| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045191 | A. Building<br>B. Wing | 06/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Good Samaritan Society - Hot Springs Village | 121 Cortez Rd<br>Hot Springs Village, AR 71909 |

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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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>48630<br><br>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to secure residents private health information on facility computers to prevent unauthorized sharing of electronic medical records (EMR), by leaving the EMR open in the hallway without staff present for 1 (Residents #5) of 16 sampled residents who were reviewed for protection on the electronic medical record.<br><br>Findings include:<br><br>A review of a facility policy titled, HIPAA (Health Insurance Portability and Accountability Act) Assigned Security Responsibilities- Enterprise, dated 04/11/2019, indicated, Confirming that Sanford's ePHI (electronic personal health information) receives reasonable and appropriate safeguards to protect its confidentiality, integrity, and availability.<br><br>During an observation on 06/10/2024 at 04:21 PM, the Surveyor observed a facility laptop on the snack cart in the hallway with the facility laptop screen facing the hallway. Visible on the facility laptop screen was Resident #5's electronic health record. Available on the laptop screen for all non-staff members to see was the resident's name with supplement order details and scheduling details. Multiple guests and family members were noted in the hallway with the laptop screen visible.<br><br>During an observation on 06/10/2024 at 4:25 PM, the Surveyor continued to observe the facility laptop on the snack cart in the hallway with the facility laptop screen facing the hallway. Visible on the facility laptop screen was Resident #5's electronic health record. Available on the laptop screen for all non-staff members to see was the resident's name with supplement order and scheduling details. Multiple guests and family members were noted in the hallway with the laptop screen visible.<br><br>During an observation on 06/10/2024 at 4:48 PM, the Surveyor observed Licensed Practical Nurse (LPN) #1 return to the medication cart, then continue to work on computer screen before taking the medication cart down the hallway.<br><br>During an interview on 06/12/2024 at 2:01 PM, LPN #2 was asked by the surveyor, What should be done to the facility laptops prior to leaving them unattended while in the hallway of the facility. LPN #2 stated, The screen should be locked within the electronic health record system prior to walking away in the hallway. LPN #2 confirmed this is performed to protect the privacy and confidentiality of each resident's electronic medical record.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/12/2024 at 03:07 PM, the Director of Nursing (DON) confirmed the facility laptop screen should be locked within the electronic medical record system prior to leaving the laptop unattended in the facility hallway. The DON also confirmed this process is in place to protect the confidentiality of each resident's electronic medical record in the facility. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48630<br><br>Based on observations, interviews, and record review, the facility failed to implement and carry out physician's orders for wound care and to identify new skin changes for 1 (Resident #18) of 1 resident reviewed for skin conditions.<br><br>Findings include:<br><br>A review of a facility policy titled, Skin Tear Treatment and Prevention, dated 05/21/2024, indicated, .To identify and treat skin tears as soon as possible. To promote early wound healing. To prevent further destruction of skin or infection . Skin Tear Treatment Skin tears should be treated before 12 hours have elapsed from the time of a tear so wound healing can begin as soon as possible.Check area of skin tear at least daily. Documentation may be captured in [Facility Computer Software] on the skin observation .<br><br>A review of a facility policy titled, Physician/Practitioner Orders- Rehab/Skilled, dated 04/01/2024, indicated, . Note: The option for the physician/practitioner to select the agent of the prescriber is contained within the standing orders . Wounds: Orders must be obtained for wound care including product to be used, when to be change and when to reassess. A licensed nurse must provide wound care .<br><br>A review of Resident #18's Medical Diagnosis form indicated the facility admitted Resident #18 with diagnoses that included: lack of coordination, difficulty in walking, unsteadiness on feet, abnormal posture, and malaise (a general feeling of discomfort, illness, or lack of well-being).