STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045201	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Woods Health and Rehabilitation	1440 East Church Warren, AR 71671

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37925 Based on observation, record review, and facility policy review, the facility failed to ensure a care plan was revised to reflect the resident's most recent care needs for 1 (Resident #3) sampled resident whose care plan was reviewed. The findings are: Resident #3's medical diagnosis screen was reviewed and indicated the resident was diagnosed with a condition which caused loss of thinking and decision-making skills which interfered with daily life (dementia) and a change in the mental status (altered mental status). A quarterly Minimum Data Set with an Assessment Reference Date of 09/27/2024, was reviewed and indicated Resident #3 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact and was taking the following high-risk drugs: an antipsychotic, an antidepressant, an antibiotic, a diuretic (removes excess fluid) and antiplatelet. Resident #3's Order Summary Report was reviewed and indicated the following orders: a. Bumex (removes excess fluid) 2 milligrams (mg) and give 1 tablet by mouth one time a day and was ordered on 09/22/2024; b. Fluoxetine (antidepressant) 20 mg give 1 tablet by mouth one time a day and was ordered on 07/25/2022; Quetiapine Fumarate (Seroquel- antipsychotic) 25 mg and give 12.5 mg by mouth four times a day for anxiety and was ordered on 09/22/2024 and Tramadol 50 mg and give 50 mg by mouth every 8 hours as needed (PRN) for pain and was ordered on 07/11/2023. The care plan, dated 09/24/2024, was reviewed and indicated Resident #3 was using an antidepressant, a diuretic, and Tramadol for pain but did not indicate which side effects or signs and symptoms to monitor the resident for while taking these high-risk medications. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/2024 at 1:25 PM, the MDS Coordinator was interviewed by another surveyor and stated she was familiar with the Resident Assessment Instrument (RAI) manual and had an active icon on her desktop which keeps the information up to date and accurate at all times. She stated when gathering information for the MDS, she visits and talks with new residents, speaks to staff and reviews the residents' charts. She stated high-risk medications should be care planned, so staff can monitor the residents, the residents' symptoms and positive or negative changes/reactions the residents may have. She stated the nurses and certified nursing assistants know how to care for the residents by their care plan information. She stated she updated the care plans quarterly and when new orders or gradual dose reductions were received. A Care Plans, Comprehensive Person-Centered policy, dated as revised December 2016 and provided by the Administrator, was reviewed and indicated the care plan interventions came from a thorough analysis of information collected from the comprehensive assessment. The care plan policy indicated the assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions change. The care plan policy indicated that the care plan must be updated with certain conditions, one being at least quarterly, in conjunction with the required quarterly MDS assessment.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37925 Based on observation, interview, record review and facility policy review, the facility failed to ensure toenail care was consistently provided during resident care for 1 (Resident #22) sampled resident reviewed for nail care. The findings are: On 10/21/2024 at 11:57 AM, Resident #22 was leaned back in a recliner and the left shoe was off. The toenails were observed to be discolored, thick and had jagged edges. The resident stated the staff used to trim the toenails on bath days, which the resident thought were Tuesdays and Fridays. Resident #22's medical diagnosis screen was reviewed and indicated the resident had a condition which affected the airflow in the lungs and breathing (chronic obstructive pulmonary disease) and a condition in which the heart could not pump blood as efficiently (heart failure). An annual Minimum Data Set with an Assessment Reference Date of 08/04/2024, was reviewed and indicated Resident #22 had a Brief Interview for Mental Status score of 12, which indicated moderately cognitively impaired and required partial/moderate assistance with the bathing activity and supervision/touch assistance with personal hygiene. A care plan, dated 09/25/2024, was reviewed and indicated Resident #22 had an activity of daily living (ADL) self-care performance deficit. The care plan indicated the resident's nail length was to be checked, trimmed and cleaned on bath days and as necessary and required one-person assistance with bathing/showers. An ADL task for bathing document was reviewed and indicated Resident #22's bath days were Tuesday, Thursday and Saturday. The ADL bathing document indicated the resident received a whirlpool bath on 10/11/2024, 10/17/2024 and 10/19/2024; a bed bath on 10/12/2024 and 10/15/2024; refused a bath on 10/18/2024 and received a shower