STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035245	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunview Respiratory and Rehabilitation	12207 North 113th Avenue Youngtown, AZ 85363

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, observations, interviews, and policy review, the facility failed to ensure one resident (#72) was treated with dignity and respect. The deficient practice could result in resident's self-esteem and self-worth not maintained, honored and valued. Findings include: Resident #72 was admitted on [DATE] with diagnoses of muscle disuse atrophy, dysphagia, cognitive communication deficit, and need for assistance with personal care. The care plan initiated on January 13, 2023 included that the resident had a potential for nutritional problems, required adaptive equipment to assist with independent feeding and had self-care performance deficit. Intervention included to encourage participation to the fullest extent possible, promote dignity by ensuring privacy, and required staff assistance for ADLs (activities of daily living). The nutrition-quarterly evaluation dated September 9, 2024 included that the resident preferred dining location preference was his room; and that, the resident needed meal tray set-up, and limited assistance, but was otherwise able to self-feed. The MDS (minimum data set) assessment dated [DATE] revealed resident was assessed by staff as severely impaired on cognitive skills for daily decision making. The MDS included that the resident coughs or chokes during meals or when swallowing medications and required a mechanically altered diet. The physician progress note dated September 15, 2024 included that there was a regression in the resident's ability to swallow. Recommendation included proper positioning during meals, and feeding the resident when less lethargic from anxiety medications. An observation was conducted on September 15, 2024 at 8:35 a.m. The resident was lying supine in bed with pureed-like substance caked around resident's mouth and beard. The resident was wearing a red short sleeved shirt which was also saturated with pureed-like substance, his legs exposed and he had one sock on and the other off. The resident's bed was placed in lowest position with a visibly soiled blue fall mat on floor; and the side table with the meal tray was elevated and placed on the right side of the resident's bed. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with a licensed practical nurse (LPN/staff #6) conducted on September 15, 2024 at approximately 9:00 a.m., the LPN stated that breakfast trays were usually picked up around 9:30 a.m. An interview with a certified nursing assistant (CNA/staff #58) was conducted on September 15, 2024 at approximately 9:50 a.m. The CNA stated that staff conducts resident rounds every two hours, or more frequent if needed to check on resident needs. However, in another observation conducted on September 15, 2024 at 11:01 a.m. (approximately 2 1/2 hours after the initial observation), the resident was sleeping in bed with pureed-like substance caked still around resident's mouth and beard. The resident was still wearing the red short sleeved shirt which was saturated with pureed-like substance. According to facility policy entitled ADL, Services to carry out, if the resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, and grooming will be provided by qualified staff.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, clinical record review, staff and resident interview, and facility policy review, the facility failed to ensure medication were not left at bedside for two residents (#62 and #71) who were not assessed to be clinically appropriate to self-administer medications. The deficient practice could result in medication not administered correctly or medication not taken by the resident. Findings include: -Resident #62 was readmitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, pleural effusion, and pneumonia. The comprehensive care plan included that the resident was at risk for adverse reaction related to polypharmacy black box warning, was prescribed with an opioid, required anticoagulant therapy for atrial fibrillation, was on diuretic therapy. Intervention included to administer medication as ordered. Review of the quarterly minimum data set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The clinical record revealed no evidence found that the resident was assessed and determined to be clinically appropriate for self-administration of medications. In an observation conducted on September 15, 2024 at 8:50 a.m., there was a small plastic medication cup containing a large oblong capsule that was left on the resident's bedside table. The resident stated that the medication was a vitamin he preferred to take after his other medications, since it was large. At this time, a certified nursing assistant (CNA) and a registered nurse (RN/staff #20) entered the resident room; and both staffs saw the medication cup on the resident's bedside table. An interview with the RN (staff #20) was conducted on September 15, 2024 at 8:59 a.m. The RN stated that she administered the resident's morning medications. At this time, resident #62 became upset and stated that he had spat the medication out and planned to take it. In another interview with the RN (staff #20) conducted on September 17, 2024 at 10:25 a.m., the RN stated that she was not aware of any residents that were permitted to self-administer medication. She stated that the risks of leaving medications unattended with residents include the medications would not be administered correctly, and, the residents may not take the medications at all. During an interview with the Director of Nursing (DON/staff #115) conducted on September 18, 2024 at 8:45 a.m., the DON stated that medications were not to be left at the resident's bedside; and if found, should be discarded. She stated that only residents who have an order for self-administration of medications can have medicines left at bedside. 51158 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Regarding Resident #71 Resident #71 was admitted on [DATE] that included a diagnosis of end stage renal disease. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) Assessment score of 15 which indicated intact cognition. Review of the clinical record revealed the following medication orders: - Ativan Oral Tablet 1MG for anxiety -Carvedilol Oral Tablet 12.5 MG for blood pressure >140 -Zoloft Oral Tablet 50 MG for depression Review of the clinical revealed no evidence of medication self administration assessment. Further review revealed no evidence of physician orders regarding self-administering medications. Review of the care plan initiated, revealed no evidence of a focus regarding self administration of medications. During an observation conducted on September 16, 2024 at 9:45 AM, revealed a clear medication cup with 5 medications tablets on Resident #7 ' s bedside table. It was observed that Resident #71 removed a white pill from the cup and threw it into the garbage can located at the bedside. An interview was conducted on September 16, 2024 at 9:43 am with Resident #71, who stated that nurses leave his medications at the bedside and do not stay to watch him take them. He further stated that if he does not want to take a medication he throws it out in the trash can located at the bedside. Resident #71 confirmed this had been going on since his admission. An interview was conducted on September 16, 2024 at 9:55 AM with Staff #96, who stated that