<br><br>The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/2024, revealed Resident #18 had a Staff Assessment of Mental Status (SAMS) score of 3, which indicated the resident had severe cognitive impairment. This MDS showed no skin issues.<br><br>A review of Resident #18's Care Plan revealed the resident had the potential for pressure ulcer development related to altered mental status, immobility, and incontinence. Interventions included educating the resident/family as to causes of skin breakdown including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, initiated on 06/03/2024; and to notify the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care, initiated 06/03/2024.<br><br>A review of the Order Summary Report, revealed Resident #18 had a physician's order with an order date of 05/21/2024 which stated may use standing orders including agent of the prescriber.<br><br>A review of the Treatment Record, revealed Resident #18 had not had any wound care orders appear on the treatment record for the month of June 2024, nor any documentation of any completed wound care that has been performed.<br><br>A review of an Activity of Daily living task Skin Check, revealed Resident #18 had no data found for the past 30 days on the Skin Check task in the resident's electronic health record.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 06/09/2024 at 10:47 AM, the Surveyor noted a skin toned dressing in place to the right elbow with black substance underneath but visible from the external surface.<br><br>During an observation on 06/11/2024 at 9:01 AM, the Surveyor noted 2 white border dressings on the right arm near the elbow, each dressing was dated 06/09/2024. The Surveyor also noted a skin tone colored dressing to the left elbow dated 06/01/2024.<br><br>A review of the Nursing Admit Re-Admit Data Collection ([NAME]) form dated 05/21/2024, revealed Resident #18 had no skin issues at the time of the form completion.<br><br>A review of Wound Data Collection form, revealed Resident #18 had an identified wound to the left elbow which documented a wound wash and bordered foam dressing was applied, this form was completed on 06/01/2024 at 11:49 AM.<br><br>A review of Wound RN [Registered Nurse] assessment dated [DATE], revealed Resident #18 had a left elbow skin tear identified and this was an initial assessment by the RN. The RN also documented the physician was notified regarding wound status, modifications to treatment plan received, and the care plan was updated.<br><br>During an interview on 06/12/2024 at 2:16 PM, Licensed Practical Nurse (LPN) #2 stated that once a skin change is identified the treatment nurse and wound nurse practitioner are notified and they will note the skin issue as well. The treatment nurse practitioner comes every Friday. LPN #2 reported nurses in the facility cannot put a dressing on any open wound without a physician's order.<br><br>During a concurrent observation and interview on 06/12/2024 at 2:34 PM, LPN #4 stated the nursing staff perform weekly skin assessments and if changes are identified the treatment nurse practitioner is notified. Typically, the initial order is to cover with a border dressing, and it will be assessed in person on Friday by the treatment nurse practitioner. LPN #4 stated none of their residents had any skin conditions that required a dressing. LPN #4 accompanied the Surveyor to Resident #18's room and confirmed the Surveyor's observations of the dressings and confirmed the Surveyor's observed dates. LPN #4 stated the dressings were not observed due to not pulling back the covers to view the resident's arms. The Surveyor accompanied LPN #4 to the nurse's station. After reviewing Resident #18's electronic medical record, LPN #4 confirmed there were no orders for skin care dressings and the last skin assessment was completed on 06/01/2024 which was the RN assessment and wound data collection forms completed.<br><br>During an interview on 06/12/2024 at 3:35 PM, the Director of Nursing (DON) was asked about the dressings in place to Resident 18's arms. The DON stated the Certified Nursing Assistant (CNA) should notify the nurses of skin changes during baths or the nurses should identify during the weekly skin assessment. The DON did confirm there were facility standing orders, which were requested by the Surveyor at this time. The DON confirmed there was no physician's orders for wound care in the resident's chart and that there was only the Nursing Admit Re-Admit Data Collection form, wound RN assessment form, and wound data collection form completed. The DON also confirmed there should have been a nursing skin assessment on 05/28/2024, 06/04/2024, and 06/11/2024. The DON stated the charted treatment on 06/01/2024 was completed without a physician's order and no follow up had been completed. The DON also confirmed the other skin conditions on the right arm had not been identified or any orders were put in place.