STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045138	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Springs Rehabilitation and Health Center	228 Pointer Trail West Van Buren, AR 72956

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38200 Based on observation, interviews, record review, and facility document review, it was determined that the facility failed to ensure a comprehensive assessment accurately reflected a resident ' s status and needs for 1 (Resident #236) of 1 sample mix residents reviewed for comprehensive care plan development. The findings are: During an observation on 1/21/25 at 11:56 AM, this surveyor observed Resident #236 with an oxygen concentrator in the room running at five (5) liters per minute (LPM). A breathing device used to treat sleep apnea (Bilevel Positive Airway Pressure (Bipap)) was also observed in the resident ' s room. Review of Resident #236's Admission Record dated 1/7/2025 noted the resident was admitted with diagnoses of acute respiratory failure with low oxygen (hypoxia), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. Review of the admission Nursing Evaluation, dated 1/7/2024, noted 8. Review of Systems A. Respiratory: 5. Does the resident have, need or use any of the following? a. Oxygen c. CPAP. 5c. CPAP/ BiPAP/ Trilogy specify (order, frequency, settings, when to apply/ remove and any pertinent information) see chart. Review of Resident #236's Care plan dated 1/8/2025 noted the resident had altered respiratory status with difficulty breathing related to diagnoses. Used oxygen and continuous positive airway pressure (CPAP) see medical doctor (MD) orders. Review of the Medicare 5- Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/9/2025 noted in Section O0110. Special Treatments, Procedures, and Programs G2. Bi-pap No; G3. Review of the Order Summary Report dated 1/22/2025 noted BiPAP settings: fi02 40%, IPAP 10, EPAP 5, Rate 12. There were no directions on the order to monitor settings or frequency of use. Review of Resident #236's Medication Administration Record (MAR) dated January 2025 did not have an area to document CPAP/ BiPAP use. During an interview with Resident #236 on 1/23/25 at 9:50 AM, Resident #236 confirmed wearing the bi-pap every night. The resident verified staff did not monitor bi-pap settings. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) on 1/24/2025 at 10:10 AM, she confirmed Resident #236 wore a bi-pap nightly and she confirmed the comprehensive assessment for Resident #236 was inaccurate as it did not document the resident had a bi-pap. During an interview with the MDS Coordinator on 1/24/2025, she confirmed the Medicare 5-day MDS did not note the resident had a bi-pap.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 35684 Based on interviews, record review, facility document review, it was determined that the facility failed to complete a Preadmission Screening and Resident Review (PASRR) for 1 (Resident #24) of 2 sample residents reviewed for PASRR, to ensure the resident received the needed care and services in the most appropriate setting. The findings are: On 01/23/2025 at 2:53 PM, the Administrator stated the facility did not have a policy for PASRR and goes by the Centers for Medicare and Medicaid Services (CMS) policy. Review of Resident #24's Division of Medical Services (DMS) 787 dated 1/22/2019 noted in Section II the resident had diagnoses of psychosis and dysthymia (depressive disorders). The DMS 787 also documented the resident had a diagnosis of dementia in answer to Section II question number 7. This DMS-787 was accompanied by a letter from [State Designated Professional Associates] that requested further information before it could be processed. Review of Resident #24's DMS-780 dated 6/30/2022 noted the Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition- (DSM-IV) was utilized to substantiate the following diagnosis of Dementia (including Alzheimer's, cognitive disorder, alcohol/drug and other related disorders). The diagnosis was made on the basis of a history or physical findings that lead to the Dementia diagnosis: diagnosis prior to admission 5/1/2014. Section II B. note the resident has a diagnosis of psychosis, panic, or anxiety disorder, and major depression. Question related to section B referencing mental illness as the primary diagnosis and mental illness prior to onset of dementia were left unanswered. Review of Resident #24's Arkansas Department of Health and Human Services Evaluation of Medical Need Criteria (DHHS-703) dated 05/01/2014 noted the resident, under Mental Status section clear checked. Part III, under RN/Counselor comments read in part, Resident had a history of delusions, and behaviors. A review of Resident 24 ' s admission records indicated the facility admitted Resident # 24 with diagnoses that included unspecified psychosis, psychotic disturbance, mood disturbance, anxiety, dementia, and major depressive disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 14 (13-15 indicated cognitively intact). Section I diagnoses indicated the following, Non-Alzheimer's Dementia, depression, psychotic disorder, and other depressive disorders. Review of Resident #24's electronic chart revealed no PASRR II, or exemption located on electronic chart. On 01/22/2025 at 3:00 PM, PASRR documentation for Resident #24 was requested. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/2025 at 3:17 PM the Social Services Director (SSD) confirmed that there had not been a preadmission screening accepted by [State Designated Professional Associates]. The SSD reported that after a phone conversation with [State Designated Professional Associates] on this date, there was no confirmed submission of the 787 form due to revision requests that were not received. The SSD stated that instructions were received by the facility consultant to submit a current PASRR. The SSD was asked if the PASRR prescreening should have been completed prior to admission and stated, Yes. On 1/24/2025 at 10:00 AM, during an interview with the MDS Care Plan Coordinator (CPC)/Interim Director of Nursing (DON). The MDS/CPC was asked how long have they been the MDS coordinator. The MDS/CPC stated about 6 years. The MDS/CPC was asked if they were currently acting DON and stated yes, interim DON, RN supervisor type thing. The MDS/CPC was asked who was responsible for completing PASRR screenings and stated the SSD is responsible for those and most are done prior to admission. The MDS/CPC stated she was familiar with Resident #24 and stated the PASRR should have been done prior to admission, the letter should be included in either the paper chart or electronic record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35684 38200 49866 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure the comprehensive care plan addressed and individualized appropriate care and services for 2 (Residents #27, #236,) of 26 sample mix residents reviewed for care plan. The findings are: 1. Review of Resident #27's Admission Record with a date of 4/3/2024 noted the resident had a diagnosis of dementia. Review of Resident #27's Care Plan, with a date of 4/3/2024 did not note dementia care or medications with black box warnings. Review of Resident #27's Admission Nursing Evaluation dated 6/19/2024 noted Diagnosis: 10. Neurological: Non-Alzheimer's dementia. B. Diagnosis MDS list: Non-Alzheimer's dementia. Review of Resident #27's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/2024 noted a score of 3 (00-07 indicates severe cognitive impairment) on the Brief Interview for Mental Status (BIMS), and the resident had a diagnosis of non-Alzheimer's dementia. It also noted the resident was currently taking insulin, antipsychotic, anticoagulant, diuretic and had diagnoses of heart failure, hypertension, diabetes mellitus, anxiety, depression, psychotic disorder (other than schizophrenia), and hypothyroidism. Review of Resident #27's Medication Administration Record (MAR) dated January 2025 did not note an area to document resident ' s targeted behaviors and expressions of distress. During an interview with the Assistant Director of Nursing (ADON) on 1/24/2025 at 10:10 AM, she confirmed Resident #27 had a diagnosis of dementia, the MDS with an ARD of 12/28/2024 noted the resident with non-Alzheimer's dementia and she confirmed that Resident #27 was not care planned for dementia that would target behaviors and expressions of distress. During an interview with the MDS Coordinator on 1/24/2025 at 10:36 AM, she confirmed Resident #27 had a diagnosis of dementia, the MDS with an ARD of 12/28/2024 noted the resident with non-Alzheimer's dementia and she confirmed that Resident #27 was not care planned for dementia that would target behaviors and expressions of distress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview with Resident #236 on 1/21/25 at 11:50 AM, the resident revealed two toenails were missing. The great toe and one next to it had nails ripped out prior to admission. The resident ' s right foot was observed with a dressing in place. This surveyor observed Resident #236 with an oxygen concentrator in the room running at five (5) liters per minute (LPM). A breathing device used to treat sleep apnea (Bilevel Positive Airway Pressure (Bi-pap) was also observed in the resident ' s room. Review of Resident #236's Care plan dated 1/7/2025 did not note wounds to toes on the right foot. Resident #236 also had altered respiratory status with difficulty breathing related to diagnosis. Used oxygen and continuous positive airway pressure (CPAP) see medical doctor (MD) orders. Review of Resident #236's Admission Nursing Evaluation dated 1/7/2025 noted right toes 1st and 2nd toenail. Admission nursing evaluation also noted 8. Review of Systems A. Respiratory: 5. Does the resident have, need or use any of the following? a. Oxygen c. CPAP. 5c. CPAP/ BiPAP/ Trilogy specify (order, frequency, settings, when to apply/ remove and any pertinent information) see chart. Review of Resident #236's Admission Record dated 1/7/2025 noted the resident was admitted with diagnoses of acute respiratory failure with low oxygen (hypoxia), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. Review of the Medicare 5- Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/9/2025 noted in Section O0110. Special Treatments, Procedures, and Programs G2. Bi-pap No; G3. Review of Resident #236's Order Summary Report dated 1/22/2025 noted clean right 1st and 2nd toes with wound cleanser, pat dry, apply triple antibiotic ointment (TAO) cover with non-adherent pad, hold in place with 4x4 gauze and [name brand dressing] Monday, Wednesday, Friday and as needed every day and as needed if soiled/missing, and BiPAP settings: fi02 40%, IPAP 10, EPAP 5, Rate 12. There were no directions on the order to monitor settings or frequency of use. During an interview with Resident #236 on 1/23/25 at 9:50 AM, the resident confirmed wearing the bi-pap every