nursing staff need to observe residents take the medication. Staff #96 stated he did not stay and observe Resident #71 take him morning medications. Staff #96 stated that the facilities protocol is to document the refusal of a medication and let the provider know, and to throw away the medication in the sharps container located in the room. The RN (staff #96) then located the white pill in the garbage can next to Resident #71 ' s bed. Staff #96 then discarded the medication in the sharps container located in the residents room. The RN (staff #96) stated that the risk could result in medication hoarding and/or can be given to someone else. The RN (Staff #96) stated he was unaware the resident was disposing of his medications. An interview was conducted by surveyor #50553 on September 18, 2024 at 9:45 AM with the Director of Nursing (DON, staff #115), who stated that the facility allows medications at bedside if they have an order to do so. Staff #115 further stated that medications are not to be left at bedside and to be discarded if they were not administered. The risk could result in missed medications and improper dosage. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled, Medication Administration: Administration of Drugs, revealed that medications must be administered in accordance with the written orders of the attending physician. As well as, if a medication is withheld, refused, or given other than at the scheduled time, the documentation will be reflected in the clinical record. Review of facility policy titled, Care and Treatment: Self Administration of Medications, revealed that if the resident is a candidate for self-administration of medications, a physician ' s order for self-administration of medications or for specific medications to be administered (example inhalers) will be obtained. Self-administration of medications will be care planned.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure that care and services was provided to related to a change in condition for one resident (#168); and, failed to ensure failed to ensure the leg rests for tilt-in-space mobility device was put on for one resident (#31) as recommended. The deficient practice could result in the resident's medical needs not being met/treated appropriately and in a timely manner. Findings nclude: -Resident #168 was admitted on [DATE] from the hospital with diagnoses that included urinary tract infection, pneumonia, type 2 diabetes mellitus (DM), urinary tract infection, and pneumonia. Review of a care plan initiated on February 9, 2023, revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to new environment and recent hospitalization and had an ADL (activities of daily living) Self Care Performance Deficit related to limited mobility. Interventions included to monitor/document /report to MD as needed any changes in cognitive function, specifically changes in: level of consciousness, mental status, any potential for improvement, reasons for self-care deficit, expected course, declines in function. The physician order dated February 9, 2023 included for the following: -Insulin Glargine (antidiabetic agent) subcutaneous solution 100 unit/ml (milliliter) inject 70 units subcutaneously every 12 hours for DM; and, -Metformin (antihyperglycemic) 1000 mg (milligram) by mouth every 12 hours for DM. The physician order dated February 10, 2023, revealed the following orders: -To monitor/document report to the physician signs/symptoms of anticoagulant complications that included frank blood in urine, lethargy, shortness of breath, loss of appetite, sudden changes in mental status and significant or sudden changes in vital signs every shift; -Blood sugar checks before meals and at bedtime, notify provider for Blood sugar <70 or >200;. -Dextrose Solution 50%, use 50 ml intravenously as needed for blood glucose less than 70. Administer 50 ml push over 5 minutes, recheck blood glucose in 10 minutes, may repeat x1 if blood glucose remains less than 70; and, -Glucose 30 gm, give 1 dose by mouth as needed for blood glucose less than 70. Recheck blood glucose in 10 minutes, may repeat x 1 if blood glucose remains less than 70. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a care plan that was initiated on February 10, 2023 to include interventions to monitor/document/report to MD PRN (as needed) any signs/symptoms of malignant hypertension and anticoagulant complications such as headache, visual problems, confusion, disorientation, lethargy, difficulty breathing (dyspnea), lethargy, shortness of breath (SOB), sudden changes in mental status, significant or sudden changes in vital signs. The resident's oxygen saturation record for February 10, 2023 were following: -At 5:26 p.m., oxygen saturation was 82% via nasal cannula; and, -At 6:16 p.m., oxygen saturation was 87% via nasal cannula. A physician order dated February 10, 2023 included to discontinue foley catheter. A Social Service assessment dated [DATE], revealed that the resident was alert and oriented x 3, had appropriate responses, and there were no concerns at this time. Per the documentation, the resident will be monitored for changes as needed. The progress note dated February 11, 2023 revealed that the foley catheter had been removed and bladder scans were conducted every 6 hours. It also incuded that resident was having wet briefs and PVR's (post void residuals) were within normal range. Review of a vitals report dated February 12, 2023 revealed the resident had the following blood sugar levels: -42mg/dl at 10:24 a.m.; -50 mg/dl at 11:54 a.m.; -43 mg/dl at 4:52 p.m.; and, -57 mg/dl at 8:47 p.m. The clinical record revealed that the resident was receiving oxygen via nasal cannula despite no documentation that the resident had shortness of breath from February 9 through February 12, 2023. The physician order dated February 12, 2023 included for for Glucagon (glycogenolytic agent) 1 mg, inject for blood glucose less than 70 and recheck blood glucose in 10 minutes. Review of the February MAR, revealed that Glucagon had been administered on February 12, 2023 for a blood glucose of 43 mg/dl. The nursing progress note dated February 12, 2023 included that the resident's blood sugar recheck after glucagon shot was 155 mg/dl. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The nursing progress note dated February 13, 2023 revealed that on February 12, 2023 at 8:35 p.m., Lantus (brand name for Insulin Glargine) was held due to blood glucose of 56 mg/dl. Per the documentation, at approximately 11:00 p.m. the blood glucose was up to 98 mg/dl. It also included that on February 13, 2023 at 5:00 a.m., the resident's blood glucose was 34 mg/dl and the resident had 2 rounds of glucagon along with nursing interventions; and that, the resident's blood glucose increased to 105 mg/dl. Per the documentation, the provider was notified, orders were received to hold Lantus until February 14, 2023 and to change Lantus to 35 units twice a day. The daily skilled note dated February 13, 2023, revealed the resident was alert and oriented and vital signs do not show any fluctuations from baseline that require interventions. Per the documentation, the resident had a BP of 91/60. The physical therapy note dated February 13, 2023, revealed that the resident was breathing heavily, and moaning in obvious distress with resident's family reporting that the resident's current status was far below the resident's baseline. Per the documentation, the registered nurse (RN) was aware and had informed spouse that the physician will provide assessment