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Standing Orders, revealed the facility had a standing order for wound care: skin tear- unable to approximate edges. The order read: skin tear: cleanse all skin tears with sterile saline wound solution. If unable to approximate edges: apply skin barrier wipe to peri-wound and allow to dry. Apply hydrogel dressing to area and secure with bandage roll. Change every 3 days or PRN [as needed] if leakage or soiling. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>48630<br><br>Based on observations, interviews, and record review, the facility failed to ensure harmful chemicals, nail trimmers, and razors were stored securely to promote resident safety for 1 (Resident #135) of 1 sampled resident reviewed for accidents and hazards.<br><br>Findings include:<br><br>On 06/12/2024 at 4:59 PM, the Administrator stated the facility did not have a policy for chemical storage/hazards.<br><br>A review of the Medical Diagnosis List, indicated the facility admitted Resident #135 with diagnoses that included unsteadiness on feet, difficulty in walking, not elsewhere classified, acute kidney failure, aftercare following joint replacement surgery.<br><br>During an observation on 06/09/2024 at 10:40 AM, a large grey top Germicidal disposable wipe container noted in Resident #135's room on the over the bed table.<br><br>During an observation on 06/09/2024 at 10:52 AM, the Surveyor observed the Bath room on the 300 Hall was fully unlocked with no lock present and the door opened for the Surveyor. Upon entering the room, the Surveyor observed a plastic storage cabinet in the room with a combination lock through a hole on the upper right door but not latched or through both doors. The bottom doors were fully unlocked with no lock present. The cabinet doors were opened for observation. The Surveyor identified:<br><br>A. (2) large spray bottles of a multi surface disinfectant cleaner with a chemical label in place was over 50% full.<br><br>B. (1) 32 ounce (oz) spray bottle of a disinfectant.<br><br>C. (1) disposable razor<br><br>D. (1) small set of nail trimmers<br><br>During an observation on 06/09/2024 at 01:10 PM, a container hand sanitizing wipes were noted in the resident common/activity area across from the nurse's station sitting on the bookshelf at waist high.<br><br>During an observation on 06/09/2024 at 1:13 PM, a large grey top germicidal disposable wipe container was noted in Resident #135's room on the bedside dresser.<br><br>During an observation on 06/09/2024 at 1:59 PM, the Surveyor observed the Bath room on the 300 Hall was unlocked with no lock present and the door opened for the Surveyor. Upon entering the room, the Surveyor observed a plastic storage cabinet in the room with a combination lock through a hole on the upper right door but not latched or through both doors. The bottom doors were fully unlocked with no lock present. The cabinet doors were opened for observation. The Surveyor identified:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A. (2) large spray bottles of a multi surface disinfectant cleaner with a chemical label in place was over 50% full.<br><br>B. (1) 32 oz spray bottle of a disinfectant.<br><br>C. (1) disposable razor.<br><br>D. (1) small set of nail trimmers.<br><br>During an observation on 06/09/2024 at 2:01 PM, the Surveyor observed the bathing/spa room on the 100 Hall. The door was closed but opened with a light touch by the Surveyor. The sign on the door read, Please keep door closed at all times this was in all caps and red letters. There was a keypad lock in place, but the door was not secured shut. Upon entering the room, the Surveyor observed a low wall mounted cabinet. This cabinet did not have locks in place. The cabinet doors were opened for observation. The Surveyor identified the following:<br><br>A. (1) small set of nail trimmers.<br><br>B. (1) 8 oz spray bottle of wound cleanser.<br><br>C. (1) large spray bottle of an all-purpose cleaner.<br><br>D. (1) large spray bottle with a chemical label in place of a multi surface disinfectant cleaner, which was full.<br><br>During an observation on 06/10/2024 at 9:06 AM, a large grey top germicidal disposable wipe container was noted in Resident #135's room on the bedside dresser.<br><br>During an observation on 06/10/2024 at 5:22 PM, a large grey top germicidal disposable wipe container was noted in Resident #135's room on the bedside dresser.