night. The resident verified staff did not monitor the bi-pap settings. During an interview with the Assistant Director of Nursing (ADON) on 1/24/2025 at 10:10 AM, she confirmed Resident #236 was admitted to the facility with two missing toenails on the right foot and confirmed the resident was not care planned for the missing toenails and wound care. She also confirmed the resident wore a bi-pap nightly and confirmed it was not noted on the care plan in order for staff to know how to properly care for residents. During an interview with the Minimum Data Set (MDS) Coordinator on 1/24/2025 at 10:36 AM, she confirmed Resident #236 was admitted to the facility with two missing toenails on the right foot and confirmed the resident was not care planned for missing toenail and wound care. She also confirmed the resident was not care planned for bi-pap use. Review of facility policy titled, Nursing Services Policy, noted residents will be assessed and individual plans of care will be developed to determine the nursing staff required to provide nursing and related services to attain or maintain the highest practical level of physical, mental and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy for care plans was requested from the Administrator and on 01/23/25 at 02:51 PM the Administrator stated no policy for care plans

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 38200 49981 Based on observation, interview, record review, and facility document review, it was determined that the facility failed to ensure resident ' s physician orders for a breathing device (bipap) had instructions for monitoring and frequency of use for 1 (Resident #236) of 1 sample mix residents with orders for bi-pap machine and to ensure fall assessments were completed for 1 (Resident #6) of 1 sample mix resident reviewed for fall assessments. The finding are: 1. During an observation on 1/21/25 at 11:56 AM, this surveyor observed Resident #236 with an oxygen concentrator in the room running at five (5) liters per minute (LPM). A breathing device used to treat sleep apnea (Bilevel Positive Airway Pressure (Bi-pap)) was also observed in the resident ' s room. Review of Resident #236's Admission Record dated 1/7/2025 noted the resident was admitted with diagnoses of acute respiratory failure with low oxygen (hypoxia), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. Review of the Admission Nursing Evaluation dated 1/7/2024 noted 8. Review of Systems A. Respiratory: 5. Does the resident have, need or use any of the following? a. Oxygen c. CPAP. 5c. CPAP/ BiPAP/ Trilogy specify (order, frequency, settings, when to apply/ remove and any pertinent information) see chart. Review of Resident #236's Care plan dated 1/8/2025 noted the resident had altered respiratory status with difficulty breathing related to diagnosis. Used oxygen and continuous positive airway pressure (CPAP) see medical doctor (MD) orders. Review of the Medicare 5- Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/9/2025 noted in Section O0110. Special Treatments, Procedures, and Programs G2. Bi-pap No. Review of the Order Summary Report dated 1/22/2025 noted BiPAP settings: fi02 40%, IPAP 10, EPAP 5, Rate 12. There were no directions on the order to monitor settings or frequency of use. Review of Resident #236's Medication Administration Record (MAR) dated January 2025 did not have an area to document CPAP/ BiPAP use. During an interview with Resident #236 on 1/23/25 at 9:50 AM, Resident #236 confirmed wearing the bi-pap every night. The resident verified staff did not monitor the bi-pap settings. During an interview with the Assistant Director of Nursing (ADON) on 1/24/2025 at 10:10 AM, she confirmed Resident #236 wore a bi-pap nightly and confirmed the order summary report did not note directions for monitoring or frequency of use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Coordinator on 1/24/2025, she confirmed the Medicare 5-day MDS did not note the resident had a bi-pap and that the order summary report did not note direction for monitoring or frequency of use. 2. On 01/21/2025 at 1:03pm, Resident #6 was observed sitting in a recliner in the bedroom with some facial bruising around the eyes and across the bridge of the nose. On the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/2025, the resident had a score of 00 on a Brief Interview for Mental Status (BIMS), (0-7 indicates severely impaired). Resident #6 was unable to answer questions regarding the bruising. During a record review, a progress note dated 1/14/2025 indicated the resident had a fall in the bedroom and the resident's face hit the walker. The nurse was notified along with the physician, and family representative. A record review was done of the resident's medical chart and the last fall risk assessment unscheduled documented was on 8/07/2024. The last quarterly fall risk assessment was dated 12/26/2024, which indicated that resident #6 did not have a fall risk assessment since the fall on 1/14/2025. In an interview with the interim Director of Nursing (DON) on 01/24/2025 at 9:57am, the DON confirmed that nursing documents in the facility's electronic medical charts of resident's falls and a fall risk assessment should be done immediately following a fall. In an interview with Assistant Director of Nursing (ADON) on 01/24/2025 at 10:07am, the ADON was asked who completed fall risk assessments. The ADON stated they are done quarterly and after a fall. The ADON confirmed