STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045377	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Southern Hills	701 South Main Street Rison, AR 71665

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49596 Based on observation, interview and record review, the facility failed to ensure medications were not self-administered without a physician's order, and the interdisciplinary team (IDT) assessed residents to determine self-administration of medications was safe for 1 (Resident #33) of 1 sampled resident. The findings are: On 04/22/2024 at 11:44 AM, a bottle of Nystatin-Triamcinolone Cream was found in Resident #33's bathroom. Resident #33 stated that the resident applies the cream to the resident because of where it is located. On 04/24/2024 at 09:19 AM, a bottle of Nystatin-Triamcinolone Cream was found in Resident #33's bathroom. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/2024 documented Resident #33 scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). Resident #33's Care Plan dated 04/01/2024, did not identify the resident as able or assessed to self-administer medications. The Medication Administration Record (MAR) dated April 2024 documented that Resident #33 had been diagnosed with candidiasis (a fungal infection caused by a yeast (a type of fungus) called Candida) and had a Physician's Order for Nystatin-Triamcinolone Cream to be applied to the abdomen, the groin and under the breasts topically every 24 hours as needed for itching/redness. On 04/24/2024 at 8:52 AM, Licensed Practical Nurse (LPN) #3 stated there were no residents that self-administered medications, and that she was unaware of any resident assessed for self-administration of medications. LPN #3 stated the reason it was important for residents to be assessed for self-administration of medications was to make sure they can actually take the medicine and that it was the right mediation. LPN #3 stated that any resident who had been assessed and approved to self-administer medications would have those medications stored in a locked cabinet in the resident's room. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 09:07 AM, the Director of Nursing (DON) stated there were no residents that self-administered medications, and that there had been no resident assessed for self-administration of medications in over a year. The DON stated the reason it was important for residents to be assessed for self-administration of medications was to make sure they know how to safely do it, to not over or under medicate, and to not allow another resident to have access to their medication. On 04/24/2024 at 9:20 AM, the DON asked Resident #33 where the medicating cream had been obtained. Resident #33 stated one of the nurses left it for the resident to self-administer. The DON explained to the resident that medication cannot be kept at bedside and the resident voiced understanding. On 04/24/2024 at 09:44 AM, the DON was unable to produce a policy for resident self-administration of medications, or a self-administration form.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Based on observation, interview and record review, the facility failed to ensure resident restrooms were cleaned to promote a clean and sanitary environment for 1 (Resident #43) of 1 sampled resident who used the bathroom in their room. The findings are: 1. Resident #43 had diagnoses of weakness and constipation as documented on an order summary. a. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/09/2024 documented the resident had a Brief Interview of Mental Status (BIMS) of 15 (13-15 indicates cognitively intact) and required substantial/maximal assistance with toileting hygiene. b. A Care Plan dated 02/16/2024 documented Resident #43 required assistance with some functional abilities related to weakness and requires assistance of one staff with toileting hygiene. c. On 04/22/2024 at 12:55 PM, Resident #43's toilet had brown stains on the inside and outside of the toilet bowl. d. On 04/23/2024 at 03:38 PM, Resident #43's toilet had brown stains on the inside and outside of the toilet bowl. e. On 04/25/2024 at 06:00 PM, Resident #43's toilet had a brown substance in front of the toilet bowl just below the seat and on the back of the seat. f. On 04/25/2024 at 07:10 PM, Certified Nursing Assistant (CNA) #11 stated that the CNAs were responsible for cleaning the resident's rooms and stated, On bath days, the CNAs goes in the room for deep cleaning. CNA #11 stated Resident #43's bath days were Tuesday and Thursday. g. On 04/25/2024, the Administrative Assistant stated they did not have a policy on cleaning resident rooms.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 (Resident #82) of 1 sampled resident reviewed for elopement. The lack of an effective monitoring plan resulted in Resident #82 eloping from the facility and being found walking in the grass on the side of a public highway, approximately 100 yards from the resident's residence. 