on 10/22/2024. On 10/23/2024 at 9:18 AM, Resident #22 was reclined in a recliner in the room, awake with black house slippers on. Certified Nursing Assistant (CNA) #11 was interviewed with concurrent observations and was asked to take off the resident's left shoe. The resident's toenails on the left foot were thick, the great toenail was jagged, discolored and long. CNA #11 was asked to describe the resident's toenails on the left foot, and she stated the toenails were thick, long, yellowish and sharp. She stated the 11 to 7 CNAs were responsible for providing nail care and nail care was to be provided when the residents were showered. She stated Resident #22's shower days were Tuesday, Thursday and Saturday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 3:00 PM, CNA #5 was interviewed and stated she did give Resident #22 whirlpool baths and provides nail care to all the residents. She stated she believed Resident #22's nail care was provided last week but did not give a date. She stated she did not give the resident a whirlpool on Tuesday, 10/22/2024, as another staff member, CNA #6, assisted the resident with a shower. On 10/24/2024 at 3:39 PM, CNA #6 was interviewed and she stated she started working at the facility on October 5th [2024] and was instructed on what to do when a resident was showered. She stated she did not recall if she gave Resident #22 a shower on 10/22/2024. A Fingernails, Toenails, Care of policy, dated as revised February 2018 and provided by the Administrator, was reviewed and indicated nail care included daily cleaning and regular trimming and trimmed, and smooth nails prevented the resident from accidently scratching and injuring the skin. The policy indicated evidence of ingrown nails, infections, pain, or if nails were too hard or too thick to cut with ease should be reported to the nurse supervisor.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49688 Based on record review and interviews, the facility failed to assess, report and monitor after a fall with a major injury for 1 (Resident #38) of 1 sampled resident. The findings are: A review of the Admission Record, revealed Resident #38 had diagnosis of chronic obstructive pulmonary disease, muscle wasting and atrophy, osteoarthritis, and adult failure to thrive. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/20/2024 documented the resident scored a 06 (Severe cognitive impairment) on a Brief Interview for Mental Status (BIMS). Functional Abilities and Goals resident is dependent to repositioning, rolling left to right and ADL's. The [Named] Fall Scale and Care Plan with an effective date 06/17/2024 revealed a score of 55, which indicated Resident #38 is a fall risk. Review of the care plan revealed interventions were put into place for Resident #38 is a high risk for falls and is to be encouraged to participate in activities that promote exercise, physical activity for strengthening and improved mobility Date Initiated: 11/30/2023 Revision on: 09/16/2024. Ensure fall mat is at bedside Date Initiated: 02/09/2023. Ensure appropriate footwear when ambulating or mobilizing in wheelchair. Date Initiated: 11/13/2024. Follow facility fall protocol provided by Administrator 10/24/2024 at 04:35 PM; Date Initiated: 11/26/2018. Place wedge to prevent him from rolling out of bed. Date Initiated: 10/17/2023 with revision on: 09/16/2024. On 10/21/24 at 10:13 PM, a brief record review revealed an Incidents By Incident Type report dated 09/06/2024 at 11:05 AM, revealed Assistant Director of Nursing (ADON) #7 wrote the physician was contacted on 08/26/2024 due to Resident #38 stating his right knee was hurting and suggested it could have been when the resident rolled out of bed a couple of nights prior. Resident #38 described the night when the resident had rolled out of bed and a couple of Certified Nursing Assistants (CNA) helped the resident off of the floor to the bed. ADON #7 noted there were no reports of the incident, and immediately an investigation began by calling all nursing staff that worked the Friday evening to Monday morning (08/23/2024 -08/26/2024) to interview to find out if anyone was aware of the fall and who helped Resident #38 back to bed. Every staff member stated they were not aware of a fall and did not assist with the transfer back to bed. Immediate Intervention on 09/06/2024 was an X-ray of the R knee. On 09/12/2024 at 10:15 AM, review of the OLTC [Office of Lont Term Care] Incident and Accident Report I&A indicated it was documented by the Administrator that she had notified Resident #38's family members to make them aware of the investigation outcome. The CNA involved had been terminated and reported to the Office of Long-Term Care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/2024 at 09:00 AM, during an interview Certified Nursing Assistant CNA #10 was asked what she would do if she noticed a resident on the floor. CNA #10 stated she would make sure they are safe and ok then go get the nurse and follow her instructions to what to do next. When asked if she had been in-serviced on falls and accidents, she replied yes. When asked if another staff member came to her for help getting