resident #6's fall that happened on 1/14/2025 was just overlooked because the DON was the responsible person for monitoring the falls and was no longer an employee at the facility. The incident most likely fell through the cracks between the DON and the interim DON. A policy and procedure was requested on quality of care and accuracy of assessments. The ADON confirmed that the facility did not have a policy or procedure for quality of care or accuracy of assessments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38200 Based on observation, record review, interview, and facility document review, it was determined that the facility failed to ensure fall mats were maintained in good condition for 1 (Resident #82) of 1 sample mix resident whose fall mats were observed. During an observation of Resident #82 on 1/21/25 11:11 AM, this surveyor observed the resident lying in bed on their back at a forty-five (45) degree angle. A fall mat was present on one side of the bed. One side of the bed was against the wall, with a fall mat approximately 6-8 inches away from the other side of the bed. The fall mat was observed to have rips/tears on it. Review of Resident #82's Care plan dated 1/3/2024 noted the resident was at risk for falls related to impaired safety awareness. The resident was documented as having falls on: 8/29/2024 fall- Intervention on 8/29/2024 noted dysem (non-slip material) to wheelchair 9/03/2024 fall- Intervention on 9/03/2024 noted fall mat 9/12/2024 fall- Intervention on 9/12/2024 noted medication review 9/25/2024 fall- Intervention on 9/25/2024 staff instructed resident not to be left without visual supervision while up in wheelchair During an interview with Certified Nursing Assistant (CNA) #9 in Resident #82's room on 1/24/2025 at 10:07 AM, she confirmed the fall mat was 6-8 inches from the bed and it had rips/ tears. CNA #9 confirmed the fall mat had not been properly maintained and should not have rips/ tears and should be placed by the edge of the resident ' s bed. During an interview with the Assistant Director of Nursing in Resident #82's room on 1/24/2025 at 10:10 AM, she confirmed Resident #82 had rips/ tears on the fall mat and that the fall mat was too far away from the resident ' s bed and should be placed near the edge of the bed. The ADON confirmed the fall mat needed to be replaced. Review of facility policy titled, Accident Hazards Prevention noted resident environment will be free from accident hazards as is possible. The frailty of some residents increases their vulnerability to hazards in the resident environment and can result in life-threatening injuries. It is important that all staff understand the facility's responsibility, as well as their own, to ensure the safest environment possible for residents. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. Encourage the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise; Directs resources to address safety concerns; and Demonstrates a commitment to safety at all levels. Resident Assessment. Resident/ Elders will receive adequate supervision and assistance devices to prevent accidents.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 38200 Based on record review, interview, facility document review, and facility policy review, it was determined the facility failed to ensure necessary care and services were provided related to dementia care, as evidenced by failure to ensure residents were assessed prior to admission to a closed unit to determine if placement on the unit was appropriate for the resident and failure to ensure sufficient staff with training in care of residents with dementia and behaviors were available to provide care to the residents who resided on the closed unit in accordance with the comprehensive assessments and plans of care for 1 (Resident #27) of 7 (Residents #1, #2, #4, #6, #12, #19, and #27) case mix residents who had behaviors and resided on the closed unit. The findings are: Review of Resident #27's Admission Record with a date of 4/3/3034 noted the resident had a diagnosis of dementia. Review of Resident #27's Care Plan, with a date of 4/3/2024 did not note dementia care. Review of Resident #27's Admission Nursing Evaluation dated 6/19/2024 noted Diagnosis: 10. Neurological: Non- Alzheimer's dementia. B. Diagnosis MDS list: ak. Non-Alzheimer's dementia. Review of Resident #27's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/2024 noted Resident #27 had a score of 3 (00-07 indicates severe cognitive impairment) on the Brief Interview for Mental Status (BIMS), and the resident had a diagnosis of non-Alzheimer's dementia. Review of Resident #27's Medication Administration Record (MAR) dated January 2025 did not contain an area to document resident targeted behaviors and expressions of distress. During an interview with the Assistant Director of Nursing (ADON) on 1/24/2025 at 10:10 AM, she confirmed Resident #27 had a diagnosis of dementia, the MDS with an ARD of 12/28/2024 noted the resident with non-Alzheimer's dementia and she confirmed that Resident #27 was not care planned for dementia that would target behaviors and expressions of distress. During an interview with the MDS Coordinator on 1/24/2025 at 10:36 AM, she confirmed Resident #27 had a diagnosis of dementia, the MDS with an ARD of 12/28/2024 noted the resident with non-Alzheimer's dementia and she confirmed that Resident #27 was not care planned for dementia that would target behaviors and expressions of distress.