1. Resident #82 followed two other residents out to the back patio for their smoke break and staff only checked on residents every 5 to 10 minutes when they were outside the residence. Resident #82 was admitted on [DATE] with a diagnosis of Alzheimer's disease and had an Admission Assessment which indicated the resident was at risk of wandering. On 04/23/2024, Resident #82 verbalized to staff that she lived close by and wanted to walk home. Staff were instructed to closely monitor the resident due to making that statement. At the time of the survey, there were 35 residents residing in the cottages who were identified as at risk for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J; 2. Based on observation, interview and record review, the facility failed to ensure aerosol cans were removed from a resident's room to decrease the potential for harm; 3. failed to ensure hazardous chemicals and equipment were secured in a closed, locked room, from wandering residents. This failed practice had the potential to affect 1 (Resident #29) of 8 residents in Cottage 4 that ambulated or self-propelled; 4. failed to ensure adequate supervision was provided, assistive devices were in place, and interventions were implemented to decrease the potential for accidents for 1 (Resident #20) of 1 resident who was at risk for falls; 1.) Resident #82 was admitted on [DATE] and had an Admission Assessment which indicated the resident was at risk of wandering. On 04/23/2024, Resident #82 verbalized to staff that [Resident #82] lived close by and wanted to walk home. A staff member was instructed to closely monitor Resident #82 due to making that statement. At the time of the survey, there were 35 residents residing in the cottages who were identified as at risk for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ began on 04/23/2024 around 6:00 PM when Resident #82 was seen walking in the grass on the side of a public highway approximately 100 yards from the resident's residence by a facility staff member who was walking to her vehicle after work. The resident was seen exiting the building with two other residents by a staff member. However, the resident left the area without staff knowledge. The Administrator, Administrator Assistant, Assistant Director of Nursing (ADON) and Nurse Consultants were notified of the IJ on 04/25/2024 at 12:39 PM. A Plan of Removal was requested. The Removal Plan was accepted by the State Survey Agency on 04/26/2024 at 3:29 PM. The IJ was removed on 04/30/2024 at 3:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. The findings are: Resident #82 was admitted on [DATE] with a diagnosis of Alzheimer's disease as documented on the Order Summary. A Care Plan initiated 04/24/2024 documented Resident #82 was an elopement risk/wanderer and was transitioned to the Secure Cottage and was to be observed for any changes in wandering or exit seeking behaviors. On 04/23/2024 at 8:04 PM, the facility submitted an Incident and Accident report to the Office of Long-Term Care that documented Resident #82 had walked away from the campus and was found by the Admission and Marketing Director and brought back to the campus. A Wandering Risk Scale dated 04/23/2024 documented Resident #82 had a score of 9 (9-10 indicates at risk for wandering/elopement). On 04/24/2024 at 12:43 PM, Resident #82 was sitting in a chair in the room looking at a book. Resident #82 was asked if Resident #82 knew why resident was moved to a new room and resident replied, I may have wandered off. Resident #82 had no memory of the incident on 04/23/2024. On 04/24/2024 at 1:04 PM, the Admissions and Marketing Director was interviewed, and she was asked to describe the incident regarding Resident #82, and she stated, I was getting ready to leave around six o'clock. I was going to my car to leave and looked up and I saw [Resident #82]. I didn't know who it was at first. I took off running when I saw [Resident #82] to stop [Resident #82] and redirect [Resident #82] back to the facility. She admitted the resident was on the road going to [Resident #82]'s right. She added Resident #82 was still on the left side of the street and was about 30-40 yards from the stop sign. She stated [Resident #82] stated [Resident #82] was fine and that [Resident #82] stated [Resident #82] was trying to get to a cousin's house because the resident's spouse was supposed to be there to pick up [Resident #82]. The Admission and Marketing Director stated when Resident #82 was told they needed to go back to the facility, Resident #82 immediately came with her. She added that the Minimum Data Set (MDS) Coordinator and Administrator saw her running, knew something was wrong and came to her and [Resident #82] after they were back on facility grounds, and they (Administrator and