STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045173	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Oaks Health and Rehabilitation	1875 Old Wire Road Camden, AR 71701

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48977 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and to care for each resident in a manner and in an environment that promoted the maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #5) of 4 sampled residents reliant on staff for incontinence assistance. The findings are: 1. Resident #5 had diagnoses of adjustment disorder with depressed mood and morbid obesity. A Quarterly Minimum Data Set with an Assessment Reference Date of 03/29/2024 documented Resident #5 scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and always incontinent of bowel and bladder. A. On 04/15/2024 at 10:00 AM, the Surveyor observed Resident #5 lying side way on bed with feet on the floor, legs open toward the door, clearly visible from the hallway. Resident #5 was wearing a hospital gown that is just above waist exposing an incontinence brief. B. On 04/15/2024 at 10:30 AM, the Surveyor observed 3 staff members pass Resident #5's room. Two staff members looked in the Resident's room as they were passing by with no intervention. C. On 04/15/2024 at 11:20 AM, the Surveyor observed Resident #5 incontinent of stool which had spilled out of the incontinence brief onto the fitted sheet. The Surveyor reported observation to Licensed Practical Nurse (LPN) #1, who then called Certified Nursing Assistant (CNA) #7 into the Resident 's room CNA #6 later entered with a shower chair. The Surveyor observed CNA #6 and #7 perform incontinence care for Resident #5, place a shower lift pad under the Resident, and lift the Resident from the bed to the shower chair using via lift. During the transfer of Resident #5 from the bed to the shower chair, the Resident's buttocks were exposed through the hole in the shower lift pad. The privacy curtain was not pulled to give Resident #5 privacy from the Resident's roommate who was present in the room. D. On 04/15/2024 at 10:41 AM, while standing way across from the Resident #7's room, the Surveyor asked LPN #1 can you tell me what you see? LPN #1 stated, Brief visible. The Surveyor asked LPN #1 with the Resident's brief visible to anyone that walks through the hall, what issue could that be? LPN #1 stated, Invade privacy. (continued on next page)

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 - Some	E. On 04/15/2024 at 12:03 PM, the Surveyor asked CNA #6, When you placed Resident #5 in the shower lift pad and placed the Resident in the shower chair on the bed, what part of her body was exposed? CNA #6 stated, bottom. The Surveyor asked CNA #6, Who was in the room other you, CNA #7, and I? CNA #6 stated, The other Resident. The Surveyor asked CNA #6 if the other Resident was able to observe Resident #5's bottom. CNA #6 stated, Yes, she could. The Surveyor asked CNA #6 what issue this could potentially cause for Resident #5. CNA #6 stated, dignity. F. On 04/18/2024 at 12:40 PM, the Surveyor asked the Director of Nursing (DON) if a Resident is lying sideways in the bed uncovered facing the door and the curtain was partially pulled and the Resident's incontinence brief is visible from the hall, what issue could that cause for the Resident. The DON stated, dignity. The Surveyor asked, if staff is transferring a Resident via lift with the Resident's buttock exposed from the bed to the shower chair and the curtain is not pulled allowing privacy from a roommate, what issue could that cause the Resident? The DON stated dignity. G. On 04/18/2024 at 01:15 PM, the Surveyor was provided a policy titled Dignity that documented Each Resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Surveyor: [NAME], [NAME] Based on observation, interview and record review, the facility failed to evaluate and determine if a resident was mentally and physically able to self-administer medication for 2 (Residents #33 and #44) of 2 sampled residents who had medications left at the bedside. The findings are: 1. Resident #33 had diagnoses of Rheumatoid Arthritis and Systemic lupus. According to Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 03/27/2024, Resident #33 scored a 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. Resident #33 had an order for Nystatin-Triamcinolone external ointment apply to breast folds every day and evening shift for yeast but there was not order for the anti-fungal powder. According to the Treatment Administration Record (TAR) the Nystatin-Triamcinolone was signed by a nurse. b. Review of Resident #33's Care Plan showed no documentation that Resident #33 self-administers medication. c. On 04/15/2024 at 11:44 AM, the Surveyor noted Antifungal powder on the bedside table and Nystatin-Triamcinolone cream in a basket next to the Resident. Resident #33 voiced that she puts the medication on reddened areas. d. On 04/15/2024 at 01:19 PM, the Surveyor asked Licensed Practical Nurse (LPN) #1 if there should be medications left at Resident #33's bedside. LPN #1 stated, no, and removed the antifungal powder and Nystatin-Triamcinolone cream from the Resident's bedside. e. On 04/18/2024 at 12:40 PM, the Surveyor asked the Director of Nursing (DON) to provide the facility's requirements for a Resident to self-administer medications. The DON stated, They are not allowed to self-administer meds. The Surveyor asked the DON to confirm that no residents self-administer medications. The DON stated, No, not to my knowledge. The Surveyor asked the DON if medications should be left at the bedside. The DON stated, no. f. On 04/18/2024 at 12:40 PM, the Surveyor was provided a policy titled Self-Administration of Medications documented 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other resident, if safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. 