<br><br>During an interview on 06/12/2024 at 2:08 PM, Licensed Practical Nurse (LPN) #2 confirmed chemicals should be stored in storage rooms, in medication/treatment carts, or anywhere secure that residents cannot get to them. LPN #2 stated they are to be secure, because a resident could use a germicidal wipe to wipe their face or perineal area and all chemicals are potentially dangerous. LPN #2 confirmed razors and nail trimmers are stored in the facility storage room to keep them out of reach of residents. LPN #2 added that with nail trimmers and razors the residents could cut themselves which could be even worse if they were on a blood thinner.<br><br>During a concurrent observation and interview on 06/12/2024 at 2:53 PM, the Director of Nursing (DON) stated chemicals are always stored in locked areas, and this does not include shower/bathing areas. The DON confirmed nail trimmers and razors should be stored locked up to prevent a resident from cutting themselves especially if they are on anticoagulants. The DON observed at this time with the Surveyor the Bath room on the 300 Hall was unlocked with an unlocked cabinet containing chemicals, razor, and a nail trimmer.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of a facility safety data sheet titled, [Germicidal Disposable Wipes], dated 10/12/2022, indicated, Use as a disinfectant on hard, non-porous surfaces. For professional and hospital use. Description of first aid measures: inhalation- not a normal route of exposure. If symptoms develop move victim to fresh air. Get medical attention if symptoms develop. Eye contact- rinse thoroughly with water. Get medical attention if irritation develops or persists. Skin contact- no first aid should be required. Wash skin with water. Get medical attention if irritation develops or persists. Ingestion- ingestion is unlikely for solid products. No first aid is required for small amounts transferred from hands to mouth.<br><br>A review of a facility safety data sheet for the [All Purpose Cleaner] dated 10/19/2015, indicated, All-purpose cleaner. Reserved for industrial and professional use. Hazardous statements: causes eye irritation. Wash skin thoroughly after handling.<br><br>A review of a facility safety data sheet for the [Multi Surface Disinfectant Cleaner] dated 08/18/2022, indicated, Disinfectant. Reserved for industrial and professional use. Hazardous statements: Causes severe skin burns and eye damage. Harmful if inhaled. Precautionary statement: Avoid breathing mist or vapors. Wash skin thoroughly after handling. Use only outdoors or in a well-ventilated area. Wear protective gloves/protective clothing/eye protection/face protection. If swallowed: rinse mouth. Do not induce vomiting. If on skin or hair take off immediately all contaminated clothing. Rinse skin with water/shower. If inhaled, remove person to fresh air and keep comfortable for breathing. Immediately call poison center/doctor. If in eyes rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Storage: store locked up.<br><br>A review of a facility safety data sheet for the [Disinfectant] dated 03/26/2014, indicated, Disinfectant. Reserved for industrial and professional use. Hazardous statements: causes serious eye damage. Wear eye protection/face protection. Warning! Do not use together with other products. May release dangerous gases (chlorine). If in eyes: rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Immediately call a poison center or doctor/physician<br><br>A review of a facility safety data sheet for the [Hand Sanitizing Wipes] dated 08/09/2018, indicated, Antiseptic. Precautionary Statements: keep away from heat, hot surfaces, sparks, open flames or other ignition sources, no smoking. Use explosion proof, electrical, ventilating, or lighting equipment. Wash thoroughly after handling. Wear eye protection. In case of fire: use water fog, alcohol-resistant foam, carbon dioxide and dry chemicals to extinguish. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49413<br><br>Based on observation, record reviews and interviews, the facility failed to ensure serving items were properly handled, hand sanitation was utilized, the kitchen was free from buildup of unknown substances that had the potential to cross-contaminate food items to be served, equipment was in safe and useable state, open food items were properly closed or sealed and had an open date, food items were not expired.<br><br>The findings are as follows:<br><br>On [DATE] at 10:35 AM, the following observations were made during the initial kitchen tour:<br><br>The right side of the floor water drain grate was broken in 2 pieces. The larger piece inside the floor drain grate were covered in a brownish unknown substance with paint missing. The left side of the floor drain grate had paint missing and was covered in a black and brownish unknown substance.