse's orders but elder could not tolerate and was in pain. Unable to locate zincpaste [sic] in the elder's room or in the nurses office. Attempted to apply med honey per wound nurse orders but again elder was in too much pain to continue. Applied antimicrobial dressings per wound nurse orders. This writer brought her concerns to the day shift nurse. Wound nurse notified as well as management..." Review of a progress note dated 12/17/23 and timed 2:09 PM showed "...Wound nurse received email stating concerns on dressing application. Looked over dressing and noted that dressing was put on well. Wrapping is still in place and no drainage is noted through wrapping. Emailed DON informing her that advanced wound care will be here on 12/18/23 to treat and evaluate lower L wound..." s. Review of a progress note dated 12/20/23 and timed 2:39 PM showed "...Large hematoma to lower left leg, Black Escar [sic] with moderate purulent drainage. Pt shows signs of pain such as moaning and pulling back when area is touched.	F 684		

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F 684	Continued From page 22 Evaluated with advanced wound care- Change in orders per recommendations..." t. Review of a "Late Entry" progress note dated 12/27/23 and timed 11:11 AM showed the elder was placed on comfort care due to the elder's family "...does not like seeing Elder in pain and would like to improve [his/her] quality of life..." Review of a progress note dated 1/6/23 and timed 12:35 AM showed the elder passed away. 2. Interview with Shahbaz #1 on 1/31/24 at 2:53 PM revealed when elder #90 developed the wound, s/he was assisted to bed and his/her leg was positioned against the heater; however, she did not recall the date of the incident. The Shahbaz revealed when the elder's position was identified, the elder was repositioned, and the nurse was notified. The Shahbaz revealed the resident developed a wound in the area where his/her leg was positioned against the heater; however, some nurses indicated it was a hematoma and others indicated it was a burn. The Shahbaz indicated the area developed into a wound which became infected and the elder was hospitalized. The Shahbaz revealed when the elder returned from the hospital, his/her family initiated comfort care and the elder passed away. 3. Interview with LPN #1 on 1/31/24 at 7:17 PM confirmed he was the night nurse on 12/8/23 through 12/11/23 who was assigned care to elder #90. The LPN revealed the resident had received a burn to his/her shin when the elder's leg had been hanging off the bed and positioned on the heater vent; however, he was not on shift when it was discovered. The LPN revealed the facility had been performing dressing changes for "a week or two;" however, the wound had	F 684		

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F 684	Continued From page 23 deteriorated from what originally appeared as blistering with discoloration to the presence of eschar (dead tissue that forms over healthy skin and then, over time, falls off). The LPN revealed when he was caring for the resident from the evening of 12/8/23 through the morning of 12/9/23, he notified the wound care nurse of an increase in the elder's pain, a fair amount of drainage, and localized warmth to the wound, and was told to monitor the wound and notify the provider if it worsened. The LPN revealed on the Saturday (12/9/23) evening through Sunday 12/10/23 morning shift, the localized warmth was not as severe and the elder's wound continued to have drainage. The LPN revealed on 12/10/23 he did not observe signs of deterioration; however, he confirmed on 12/11/23 the elder was transferred to the hospital after he left the facility. The LPN confirmed he did not call the physician and was unable to say why he notified the wound nurse instead. He stated he may have "messaged" the physician at that time; however, he could not remember. The LPN revealed the facility policy was to notify the physician if an elder had a need for immediate medical treatment and he confirmed the resident was diagnosed with and infection resulting in treatment while at the hospital. The LPN revealed the elder's wound improved when s/he returned; however, s/he was placed on comfort measures and passed away. Further interview revealed the elder was gradually declining and the wound made day-to-day living more difficult. 4. Interview with Shahbaz #2 on 1/31/24 at 7:40 PM revealed she was caring for the elder on the day s/he obtained the wound; however, she did not recall the date. The Shahbaz revealed she attempted to get the nurse on shift to assess the	F 684		