2. Resident #44 had diagnoses of Gastro-esophageal reflux disease without esophagitis (heartburn) and mild cognitive impairment of uncertain or unknown etiology (cause). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A Physician's orders dated 09/10/2022 documented, [named brand of an antacid used to relieve heartburn, sour stomach, acid indigestion, and upset stomach associated with these symptoms] Tablet Chewable . Give 1000 mg by mouth with meals . There was no physician's order that the resident could self-administer medications. b. A Quarterly MDS with an ARD of 02/02/2024 documented a BIMS score of 15 (13-15 indicates cognitively intact). c. A Care Plan dated 02/15/2024 documented Resident #44 was at risk for impaired cognitive function or impaired thought processes and required one thought, idea, question, or command be presented at a time. There was no documentation that the resident was able to self-administer medications. d. An April electronic Medication Administration Record (eMAR) documented, [named brand antacid used to relieve heartburn, sour stomach, acid indigestion, and upset stomach associated with these symptoms] Tablet Chewable . Give 1000 mg by mouth with meals . 0800 (8:00 AM) 1200 (12:00 PM) 1700 (5:00 PM) . There were initials in the boxes for 4/15/24 at 0800 and 1200. e. A review of Resident #44's assessment section had no documentation that indicated the resident had been assessed to self-administer medications. f. On 04/15/2024 at 12:02 PM, Resident #44 was not in the room. On the bedside table there was a pill cup with one tablet labeled [named brand antacid] inside. At 12:18 PM Resident #44 was propelled to the room in a wheelchair by staff a member. The resident reported just returning from an appointment. g. On 04/15/2024 at 12:20 PM, the MDS Coordinator was asked to look in Resident #44's pill cup on the bedside table and tell this Surveyor what was in the pill cup. She looked in the pill cup and said it lools like a [named brand antacid].

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49596 Based on observation, interview, record review and policy review the facility failed to ensure privacy curtains were provided for 1 (Resident #51) sampled resident residing in a semi-private room. The findings include: Resident #51 had diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder. On 04/15/2024 at 01:05 PM, Resident #51 was residing in a semi-private room. There were no privacy curtains in the room. On 04/15/2024 at 01:19 PM, Certified Nursing Assistant (CNA) #3 and CNA #4 stated they did not know why the curtains were not in the Resident's room and they did not know how long they have been down or why they were taken down. On 04/15/2024 at 03:27 PM, there were no privacy curtains in Resident #51 ' s room. On 04/16/2024 at 08:38 AM, there were no privacy curtains in Resident #51 ' s room. On 04/17/2024 at 10:10 AM, there were no privacy curtains in Resident #51 ' s room. On 04/17/2024 at 10:20 AM, review of Resident #51 ' s care plan showed no documentation indicating a privacy curtain was inappropriate for use. On 04/17/2024 at 11:00 AM, Maintenance #1 and #2 stated they have no idea who took the curtains down or why, but they did not take them down. On 04/17/2024 at 11:06 AM, Registered Nurse (RN) #1 stated, I was not aware they were down, and I don't know why they aren't there. When asked what the purpose of a privacy curtain is, RN #1 stated, To protect the resident's dignity and privacy. On 04/17/2024 at 11:08 AM, CNA #5 was asked when the curtains were removed and why. CNA #5 stated, It's been a while since they were taken down to be cleaned, possibly three months ago, but they had to be cleaned. On 04/17/2024 at 11:19 AM, Maintenance was observed hanging two privacy curtains in Resident ' s room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/2024 at 02:05 PM, the Director of Nursing (DON) was asked, What is the purpose of a privacy curtain? The DON stated, To allow privacy to the patient during care and protect their dignity. The DON was asked how long have the curtains been down in Resident #51 ' s room. The DON stated, I just found out this morning that they were down. The DON was asked if it should have taken 3 months to replace the privacy curtains. The DON stated, no. The DON was asked how the staff are providing privacy for the resident. The DON stated, They ' re not, they can't. The DON was asked if the facility had anyone care planned to not have a privacy curtain. The DON stated, Not to my knowledge. I don't know any reason why they would. A review of a facility policy titled, Dignity, dated February 2021, indicated, Policy Interpretation and Implementation, private space and property are respected at all times .The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37925 48977 Based on observation, interview, and record review, the facility failed to ensure that residents had a safe, clean, and/or comfortable environment for 2 (Residents #5, #15) sampled residents. The findings are: 1. Resident #15 had