<br><br>The floor under the ice machine had a grimy, sticky looking black and blackish-brown unknown substance.<br><br>The cleaning closet contained boxes directly on the floor.<br><br>The dry goods storage room had unknown stains and spots of black, brown, and various specks of debris, paper, and plastic; one 8 ounce bottle of water and one 6 ounce can of lime soda was on the floor; a 3-tier rolling cart had brownish-orange spills with a blue cloth with purplish colored stains.<br><br>The walk-in freezer and refrigerator doors and walls on either side were covered in a blackish-brown unknown substance. The floor crevasse along the walls had a thick greyish-black substance built up with various white and brown unknown particles.<br><br>A ventilation cover screwed into a wood like frame had a buildup of white, brown and/or grey fuzzy unknown substance.<br><br>A three-tiered cart in the main kitchen area held 1 box of hot breakfast cereal and spaghetti noodles in the original package that was sealed shut with clear wrap. The three-tiered cart had a grimy buildup of a black unknown substance. The Dietary Manager confirmed the cart needed to be cleaned and could have bacteria and cause cross contamination.<br><br>The sandwich refrigerator cart had a white plastic cutting board with numerous cut indentations and a yellowish-brown stain. When the Dietary Manager lifted the cutting board a pool of stagnant whitish liquid covered the surface directly under. The front panel had streaks of brown, white and grey with adhered pieces of white and brown unknown substances. The front right wheel had a buildup of an unknown whitish substance. The floor under the cart had a thick black, white, and grey built up. The Dietary Manager confirmed stagnate pooling water was a concern due to mildew, mold, and bacteria.<br><br>(continued on next page) |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The dishwasher room had 5 dish racks sitting directly on the floor. The floor under the dishwasher, sink compartment and countertop had a blackish build up between the tile grooves and floor drain gratings.<br><br>The dishwasher front had white streaks running down the front. The top had a brownish unknown substance built up around the bottom groove of the detergent and rinse container. The temperature gauge side and cover of the dishwasher had a brown build up and white speckles of unknown substances that adhered to the dish washer outer surface.<br><br>2. On [DATE] at 7:18 AM, the following was observed in the kitchen area:<br><br>The can opener blade had black, orange, and white unknown substances adhered to the blade. On [DATE] at 1:25 PM, the Dietary Manager confirmed the can opener needed to be cleaned and could cause cross-contamination or an allergic reaction.<br><br>A preparation table held 2 desert bowls, 1 stack of Styrofoam plates, and 4 desert bowls that were not covered. One 32 ounce opened bottle of lemon juice was on the prep table. There was not an open date on the bottle and directions showed, refrigerate after opening. The Lead [NAME] confirmed the bowls and Styrofoam plates were not covered and the lemon juice did not have an open date, nor had it been placed in the refrigerator.<br><br>The dishwasher room had 5 dish racks sitting directly on the floor. The floor under the dishwasher, sink compartment and countertop had a blackish build up between the tile grooves and floor drain gratings.<br><br>The dishwasher front had white streaks running down the front. The top had a brownish unknown substance built up around the bottom groove of the detergent and rinse container. The temperature gauge side and cover of the dishwasher had a brown build up and white speckles of unknown substances that adhered to the dish washer outer surface.<br><br>There was one spray bottle of a multi-surface cleaning substance in the serving area on the bottom shelf next to the bread. One bottle of multi-surface cleaning substance was in the kitchen on the bottom shelf of the prep table in front of a one gallon container of white distilled vinegar. The label showed, .All food contact surfaces must be thoroughly rinsed with potable water after use of this product.; Keep out of reach of children .Wash hands thoroughly after handling; .Read Safety Data Sheet before using this product .<br><br>On [DATE] at 1:26 PM, the Dietary Manager confirmed the kitchen and equipment needed to be cleaned so cross-contamination does not occur.