within the hour. The occupational therapy note dated February 13, 2023, revealed that the therapist attempted to see the resident, but the resident was too lethargic, very shaky, and with labored breathing. Per the documentation, the resident's family was present and reported that the resident was not being himself, had increased confusion and decreased focus. The documentation included that nursing was consulted and that nursing reported that the resident's blood sugar levels were low earlier. It also included that the provider was notified/consulted about the resident's condition. Review of a speech therapy (ST) note dated February 13, 2023, revealed that the resident was seen sitting upright in bed on 6L of oxygen O2, via nasal cannula, had decreased alertness and arousal. Per the documentation, the resident's family was present and reported concerns regarding the resident's change status. The documentation also included that nursing staff were notified. Review of a vitals report dated February 13, 2023, revealed the resident had the following blood sugar levels: -34 mg/dl at 5:36 a.m.; -40 mg/dl at 11:36 a.m.; and, -33 mg/dl at 7:58 p.m. The medication administration note dated February 13, 2023 at 11:36 a.m., revealed that the resident was alert and had a blood sugar level was 40 mg/dl. Per the documentation, glucagon was administered, the provider was aware and there were pending new orders. The physician order dated February 13, 2023 included the following: -Humalog subcutaneous solution (Insulin Lispro) inject per sliding scale; an, -Insulin Glargine Subcutaneous solution 100 unit/ml, inject 35 units subcutaneously every 12 hours for DM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A care plan initiated on February 13, 2023, revealed an additional focus of oxygen therapy related to ineffective gas exchange, with interventions that included to monitor signs and symptoms of respiratory distress and report to provider as needed, and oxygen settings as ordered. The clinical record revealed no evidence that the provider was notified or made aware of the change in the resident's condition such as lethargy, increased confusion or labored breathing. Another physician order dated February 13, 2023 revealed an order for a STAT CMP (comprehensive metabolic panel) and ammonia and chest x-ray related to congestion. The Xray results dated February 13, 2023 included patchy opacity in both lungs, likely secondary to pulmonary edema, atelectasis and/or pneumonia. There was no evidence that the provider was notified with the x-ray report results. Review of a vitals report dated February 14, 2023 at 1:22 AM, revealed the following blood sugar levels of 56 mg/dl. Review of a nursing progress note dated February 14, 2023 included a blood sugar level of 56 mg/dl was reported to the provider with orders to try to get the resident to eat, if not start dextrose 5%. Per the documentation, the resident consumed 360 ml of supplement and med pass drink and ice cream; and that, the provided was notified that blood glucose will be rechecked at approximately 2:00 a.m. The documentation also included that the provider instructed to recheck blood sugar between 4:00 a.m. and 5:00 a.m. However, there was no evidence found in the clinical record that the resident's blood sugar was rechecked on February 14, 2023 at 2:00 a.m., or between 4:00 a.m. and 5:00 a.m. as documented. Review of a provider's history and physical note dated February 14, 2023 included chief complaints of physical deconditioning, catheter associated UTI, and diabetes mellitus type 2. Per the documentation, since admission the resident had episodes of hypoglycemia, looked like he was not eating well, was having hematuria, and was not behaving well. The documentation also included that the resident appeared acutely ill, had physical deconditioning, confused metabolic encephalopathy etiology unclear, hematuria likely due to recent foley catheter discontinuation. A Daily Skilled Note dated February 14, 2023 revealed the resident was confused and family was at bedside and reported that the resident was not at his baseline a couple of days ago. Assessment included acute encephalopathy. It also included that the resident continued on 5 liters of oxygen via nasal cannula. The admission Minimum Data Set (MDS) dated [DATE], revealed a Staff Assessment for Mental Status indicating memory problems, moderate impairment and altered level of consciousness that comes and goes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the State Agency complaint tracking system revealed that February 16, 2023, a complaint was filed by the resident's family who reported that the resident got sick the day after he was admitted at the facility; and that, the resident had a bad episode and confusion. Per the report, the family asked the facility to call 911 but was told that the paramedics cannot come into the facility and the facility's doctor would come; but, that the facility doctor did not come. An interview was conducted on September 16, 2024 at 09:45 AM with the resident's family who stated that on February 14, 2023 she observed that the resident was more confused, was groaning, and as the time progressed he became non-responsive, and that this occurred approximately 2 days after the catheter was removed due to blood clots. The family stated that there was no provider who came in to evaluate the resident and the catheter was not replaced. The family stated that the resident was unconscious in the hospital for almost 30 days, was still recovering; and that, the resident now has as short term memory loss. She further stated that the hospital told her that the resident became sick from toxins that got into his body related to the catheter being removed, and not replaced. In another interview with the resident family conducted on September 16, 2024 at 10:20 a.m., the family stated that when she went into see the resident in the morning of September 13, 2023, the resident was already sick; and that, an occupational therapist conducted a cognitive test on February 13, 2023. The family said that the resident did not know what state he was currently living in, and this was unusual for him. An interview was conducted on September 16, 2024 with the Assistant Director of Nursing (ADON/staff #91), who stated that when a resident representative would ask a nurse to send a resident out to the hospital, the provider would be notified and the resident would be sent to a higher level of care. She stated that it would not meet her expectations that a nurse would tell a family member, that the paramedics cannot come in and that the provider would come see them. She stated that paramedics were able to come into the facility during February 2023. She stated that the nurse should document per family request that they requested the resident to be sent to the hospital. Further, the ADON stated that the expectation was that the nurse would follow standing orders for glucose and notify the provider for further orders, and not impede a resident being sent out if the family requested. A telephone interview was conducted with a Licensed Practical Nurse (LPN/staff #149) on September 17, 2024, who stated that when physical therapy or a resident's representative informs nursing of a resident health concern the resident should be immediately assessed, the provider should be notified, and it should be documented in progress notes. The LPN also stated that a change of condition would include an increase in a resident's oxygen needs, uncontrolled blood