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F 684	Continued From page 24 elder's leg as the Shahbaz had found the elder with his/her leg wrapped in a blanket and positioned up against the heater. The Shahbaz revealed the blanket and the elder's leg were both hot to the touch and the elder developed a blister in the area. The Shahbaz revealed the nurse observed the area twice; however, there was no documentation in the record. The Shahbaz revealed she was told the wound being caused by a burn was speculation. The Shahbaz revealed after the "blister popped," the elder developed an infection and was sent to the hospital for treatment. The Shahbaz stated the elder was in a lot of pain and would cry, as a result of the wound. The Shahbaz confirmed the elder was placed on comfort care and passed away after s/he returned from the hospital. 5. Interview with the wound care nurse on 2/1/24 at 8:33 AM revealed elder #90's wound was first identified on a night shift; however, she did not know the date. She confirmed it was reported the elder's leg was wrapped in a blanket, against the heater, and the blanket was warm to the touch. The wound care nurse revealed initially the area appeared to be a blister with the peri area intact; however, it then began to drain the fluid. She revealed the facility was observing the area daily and during the weekend of 12/8/23 through 12/11/23 the nurse reported the area was more red and more inflamed. She revealed she recommended the nurse escalate it to the provider if it worsened. The wound nurse revealed when she returned on Monday, the area had hardened and deteriorated and the elder was admitted to the hospital. Upon return from the hospital, the facility treated the wound with medi-honey for debridement and as the wound progressed, the eschar moved inwards. The	F 684		

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F 684	Continued From page 25 wound nurse revealed she classified the wound as unstageable and the hospital called it a hematoma; however, the facility was unable to identify an origin. She confirmed one thought was the wound could have been a burn; however, physical therapy did not believe it was and the hospital did not classify it as a burn. The wound nurse revealed interventions implemented were the development of a wound care team, advance wound care services, and moving the elder's bed away from the heater. Further interview revealed triple antibiotic oinment and an abdominal pad were not an appropriate treatment for the wound and she would expect the nurses to send an elder out for treatment based on what the nurse had reported to her about the wound's condition and what she observed the following Monday. 6. Interview with the RN QA/Educator on 1/31/24 at 5:42 PM revealed the facility identified concerns with elder #90's wound deterioration and change of condition which resulted in hospitalization, and as a result initiated an investigation on 12/13/23, 20 days after the first wound note was documented. She revealed when the investigation was complete, education was provided to all nurses related to wound assessment, wound care, and change of condition. She revealed during the investigation, the facility was unable to identify a wound origin and she revealed she did not observe the wound until after the investigation was initiated, following the elder's return from the hospital. She revealed the expectation was for nurses to notify the physician and family any time there was a change of condition. She revealed LPN #1 notified the physician via cerner, which was an email system; however, in this situation the physician should have been notified via telephone or sent to the	F 684		

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F 684	Continued From page 26 ER. She revealed the LPN should not have delayed the resident's treatment and confirmed the elder's treatment was delayed as a result of the nurse's failure to notify the physician or transport to the ER. She revealed corrective action included education and disciplinary action for the LPN. She revealed the facility identified all residents were potentially at risk and as a result the entire staff was educated as part of the facility's system changes. She revealed additional system changes included hiring another nurse to create a wound team. She revealed the facility was monitoring for compliance through weekly audits for wound care, change of condition, and physician notification and were reviewing audits in QA. 7. Review of the "Change in Elder Condition" policy last updated 12/14/23 showed "...1. The Nurse will notify the elder's Attending Physician or On-Call Physician when there has been: ...d. A significant change in the elder's physical/emotional/mental condition. e. A need to alter the elder's medical treatment significantly...g. A need to transfer the elder to a hospital/treatment center..." 8. Review of the facility's investigation showed it was initiated on 12/13/23. The following interventions were implemented: a. LPN #1 received disciplinary action. In addition, the nurse received individual training and signed off on understanding on 1/5/24. b. Quality performance audits were initiated on 1/1/24 to review family/power of attorney notification, physician notification, elder change of condition and transfer, and wound nurse notification. Review of the Facility QAPI meeting minutes performance improvement plan	F 684		