<br><br>3. On [DATE] at 7:47 AM, the Food Service Assistant placed his left thumb on the surface area of the plate then place food items on the plate. At 1:27 PM, the Dietary Manager confirmed nothing should meet the plate surface.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045191 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/12/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Hot Springs Village | 121 Cortez Rd Hot Springs Village, AR 71909 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. On [DATE] at 7:50 AM, the Food Service Assistant left the serving area, opened the door between the serving area and kitchen area with his right hand, then placed his right hand on the handle of the can opener. The Food Service Assistant then returned to the serving line and began to serve. The Lead [NAME] informed the Food Service Assistant that hand washing was required prior to serving when you leave the serving area.<br><br>5. On [DATE] at 10:05 AM, during observation of the spice cabinets, the following spices were open and did not have an open date:<br><br>One 18 ounce container of ground cinnamon;<br><br>One 16 ounce container of ground cloves;<br><br>One 16 ounce container of ground all spice;<br><br>One 16 ounce container of ground turmeric;<br><br>One 8 ounce container of cinnamon sticks;<br><br>Two 16 ounce containers of paprika;<br><br>One 13 ounce container of Mediterranean style ground oregano;<br><br>One 23 ounce container of Montreal chicken;<br><br>One 16 ounce container of ground mustard;<br><br>One 20 ounce container of lemon and pepper seasoning salt;<br><br>One 29 ounce container of Montreal steak seasoning;<br><br>One 11 ounce container of ground thyme;<br><br>Two16 ounce containers of chili powder;<br><br>One 18 ounce container of ground white pepper;<br><br>One 6 ounce container of whole rosemary;<br><br>One 14 ounce container of ground cumin;<br><br>One 6 ounce container of rubbed sage;<br><br>One 12 ounce container of poultry seasoning;<br><br>One 26 ounce container of granulated garlic.<br><br>The Lead Food Service Assistant confirmed there were no open dates on the containers.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045191 | A. Building<br>B. Wing | 06/12/2024 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 6. On [DATE] at 10:15 AM, during observation of the spice cabinets the following items were expired:<br><br>One 15-ounce container of dessert sauce mango flavor expired [DATE];<br><br>One 5-ounce container of dill week expired [DATE];<br><br>One 15-ounce container of dessert sauce kiwi lime expired on [DATE].<br><br>7. On [DATE] at 8:45 AM, the following was observed in the walk-in refrigerator:<br><br>The door did not seal properly. At 1:15 PM, the Dietary Manager confirmed the door did not properly seal.<br><br>The following items failed to have an expiration date:<br><br>1 pan of sloppy joe meat;<br><br>1 pan or brown gravy;<br><br>2 pans of mashed potatoes;<br><br>1 pan of mandarin oranges;<br><br>1 pan of roasted potatoes;<br><br>1 pan meatballs and sauce.<br><br>The Lead [NAME] confirmed the items did not have an expiration date. At 1:18 PM, the Dietary Manager confirmed there was not an expiration date and said an expiration date needs to be on the items to know when they are not safe to serve.<br><br>8. The following open items in the walk-in refrigerator did not have an opened date:<br><br>One 12-pound container of potatoes salad;<br><br>One 15-pound box of bacon;<br><br>One box with 4 of 6 packages of 12-pound deli sliced turkey breast.<br><br>One 15-pound box of bacon was not completely sealed.<br><br>At 1:19 PM, the Dietary Manager confirmed the items needed an open date written on the containers or boxes.<br><br>9. On [DATE] at 9:20 AM, the following was observed in the dry good storage area:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | a. A container holding elbow noodles had a black and white unknown substance on the bottom of the container<br><br>b. The opened food items did not have an open date. Food items removed from their transportation boxes did not have a received date nor an open date.<br><br>c. One 6.75-pound can of pineapple slices with a dent by the top rim and a dent by the bottom rim; and another 6 pound can of pineapple slices with a dent on the bottom of the can. The Lead Food Service Assistant confirmed the dents and that the dents could lead to ruptures that could cause botulism.<br><br>d. Six 40-ounce boxes of hashbrown potatoes were past the best by date of [DATE].