glucose, and observations of the resident shaking; and, this should be documented in the progress notes. An interview with a ST (staff #118) was conducted on September 17, 2024 at 11:52 a.m. The ST stated on February 13, 2023, she spoke with the resident's family who was concerned about the resident's medical status. The ST stated that she notified the nurse approximately at 11:00 a.m. - 12:30 p.m. on February 13, 2023. The ST stated that the resident had a change in condition from her initial evaluation on February 10, 2024; and that, the resident was The ST also stated that the resident demonstrated decreased alertness and was not easily arousable. She stated that the facility's policy on change of condition related to cognition and not eating would include notifying the nursing staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on September 17, 2024 at 12:06 p.m. with an OTA (occupational therapy assistant/staff #68), who stated that he treated the resident on February 13, 2024; and that, the resident was too lethargic to treat that day. Further, the OTA stated that he reported the resident's status to nursing staff. An interview was conducted on September 17, 2024 at 12:24 p.m. with a Licensed Practical Nurse (LPN/staff #6), who stated that if therapy or resident family notifies her of a resident's change in condition or health concern she would immediately observe the resident, take vitals, talk to the resident and notify the provider. She also stated the nurse should be familiar with the resident and have caught the change earlier. She stated that if the provider had been notified earlier regarding a blood glucose concern or if the resident's representative or therapist reported concerns about a resident's change in health status, she would notify the provider and documented the concerns and provider notification in a progress or change of condition (COC) note. She further stated that for a change in cognition, or blood glucose concern would also be documented in a change of condition note. A review of the clinical record was conducted during the interview with the LPN who stated that there was no evidence that the nurse contacted the provider regarding the reports made by the therapist/s or resident representative regarding the resident's change in cognition or health status such as lethargy or confusion or not easily arousable. The LPN stated that the clinical record only showed that the provider was notified only of the resident's blood sugar (BS) level. She further stated that for a COC note, they document what was done to address the concern, recheck the blood sugar levels, when the provider was notified, and the times that he was notified. The LPN stated that nursing should notify the provider after each BS check to see if the BS was improving. She also said that nursing should have started a new COC assessment/charting for the new changes in cognition and blood glucose control, and document the findings on the MAR. During the review of the clinical record, the LPN stated that there was a change in cognition monitoring/documentation for the resident's new admission; however, there was no evidence that change of condition assessments/vitals had been provided to the provider regarding the reports from the therapist and the resident's family related to the resident's lethargy, confusion and not easily arousable. The LPN stated that a STAT lab and stat X-ray were ordered and completed; but, there was no evidence in the clinical record that the provider was notified of the X-ray results. The LPN also stated that the risk in not notifying the provider of x-ray results could result in respiratory distress or death. The LPN also stated that an infection could cause a fluctuation in blood sugar levels, as well as some antibiotics; and, a low oxygen saturation and an increased oxygen need could also be a change in the resident's condition. The LPN stated that if the resident's family requested that a resident be sent to the hospital, the provider would be notified; and that, the resident's representative and resident have overall decision and there was no physician that would disagree. Regarding resident #168, during February 2023 there was no reason why EMS could not have entered the facility to transfer the resident to a higher level of care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sunview Respiratory and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12207 North 113th Avenue Youngtown, AZ 85363	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was conducted on September 18, 2024 at 8:32 a.m. with the Director of Nursing (DON/ staff #115), who stated that the expectation was for nurses to assess a a resident when therapy informs them of a resident health concern. She also stated that if the nurse feels that there was a decline in the resident's condition, the provider would be notified, and it would be documented in the clinical record. The DON also stated that when a resident's representative requests that the resident be transferred to another facility, they would follow what the family requested, contact the provider and document in the clinical record. The DON stated that anything outside of baseline should be documented as a change of condition and could include an increase in oxygen needs, shortness of breath, increased temperature, uncontrolled blood glucose. The DON also stated that nursing should inform the provider regarding the representative's and therapist's concerns about a resident's decline that included being shaky, and increased oxygen needs. The DON stated that she had previously reviewed Resident #168's clinical record and knew that there were 3 days with hypoglycemia. She further stated that it did not meet her expectations that nursing did not complete an assessment after therapy reported concerns about the resident #168's status. The DON stated that there was no evidence in the clinical record that that an assessment had been conducted; and that, the resident's change of condition had not been addressed as quickly as it should have been. The DON further stated that the resident's provider was no longer at the facility, and she did not feel like he acted or addressed things promptly. The DON also stated that the clinical record revealed that the provider saw resident #169 on February 14, 2023 at 6:37 a.m.; and that, a late entry note for this encounter was dictated by the provider on February 18, 2024. She further stated that the risk of not addressing a change in condition could result in sepsis leading to death. In another interview conducted with the DON on September 18, 2024 at 12:51 p.m., the DON stated that the clinical record revealed no evidence that the provider was notified of the chest X-ray results; and that, the results had been marked as reviewed by the provider. She stated that the physician progress note dated February 14, 2023 that was a late entry on February 18, 2024, may have been mis-dated and should have been dated February 13, 2024. A policy titled, Change of Condition Reporting, relayed that all changes in resident condition will be communicated to the physician and resident representative and documented. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse will notify the physician. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met. Routine medical change: unusual signs and symptoms will be communicated to the physician promptly. Routine changes are minor changes are minor changes in physical and mental behavior, abnormal laboratory and X-ray results that are not life threatening. The nurse is responsible for notification of physician prior to end of assigned shift when a significant change in resident's condition is noted. Document resident change of condition and response in nursing progress notes and update resident care plan as indicated. All attempts to reach the physician will be documented in the nursing progress notes, and will include time and response. The comprehensive care plan will be updated/revised accordingly. 51124 -Resident #31 was readmitted on [DATE], with diagnoses of acute respiratory failure, stroke, hemiplegia and hemiparesis affecting the right side, and unspecified psychosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the Quarterly MDS (minimum data set) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to complete the interview for cognitive screening. The assessment included that the resident was dependent for toileting, dressing, and rolling in bed.; and that, the resident had impairments in functional range of motion in both of her lower extremities. Review of the care plan initiated May 18, 2022 revealed the resident was at risk for falls. Intervention included for physical, occupational, and speech therapy services per physician orders. The Wheelchair and Seating Evaluation dated December 28, 2022 revealed that the resident spends all waking hours, 12-15 hours in the wheelchair. The goals of obtaining a custom tilt-in-space manual wheelchair were to be able to tolerate sitting in a chair all day, to facilitate pressure relief to reduce the risk of pressure ulcer formation, and to facilitate postural control. Additionally, it was documented that the Assistive Technology Professional (ATP) from the contracted wheelchair company along with the physical therapist (PT/ Staff #16) were present for the evaluation. Per the documentation, the resident required the use of a tilt-in-space mobility device to meet the needs of her medical condition and address her mobility impairments; and that, the resident was unable to maintain her sitting balance without support. The documentation also included that the recommended parts for the custom chair included manual elevating swing away leg rests with a foot box for proper lower extremity positioning and decrease risk of wounds. A physical therapy evaluation dated June 4, 2024 revealed that the resident had impaired range of motion in both of her ankle joints, had a 45 degree deficit in the right ankle and a 40 degree deficit in the left ankle. The therapy goals included for Resident #31 to improve her bilateral ankle dorsiflexion (ability to bend the ankle to move the foot upward/toward the body). The occupational therapy treatment encounter notes dated June 10 and June 25, 2024 revealed the resident presented to therapy in her custom chair without the foot rests in place. A therapy progress note dated September 15, 2024 revealed that the resident required maximum to total assistance for completion of activities of daily living (ADLs) and mobility, had a custom tilt-in-space wheelchair, and had a slight decline in the range of motion of both of her ankles. An observation was conducted on September 15, 2024 at 11:46 a.m. and revealed that the resident was sitting in a custom tilt-in-space wheelchair reclined approximately 30 degrees, with no leg rests on. The resident's legs were dangling from the chair unsupported. and her feet were pointed downward from the ankle joints. There was no evidence of the resident's leg rests were in the room. In another observation conducted on September 16, 2024 at 9:24 a.m. the resident was in the hallway next to the nurse's cart, sitting in a custom tilt-in-space wheelchair reclined approximately between 30 to 45 degrees, with no leg rests on, and her legs were dangling from the chair unsupported. The resident's feet continued to point downward from the ankle joints. The staff at the nurse's cart then pushed resident #31 down the hall and stated that they were going to activities. An observation conducted on September 16, 2024 11:15 a.m. The resident was positioned in the same wheelchair with no leg rests and the chair's tilt was positioned so that the resident was sitting almost fully upright. The resident's legs continued to dangle without support as they did not reach the floor. Both feet continued to point downward from the ankle joints. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On September 17, 2024 at 9:37 a.m., the resident was in the same custom tilt-in-space wheelchair with no leg rests. The tilt was reclined to approximately 30 degrees. The resident's legs dangled in the air with the feet pointed downward from the ankles. In an interview conducted on September 17, 2024 at 9:37 a.m., a certified nursing assistant (CNA/Staff #55) stated that she was very familiar with Resident #31 and worked with her daily. The CNA stated that the resident's custom wheelchair leg rests had been missing for the past approximately 2 weeks; and that, she had told someone from therapy about it 2 weeks ago, but could not recall which therapist she had notified. An interview with the Director of Rehab (DOR/Staff #16) was conducted on September 17, 2024 at 9:57 a.m. The DOR stated that a resident should be properly positioned in a wheelchair with arms and legs supported and with adequate back support. The DOR said that most people do not like their feet dangling and therapy does not want the resident's feet positioned downward for positioning. The DOR stated that prior to this date, there was no staff who reported to him that the leg rest for the resident's (#31) wheelchair were missing. However, the DOR said that the leg rests were missing approximately a month ago and were then found. The DOR stated that the CNA (staff #55) reported that the leg rests of the resident's wheelchair were missing; and that, he was able to locate them and put them on the resident's wheelchair. An interview was conducted on September 17, 2024 at 1:01 p.m. with a physical therapist (PT/staff #2) who stated that when positioning a resident in a wheelchair, it was important to have proper support, including armrests, leg rests if needed, and a wheelchair cushion. However, the PT stated that types of equipment and recommendations were resident-specific. The PT stated that a benefit of utilizing leg rests for a resident for whom it was recommended would be comfort and to keep the legs in neutral positioning. The PT also said that the risks of not having leg rests would be the potential for legs to catch on something or a soft tissue injury during transportation if a resident's legs were hanging down. Regarding resident #31, the PT said that the resident had tightness in her ankles that could be from prolonged bedrest or a position in which the feet point downward from the ankle joints. She further stated that she had been aware of Resident #31 having missing leg rests for her wheelchair however could not specify when. In another interview with the DOR (staff #16) conducted on September 17, 2024 at 1:13 p.m., the DOR stated that the resident's leg rests had been missing on and off; and, at times, the resident refuse putting on her leg rests. A review of the therapy notes was conducted with the DOR who stated that he could find no evidence of documentation that resident #31 refused her leg rests. Further, the DOR stated that the care plan was revised to add that the resident can refuse her leg rests. The DOR also said that proper positioning was important for contracture management. Another interview with the DOR (staff #16) was conducted on