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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. 03508 49981 Based on observation, interview, record review, and facility policy review, the facility failed to ensure food stored in the freezer was covered or sealed; manufacturer's instructions were followed; 1of 2 ice machines on B-Hall was maintained in clean and sanitary condition; the kitchen floor and door frames were maintained in good repair and were free of chips, paint peeling, stains and rust; baseboards were secured and were maintained in clean sanitary conditions; and dietary staff washed their hands before handling clean equipment or food items for 2 of 2 meals observed. The findings are: 1. On 1/21/2025 at 10:33am during the initial tour of the kitchen, Dietary [NAME] (DC) #1 was asked to pull out the grease trap under the stove top. DC #1 pulled the slide out drawer beneath the stove top and the aluminum foil covering the top was covered in a 16-inch by 6-inch area of charred food particles and spillage. DC #1 was asked how often the grease traps were cleaned. DC #1 said that the grease traps were checked and cleaned once per week. DC #1 confirmed that the grease traps were dirty. 2. On 1/22/25 at 2:18 PM, an opened box of steak fingers was on a shelf in the walk-in freezer. The box was not covered or sealed. 3. On 1/22/25 at 2:21 PM, a box of hamburger buns was on a shelf in the storage room. The manufacturer's specifications on the box indicated it should be kept frozen at 0 degrees Fahrenheit or below. There were also 4 bags of hamburger buns, with 12 buns in each bag. DC #1 was interviewed and asked if the box of hamburger buns should have been stored in the storage room. She stated she did not have space in the freezer to store it but was not aware hamburger buns needed to be frozen. 4. On 1/22/25 at 2:50 PM, a container of cottage cheese was on a shelf in the refrigerator. The lid was cracked, exposing cottage cheese. 5. On 1/22/25 at 2:53 PM, DC #1 opened the cabinet, grabbed containers of spices, and checked their expiration dates, contaminating her hands without washing her hands. She used her contaminated hands to pick up loose filters which were intended for use when brewing coffee and handed them to Dietary Aide (DA) #2 to store them in a bag for later use. The Dietary Manager was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment she confirmed her mistake, stating she should have washed her hands and disposed of the coffee filters since they were touched with contaminated hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 1/22/25 at 3:03 PM, DA #2 lifted the trash can lid and threw away tissue papers, contaminating his hands. Without washing his hands DA #2 placed gloves on his hands contaminating the gloves in process. DA #2 then used his contaminated gloved hands to pick up glasses that contained beverages to be served to the residents for lunch and placed them on the trays. DA #2 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment. He stated he should have washed his hands. 7. On 1/22/25 at 3:12 PM, an opened box of egg rolls was on a shelf in the freezer. The box was not covered or sealed, exposing egg rolls to freezer burn. The bottom of the freezer had dried brown stains smeared on it. 8. On 1/22/25 at 3:31 PM, the following observations were made in the kitchen areas: a. The bottom of the deep fryer had an accumulation of grease buildup on it. DC #3 was interviewed and asked how often she cleaned the bottom of the deep fryer. She stated she cleaned it 2 times a week. DC #3 was asked if the area looked like it had been cleaned 2 times a week and she stated it had not been cleaned. b. The floor between the oven and the deep fryer had an accumulation of caked on grease buildup with loose food crumbs on it. c. The grease trap under the grill had an accumulation of black greasy residue and mixture of greasy food particles settled on the walls of it. DC #1 was interviewed and was asked how often she cleaned the grease tray and stated the kitchen staff cleaned it every night. DC #1 was asked if the grease trap looked like it had been cleaned every night. She confirmed it had not been cleaned. d. The floors and the edges of the food preparation counter had accumulations of loose food crumbs and grease. e. Three of three trays on the counter by the steam table where clean plates were placed face down had loose food crumbs on them. f. The bottom of the food preparation counter where the cutting board and pans were kept had loose food crumbs on it. g. The bottom of the steam table where plate covers were kept had loose food crumbs on it. h. A cart by the steam table where food trays were kept had loose food particles on it. i. The floor throughout the kitchen had black stains. 