<br><br>10. On [DATE] at 4:45 PM the Administrator provided Policy for Food-Supply Storage which showed, .Plastic bins may be used if preferred but must be in good repair and washed routinely. Stock items are individually dated with delivery date if removed from the original container .Foods that have been opened or prepared are placed in an enclosed container, dated, labeled, and stored properly .Once meal service is over, cover, date, and label trays of individually portioned items such as desserts, salads, glasses of juice, milk, and supplements . Chemicals are not stored near food items .<br><br>11. On [DATE] at 4:45 PM the Administrator provided a policy for Cleaning Schedule which showed, .Check each equipment item in kitchen for cleanliness and that it is in good repair.7. Dry storage areas: a. Floors are to be swept and scrubbed regularly. b. Walls are to be spot cleaned on an as-needed basis and washed at a minimum annually . 10. Floor drains: a. Wear heavy-duty gloves. b. Clean with drain brush . 14. Walls and vents: a. Wipe up splashes as soon as possible with clean cloth and detergent. b. Schedule thorough cleaning about every six months or at a minimum, annually . 16. Refrigerator, freezer, and gaskets: a. Place on weekly cleaning schedule. b. Report concerning the DFN [Director of Food and Nutrition Services]. 17. Cabinets, drawers, and counter tops: a. Clean and sanitize between uses and at the end of the day. b. Empty and clean drawers weekly. 18. Carts: a. Clean and sanitize at the beginning of the a.m. shift and at least every four hours throughout the day. b. clean wheels weekly .<br><br>12. On [DATE] at 4:45 PM, the Administrator provided a policy titled, Chemical Use and Storage which shows, .5. Chemicals are stored away from the food supply in a separate room, on a shelf and off the floor . |

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| | 045191 | A. Building<br>B. Wing | 06/12/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>48630<br><br>Based on observations, interviews, and record review, the facility failed to perform proper hand hygiene during resident care for 1 (Resident #23) of 1 sampled resident reviewed for tube feeding.<br><br>Findings include:<br><br>1. A review of a facility policy titled, Hand Hygiene- Enterprise dated 03/29/2022, indicated, Hand Hygiene: a general term that applies to either handwashing or applying hand sanitizer. Handwashing includes washing hands with soap and water. Hand sanitizer involves using a waterless antiseptic agent. All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 moments of hand hygiene and 2 zones of hand hygiene. 1. Entering room. 2. Before clean task. 3. After bodily fluid/glove removal. 4. Exiting room. 5. Zones: patient zone and health-care zone. Gloves are a protective barrier for the HCW (Healthcare Worker) according to standard precautions. 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal.<br><br>A review of the Order Summary Report indicated the facility admitted Resident #23 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia following cerebral infarction, and encounter for attention to other artificial openings of digestive tract.<br><br>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/2024, revealed Resident #23 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment and had a feeding tube while a resident.<br><br>A review of Resident #23's Care Plan revised on 02/27/2024, revealed the resident required tube feedings. Interventions included the resident was to receive a nutritional supplement 5 times a day (every 4 hours from 6:00 AM to 10:00 PM daily) and the head of the bed was to be elevated 45 degrees during and 30 minutes after each tube feeding bolus.<br><br>A review of the Order Summary Report, revealed Resident #23 had a Physician's Order dated 11/20/2023 for a nutritional supplement bolus five times a day with 100 cc (cubic centimeters) of water before and after each bolus.<br><br>During an observation on 06/11/2024 at 2:00 PM, Licensed Practical Nurse (LPN) #2 checked the residual of the PEG (percutaneous endoscopic gastrostomy) tube using a large syringe. LPN #2 removed her gloves to retie the resident's gown and did not perform hand hygiene and applied a new pair of clean gloves and finished the task.<br><br>During an interview on 06/11/2024 at 2:26 PM, LPN #2 confirmed contaminated gloves were removed to retie the isolation gown and hand hygiene was never performed before applying a clean pair of gloves. LPN #2 said hand hygiene should be performed when applying a new pair of gloves and removing a used pair to prevent cross contamination to the new pair of gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/12/2024 at 2:49 PM, the Director of Nursing (DON) confirmed hand hygiene should be performed following each glove removal and/or before applying a clean pair of gloves to prevent the transmission of bacteria. |