September 18, 2024 at 9:10 a.m. The DOR stated that the purpose of getting a resident a custom wheelchair would include to decrease risk of wounds, increased participation in activities, contracture management, accommodate specific residents' positioning, and to allow residents to spend more time out of their room. The DOR stated that part of the process for getting a resident a custom wheelchair was that a physician provides a signature certifying that the custom wheelchair is medically necessary for the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on September 18, 2024 at 9:25 a.m., the social services director (SSD/staff #88) stated that she receives reports of missing items; but, she had not received any missing item report for Resident #31 for the past month. On September 18, 2024 at 10:33 a.m., an interview was conducted with the Director of Nursing (DON/staff #115) who stated that proper positioning and comfort are important parts of positioning a resident in a wheelchair. Further, the DON stated that there could be a risk of injury if a limb was dangling down unsupported. The DON also said that if a resident had a custom wheelchair and was not seated or positioned as recommended the risk would be improper positioning that could lead to contractures, falls, or pressure ulcers. Further, the DON stated that it was the staff's responsibility to ensure that equipment was not misplaced for a resident who is dependent for care; and, if an equipment was missing, staff should attempt to locate it as soon as possible and notify social services if it cannot be found. Review of the facility's policy titled Quality of Care: ADL, Services to Carry Out, revised July, 2015, revealed that residents are to be given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Mobility aids, such as wheelchairs, will be provided according to the resident's assessed needs. Review of the facility's policy titled Personal Property, Resident's, revised May, 2007, revealed that the facility is to provide space and safety for resident's personal property, and that the facility is to store all items in appropriate place. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure there was physician order for the oxygen use for two sampled residents (#219 and #168). The deficient practice could result in unnecessary oxygen use for the resident. Findings include: -Resident #219 was readmitted on [DATE] with diagnoses of that included end stage renal disease (ESRD) with dependence on renal dialysis, respiratory failure and type 2 diabetes mellitus. The care plan dated January 28, 2023 included that the resident had altered respiratory status and difficulty breathing related to hypertension and ESRD. Intervention included to maintain a clear airway by encouraging resident to clear own secretions with effective coughing. A review of the oxygen summary from February 17 through March 15, 2023 revealed the resident was documented to be on oxygen via nasal cannula on February 20, March 3, 8, 9, 10, 13, 14 and 15, 2023. The daily skilled note dated March 13, 2023 included that resident had an oxygen saturation (O2 sat) of 98% and was on oxygen via nasal cannula. A late entry physician progress note dated March 13, 2023 revealed the resident had chronic hypoxic respiratory failure with hypoxia and OSA (obstructive sleep apnea) with CPAP (continuous positive airway pressure) during the night. Despite documentation that the resident was on oxygen via nasal cannula, there was no physician order for the use of oxygen found in the clinical record from February 17 through March 15, 2023. The physician order dated March 16, 2023 included for oxygen at 1-3 liters/minute via NC continuously and may titrate to maintain O2 sats greater than 90%. the start date for this order was March 17, 2023. An additional order was present dated March 17, 2024 for O2 at 1-3 liters per minute via nasal cannula to maintain O2 saturation greater than 90%. There was no evidence of any other oxygen orders to cover the timeframe from when Resident #219 re-entered the facility on February 17, 2023 until March 16, 2023. The care plan dated March 17, 2023 revealed the resident had oxygen therapy related to ineffective gas exchange. Interventions included oxygen settings as ordered, give medication as ordered by physician and monitor/document side effects and effectiveness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the Assistant Director of Nursing (ADON/staff #91) conducted on September 17, 2024 at 8:42 a.m., the ADON stated that according to facility policy, oxygen therapy would require a physician order in place. A review of the clinical record was conducted with the ADON who stated that she could find no evidence of any physician order for oxygen use for resident #219 from February 17 through March 16, 2024. An interview was conducted on September 17, 2024 at 9:03 with the respiratory therapy director (RTD/staff #59) who stated that respiratory therapy was following and providing care to Resident #219 when he was initially admitted to the facility in December 2022. The RTD said that when the resident went to the hospital in February 2023, respiratory services were discontinued. The RTD said that when the resident was readmitted on [DATE], there was no referral or order for respiratory therapy for resident #219. During the interview, the RTD reviewed the clinical record and stated that there was no evidence of any oxygen orders and respiratory care plan in place for resident #219 from in February until March 16, 2023. In an interview with the Director of Nursing (DON/staff #115) conducted on September 18, 2024 at 10:52 a.m. , the DON stated that it was the facility's policy that oxygen administration has a physician order; and that, the risk of administering oxygen without an order could be over delivery of oxygen for a resident. The DON said that this would not align with the facility's policy. 43863 -Resident #168 was admitted on [DATE] with diagnoses of urinary tract infection (UTI), pneumonia and type 2 diabetes mellitus The physician order dated February 10, 2023 revealed to document the following: -Temperature and oxygen saturations and monitor for symptoms: fever, cough, shortness of breath, chills, shaking/chills, headache congestion every shift; -Shortness of breath at rest every shift for 10 day; -Shortness of breath lying flat every shift for 10 days; and, -Shortness of breath with exertion every shift for 10 days. The resident's oxygen saturation record for February 9, 2024 was 92%. The resident's oxygen saturation record for February 10, 2023 were following: -At 5:26 p.m., oxygen saturation was 82% via nasal cannula; and, -At 6:16 p.m., oxygen saturation was 87% via nasal cannula. A medication administration note dated February 11, 2023 included that a new admission change of condition assessment was done; and that, the resident was receiving 4 liters of oxygen via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The resident's oxygen saturation record for February 11, 2023 were following: -At 12:12 a.m. - 87% via nasal cannula; -At 5:23 a.m. - 94% via nasal cannula; -At 5:46 p.m. - 93% via nasal cannula. A daily skilled note dated February 11, 2023 revealed the resident had an oxygen saturation of 94% with oxygen via nasal cannula. The resident's oxygen saturation record for February 12, 2023 were following: -At 8:43 a.m. - 93% via nasal cannula; and, -At 7:21 p.m. - 95% via nasal cannula. The daily skilled note dated February 12, 2023 included an oxygen saturation at 93%, with oxygen via