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F 684	Continued From page 27 discussed on 1/10/24 confirmed the audits were implemented. c. All nurses were educated on 1/5/24. d. Facility wound care policy updated on 1/5/24. e. Facility compliance was determined to be met on 1/5/24 when all nurses were educated, including LPN #1, and the wound care policy was updated. All other interventions were implemented prior to 1/5/24.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on schedule review, daily staff posting review, and staff interview, the facility failed to ensure an RN was on duty for at least 8 consecutive hours a day, 7 days a week. The Census was 37. The findings were: 1. Review of the November 2023 nursing schedule showed the facility failed to ensure an RN was on duty 8 hours on the 1st, 3rd, 4th, 5th,	F 727	1. No immediate risk exists to any elders as the facility has reviewed the current staffing schedule, observing that the daily 8 hours of consecutive RN coverage has been met due to recent RN hires. Green House will maintain the required coverage to ensure the risk to elders does not arise. 2. Administrative staff, HR and staffing coordinators have been re-educated on	2/23/24

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F 727	Continued From page 28 8th, 9th, 10th, 11th, 15th, 16th, 17th, 18th, 19th, 22nd, 24th, 25th, and 29th. 2. Review of the December 2023 nursing schedule showed the facility failed to ensure an RN was on duty 8 hours on the 1st, 2nd, 3rd, 16th, 17th, 23rd, and 24th. 3. Interview with the DON on 2/1/24 at 8:38 AM confirmed the facility did have an RN shortage and additional staff were needed. She revealed due to her salary status she was unable to provide evidence of days and times she may have been at the facility on the identified days. Further interview revealed she was on leave from 12/8/23 until the week of 1/22/24 and confirmed she worked Monday through Friday.	F 727	the requirement and have signed an acknowledgement statement. 3. Policy review reflects Green House's acknowledgement that this requirement is to be met by the facility. 4. Although the current full-time staff automatically allows Green House to meet this requirement, the DON and/or staffing coordinator will monitor coverage requirements are met on an ongoing and permanent basis. HR will ensure RN staffing needs are met on an ongoing and permanent basis in order to maintain the coverage requirements. 5. RN staffing needs will be reviewed monthly by QA for the next 3 months to ensure compliance requirements are met on a long-term and permanent basis.	
F 880 SS=E	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,	F 880		2/23/24

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F 880	Continued From page 29 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 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.	F 880		

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F 880	Continued From page 30 §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 observation, staff interview, review of the Centers for Disease Control (CDC) guidance, professional reference review, and review of the policy and procedure, the facility failed to ensure staff used appropriate personal protective equipment (PPE) in 2 of 4 cottages (Founders, Scott) while in elder care areas. In addition, the facility failed to ensure proper hand hygiene was performed and failed to prevent cross-contamination during wound care for 2 of 3 sample residents (#3, #15) with wounds. The findings were: In regard to PPE use: 1. The following PPE use concerns were observed in the Scott cottage: a. Observation on 1/29/24 at 6:15 showed at the time entrance there were signs posted on the Founders cottage door indicating a need for mask use due to COVID-19. Interview with LPN #2 revealed the facility was experiencing active COVID-19 cases amongst residents. b. Interview with the DON and administrator on 1/29/24 at 6:53 PM confirmed the facility had active COVID-19 cases amongst residents and masks were to be worn in all 4 cottages. c. Observation on 1/31/24 at 9:47 AM showed Shahbaz #3 was wearing a surgical mask;	F 880	1. Immediate Actions will include immediate re-education of staff when failure to properly use masks and hand hygiene techniques is identified. 2. Signs will be placed within 1 week to remind staff how to properly perform masking and hand hygiene at strategic locations throughout the cottage buildings. 3. N95 respirators have been ordered by the administrative assistant. The IP nurse will monitor PPE needs, including N95 masks, and report to the administrative assistant for ordering as needed on an ongoing and permanent basis. The IP nurse will audit facility infection carts for proper PPE monthly. 4. All staff will be formally re-educated on proper PPE use, mask wearing technique including the proper type of mask to use, proper handwashing and when to perform hand-hygiene within 30 days. 5. The DON and IP will review all infection control policies and procedures including the wound care policy and procedure during dressing changes to ensure they are proper and up to date within 14 days. QA will review the policies at the next meeting.	