MDS Coordinator) walked the resident the rest of the way and she left. On 04/24/2024 at 2:50 PM, Certified Nursing Assistant (CNA) #11, was asked when she saw Resident #82 last and she stated it was after 5:30 PM and going on 6:00 PM after supper. She stated Resident #82 had got up from the table and followed two residents to the back patio to smoke. She added Resident #82 did not smoke when asked and that she thought the resident liked the company but usually came back it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She confirmed that no staff member went outside with the residents and that she was not aware that the nurse had told a co-worker to keep an eye on Resident #82. CNA #11 was asked how she knew which residents needed supervision and she stated she had not been told about anyone who needed supervision. On 04/24/2024 at 3:17 PM, CNA #12 was asked if residents were allowed to be on the porch alone and he stated, Yes, if they are not visually disoriented, but we have to keep an eye on them, depending on who they are. If it's someone new, we try to check on them every 5 to 10 minutes. He confirmed that CNAs were responsible for watching the residents when they were on the porch. He was asked if he was familiar with [Resident #82] and he stated it was his second day with the resident since the resident's admission. CNA #12 denied knowing if the resident had any exit seeking behavior. He admitted the last time he saw Resident #82 was about 5:30 PM to 5:45 PM when Resident #82 was sitting at the dinner table eating. He confirmed that he was told by the nurse to keep an eye on Resident #82 because the resident could possibly wander off. On 04/24/2024 at 4:39 PM, Registered Nurse (RN) #1 was asked to describe the incident regarding Resident #82 and she stated, About 4:50 [pm] I was packing up my things and an aide brought [Resident #82] in from the back porch to the library and the aide stated she didn't want [Resident #82] to get hurt because they were mowing and then [Resident #82] stated [Resident #82] thought [Resident #82] lived pretty close down the street and [Resident #82] thought [Resident #82] could walk there. So, we re-orientated [Resident #82] and took [Resident #82] back to [Resident #82]'s room. Then I was about to go across the street and the aide, at the CNA [documentation area], I told to keep an eye on the elder because [Resident #82] made a comment that [Resident #82] lived down the street and thought [Resident #82] could walk there and I didn't want [Resident #82] to try to leave, thinking that [Resident #82] lived there from the Alzheimer's. At that point the resident was in [Resident #82]'s room and [Resident #82]'s door was visible from the [documentation area]. After that, I went to [NAME] Cottage for my 5 o'clock med [medication] pass. She confirmed Resident #82 did not show any exit seeking behaviors on her shift, but the night nurse stated Resident #82 commented about wanting to go home. On 04/24/2024 at 05:34 PM, the Administrator was interviewed and stated that she and the MDS Coordinator were walking to their vehicles around 5:50 PM and observed the Admissions and Marketing Director talking to Resident #82. She stated they met Resident #82 and the Admissions and Marketing Director and walked Resident #82 back and Resident #82 was taken to the Secure Cottage and [Resident #82]'s belongings moved. The Administrator stated she met with the staff and had the MDS Coordinator start running risks assessments. The Administrator added, I sent nursing, ADON, to do a body audit immediately and the Nurse Practitioner was on the phone with the ADON, and the 15 minutes checks were started, and all notifications were being done and family was notified. She stated she sent the Dietary Assistant/CNA to the cottages with the in-services to make sure they understood and to let them know that she would follow before she left but she needed them [in-services] to go out immediately. She had another staff nurse to get witness statements. She stated, After I left 3 [Cottage #3], I did go find the nurse and I told her to do an I&A [incident and accident] and that I needed her to make sure [Resident #82] meds and belongings got transferred to Cottage 1. The Immediate Jeopardy was removed on 04/26/2024 at 03:00 PM when the following Plan of Removal was implemented by the facility: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon notification to Administrator that Resident #82 was observed off campus, the Resident was returned to the campus by the Admission Coordinator, a body audit was conducted by a Licensed Practical Nurse with no negative findings and Resident #82 was placed in the secure cottage on 04/23/2024 at 06:15 PM. Resident #82's wandering risk assessment was reassessed by the Minimum Data Set Coordinator and the plan of care was updated to include risk of wandering on 04/23/2024. CNA