9. On 1/22/25 at 4:49 PM, DC #3 used a tissue to wipe off spilled food from the food preparation counter, contaminating her hands. Afterward, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for supper. DC #3 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she had contaminated the blade, and she should have washed her hands before touching the blade. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 1/22/25 at 5:15 PM, DC #3 picked up a spray bottle and placed it on the counter, contaminating her hands. Without washing her hands, DC #3 picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for supper. 11. On 1/23/25 at 9:34 AM, the area in the ice machine panel located in the dining room on B-hall (Unit) where ice forms before dropping into the ice collector had wet black and brownish colors on it. DC #1 was asked if she could wipe the area. The black and brownish residue easily transferred to the tissue. DC #1 was interviewed and was asked to describe what was observed, who used the ice from the ice machine, and how often she cleaned it. She confirmed the area was dirty and had black and brown residue on it, the maintenance man cleaned it once a month, and the CNAs [Certified Nursing Assistants] used it to fill beverages served to the residents who reside on B-Hall at mealtimes and for the water pitchers in the residents' rooms on B-Hall. 12. On1/23/25 at 9:45 AM, the Maintenance Director was interviewed and was asked how often he cleaned the ice machine. He stated he cleaned it once a month, and stated it was old and dirty. 13. On 1/23/25 at 12:37 PM, DA #4 opened the refrigerator, removed a bag of fresh lettuce, and placed it on the counter. DA #4 then opened the bag, removed one lettuce head, and placed it on the cutting board, without rinsing the lettuce. DA #4 sliced the lettuce and placed the pieces in a bowl. DA #4 then removed a fresh tomato from a box in the refrigerator and placed it on the cutting board, without rinsing it. DA #4 sliced the tomato and placed the pieces on top of the lettuce, creating a tossed salad. DA #4 covered the bowl with a plastic lid and placed it on the counter. Then DA #4 picked up the bowl of tossed salad to send it out with a meal tray to the resident who requested it with their lunch meal. DA #4 was interviewed and asked what she should have done before processing fresh tomato and fresh lettuce for use. She confirmed she should have rinsed them, then removed it and prepared a new one after rinsing the lettuce and tomato. 14. A review of facility policy titled, Handwashing and Glove Usage in Food service, initiated 2016, provided by the DC #1 on 1/23/2025 indicated, food handlers should wash their hands before starting work, after touching dirty dishes or clothing and after touching anything else such as dirty equipment. 15. On 01/21/2025 at 12:35pm, Certified Nursing Assistant (CNA) #6 passed out residents ' food trays and did not sanitize in between each resident. CNA #6 passed the food tray to a resident, assisted them setting up their plate, and then went and got another food tray for another resident. 16. On 01/23/25 12:52pm, CNA #6 was observed passing meal trays to residents. CNA #6 did not wash or sanitize hands between each resident's food tray. CNA #6 picked up a cellphone that was lying on the kitchen counter and touched the screen a few times with the right index finger then laid it back down on the counter. CNA #6 picked up another resident's food tray and took it to a resident's room. CNA #6 returned to the kitchen and picked up another food tray and took it to a resident sitting at the table. 17. On 1/23/2025 at 12:59pm, CNA #6 was asked what should be done between passing food trays to residents. CNA #6 confirmed that hands should be sanitized or washed between each food tray to prevent spreading infection. CNA #6 was asked what should be done after touching a cellphone and before passing another food tray. CNA #6 confirmed that hands should be washed or sanitized because it was part of infection control. CNA #6 confirmed that she did not wash her hands like she should have. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. On 01/23/2025 at 1:05pm, Licensed Practical Nurse (LPN) #8 was asked what was important to do when passing resident's food trays. LPN #8 stated that hands should be sanitized between each one. LPN #8 confirmed that proper hand hygiene while passing resident's food trays out was part of the facility's infection control and that is something the facility taught its staff. On 01/23/2025 the facility's policy on hand washing and staff in-services were provided. Section G on in-service dated 10/04/2024 indicates that staff should sanitize hands before and after assisting residents with meals.