diagnoses of Alzheimer's disease and Neuromuscular dysfunction of bladder. According to a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/2024 Resident #15 scored a 10 (8-12 indicates moderate cognitive impairment) on Brief Interview for Mental Status (BIMS) and was frequently incontinent of bowel and bladder. a. On 04/15/2024 at 10:05 AM, the Surveyor observed Resident #15 sitting in a chair in their room. The room had a strong smell of urine. The Surveyor noted several flies crawling on and around the Resident. The Surveyor noted dirty clothes on the floor. b. On 04/15/2024 at 01:20 PM, the Surveyor observed Resident #15 sitting in a chair in their room. The room had a strong odor of urine and there were several flies on and around the Resident. c. On 04/15/2024 at 03:05 PM, the Surveyor observed Resident #15 sitting in a chair in their room. The room had a strong odor of urine and there were several flies on and around the Resident. d. On 04/16/2024 at 11:54 AM, Resident #15 was sitting in a chair in their room. The room had a strong odor of urine and there were several flies on and around. e. On 04/16/2024 at 03:15 PM, Licensed Practical Nurse (LPN) #3 was asked at the Resident's bedside to describe what was seen. LPN #3 stated, Multiple flies, more than 2 more than 3. f. On 04/16/2024 at 03:25 PM, the Surveyor asked the Director of Nursing (DON) to accompany them to Resident #15's room. Upon approaching the Resident's room, the DON stated to the Surveyor, Watch your step. The Surveyor asked the DON why they should take caution. The DON stated, [Resident #15] pees on the floor. Once at the bedside, the Surveyor asked the DON to describe what was seen. The DON stated, I see flies. The Surveyor asked how many. The DON stated, At least 6. 2. Resident #5 had diagnoses of adjustment disorder with depressed mood and Morbid obesity. a. A Quarterly Minimum Data Set (MDS) with Assessment Reference date (ARD) of 03/29/2024 documented Resident #5 scored 15 (13-15 indicates cognitively intact) on Brief Interview of Mental Status and always incontinent of bowel and bladder. b. A Significant change MDS with an ARD of 08/13/23 documented that Resident #5 required extensive assistance with bed mobility and was dependent for transfer via lift according to care plan. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 04/15/2024 at 12:03 PM, the Surveyor observed Certified Nursing Assistant (CNA) #6 and #7 had moved fall mat to provide care to Resident #5. The Surveyor smelled a strong smell of urine and noted that the floor was wet where the fall mat had been. The Surveyor asked what is that on the floor? CNA #7 stated, Smells like pee. d. On 04/18/2024 at 12:40 PM, the Surveyor asked the DON if a Resident's room smells like urine, there is a wet substance is noted where the fall mat had been, and a staff member states she believes it is urine is that considered cleanliness? The DON stated, No. The Surveyor asked the DON if a room smells like urine, and if there are flies on/around the Resident is that considered cleanliness? The DON stated, No. e. On 04/18/2024 at 01:15 PM, the Surveyor was provided a policy titled Homelike Environment that documented Resident are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary, and orderly environment; f. pleasant neutral scents;

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on observation, interview and record review, the facility failed to clarify orders for the correct flush amount to be administered before and after medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube to decrease the potential for harm for 1 (Resident #52) of 2 sampled residents with a PEG tube. The findings are: Resident #52 had diagnoses of dysphagia (difficulty swallowing), following cerebral infarction (disruption of blood flow to the brain) and encounter for attention to gastrostomy (a medical procedure where a tube is inserted into the stomach). The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2024 revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the Resident was moderately cognitively impaired. Further review of the MDS indicated the Resident had diagnoses of seizure disorder, malnutrition, cognitive communication deficit, and had a gastrostomy. Resident #52 also required a feeding tube for nutrition. A Physician's order dated 07/06/2023 documented, Enteral Feed Order every shift Peg Tube with 175 ml [milliliters] H20 [water] before and after medications and feedings . Physician's orders dated 1/23/24 documented, Enteral Feed Order every 4 hours . Flush 50 ml H2O [water] every 4 hours . Enteral Feed Order . Flush 125 ml H2O before and after meds [medications] and feeding. The orders did not indicate how the flush should be provided, such as by gravity or by pump. A Care Plan dated 02/15/2024 documented Resident #52 required tube feeding related to Dysphagia and swallowing problems. The facility developed interventions indicating the Resident dependent with tube feeding and water flushes and to follow the physician's orders. Resident #52 also had a nutritional problem or potential for nutritional problem related to high blood pressure and diabetes. The facility developed an intervention to observe, record, and report signs and symptoms of malnutrition to the physician. Resident #52's April 2024 electronic Medication Administration Record (eMAR) documented the following: On 04/01/2024 through 04/13/2024 and 04/15/2024, Resident #52 was administered 50 ml flushes six times each day, 04/14/2024 only at 0000 through 1600 (Midnight through 4:00 PM) and on 04/16/2024, only at 0000 and 0400 (4:00 AM). On 04/01/2024 through 04/15/2024, the Resident was administered 125 ml flushes three times each day. On 04/01/2024 through 04/15/2024, the Resident was administered 175 ml flushes three times each day. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	There were medications scheduled at 0800 (8:00 AM), 0900 (9:00 AM), 1300 (1:00 PM), 2000 (8:00 PM) and 2100 (9:00 PM). Per physician's orders, the total amount of water flush would equal to 3,3 of water for a 24-hour period. On 04/15/2024 at 12:27 PM, Resident #52 was lying in bed with eyes closed. [Brand name] feeding was flowing by way of a feeding pump at 60 ml /hr (hour) and the flush was set at 175 ml q [every] 0 hours. The amount of flush documented on the pump showed zero had been administered as of 12:27 PM by the pump. Flush bag had 900ml in the bag. On 04/15/2024 at 03:14 PM, Resident #52's feeding pump set had the flush set to 175 ml q 0 hours and the flush bag had about 900 ml inside and the pump showed 0 ml had been administered by the pump. On 04/16/2024 at 08:26 AM, Resident #52 was lying in bed with eyes closed. Resident #52's respirations were 48 per minute and the Resident's skin appeared clammy. There was a female in a uniform in the room and she washed the Resident's face with a towel. The Resident did not respond, and eyes remained closed. This Surveyor walked to the Resident's right side and spoke to the Resident and the Resident did not respond or move. There was a nurse in the hall with a medication cart and had not made it to the Resident's room at this time. On 04/16/2024 at 08:45 AM, this Surveyor entered the room of Resident #52, and the Resident was lying in bed with eyes closed, skin clammy and respirations were 48 breaths per minute. At 08:48 AM, the Surveyor went to the Assistant Director of Nursing's (ADON) office and asked if she or the Director of Nursing (DON) could come to the Resident's room and check the Resident due to this surveyor's concerns. After the DON assessed the Resident and obtained Resident's vital signs, she stated she was going to get the Practitioner. She left the room, walked to the medication cart where the Treatment Nurse was standing, informed her of the Resident's status and left the area. At 9:03 AM, a female Practitioner entered the Resident's room. On 04/16/24 at 9:04 AM this surveyor waited for the Treatment Nurse to finish passing medication she had prepared and then asked her to come to Resident #52's room. She was asked to look at the Resident's feeding pump and tell surveyor the rate on the machine for the Resident's flush. She walked to the pump, looked at the display screen and stated, Oh, it says 0 every hour. This surveyor and the Treatment nurse exited the room and went to nurse's medication cart. She was asked, Do you know if [Resident #52] is supposed to have a rate set, such as q 1 hour or so? She stated, I don't know. I usually don't work over here. I do treatments and I just got pulled over here. A review of Progress Notes indicated on 4/16/2024 at 9:15 AM, . Resident very lethargic [sluggish] not alert or waking up to sterna rub, vitals- T [temperature]-101.4 P [pulse]-153 R [respirations]-48 02 [oxygen] -86% on RA (room air). [Staff Name] looked at Resident upon arrival and ordered to send Resident to [Hospital abbreviated name] ER [emergency room] for observation . (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	On 04/18/2024 at 12:43 PM, LPN #2 confirmed the amount of flush Resident #52 was supposed to receive before and after medications was 175 ml. She confirmed the Resident was not supposed to have a flush rate set on the pump and the Resident received the flush amount by gravity. This surveyor asked LPN #2 to look at the Resident's orders in the electronic health record and she was asked if the Resident had been administered all the ordered flush amounts during her medication pass. She confirmed the Resident had not been administered all the ordered flush amounts, although all the amounts had been signed on the eMAR as being administered on 04/16/2024 during her time on shift. She confirmed the Resident's flush orders should have been clarified. When she was asked who clarifies the orders with the physician, she stated the RD (Registered Dietician) would be the one who clarified the flush orders since she made the recommendations. On 04/18/2024 at 04:06 PM, the DON confirmed that any concerns with a Physician's order would be clarified by the nurse taking care of the patient. On 04/18/2024 the DON was asked for Resident #52's hospital records. She stated she would get them and have them entered into the Resident's electronic health record (EHR). The Resident's hospital records with an admitted [DATE] documented on page 10 of 22 a Sodium level of 164 (normal range 135-145), Chloride level of 135 (normal range of 98-107) and on page 12 of 22 the resident's assessment and plan contained the Resident had hyphenate [elevated blood sodium level] with hyperchloremia [elevated blood chloride level] secondary to dehydration [possibly caused by not receiving enough water or fluids]. An Enteral Nutrition policy provided by the DON on 04/18/2024 documented, .11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include .Instructions for flushing (solution, volume, frequency, timing and 24-hour volume) .