in Secure Cottage Began 15 minute checks on Resident #82 on 04/23/2024. These 15-minute checks will continue until Resident #82 no longer exhibits exit seeking behavior. The Administrator and Assistant Administrator began in-service training for all staff on duty on 04/23/2024 related to abuse, neglect, and elopement. All other staff will be trained before coming on duty on abuse and neglect and elopement. The training included if an elder seems more confused, is exit seeking, found to have an increase in wandering or any change of condition, staff are to notify a supervisor/nurse immediately and staff to perform more frequent checks on them. This has a completion date of 04/26/2024. Facility Registered Nurse and Licensed Practical Nurse reassessed all other elders on current census for their wandering risk assessment on 04/23/2024. Resident's care plans and wandering assessments will indicate if a resident is at risk for wandering. All corrections were completed on 04/26/2024. The Administrator provided a Missing Resident/Elopement Protocols policy on 04/24/2024 that documented, . It is the policy of the Green House Cottages of Southern Hills to provide a safe and secure environment for all residents. In the event of resident elopement, it is the policy of the Green House Cottages of Southern Hills to implement its elopement protocols immediately to locate the resident in a timely manner . On 04/26/2024 at 12:30 PM, the Administrative Assistant provided an Inservice Education Report on Elopement, a second one on Abuse and Neglect Investigation and Reporting and a third one that documented, All elders are to be monitored every 15 minutes . with different signatures and titles on each in-service. Onsite Verification: The IJ was removed on 04/26/2024 at 03:00 PM after the survey team performed an onsite verification that the Removal Plan had been implemented. On 04/30/2024 at 10:45 AM, the Surveyor entered the facility to verify removal of the immediate jeopardy. Reviewed Resident #82's placement, verified resident census for the secure cottage. Resident #82's wandering risk assessment was reassessed by the Minimum Data Set Coordinator and the plan of care was updated to include risk of wandering on 04/23/2024. Reviewed Certified Nursing Assistant (CNA) in Secure Cottage l5 minute checks on Resident #82 on 04/23/2024. The checks began on 04/23/2024 at 7:00 PM, and ended on 04/24/2024 at 7:00 PM, with no notation of exit seeking behavior since 04/24/2024 at 10:30 AM, noted Resident 'beating on door.' On 04/30/2024 at 2:10 PM, Resident #82 observed sitting in the resident's room of the secure cottage pleasantly visiting with a peer. No exit seeking or wandering behaviors observed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Reviewed staff in-service related to abuse, neglect, and elopement that began on 04/23/2024. The Assistant Administrator provided an audit list of employees for the facility to verify all staff were in-serviced by 04/26/2024. The Assistant Administrator reported the audit list was compared to staff signatures and phone calls to staff so they could verify every staff member had been in-serviced. On 04/30/2024 between 12:00 PM and 2:40 PM, 20 Certified Nursing Assistants, 3 Licensed Practical Nurses and 1 Registered Nurse that work various shifts, were interviewed to verify they received and understood the in-service. They were able to verbalize the training included that if a resident seemed more confused, is exit seeking, found to have an increase in wandering or any change of condition, staff are to notify a supervisor/nurse immediately and staff to perform more frequent checks on them. This had a completion date of 04/26/2024. Reviewed resident audit list for wandering risk assessment on 04/23/2024. Two residents were identified with a change in risk, verified both resident's care plans were updated to indicate resident is at risk for wandering. The Administrator and the Regional Consultant were informed of the Immediate Jeopardy Plan of Removal with a Completion Date of 04/26/2024 verified removal on 04/30/2024 at 03:00 PM. 48390 2). A facility policy titled, Accident Hazards Prevention, dated 04/24/2024, indicated, The environment will be free from accident hazards as is possible. On 04/22/2024 at 11:24 AM, the Surveyor observed in room [ROOM NUMBER] an aerosol can of air freshener on the open shelf in the room next to the door. Also observed on the shelf in the bathroom was an aerosol can of [named] air freshener in the open cabinet. On 04/22/2024 at 01:20 PM, the Surveyor went into room [ROOM NUMBER] and observed a resident lying in a bed. A can of [named] aerosol air freshener, 8.3 ounce size, was out on the shelf in the resident's room. In the bathroom the cabinet was open and a can of aerosol air freshener, 8.8 ounce size, was observed on the shelf. During an interview on 04/25/2024 at 04:13 PM, Licensed Practical Nurse (LPN) #3 was asked if a resident could have an aerosol can in their room. LPN #3 indicated that they could not have anything like that at all. During an interview on 04/25/2024 at 04:17 PM, Certified Nursing Assistant (CNA) #9 was asked if a resident could have an aerosol can in their room. CNA #9 stated No. CNA #9 was asked if any resident in Cottage 3 had an aerosol can in their room. CNA #9 indicated not to my knowledge. 