a resident off the floor what would she do, she replied she would get the nurse prior to moving a resident. On 10/23/2024 at 09:25 AM, during an interview, CNA #9 was asked what she would do if you noticed a resident on the floor. She stated she would make sure the resident was safe, move things out of the way, go get the nurse and do what she (the nurse) tells me to do. When asked if she had been educated on falls and accidents, she stated yes, she had participated in the in-service on falls and accidents. When asked what if another staff member came to you for assistance to get a resident off the floor, she replied with the same answer always get the nurse first before moving a resident. On 10/23/24 at 09:52 AM, during an interview the Certified Activities Director was asked what she would do if you noticed a resident on the floor. She replied that after making sure they were ok, she would go get a nurse immediately. The Certified Activities Director was then asked what she would do if another staff member asked for help with moving a resident. She stated she would make sure the nurse had assessed the resident first. On 10/23/2024 at 03:56 PM, during a phone interview with a Former CNA, when the surveyor asked if she remembered the incident with Resident #38 falling. She stated yes, someone from state called last week about this and something about some lift they knew nothing about on 08/24/2024. The Former CNA stated CNA #8 came and got her and said my resident needed my assistance. By the time she got there the resident was in bed. She didn't hear anything about the fall until a couple of weeks later. They let her go saying she was texting people and asking them to lie about what happened. She said that didn't make sense to her, and she just took the loss and accepted it. On 10/23/2024 at 04:32 PM, during an interview the Surveyor asked the Director of Nursing (DON) about Resident #38's fall; The Administrator stated the resident was able to tell them the resident had fallen and was trying to get out of bed. During the investigation process we learned one of the aides had walked by and saw it, and began checking the resident out, and got the resident back into bed. We had only learned of this several days later when the resident started complaining of pain. After notifying the doctor for x-rays on 08/26/2024, the results showed nothing. As Resident #38 kept complaining of pain, the Advanced Practiced Registered Nurse (APRN) ordered a Magnetic Resonance Imaging (MRI) of the Resident #38's knee on 09/06/2024, the results were a fracture and torn meniscus. We terminated one CNA and the other CNA, # 8 was suspended at first and then educated one on one, then resuspended, because no lift was used while transferring the resident without using a mechanical lift. After being counseled and educated on not moving a resident without a nurse assessment and lift, she was then able to return to work. The Surveyor asked what interventions were in place and she replied a fall mat, bed low position, wedge and bolster mattress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/2024 at 05:00 PM, during an interview the Surveyor asked the Administrator to describe what happened with Resident #38's fall. She stated the (family member) called to discuss the resident's knee pain. The resident had discussed the fall with them. The Administrator had asked the family more details because she knew the resident couldn't get up on their own, as the resident kept stating the girls helped me, we started interviewing staff. The Former CNA denied knowing anything and we kept calling all staff that had worked that Friday and Saturday night, Another staff member overheard the two CNA ' s outside talking about the incident and the investigation and how they had told CNA #8 to stick with their story and CNA #8 immediately reported it to the administrator with her side of the story. CNA #8 stated the Former CNA came to ask for help with Resident #38 on the floor and she assisted, assuming the nurse was already aware and resident just needed to be transferred back to bed. On 10/24/2024 at 04:35 PM, the Administrator provided a facility policy titled, Assessing Falls and Their Causes, as their Fall protocol which stated when a resident has a fall or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. Obtain and record vitals as soon as it is safe to do so, if evidence of injury, provide appropriate first aid and or obtain medical treatment immediately, if an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position and then document relevant details. Notify residents attending physician and family in an appropriate time frame, when a fall results in a significant injury or condition change, notify practitioner immediately by phone. When a fall does not result in, injury or a condition change notify the practitioner routinely by fax, phone, the next day. Observe for delayed complications of a fall for approximately forty-eight hours after observed or suspected fall and will document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity and or decreased mobility and any changes in level of responsiveness/consciousness and