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Silver Oaks Health and Rehabilitation	1875 Old Wire Road Camden, AR 71701

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37925 Based on observation, interview and record review, the facility failed to ensure that a narcotic box located in the refrigerator in the medication storage room was permanently affixed in 1 of 1 facility and the facility failed to ensure expired medications in 1 of 1 medication room and in 1 medication cart (100 Hall) of 4 (100, 200, 300 and 400 Hall) medication carts. The findings are: 1. On 04/17/2024 at 02:08 PM, Licensed Practical Nurse (LPN) #3 was interviewed. She was asked to describe the process of disposing medications residents no longer need and she stated, The card is pulled out [from the medication cart], logged in a book in the med [medication] room and placed in the bin in the med room. 2. On 04/17/2023 at 02:13 PM, the 100 Hall Medication Cart was checked and there was a bottle of Cranberry 450 mg (milligrams) tablets with a best by date of 02/24 (February 2024). The nurse was asked to look at the bottle and state the expiration date. She stated, 02/24. She was asked if there were any residents taking this medication and she stated two residents on the 100 Hall took them. 3. On 04/17/2024 at 02:22 PM, LPN #3 and this Surveyor went to the medication storage room on the 100 Hall. There was a black refrigerator sitting on the floor. LPN #3 was asked if there were narcotics inside and she confirmed there were. She opened the door and picked up a metal lock box and sat it on the counter. She asked if the Surveyor needed her to unlock it and after this Surveyor stated yes, she stated she had to get the key from another nurse. At 2:28 PM she returned with keys and opened the narcotic box. The following medications were inside: a. A plastic ER (emergency) kit that was labeled Lorazepam 1 mg/ml (milligrams per milliliter) and three (3) visible syringes and 1 vial of Lorazepam 2 mg /ml were inside. b. There was a 30 ml bottle of Lorazepam with an expiration date of July 2025 for a resident and LPN #3 confirmed the resident was yet in the facility. 4. On 04/17/2024 at 02:38 PM, there was a shelf with over-the-counter pills and one shelf had two bottles of gas eliminating pills and one box was opened. Both boxes had an expiration date of 03/24 (March 2024). LPN #3 was asked to look at the boxes and state what the expiration dates were. She stated, It looks like 24 and I think that's 03. 5. On 04/17/2024 at 02:39 PM, LPN #3 was asked, Who checks the med room for expired meds? and she stated, I don't know. So, the treatment nurse orders all the stock so I'm not sure if she checks it or not. She was asked, Do you know if any residents take gas preventing pills? and she stated, Not on my hall (100 Hall). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A Medication Labeling and Storage policy provided by the Director of Nursing (DON) on 04/18/2024 documented, .Medication Storage .If the facility had discontinued, outdate or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .Controlled substances .and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package distribution systems in which the quantity stored is minimal and a missing dose can be readily detected .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 1 of 1 meal observed. This failed practice had the potential to affect 10 residents who received pureed diets. The findings are: 1. On 04/16/2024 at 08:29 AM, the following pureed were served to the residents on pureed diets for breakfast. a. Pureed sausage was served to the residents on pureed diets. The consistency was lumpy and not smooth. There were pieces of sausage visible in the mixture. b. Pureed biscuit was thick. Pureed eggs were not formed and were separated. 2. On 04/16/2024 at 08:31 AM, the Surveyor asked Certified Nursing Assistant (CNA) #1 to describe the consistency of the pureed foods served to the residents on pureed diets. She stated, Pureed sausage was gritty and pureed bread was thick. 3. On 04/16/2024 at 08:32 AM, the Surveyor asked CNA #2 to describe the consistency of the pureed foods served to the residents on pureed diets. She stated, Pureed sausage was gritty and pureed bread was sticky. 4. On 04/16/2024 at 08:38 AM, the Surveyor asked the Dietary Supervisor to describe the consistency of the pureed foods served to the residents who received pureed diets. She stated, Pureed sausage was gritty and pureed bread was stiff.