48977 3). On 04/22/2024 at 10:50 AM, the Surveyor observed keys in the doorknob of a closet. The Surveyor opened the door and noted full and empty portable oxygen tanks sitting on the floor behind boxes of items to provide care (razors, saving cream, gloves, oral swabs, incontinence briefs, toilets paper). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/22/2024 at 10:53 AM, the Surveyor asked Registered Nurse (RN) #1 if the door should be unlocked? RN #1 stated, No. The Surveyor asked why is it important that the door remains locked? RN #1 stated, There is stuff in there like mouth wash, razors, and oxygen that the elders could get into and it could be harmful to them. The Surveyor asked whose keys were in the door. Certified Nursing Assistant (CNA) #1 walked up and stated, mine and removed the keys from the doorknob. On 04/25/2024 at 10:37 AM, the Surveyor asked the Assistant Director of Nursing (ADON), if the door to the closet used to store items to provide care, clean linens, and portable oxygen tanks should be locked? The ADON stated, Yes. The Surveyor asked with the closet containing portable oxygen tanks, could it be a danger to the residents? The ADON stated, Yes. On 04/25/2024 at 11:39 AM, the Surveyor was provided a policy titled, Accident Hazards Prevention that documented Resident Environment. The Environment will be free from accident hazards as is possible. A Life Safety manual will be maintained. 49596 4). Resident #20 had diagnoses of dementia, psychotic disturbance, anxiety, and delirium. Fall Assessments dated 03/29/2024, 3/11/2024, 3/1/2024, 12/28/2023, 10/10/2023, 10/7/2023, and 10/1/2023 all identified Resident #20 to be a High Fall Risk. Resident #20 had a BIMS of 7, as identified on a MDS dated [DATE], which indicated Resident #20 had severe cognitive impairment. Resident #20 ' s Care Plan dated 04/03/2024 identified Resident #20 to be at risk for falls and dates for falls of 10/01/2023; 10/07/2023; 10/20/2023; 01/03/2024; 02/01/2024; 03/11/2024. The Care Plan initiated 09/20/2023 with revision of 04/08/2024 documented: Resident #20 will be free of falls through the review date. Date Initiated: 04/03/2024. 10/01/2023 encouraged to use the call light for assistance; 10/20/2023 blanket was removed from w/c [wheelchair], encouraged to lock brakes on w/c; 10/07/2023 fall mat to floor right side of bed; 02/01/2024 maintenance inspected threshold to door. And 03/11/2024 fall mat to floor, new low bed ordered by hospice. A Nursing Progress Note dated 03/11/2024 at 19:43 (7:43) PM documented, The elder was reaching for a drink off the nightstand, and she slid out of the bed hitting her head on the bedside table. She has a small laceration to the top of the scalp on the left side. The area was cleaned, and the bleeding stopped. She was assessed and assisted to a wheelchair. Neuros [neurological checks] started at this time. The hospice nurse was notified and came to see the elder also. MD [Medical Doctor] was notified of the fall along with family member . A Nursing Progress Note dated 03/13/2024 at 11:23 PM documented, .Continues on observation for fall. No c/o [complaints of] px [pain] or discomfort voiced at this time. Currently resting in bed with bed in lowest position. No acute distress noted. Will continue with current plan of care. C/L [call light] in reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A MDS Progress Note dated 04/03/2024 at 03:07 PM documented, Quarterly MDS Assessment Completed. Elder requires staff assistance with some functional abilities . Fall X2 noted during the look back period. No skill therapy services, referrals or plan of discharge. Elder continues with [named provider] hospice services. On 04/22/2024 at 10:25 AM, Resident #20 was observed lying in bed, the bed was not in the lowest position, the bed was at normal height. On 04/22/2024 at 11:50 AM, Resident #20 was observed lying in bed, the bed was not in the lowest position. On 04/22/2024 at 02:05 PM, Resident #20 was observed lying in bed, the bed was not in the lowest position. On 04/23/2024 at 10:15 AM, Resident #20 was observed in bed, the bed was not in the lowest position. The bed height was that of a normal hospital bed. On 04/23/2024 at 2:20 PM, Resident #20 was observed in bed. The bed was at normal height, and not in low position. The bed height was that of a normal hospital bed. On 04/23/2024 at 03:15 PM, Resident #20's bed height