overall function. Complete an incident report for a resident fall no later than twenty-four hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Define details of falls. On 10/25/2024 at 10:00 AM, during an interview the Surveyor asked the Assistant Director of Nursing (ADON) about Resident #38's fall history. The ADON could only remember the resident having this one fall. On 10/25/2024 at 10:30 PM, during an interview the Surveyor asked the Administrator about Resident #38's fall history. The Administrator reported the resident had not fallen since January and provided his fall history documentation. On 10/25/2024 at 10:15 AM, during an interview the Surveyor asked Resident #38, who can answer yes and no answers, are you able to roll left and right in different positions on your own? Resident #38 answered yes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37925 Based on record review, interview, and facility policy review, the facility failed to ensure the process for dispensing controlled substances was consistently implemented to decrease the potential for diversion of medications from one of four medication carts from which a random narcotic count was performed. The findings are: On 10/24/2024 at 1:19 PM, this surveyor and Licensed Practical Nurse (LPN) #3 performed a random narcotic count of the contents of the controlled substance box on the medication cart for halls E and F. During the count, the following were observed: 1. Page 74 indicated Resident #75 had Diazepam 5 milligrams (mg), last signed out on 10/24/2024 at 0900 (9:00 AM) by LPN #3 and 39 tablets (tabs) remaining for the balance. Upon review of the medication card, there were 38 tabs remaining. LPN #3 stated the medication was sent out of the facility at 11:30 AM with Resident #75's family member. (Diazepam is used to treat anxiety, muscle spasms, and seizures.) 2. Page 77 indicated Resident #25 had Hydro-APAP (Hydrocodone-Acetaminophen) 5/325 (5 milligrams per 325 milligrams) tabs with 17 tabs for the balance. The last dose was signed out on 10/24 (10/24/2024) at 0545 (5:45 AM), and the name was illegible. Upon review of the medication card, there were only 16 tablets remaining. The nurse stated she had administered the medication to the resident at 12 noon but had not signed the pill out of the narcotic log. 3. Page 79 indicated a non-sampled resident had Hydro-APAP 7/325 and 9 tabs remaining for the balance and the last dose was signed out on 10/24/24 at 0800 (8:00 AM) by LPN #3. Upon review of the medication card, there were only 8 tablets remaining. LPN #3 stated she had administered the medication to the resident at 12 noon but had not signed the medication out of the narcotic log. On 10/24/2024 at 1:35 PM, LPN #3 was interviewed and stated Resident #75's family member was taking the resident out of the facility for a while and the resident would not be back in time for the 2:00 PM dose of Diazepam. LPN #3 stated around 11:30 AM, she removed a pill, placed it in a clear plastic bag and gave the medication to the Administrator, who was standing at the doorway of the medication room, to take the medication to Resident #75's family member. LPN #4 was sitting in a chair in the medication room and stated she witnessed LPN #3 pass the pill to the Administrator. LPN #3 stated she did not sign the medication out of the narcotic log after it was removed. LPN #3 stated that medication removed from the narcotic box was supposed to be signed out after the medication was removed. She stated the family member who received the medication for the resident leaving the facility was supposed to sign the narcotic book with the nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/2024 at 4:11 PM, the Director of Nursing (DON) was interviewed and stated two nurses performed the narcotic count at shift change. She stated the nurses were required to sign the count sheet as soon as the count was finished. She stated the narcotic log was audited and she was ultimately responsible for this task, but she assigned the task to her nurse manager. She stated she liked to review the narcotic log at least weekly. She stated when a nurse removes a narcotic from the medication cart, the nurse is supposed to sign the medication out immediately. She stated two nurses normally sign the narcotic medication out together in the book (narcotic log). She stated once the medication was signed out of the narcotic log, the medication should be given to the direct family member taking the medication from the facility. She stated the family member receiving the medication for the resident was supposed to sign the narcotic log to indicate the medication was issued. At 4:25 PM, the DON was informed about the concern regarding Resident #75's Diazepam count. The DON was informed about the other controlled medications whose remaining balance on the card did not match the balance in the controlled substance book. A Controlled Substances policy, dated as revised November 2022, was reviewed and indicated controlled substance inventory was monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The policy indicated the nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count