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation and interview, the facility failed to ensure food items stored in the freezer were covered and dated, failed to ensure that the kitchen vents were cleaned to provide a sanitary environment for food preparation, floors, the door frames, and ceiling tiles were free of chipped, holes, paint peeling, rust, stains. dietary staff washed their hands when contaminated to decrease the potential for food borne illness for residents receiving food from 1 of 1 kitchen, dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. The failed practices had the potential to affect 89 residents who received meals from the kitchen. The findings are: 1. On 04/15/2024 at 09:48 AM, the following food items on a shelf in the walk-in freezer did not have an open date on them: a. A box of cinnamon rolls. b. A box of dinner rolls. c. A box of biscuits. d. A box of bread sticks. 2. On 04/15/2024 at 09:57 AM, the following spices in the cabinet did not have an open date on them. a. A bottle of imitation banana extract. b. A bottle of red food color. c. A bottle of imitation almond extract. d. A gallon of garlic powder. e. A gallon of parsley flakes. 3. On 04/15/2024 at 10:28 AM, a box of spaghetti with meat sauce was in the freezer. There was no name on the box to indicate whom it belongs to, and the received date was not on the box. 4. On 04/15/2024 at 10:45 AM, the following observations were made in the storage room. a. The air vent in the storage room had rust stains on it. b. The vent had paint peeling, exposing the metal. c. A crack on the inside of the vent. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. A crack on the ceiling tile around the vent. e. Discoloration of yellow /gray stains around the vent. f. Yellow and brown looking stains on the ceiling tile. g. The floor leading to the walk-in refrigerator had gray and rust stains on it. h. The right side of the door frame leading to the walk-in refrigerator was missing, exposing the wood. i. A hole in the door frame that exposed the wood. j. Sage and gray stains on the area that was exposed. k. The left side of the door frame leading to the walk-in refrigerator was chipped, exposing the wood. The door frame also had a sage color on it. l. The ceiling tile above the food preparation counter had an accumulation of black stains on it. m. The vent above the food preparation counter where a mixer was located had lint stuck in their slats. n. The air vent above the 2-compartment (food preparation sink) had rust on it. o. There was a crack around the ceiling tile. p. The air vent above the 3-door refrigerator had black stains on it. The corners of the vent had black dust on it. 5. On 04/15/2024 at 10:58 AM, Dietary Employee (DE #1 opened the door to the kitchen and went to the dining room and immediately DE #1 returned to the kitchen. Without washing her hands, DE #1 picked up clean plates and placed them on the counter to be used in portioning dessert to be served to the residents for the noon meal with her fingers touching inside the plates. 6. On 04/15/2024 at 11:00 AM, DE #1 took out pan liners from the storage room and used them to cover pans of cake. Without washing her hands, DE #1 used it to push slices of cake from a spatula into individual plates to be served to the residents for the noon meal. 7. On 04/15/2024 at 11:08 AM, DE #2 picked a package of napkin from the storage room, opened, and placed it on the counter. DE #3 did not wash her hands when she picked up utensils by the area that went into the mouth and placed them in an individual napkin wrapped for the residents to use when eating their lunch meal. The surveyor asked DE #2 what should you have done after touching dirty objects and before handling clean equipment. DE #2 stated, I should have washed my hands. 8. On 04/15/2024 at 11:28 AM, DE #1 pushed a cart that contained pans of cake towards the steam table. Without washing her hands, DE #1 used her bare hand to pick up slices of cake and placed them in individual plates to be served to the residents for supper meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. On 04/15/2024 at 11:40 AM, DE #3 removed serving utensils from the drawer and placed them on the counter. Without washing her hands, she removed a clean blade from a clean dish rack and attached it to the base of the blender to be used in pureeing food items to be served to the residents who required pureed diets. The surveyor immediately asked DE #3 what should you have done after touching dirty objects and before handling clean equipment? She stated, Washed my hands. 10. A facility policy titled, Employee Cleanliness and Handwashing Technique provided by the Dietary Supervisor on 04/16/2024 at 09:24 AM documented, under Dietary department employees are required to wash their hands on the occasions listed below. a. Before beginning shift. b. Any other time deemed necessary .