was that of a normal hospital bed. During continued rounds in the cottage, the resident was observed attempting to get out of bed. On 04/23/2024 at 03:18 PM, CNA #4 stated that staff keep Resident #20 ' s bed in its lowest position when Resident #20 is not eating or drinking. On 04/23/2024 at 03:20 PM, LPN #1 stated the bed was to be kept in the lowest position when the resident was in it, this was an intervention after a fall. It is supposed to be kept down, at all times, except when they are changing the resident. On 04/25/2024 at 08:59 AM, Resident #20's bed was observed not to be in the lowest position. CNA #4 measured the bed to be at 69 inches, the height was verified by CNA #11. On 04/25/2024 at 02:45 PM, the ADON stated they do not have a policy on bed height. The Surveyor asked the ADON, How do you expect the staff to use the Hi-Low bed for Resident #20? The ADON stated, They are to leave it in the lowest possible position. They are not to leave her in a high position. The Surveyor asked, If the resident requested to remain in the high position, how would you instruct the staff? The ADON stated, We can't leave her up because if she fell at that height, it could cause a serious injury. It is for her safety.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48977 Based on observation, interview and record review, the facility failed to ensure residents received proper and punctual incontinence care for 1 (Resident #25) sampled resident. The findings are: Resident #25 had diagnoses of Urinary tract infection and Candidiasis. An Admission Minimum Data Set (MDS) with an Assessment Referenced Date (ARD) of 02/13/2024 documented Resident #25 scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and was occasionally incontinent of bowel and bladder. A Care Plan with a review date of 02/23/2024, documented Resident #25 required assistance with functional abilities related to muscle weakness, lack of coordination, and fracture to left femur and shaft of right tibia. On 04/22/2024 at 09:55 AM, the Surveyor noted the odor of urine upon entering Resident #25's room that got stronger upon approach to the resident. Resident #25 was lying in bed with a blue disposable incontinence pad visible underneath the resident's body. On 04/22/2024 at 12:15 PM, the Surveyor observed Resident #25 lying in bed. The Surveyor noted that the Resident's bed was wet, with the blue incontinent pad placed under the resident having a yellow discoloration in a circular pattern. Resident #25 acknowledged the blue disposable incontinence pad underneath the resident was wet and had had an episode of urinary incontinence. On 04/22/2024 at 12:20 PM, Certified Nursing Assistant (CNA) #2 and #3 provided incontinence care to Resident #25. The Resident's incontinence brief, blue disposable incontinence pad, and sheet were saturated with urine as evidenced by yellow discoloration. Resident #25 had visible skin irritation in the form of reddened excoriation in the areas that contacted the wet brief. When cleaning Resident #25's perineal area, CNA #3 did not properly clean all affected areas of the skin. CNA #2 and #3 did not perform proper hand hygiene or gloves changes after completing incontinence care, after disposing of soiled linens, after applying clean linens, or before applying topical skin barrier cream to the resident's perineal area. On 04/22/2024 at 12:37 PM, CNA #3 stated that neither CNA that performed incontinence care for Resident #25 had performed hand sanitation while performing glove changes. CNA #2 confirmed that the resident's perineal area had been incompletely cleansed, and that soiled gloves had been used to apply the clean sheets, incontinence pad, brief, and topical barrier cream. CNA #2 stated that she had last checked the Resident #25 for incontinence at 08:00 AM that morning. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/2024 at 10:37 AM, the Assistant Director of Nursing (ADON) stated every part of the body that comes in contact with urine should be cleaned when providing incontinence care, and that it is important to clean all areas that come in contact with urine, so their skin doesn't become irritated, or any skin breakdown occurs. The ADON stated that improper incontinence care could lead to a urinary tract infection, that staff should sanitize or wash hands between glove changes, and that clean items should not be touched with soiled gloves to prevent the spread of infection. On 04/25/2024 at 11:39 AM, a policy titled Hand Hygiene documented Perform Hand Hygiene .When .After removing gloves. On 04/25/2024 at 11:39 AM, the Surveyor was provided a policy titled Peri Care Check Off that documented the proper procedure for providing incontinence care, which included to change gloves after touching a soiled area and to change gloves after providing incontinence care to the front of the resident and the back.