and the on-coming and off-going nurse made the count together, documented and reported any discrepancies to the DON. The policy also indicated the controlled substance was not surrendered to anyone except for a resident on pass or therapeutic leave, to a resident or responsible party upon discharge from the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37925 Based on record review, interview, and facility policy review, the facility failed to ensure a pharmacist medication regimen review recommendations were addressed for 3 (Residents #2, #3 and #69) of 5 (Residents #2, #3, #53, #69 and #77) sampled residents who were reviewed for unnecessary and psychotropic medications, and medication regimen reviews (MRRs). The findings are: Resident #3's medical diagnosis screen was reviewed and indicated the resident was diagnosed with a condition which caused loss of thinking and decision-making skills which interfered with daily life (dementia) and a change in the mental status (altered mental status). A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/27/2024, was reviewed and indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact and was taking the following high-risk drugs: an antipsychotic, an antidepressant, an antibiotic, a diuretic (removes excess fluid) and antiplatelet. Resident #3's Order Summary Report was reviewed and indicated the resident had an order for Quetiapine Fumarate (Seroquel-antipsychotic) 25 mg and give 12.5 mg by mouth four times a day for anxiety and was ordered on 09/22/2024. A Pharmacy MRR-Antipsychotic form, dated 09/24/2024, was reviewed and indicated Resident #3 was receiving Quetiapine Fumarate (Seroquel) 12.5 mg by mouth four times a day since 09/22/2024 and recommended a gradual dose reduction or tapering the dose to determine either the most favorable (optimal) dose or if the medication was necessary for the resident as the resident had a documented fall. On 10/15/2024, the Advanced Practice Registered Nurse (APRN) documented on the form to make the changes per pharmacy recommendations. As of 10/25/2024, the medication had not been adjusted. 48390 2. Resident #69's medical diagnosis screen was reviewed and indicated the resident had a condition which caused loss of thinking and decision-making skills which interfered with daily life (dementia) and depression. A quarterly MDS with an ARD of 10/03/2024, was reviewed and indicated Resident #69 had a BIMS of 6, which indicated severely cognitively impaired and was receiving antianxiety and antidepressant medications. Resident #69's Order Summary Report was reviewed and indicated Mirtazapine 7.5 milligrams (mg) every night at bedtime and was ordered on 06/24/2024 for depression and Buspirone 7.5 mg three times a day for anxiety and was ordered on 10/26/2023. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 10/04/2024, was reviewed and indicated Resident #69 was taking an antidepressant and antianxiety medication and listed signs and symptoms to monitor the resident for. A Pharmacy MRR-Anxiolytic form, dated 05/30/2024, was reviewed and indicated Resident #69 was receiving Buspirone 7.5 mg by mouth three times a day since 03/10/2024 and recommended a gradual dose reduction or tapering the medication dose to determine the optimal dose or if the medication was necessary for the resident. There was no response from the attending physician/prescribing practitioner on the form. As of 10/25/2024, the resident was yet receiving the dose indicated above. 3. A review of Admission Record indicated Resident #2 had diagnoses of dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of the care plan initiated on 10/07/24 indicated Resident #2 was on antianxiety therapy related to an antianxiety medication. The facility developed interventions to include to monitor the resident's condition based on clinical practice guidelines or clinical standards of practice related to the use of the antianxiety medication. A review of Order Summary Report indicated Resident #2 had a physician order dated 08/07/2024 for an antianxiety medication and to give 1 tablet via PEG-Tube every 8 hours as needed for anxiety. A review of Medication Administration Records (MARs) from August through October 2024 (08/08/24 through 10/24/2024) were reviewed with the following findings: - August 2024: Nurses' initials documented the antianxiety medication was administered 11 out of the 24 remaining dates of the month (08/08/24 through 08/31/24). - September 2024: Nurses' initials documented the antianxiety medication was administered 17 times, on 14 out of 30 days, - October 2024: Nurses' initials documented the antianxiety medication was administered 4 times on 3 out of 24 days. A review of Medication Regimen Review dated and signed by the Pharmacist on 08/22/2024 showed no discrepancies. During an interview on 10/25/24 at 10:50 AM the Assistant Director of Nursing (ADON) was asked, a PRN (as needed) anxiety medication is supposed to be for how long? The ADON indicated 30 days. The ADON was asked when a PRN antianxiety medication that was ordered on 08/07/24 be reassessed? The ADON indicated it should have already been reassessed by the physician.