nasal cannula. The Medication Administration Record (MAR) for February 2023 also revealed no evidence that the resident was administered oxygen from February 9, 2023 through February 12, 2023. Despite documentation that the resident was receiving oxygen via nasal cannula, there was no evidence of a physician order for oxygen use and administration for resident #168 from February 9 through February 12, 2023. The care plan was revised on February 13, 2023 reveal to include an additional focus of oxygen therapy related to ineffective gas exchange. Interventions included to give medications as ordered by physician, monitor/document side effects and effectiveness, monitor signs and symptoms of respiratory distress and report to provider as needed, and oxygen settings as ordered. The daily skilled note dated February 13, 2023 revealed the resident was alert and oriented and had oxygen saturation at 92%, with oxygen via nasal cannula. The resident's oxygen saturation record for February 13, 2023 were following: -At 6:35 a.m. - 92% via nasal cannula; -At 7:07 p.m. - 94% via nasal cannula. The speech therapy (ST) note dated February 13, 2023 revealed the resident was sitting upright in bed on 6L (liters) of oxygen via nasal cannula. A pulmonary consult note dated February 13, 2023 included the resident was discharged from the hospital on 5 liters oxygen via nasal cannula; and that, to wean oxygen to maintain SpO2 (oxygen saturation) >90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	However, the physician order dated February 13, 2023, included to administer oxygen at 2 liters/minute via nasal cannula continuously; may titrate to maintain oxygen saturations greater than 90%. Review of the clinical records dated February 11 through February 14, 2023 revealed no evidence that the provider was notified of the increase in oxygen from 2 liters to up to 6 liters. Continued review of the MAR revealed that an order for oxygen was transcribed onto the MAR with order date of February 13, 2023. And had a discontinued dated of February 15, 2023. It also included that oxygen was administered to the resident on February 13 and 14, 2023. The admission Minimum Data Set (MDS) dated [DATE], revealed a Staff Assessment for Mental Status indicating memory problems, moderate impairment and altered level of consciousness that comes and goes. The provider's history and physical dated February 14, 2023 included a chief complaint of recent influenza along with COVID-19 infection with acute hypoxic respiratory failure; and that, the resident was stabilized at an acute care hospital and was transferred to the facility on 2 liters of oxygen for ongoing rehabilitation. Per the documentation, the resident appeared acutely ill; and had acute respiratory failure with hypoxemia due to underlying pneumonia/influenza. It also included that the resident remained on oxygen. The vitals report for February 14, 2023 revealed the resident had 91% oxygen saturation at 8:05 a.m. and 12:51 p.m. A Daily Skilled Note dated February 14, 2023 revealed an oxygen saturation of 91% at 8:05 a.m.; and that the resident received oxygen via nasal cannula. Per the documentation, the resident was confused and family was at bedside and reported that the resident was not at his baseline a couple of days ago. Assessment included acute encephalopathy. It also included that the resident continued on 5 liters of oxygen via nasal cannula. A Case Manager progress note dated February 14, 2023 included that the resident was alert and oriented and was currently on 4 liters of oxygen. Per the documentation, cognitive symptoms were described as able to answer minimal questions, able to answer to name being called. An interview was conducted on September 17, 2024 at 12:24 p.m. with a Licensed Practical Nurse (LPN/staff #6), who stated that if a resident has a low oxygen saturation she would notify the provider for orders, and that this would be a change in condition. She stated she would assess the resident, check the vitals, talk to the resident, notify the provider, and document in the clinical record. The LPN stated that she would expect that the provider was notified of the resident's increased need for oxygen; and that, a new oxygen order was received from the provider for administration if oxygen was increased from 2 to 6 liters. A review of the clinical record was conducted with the LPN who stated that there was no evidence of a physician order to administer oxygen at 4-6 liters to resident #168. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with the with the Director of Nursing (DON/staff #115), was conducted on September 18, 2024 at 8:32 a.m. The DON stated that anything outside of the resident's baseline should be documented as a change in condition and that could include an increase in oxygen needs, or shortness of breath. She further stated her expectation was that the provider would be notified regarding the changes in a resident's condition, and, the change would be documented in the clinical record. The DON also stated that nurses may titrate oxygen up or down, but if there was continuous increase the nurse should notify the provider, especially if there was still shortness of breath, and document in the clinical record. She further stated that she would expect nursing to notify the provider using SBAR (situation, background, assessment, recommendation) regarding an increase in oxygen needs. Review of the facility's policy on Oxygen Administration, revised in July 2013, revealed that oxygen therapy is administered as ordered by the physician or as an emergency measure until the order can be obtained. It also included a purpose to provide sufficient oxygen to the blood stream and tissues. The policy included that oxygen therapy is administered as ordered by the provider or as a nursing measure until the order can be obtained. The clinical record will include charting and documentation related to oxygen use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, staff interviews, and facility documentation and policy review, the facility failed to ensure food items were dated when opened; failed to ensure food readily available for resident use were not expired; and, failed to ensure that the ceiling air vents above the food tray line and the kitchen ice machine were clean. The deficient practices increase the potential for foodborne illness. Findings include: -Regarding food storage and expired food items: A kitchen observation was conducted on [DATE] at 8:24 a.m. and revealed the following food items found in the refrigerator were beyond their use by date: -A bag of grated parmesan cheese with a use by date of [DATE]; -An opened bag of lettuce salad secured with a tie, with a use by date of [DATE]; and, -Two additional bags of lettuce salad with a use by date of [DATE]. An observation of the first unit refrigerator was conducted on [DATE] at 8:48 a.m. There were 7 small cartons of milk with a use by date of [DATE]. The following food items were found in the refrigerator, opened but not dated or had no use by date: -An opened bottle of orange juice with a resident's name; -An opened turkey deli meat package with a resident's name marked; and, -A piece of pizza wrapped in paper towel with no resident room number. An observation of the second unit resident refrigerator was conducted on [DATE] at 9:03 a.m. There was a bottle of salad dressing with a use by date of [DATE]. The following food items were found in the refrigerator, opened but not dated or had no use by date: -Cheesecake with a resident's room