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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. 49596 48977 Based on observation, interview, record review, and facility policy review, the facility failed to ensure clean linens were stored away from dirty items to prevent the spread of infection, failed to ensure the Treatment Nurse followed the facility guidelines when performing wound care; failed to ensure a clear bag of clean linens were not placed directly on the floor before being placed on a bedside table and a resident bed; and failed to ensure hand hygiene was performed during incontinence care for 1 (Resident #15) of 3 sampled residents. The findings are: A review of a facility policy titled, Laundry and Bedding, Soiled, dated September 2022, indicated, Storage 3. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination. During an observation of the dirty side of the laundry area on 04/16/2024 at 11:40 AM, the surveyor noted a white wire shelf on the wall above the laundry chemicals, the eye wash station and a black bin tossed in the corner. This white wire shelf contained clean shoes and clean privacy curtains. During an observation of the dirty side of the laundry area on 04/16/2024 at 11:44 AM, surveyor noted a storage closet propped open with a blue barrel. The shelves in the room contain clean pillows and other linens, with green curtains hanging on a hanger which hangs from one of the shelves. During observation and interview of the clean side of the laundry on 04/16/2024 at 12:19 PM, the Surveyor noted 3 cardboard boxes and 2 white laundry baskets being stored directly on the floor below the folding table. Laundry worker #1 was asked what was being stored in the boxes. Laundry Worker #1 stated, Oh those are extra socks, towels and things for the residents. Laundry Worker #1 was asked. What is the problem with storing items in cardboard boxes? Laundry Worker #1 stated Because if it floods in here, they will get wet and molded. Laundry Worker #1 was asked what the problem is with storing these directly on the floor. Laundry worker #1 stated, Because of germs. Resident #42's Treatment Administration Record (TAR) documented: Assess Peri wound area for signs/symptoms of infection everyday shift . Notify MD (medical doctor) or APN (Advance Practice Nurse) if signs or symptoms are present and document -Order Date- 04/09/2024. Cleanse stage II pressure (ulcer) to sacrum with wound cleaner, pat dry, apply [named brand of gel wound and burn dressing], foam dressing 3 x weekly and PRN (as needed) if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing. -Order Date- 04/09/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleanse stage III pressure (ulcer) to R thigh rear with wound cleaner, pat dry, apply collagen and foam dressing 3 x weekly and PRN if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing -Order Date- 04/09/2024. Cleanse stage IV pressure (ulcer) to L BKA (below knee amputation) stump with wound cleaner, pat dry, apply collagen, cover with 4 x 4 gauze, wrap with [gauze], secure with stretch net and tape 3 x weekly and PRN if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing -Order Date-04/09/2024. Cleanse unstageable pressure (ulcer) to R heel with wound cleaner, pat dry, apply [named brand of gel wound and burn dressing] and foam dressing 3 x weekly and PRN if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing -Order Date- 04/09/2024. Cleanse unstageable pressure (ulcer) to R lateral foot with wound cleaner, pat dry, apply [named brand of gel wound and burn dressing] and foam dressing 3 x weekly and PRN if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing. Order Date-04/09/2024. Cleanse unstageable pressure (ulcer) to R outer ankle with wound cleaner, pat dry, apply [named brand of gel wound and burn dressing] and foam dressing 3 x weekly and PRN if dislodged or soiled. every day shift every Mon, Wed, Fri for wound healing -Order Date-04/09/2024. Resident #42's Minimum Data Set with an Assessment Reference Date of 04/07/2024 showed, the Resident was moderately cognitively impaired, and had 1 stage 2, 1 stage 3, 1 stage 4, and 4 unstageable pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/2024 at 03:58 PM, the Treatment Nurse is observed gathering materials to perform wound care for Resident #42. The Treatment Nurse took a handful of blue gloves from the drawer on the treatment cart and put them on the keyboard section of the laptop sitting on the cart. The Treatment Nurse then put the gloves back into the drawer. The Treatment Nurse had prepared a medication cup of [named brand of gel wound and burn dressing] and had laid a packet of Collagen dressing on the top of the treatment cart prior to surveyor arriving to cart. The Treatment Nurse then walked down toward another resident's room but came back to the cart as the other resident was going home. The Treatment Nurse then came back to the treatment cart and took the handful of blue gloves from the drawer on the cart and put them on top of the keyboard of the laptop on the cart. The gloves remained on the keyboard while the Treatment Nurse gathered other supplies. The Treatment Nurse