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	045201	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Woods Health and Rehabilitation	1440 East Church Warren, AR 71671

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. The findings are: 1. On 10/21/24 at 11:41 AM, during the noon meal preparation Dietary Aide (DA) #1 placed 10 servings of cheesy biscuits into a blender added milk, pureed, and used a #8 scoop to portion it into 10 individual bowls, covered the bowls with lids and placed them in the refrigerator. a. On 10/21/24 at 12:46 PM, 7 of 8 residents did not receive pureed cheesy biscuits. b. On 10/21/24 at 12:56 PM, during an interview DA #1 stated she forgot to serve pureed cheesy biscuit to the remaining 7 residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff thoroughly washed their hands and changed gloves when contaminated; expired food items were promptly removed/discarded on or before the expiration or use by date; foods stored in the freezer, refrigerator and dry storage area were covered, sealed, and dated; and hot food item was maintained at the required temperature on the tray above the steam table for one meal observed. The findings are. 1. During a concurrent observation and interview on [DATE] at 10:02 AM, Dietary Aide (DA) #1 removed bananas from the original box and placed them on the counter, contaminating her hands. DA #1 then peeled off the skin layers from the bananas and placed them on the cutting board and held it with her hands while she sliced them with a knife. DA #1 then transferred the slices of bananas into a bowl on the counter to be used in preparing dessert to be served to the residents for lunch. DA #1 stated she should have washed her hands. 2. On [DATE] at 10:05 AM, an opened box of bread sticks were on a shelf in the freezer with no opened date. 3. During a concurrent observation and interview on [DATE] at 10:09 AM, one pan with 34 thawed biscuits, covered with clear wrap dated [DATE] was on a shelf in the glass refrigerator. When asked about it, Dietary [NAME] (DC) #2 stated they had put it out to thaw in the refrigerator at 8:30 AM, this morning, as it takes time to thaw completely by the next morning. The Dietary Manager confirmed they prepared it this morning at 8:30 AM for the breakfast meal tomorrow, emphasizing the need for adequate thawing time. When asked about the instructions on the box. The Dietary Manager checked and said it indicated that the item should be baked while frozen. The Dietary Manager confirmed it was thawed and they will throw them away. 4. During a concurrent observation and interview on [DATE] at 10:57 AM, DA #1 wore gloves when she picked up the water hose with her bare hands and used it to spray leftover food from inside of the blender. DA #1 placed the blender, a blade, and the lid in the dirty racks and pushed the rack into the dish washing machine to wash. After the dishes stopped washing, DA #1 moved to the clean side of the dishwasher area and picked up a clean blade and attached it to the base of the blender to be used in pureeing foods to be served to the residents who received pureed diets for lunch. DA #1 stated she should have washed her hands. 5. On [DATE] at 11:21 AM, the Station 2 freezer temperature was -10 degrees Fahrenheit, and refrigerator temperature was 39 degrees Fahrenheit. The following observations were made on a shelf in the refrigerator at the nurse's station in Station #2: a. One carton of whole milk with an expiration date of [DATE]. b. One carton of 2% milk with an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. An opened carton of discolored pudding. There was no opened or received date on the carton. The Dietary Manage stated it looked old. d. A bowl of leftover chili with chips. There was no received date and no name to indicate who it belongs to. The Dietary manager stated it looked like it's been there for more than 3 days. It is supposed to be there for 3 days. 6. On [DATE] at 11:36 AM, the following observations were made on the tray on top of the freezer at the nurses' station in Station #2. a. An opened box of vanilla wafers had a best when used by date of [DATE]. b. A bottle of pizza sauce with no name and no received date on it. c. Two bags of smoking crackers with no name and no received date on the