number marked; -Tortilla chips and salsa in a bag with a resident's room number; and, -A piece of cake stored in a Styrofoam bowl with another upside-down Styrofoam bowl on top to cover it, with a resident's room number marked. An observation of the third unit resident refrigerator was conducted on [DATE] at 9:10 a.m. and revealed the following food items found in the refrigerator were beyond their use by date: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER: Sunview Respiratory and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 12207 North 113th Avenue Youngtown, AZ 85363	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A Danish pastry with a use by date of [DATE]; and, -An opened container of orange juice with a date marked as [DATE]. An interview was conducted on [DATE] at 8:54 a.m. with a certified nursing assistant (CNA/staff #33) who stated that for food brought in by resident's visitors, the CNAs/staff would check with the nurse to ensure the food brought in aligned with the resident's diet orders, ensure the food was in a sealed container, and was marked with the resident's room number. In an interview with a dietary aide (staff #78) conducted on [DATE] at 8:55 a.m., the dietary aide (staff #78) stated that there was a 3-day limit for food brought in for residents from outside sources to be stored in the unit refrigerators, and that it must be disposed of after the three days. An interview was conducted on [DATE] at 9:03 a.m. with the Dietary Manager (staff #144) who stated that food brought in by visitors would be kept for 3 days, and marked so that it can be disposed of on the correct date. The dietary manger stated that if the food was a condiment such as bottled salad dressing, it can be kept for 30 days or the manufacturer's use by date, whichever comes first. An interview was conducted with the Administrator (staff #101) on [DATE] at 1:34 p.m. The Administrator stated that it was his expectation that staff follow the facility's policies to ensure safe food storage. Review of the facilities policy on Food Storage, dated 2013, revealed that potentially hazardous foods and time/temperature control for safety (PHF/TCS) foods should be covered, labeled, and dated. All foods will be checked on to ensure that foods will be consumed or discarded by their use by dates. -Regarding the ceiling vents: An observation was conducted in the facility's kitchen on [DATE] at 10:32 a.m. The ceiling vent located above and between the sink and the tray line was coated with a layer of dust and debris that extended from the vent onto the surrounding ceiling and onto the light fixture that was next to the vent. An interview was conducted with the Dietary Manager (staff #144) on [DATE] at approximately 10:40 a.m. The dietary manager stated that the ceiling vents were to be cleaned monthly; and that, she thinks that the ceiling vent between the sink and the tray line previously observed got overlooked. In an interview conducted on [DATE] at 11:35 a.m., the Maintenance Director (staff #171) stated that the vents in the kitchen were last cleaned in [DATE]. The facility policy for Cleaning Vent Fans issued by the facility's electronic maintenance log revealed that the Maintenance Department is to inspect exhaust fans for proper operation and clean if necessary and monthly. The policy included to clean vents using vacuum and air compressor to remove all dust. -Regarding the ice machine: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A kitchen observation was conducted with the dietary manager (staff #144) on [DATE] at 10:32 a.m. On the side of the ice machine was a paper cleaning log for the ice machine which was labeled as monthly; and, there were weekly spaces on the log for employees to initial. Review of the log for the third week in [DATE] revealed that it was marked that a deep clean occurred from a contracted company. There were no markings present on the log for the last week in [DATE], and for any of the weeks in August or [DATE]. Continued observation of the ice machine revealed that the inside of the ice machine had a gray plastic shroud that had a black-brown discoloration on the bottom edge. During the observation, a clean, white cloth was provided by the dietary manager and the edge of the plastic shroud in the ice machine was wiped to reveal a residue that appeared brown on the white cloth. An interview was conducted with the dietary manager (staff #144) on [DATE], at 10:34 a.m. The Dietary Manager stated that the ice machine gets deep cleaned every three months by an outside contracted company; and, it was supposed to be wiped down weekly. Staff #144 stated weekly cleaning of the ice machine involved taking a clean cloth and wiping the inside of the ice machine with soapy water. In an interview conducted on [DATE] at 11:35 a.m., the maintenance director (staff #171) stated that there was a deep cleaning for the ice machine from a contracted company that occurred in [DATE]; and that, the maintenance department has not cleaned the ice machine since then. The facility's policy for the Ice Machine issued by the facility's electronic maintenance log revealed that the Maintenance Department is to wipe clean the ice machine monthly. Review of the facility's policy titled Cleaning Instructions: Ice Machine and Equipment revealed that the ice machine is to be cleaned on a regular bases to maintain a clean, sanitary condition. The steps include to remove the ice, wash the interior thoroughly with a detergent solution, to sanitize, and to allow to air dry.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51239 Based on observations, staff interviews, and facility policy review, the facility failed to ensure proper hand hygiene was conducted during medication administration. The deficient practice could result in contamination. Findings: During the Medication Administration observation with the Licensed Practice Nurse (LPN/staff #6) conducted on September 17, 2024 at 7:58 a.m., the LPN dropped a used plastic vial of normal saline on the floor. The LPN then picked the vial up off the floor with her bare hands, and placed the empty vial in the sharps container on the medication cart. The LPN proceeded to open medication cart drawers and started preparing medications to be administered without sanitizing her hands. In another observation was conducted the LPN (staff #6) on September 17, 2024 at 8:25 a.m., the LPN dropped a packet on the floor from her pocket. She picked up the packet off the floor with her bare hands and placed it back in her pocket. Without sanitizing her hands, she locked the medication cart, picked up the prepared medications and entered the resident's room with the prepared medications. An interview was conducted on September 17, 2024 at 8:40 a.m. with the LPN (staff #6) who stated that the hand hygiene included sanitizing hands after picking items up off the floor. She stated she did not sanitize her hands after picking both items up off the floor; and that, the risk could include contamination. An interview was conducted on September 18, 2024 at 10:14AM, with Director of Nursing (DON/staff #115) who stated that the hand hygiene included for a staff to use sanitizer or wash their hands after picking items off the floor with bare hands. She further stated that the risk of not perfroming hand hygiene could include contamination. Review of the facility policy titled, Hand Hygiene, revealed that hand washing/hand hygiene is generally considered the most important single procedure for preventing the transmission of infection.