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F 880	Continued From page 31 however, mask was positioned below the Shahbaz's nose. d. Observation on 1/31/24 at 10:03 AM showed maintenance tech #1 and an unidentified male staff member entered the Scott cottage and walked through the common area where residents were present. Neither staff member wore a face mask. e. Observation on 1/31/24 at 10:10 AM showed Shahbaz #3 visiting with elders in common area. The Shahabaz wore a surgical mask; however, mask was positioned below the Shahbaz's nose. f. Observation on 1/31/24 at 10:11 AM showed maintenance tech #1 exited Scott cottage by walking through the common area where elders were present. No facemask was used. g. Observation on 1/31/24 at 10:15 AM showed the unidentified male staff member exited Scott cottage by walking through the common area where elders were present. No facemask was used. h. Observation on 1/31/24 at 10:26 AM showed maintenance tech #1 entered Scott cottage and had a surgical facemask on; however, the mask was positioned below the maintenance tech's nose. i. Observation on 1/31/24 at 10:43 AM showed the unidentified male staff member entered the Scott cottage and walked through the common area where residents were present. No facemask was used. j. Observation on 1/31/24 at 10:45 AM showed the unidentified male staff member exited Scott cottage by walking through the common area where elders were present. No facemask was used. k. Observation on 1/31/24 at 10:55 AM showed Shahbaz #3 was standing in the kitchen	F 880	6. Random audits will occur weekly by the DON, QA/Educator or IP to monitor staff compliance including the observation of wound care at least once monthly until compliance has been observed 100% for 3 months. Findings will be reviewed by QA monthly.	

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F 880	Continued From page 32 area and her face mask positioned below her nose. 2. The following PPE use concerns were observed in the Founders cottage a. Observation on 1/29/24 at 6:45 PM showed Shahbaz #4 donned a gown, gloves, 2 surgical masks, and a face shield. The Shahbaz entered an elder's room, who was on COVID-19 isolation. Upon exiting the room, she doffed the PPE, except the 2nd surgical mask, which she continued to wear while interacting with other elders in the cottage. Interview, at that time, with LPN #2 revealed "the expectation is for us to double mask if we don't have N95s, gloves, gown, face shield." b. Observation on 1/30/24 at 12:58 PM showed RN #1 donned a gown, gloves, 2 surgical masks, and a face shield and entered a COVID-19 positive resident isolation room. Upon exiting the room, she doffed the PPE, except the 2nd surgical mask, which she continued to wear while interacting with other elders in the cottage. c. Observation on 1/30/24 at 1:11 PM showed the wound care nurse and RN #1 donned a gown, gloves, 2 surgical masks, and a face shield and entered a COVID-19 isolation room. Upon exiting the room, they doffed the PPE, except the 2nd surgical mask. 3. Interview with RN #1 and the DON on 1/31/24 at 5:09 PM revealed staff donned 2 surgical masks due to not having any N95 masks available in the facility. Further interview revealed they thought it was appropriate to double mask instead of utilizing an N95 mask. 4. Observation of room 1 of Watt cottage on 1/29/24 at 6:15 PM showed a box of N95 masks	F 880		

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F 880	Continued From page 33 was available and sitting on a table. 5. Interview with the DON and infection preventionist on 1/31/24 at 5:05 PM confirmed the facility had active COVID-19 cases in some of the cottages and revealed all staff were expected to wear surgical masks over their nose and mouth when inside the cottages. Further interview revealed the infection preventionist was told double masking was approved for care of elders with COVID-19 when N95 masks were unavailable. The facility was unable to provide evidence of a standard of practice for health care personnel double masking when caring for COVID positive elders. 6. Review of the policy titled "COVID-19 Policies and Procedures" last updated 8/24/23 showed "...Procedure for Fully Vaccinated and Un-vaccinated Employees for GHL [Green House Living] COVID-19 Outbreak...1. Staff that are fully vaccinated will be required to: a. Wear source control when indicated per guidelines as recommended by CD, CMS, and the local health departments. 2. In the case of identified COVID-19 cases with GHL, the facility will provide a clean, undamaged N95 or Surgical Mask. a. It is the responsibility of the manager to ensure N95 or Surgical masks are properly worn by the employee over the nose and mouth when indoors, inquiries should be made to infection control..." 7. Review of the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel [HCP] During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised 5/8/23 showed "...Source control options for HCP include: A NIOSH	F 880		