bags. d. One box of pizza crust with no name or received date on the box. 7. During a concurrent observation and interview on [DATE] at 11:41 AM, DA #1 wore gloves on her hands when she picked up a pan of cheesy biscuit from the counter in the food preparation room and placed it on the counter by the mixer. DA #1 opened the refrigerator, took out a gallon of milk from the refrigerator and poured some on top of the cheesy biscuits inside the blender. After placing the gallon back in the refrigerator, DA #1 then, attempted to cover the blender bowl with its lid to puree the cheesy biscuits. However, the lid wouldn't fit because the blade wasn't fully attached to the base. DA #1 then used her contaminated gloved hand to adjust the blade at the base of the blender. DA #1 stated she should have washed her hands. She pureed the cheesy biscuits, used #8 scoop to portion the pureed mixture into 10 individual bowls on the tray and placed it in the refrigerator. DA #1 stated she should have washed her hands. 8. During a concurrent observation and interview on [DATE] at 12:24 PM, DA #1 removed the pan with individual bowls of pureed cheesy garlic biscuits from the refrigerator and placed it on top of the steam table. The Dietary Manager was asked if she could check the temperature of cheesy garlic biscuit, she did and stated it was 84 degrees Fahrenheit. DC # 2 stated they were to serve it hot. 9. On [DATE] at 12:29 PM, the following observations were made on a shelf in the refrigerator in Station #1's medication room: a. Two packages of honey buns with an expiration date of [DATE]. b. An opened box of pudding. The box was not covered and there was no open date or received date on the box. The freezer temperature was 0 degrees Fahrenheit. On [DATE] at 12:38 PM, the following observations were made in the freezer: a. One box of salisbury steak with no name or received date on it. b. One box of chocolate chip cookies with no name or received date on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. During a concurrent observation and interview on [DATE] at 4:45 PM, Dietary Aide (DA) #3 was wearing gloves on his hands when he picked up a bread bag from the rack and placed it on the counter. After that, he opened the refrigerator, removed 2 cartons of milk and placed them in the preparation sink, near the blender machine. He then united the bread bag and used his contaminated gloved hands to remove slices of bread from the bag, preparing to put them into a blender to puree. DA #3 stated he should have removed the gloves, washed his hands, and used a tong to pick up the bread. 11. The undated facility policy titled, Employee Cleanliness and Handwashing Technique provided by the Dietary Manager, indicated hands should be washed before beginning a shift and after picking up anything from the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48977 Based on observation, interviews, record reviews, and facility policy review the facility failed to ensure staff donned the proper Personal Protective Equipment (PPE) while performing high contact resident activities for 1 (Resident #76) sampled resident on Enhanced Barrier Precautions (EBP). The findings include: A review of the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/18/2024 revealed Resident #76 had memory problems and a history of coughing/choking during meals or when swallowing medications. A plan of care (revision date: 9/17/2024) revealed Resident #76 required Enhanced Barrier Precautions related to Percutaneous Endoscopic Gastrostomy (PEG) tube. On 10/23/24 at 7:50 AM, the Surveyor observed Licensed Practical Nurse (LPN) #2 administer medication to Resident #76 via PEG tube wearing only gloves, with no additional PPE. On 10/23/24 at 8:00 AM, during an interview LPN #1 stated, I messed up, I did not wear a gown. On 10/23/24 at 2:18 PM, during an interview the Director of Nursing (DON) stated staff should wear a gown and gloves when administering medication through a PEG tube, to protect the resident from potential infections. A policy titled, Enhanced Barrier Precautions, noted that high contact resident care activities requiring the use of gown and gloves include device care or use (central line, urinary catheter, feeding tubes) to prevent the spread of multi-drug resistant organism (MDRO).