opened the drawer on the cart with bare hands. The Treatment Nurse took a stack of gauze pads out of the drawer with bare hands, sprayed them with Dermal Wound Cleanser and pushed them down into a white Styrofoam cup sitting on top of the treatment cart. The Treatment Nurse had not disinfected her hands since walking down the hall and coming back to the treatment cart. The Treatment Nurse gathered the white Styrofoam cup, a medication cup of [named brand of gel wound and burn dressing] gel, a packet of Collagen Dressing, a red bio-hazard bag, packets of gauze and 2 cotton topped applicators. All supplies were placed into the red bio-hazard bag and taken into the Resident's room and placed on Resident #42 over-the-bed table. At 04:28 PM during wound treatments, the Treatment Nurse dropped the packet of Collagen Dressing onto the floor. The Treatment Nurse then picked up the packet from the floor with her gloved hands and opened the packet, stuck her gloved fingers down into the packet, pulled out the Collagen dressing, placed it on the resident's wound, and completed the dressing of the wound. On 04/18/2024 at 12:07 PM, an interview was conducted with the Treatment Nurse. the Surveyor asked, If during your treatment of a wound you drop something what should you do? LPN Treatment Nurse stated I'm not supposed to use it. I know y'all saw me drop the Collagen packet yesterday and pick it up and use it, I was just nervous. The Surveyor asked what should have happened. The Treatment Nurse said, I should not have used it. On 04/15/2024 at 10:35 AM, the Surveyor observed Certified Nursing Assistant (CNA) #6 walk into a Resident's room carrying 3 clear bags containing linens and placed 1 clear bag on the floor just inside the door. CNA #6 walked into another Resident's room and placed 1 clear bag on the floor just inside the door. CNA #6 walked into a 3rd Resident's room and placed 1 clear bag in the room on the bed. The Surveyor observed CNA #6 walk back to the first room pick up the clear bag and place it on the bedside table. After placing the bag on the bedside table near bed B, CNA #6 removed the linens from the clear bag, made the bed, and exited the room without cleaning the bedside table. CNA #6 entered the second room picked up the clear bag that was on the floor and placed it on bed B on top of the bunched-up blanket at the foot of the bed. After placing the clear bag on the blanket, CNA #6 removed the linens from the clear bag, and made the bed using the same blanket. On 04/15/2024 at 10:45 AM, the Surveyor asked CNA #6, Where did you put those 2 clear bags you had in your hand? CNA #6 voiced that she placed the other 2 bags by the door. The Surveyor asked CNA #6, Where exactly by the door? CNA #6 stated, On the floor. The Surveyor asked CNA #6, After you removed the bag from the floor where did you place it? CNA #6 looked back into that room then stated, On the bedside table. The Surveyor asked CNA #6, What about the second room you entered, where did you place the clear bag after removing it from the floor? CNA #6 said, on the bed. The Surveyor asked CNA #6, Since the bag was initially on the floor then moved to bedside table and/or bed, what issue could that potentially cause? CNA #6 stated, cross 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 04/15/2024 11:20 AM, the Surveyor observed CNA #6 enter the room with a clear bag filled with linen to provide peri-care to Resident #5 with help from CNA #7. The Surveyor observed CNA #6 clean stool from Resident #5 with wipes and discard in the trash. The fitted sheet was soiled therefore removed, but CNA #6 did not have a bag to place the soiled linen. CNA #6 removed dirty gloves and applied clean gloves without sanitizing hands. CNA #6 removed clean linen from bag, cleaned the table with wipes, placed clean linen on the bed side table, and placed soiled linen in an empty clear bag. On 04/15/2024 at 12:03 PM, the Surveyor asked CNA #6, What do you do between glove changes? CNA #6 stated, Sanitize hands. The Surveyor asked CNA #6, Did you do that when you changed your gloves while providing care to Resident #5? CNA #6 stated, no. On 04/18/2024 at 12:40 PM, the Surveyor asked the Director of Nursing (DON), If a staff member places a bag filled with linen on the floor, then on the bedside table and/or Resident's bed on top of a blanket reused, and does not clean the bed side table what potential issue could that cause? The DON stated, infection control. The Surveyor asked the DON, What should be done between glove changes? The DON stated, Hand washing/ sanitizer. The Surveyor asked the DON, Does wiping a bedside table with peri-care wipes count as sanitizing? The DON stated, no. The Surveyor asked the DON, What should be used to sanitize a table? The DON stated, purple top. On 04/18/2024 at 01:15 PM, the Surveyor was provided with the following policies: a. The Handwashing/Hand Hygiene policy showed This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for Hand Hygiene g. immediately after glove removal. b. A second policy titled Policies and Practices-Infection Control that documented Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infection. 37925