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F 880	Continued From page 34 Approved particulate respirator with N95 filters or higher; A respirator approved under standards used in other countries that are similar to NIOSH Approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH approved respirator when respiratory protection is indicated); A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR A well-fitting facemask...Personal Protective Equipment...HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher , gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard (29 CFR 1910.134) Additional information about using PPE is available in Protecting Healthcare Personnel..." In regard to wound care: 1. Observation of wound care for elder #3 on 1/31/24 at 11:13 AM showed the wound care nurse donned gloves and removed an old dressing. The wound care nurse doffed the gloves and, without performing hand hygiene, donned a new pair of gloves, picked up and opened clean gauze packaging, and cleaned the elder's wound with saline and a 4 by 4 gauze. Without performing hand hygiene or changing her	F 880		

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F 880	Continued From page 35 gloves, she picked up and opened additional dressing supplies, removed a pen from her scrub pocket, and dated the mepilex dressing. Without performing hand hygiene or changing gloves, she placed the clean dressing on the elder's wound, assisted RN #1 to position the elder's clothing back in place, and doffed her gloves. 2. Observation of wound care for elder #15 on 1/31/24 at 11:34 AM showed the wound care nurse performed hand hygiene, donned gloves, removed the elder's pillow, adjusted clothing for wound care access, provided pericare, and, without performing hand hygiene or doffing her gloves, removed the elder's dressing. At that time she doffed the gloves and donned clean gloves; however, no hand hygiene was performed. The wound care nurse transfered the sealed dressing supplies to the bed and no barrier was placed. She opened a package of 4 by 4 gauze, cleaned the wound with saline and the 4 by 4 gauze, doffed her gloves and donned clean gloves; however, no hand hygiene was performed. She obtained her cell phone, took pictures and measurements with the phone, opened the packaging for the dressing, removed her pen from her scrub pocket, and dated the dressing. She opened the skin prep package and applied skin prep to the outer edge of the wound, and placed the dressing to the elder's wound. She assisted repositioning the elder's clothing, doffed her gloves, and performed hand hygiene. At that time, she began changing the dressing to the elders right great toe by donning gloves, and removing the dressing. She performed hand hygiene and donned gloves, placed the sealed supplies on the bed-side table, opened the packaging, and cut dressing with scissors. She doffed her gloves and donned clean gloves;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 36	F 880		

however, there was no hand hygiene performed. The wound nurse cleaned the wound with saline and a 4 by 4 gauze, and took pictures and measurements with her phone. She doffed her gloves and donned clean gloves, obtained her pen from off the bed and dated the dressing. She then doffed her gloves and donned clean gloves, applied medihoney to a cotton tip applicator, then to the wound and applied the dressing to the wound. Interview with the wound care nurse revealed she was performing clean dressing changes.

3. Interview with wound care nurse on 1/31/24 at 3:23 PM confirmed she performed the wound care as it was observed and revealed she did not know she needed to do hand hygiene prior to re-gloving, and between dirty and clean dressing changes.

4. Interview with the administrator on 1/31/24 at 3:29 PM revealed she expected staff to follow the policy with hand hygiene and donning and doffing of gloves.

5. Review of the policy "Hand Hygiene" last updated 5/30/22 showed hand hygiene should be performed "...u. After removing gloves or aprons...6...e. Before handling clean or soiled dressings, gauze pads, etc. f. Before moving from a contaminated body site to a clean body site during resident care...h. After handling used dressings, contaminated equipment, etc..."

6. Review of Perry/Potter seventh edition "Nursing Interventions & Clinical Skills" copy written in 2020 showed "Performing a Wound Assessment ...5. Perform hand hygiene. b. expose only the area of the wound... 8. Apply

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F 880	Continued From page 37 clean gloves and remove soiled dressings... 10. Perform hand hygiene and apply clean gloves. 11. Inspect wound... 14. Apply dressings per order. Place time, date, and initials on new dressing..." 7. Review of the "Journal of Wound, Ostomy and Continence Nursing" on 2/13/24 showed Clean vs. Sterile Dressing Techniques for Management of Chronic Wounds. ..."Clean technique. Clean means free of dirt, marks, or stains. Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous hand washing, maintaining a clean environment by preparing a clean field, using clean gloves and sterile instruments, and preventing direct contamination of materials and supplies. No "sterile to sterile" rules apply. This technique may also be referred to as non-sterile. Clean technique is considered most appropriate for long-term care, home care, and some clinic settings; for patients who are not at high risk for infection; and for patients receiving routine dressings for chronic wounds such as venous ulcers, or wounds healing by secondary intention with granulation tissue."	F 880		