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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. 38200 49981 Based on observation, interview, facility document review, and facility policy review, it was determined that the facility failed to ensure staff maintained hand hygiene during meal service while on the secured unit to prevent cross contamination and to ensure an indwelling catheter was kept out of a resident ' s trash can and was kept off of the floor for 1 (Resident #79) of 2 (Resident #79, #82) sample mix residents with indwelling catheters. The findings are: During an observation of Resident #79 on 1/21/25 at 2:23 PM, this surveyor observed the resident lying in bed on their left side. An indwelling catheter tube draining yellow urine was observed sitting in the resident ' s trash can. Review of Resident #79's Care Plan dated 1/5/2025 noted the resident required partial to moderate assistance with toileting hygiene and helper does all the effort. Resident #27 had an indwelling catheter related to enlarged prostate. Review of Resident #79's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/12/2025 noted the resident had neurogenic bladder. Section H0100. Appliances A. Indwelling catheter yes. During an observation of Resident #79 on 1/21/25 at 2:27 PM, this surveyor observed Resident #79 sitting in a wheelchair self-propelling down the hallway with indwelling catheter collection bag underneath the wheelchair dragging on the floor. During an interview with Resident #79 on 1/22/25 at 9:28 AM, this surveyor asked the resident why they had an indwelling catheter. The resident stated it helped them with going to the bathroom. This surveyor observed the indwelling catheter bag underneath the wheelchair touching the floor. Review of Resident #79's Order Summary Report dated 1/23/2025 noted enhanced barrier precautions every shift, foley: may replace foley drainage bag as needed (PRN) for blockage/build up. May replace leg band prn related to neuromuscular dysfunction of bladder. During an interview with Certified Nursing Assistant (CNA) #9 on 1/24/2025 at 10:07AM, she confirmed Resident #79's indwelling catheter bag was dragging the floor underneath the wheelchair and was an infection control concern. During an interview with the Assistant Director of Nursing (ADON) at the resident's room on 1/24/2025 at 10:10 AM, she confirmed Resident #79 had an indwelling catheter and that it should not be placed in the resident ' s trash can or dragged on the ground underneath the wheelchair. The ADON confirmed it was an infection control issue and could cause contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/21/2025 at 12:35pm, Certified Nursing Assistant (CNA) #6 passed out residents ' food trays and did not sanitize hands in between each resident ' s tray. CNA #6 passed the food tray to a resident, assisted them setting up their plate, and then went and got another food tray for another resident. On 01/23/25 at 12:52pm, CNA #6 was observed passing meal trays to residents. CNA #6 did not wash or sanitize hands between each resident's food tray. CNA #6 picked up a cellphone that was lying on the kitchen counter and touched the screen a few times with the right index finger then laid it back down on the counter. CNA #6 picked up another resident's food tray and took it to a resident's room. CNA #6 returned to the kitchen and picked up another food tray and took it to a resident sitting at the table. On 1/23/2025 at 12:59pm, CNA #6 was asked what should be done between passing food trays to residents. CNA #6 confirmed that hands should be sanitized or washed between each food tray to prevent spreading infection. CNA #6 was asked what should be done after touching a cellphone and before passing another food tray. CNA #6 confirmed that hands should be washed or sanitized because it is part of infection control. CNA #6 confirmed that she did not wash her hands like she should have. On 01/23/2025 at 1:05pm, Licensed Practical Nurse #8 (LPN) was asked what was important to do when passing residents ' food trays. LPN #8 stated that hands should be sanitized between each one. LPN #8 confirmed that proper hand hygiene while passing residents ' food trays was part of the facility's infection control and that was something the facility taught its staff. On 01/23/2025 the facility's policy on hand washing and staff in-services were provided. Section G on in-service dated 10/04/2024 indicates that staff should sanitize hands before and after assisting residents with meals.