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F 0693 Level of Harm - Minimal harm or potential for 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. 48977 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services for residents receiving enteral nutrition via Percutaneous Endoscopic Gastrostomy (PEG) tube for 1 (Resident #23) of 1 sampled resident. The findings are: Resident #35 had diagnoses of sequelae of cerebral infarction, epilepsy, aphasia, and dysphagia. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/23/2024 documented Resident #35 scored 3 (3 indicates severely impaired cognitive skills) on a Staff Assessment for Mental Status (SAMS) and had a PEG tube while a Resident. A Physician ' s Order for Resident #35 documented, Enteral Feed 45 ml (milliliter)/hour for 23 of 24 hours a day, enteral feed every shift flush rate of water (H2O) 60ml/hour, elevate HOB (Head of Bed) 30 to 45 degrees. A Care Plan with a review date of 04/04/2024 documented that Resident #35 had a PEG tube and needs HOB elevated 30 to 45 degrees during tube feeding. On 04/22/2024 at 10:40 AM, the Surveyor observed Certified Nursing Assistant (CNA) #1 at the bedside of Resident #35 providing care. Resident #35's bed was positioned flat, without HOB inclined, while enteral nutrition was infusing at 45 ml/hour with 60ml flush. On 04/22/2024 at 10:45 AM, CNA #1 confirmed it is important to make sure that the infusion has stopped prior to lying the resident flat because the resident could aspirate. On 04/22/2024 at 10:53 AM, Register Nurse (RN) #1 confirmed it was essential to pause the pump providing enteral nutrition before lying the bed flat to prevent aspiration. On 04/25/2024 at 10:37 AM, the Assistant Director of Nursing (ADON) confirmed residents should not be laid flat with enteral nutrition being provided to prevent aspiration, or pneumonia from the aspiration. On 04/25/2024 at 11:39 AM, the ADON voiced that the facility did not have a policy on eternal infusion/feeding.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48977 Based on interview and record review, the facility failed to ensure a pharmacist's recommendation for the provider to provide an appropriate diagnosis before administering an antipsychotic medication was followed for 1 (Resident #20) sampled resident. The findings are: 1. Resident #20 had diagnoses of Dementia, Major depression, and Delirium due to unknown physiological condition. 2. Resident #20 had an order in place for Zyprexa, which is an antipsychotic medication that can treat several mental health conditions like schizophrenia and bipolar disorder. 3. A Medication Regimen Review (MRR) dated 09/29/2023 documented, A. Consultant Pharmacist . Antipsychotic recommendation . Unnecessary Psychotropic Medication . ZyPREXA Oral Tablet 5 MG (milligram) . Diagnosis: F33.1 MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE . Consultant Pharmacist Notes .Consider appropriate diagnosis . a. The Attending Physician/Prescribing Practitioner response was, .Continue current medication regimen with no changes . Clinical rationale and/or documentation for continued need (risk vs. benefit): hospice . b. The Director of Nursing (DON)/Designee response was, MD (medical doctor) response received and accepted .MD Response received and follow up required .The following action has been taken: hospice patient . 4. On 04/25/2024 at 10:37 AM, the Assistant Director of Nursing reported there was no documentation stating that hospice was notified of the recommendations by the Pharmacist dated 09/29/2023. C. On 04/25/2024 at 11:39 AM, the Assistant Director of Nursing stated the facility did not have a policy on unnecessary medications.

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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. 48977 Based on observation, interview, and record review, the facility failed to ensure medications were not left at the bedside for 2 (Residents #7 and #29) sampled residents. The findings are: 1. Resident #7 had diagnoses of dementia and pelvic/perineal pain. a. An Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/06/2024 documented Resident #7 scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. b. Resident #7 had a Physician's Order for Diclofenac Sodium External Gel 1 % to be applied as needed for localized pain. c. Resident #7's Care Plan documented that the resident has pelvic and perineal pain and included intervention as follows: administer pain medications as ordered/needed, notify MD/Practitioner if not effective, administer PRN (as needed) pain medications as ordered to alleviate pain or for breakthrough pain. d. On 04/22/2024 at 10:10 AM, the Surveyor observed a container of Diclofenac Sodium 1% in the Resident's bathroom on a shelf. e. On 04/22/2024 at 12:13 PM, the Surveyor observed a container of Diclofenac Sodium 1% in the Resident's bathroom on a shelf. f. On 04/23/2024 at 08:45 AM, the Surveyor observed a container of Diclofenac Sodium 1% in the Resident's bathroom on the shelf. g. On 04/23/2024 at 09:10 AM, the Surveyor observed a container of Diclofenac Sodium 1% in the Resident's bathroom on the shelf. h. On 04/23/2024 at 09:10 AM, the Surveyor asked Medication Administration Certified aide (MA-C), while in the Resident's bathroom, Can you tell me what you see that should not be unlocked in a Resident's room? MA-C identified zinc cream, arthritis cream (Diclofenac), and aerosol air freshener. 2. Resident #29 had diagnoses of Down syndrome, adjustment disorder, and other specified mental disorders due to know physiological condition. a. A Quarterly MDS with an ARD of 04/20/2024 documented Resident #29 had short term and long-term memory problems. According to care plan Resident 29 was dependent on staff, mother, family for meeting emotional, intellectual, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physical and social needs related to Cognitive deficits mental disability. b. A review of Resident #29's physician's orders revealed there was no order in place for triple antibiotic ointment. c. On 04/22/2024 at 10:25 AM, the Surveyor observed 3 sample size packs triple antibiotic ointment on a shelf near the entrance in Resident #29's room. d. On 04/22/2024 at 10:39 AM, the Surveyor observed 3 sample size packs triple antibiotic ointment on a shelf near the entrance in Resident #29's room. e. On 04/22/2024 at 10:53 AM, the Surveyor asked Registered Nurse (RN) #1 if the antibiotic cream should be left in the resident's room. RN #1 stated, No. The Surveyor asked RN #1 why this medication should not be left out in the Resident's room. RN #1 stated, Because it's a medication. f. On 04/25/2024 at 10:37 AM, the Surveyor asked the Assistant Director of Nursing (ADON) if any resident in any of cottages were self-administering medications. The ADON stated, No ma'am. The Surveyor asked the ADON if there should be over the counter medications in the Resident's room. The ADON stated, No. 3. On 04/25/2024 at 11:39 AM, the Surveyor was provided a policy titled, Medication Storage in the Facility that documented Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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 2 of 2 meals observed. This failed practice had the potential to affect 1 resident who received pureed diets in Cottage #4, 1 resident who received pureed diets in Cottage #6, and 3 residents who received pureed diets in Cottage #7. The findings are: 1. On 04/22/2024 at 12:28 PM, the lead Certified Nursing Assistant (CNA) in Cottage #7 used a 4-ounce spoon to place 4 servings of cut green beans into a blender and pureed. She poured it into a divided plate on the counter. The consistency of the pureed green beans was runny and was not formed. Water was separated from the beans. 2. On 04/22/2024 at 12:30 PM, the lead CNA placed 4 servings of bread sticks into a blender, added whole milk and pureed. She poured the pureed bread into a divided plate. The consistency of the pureed bread was lumpy, and not smooth. The consistency of the pureed chicken alfredo on the plate to be served to the residents on pureed diets was lumpy and not smooth. 3. On 04/22/2024 at 12:03 PM, CNA # 2 in Cottage #6 used a 4 ounce spoon to place 2 servings of chicken alfredo into a blender, added milk and pureed. She poured the pureed chicken alfredo on a divided plate. The consistency of the chicken alfredo was gritty and not smooth. There were pieces of noodles and chicken. 4. 3. On 04/22/2024 at 12:33 PM, the Surveyor asked the Dietary Supervisor to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, Pureed chicken alfredo was a little gritty. Pureed cut green beans was loose and pureed bread was a little gritty. 5. On 04/23/2024 at 08:46 AM, the residents who received pureed diets from the kitchen in Cottage #7 were served pureed sausage and pureed French toast sticks for breakfast. The consistency of the pureed sausage was lumpy, runny and was not smooth. There were pieces of meat visible in the mixture. The consistency of the pureed French toast sticks was thick. At 08:50 AM, the Surveyor asked Medication Assistant-Certified #1 to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, Pureed sausage was mushy, running and had pieces of sausage in it. Pureed French toast was thick.

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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, record review and interview, the facility failed to ensure (1) food preparation equipment was free of peeling and chipped paint to prevent potential food borne illness for resident who received meals from the kitchen in Cottage #6, (2) expired food items were promptly removed from stock to prevent potential food borne illness for residents who received meal trays from 7 of 7 kitchens, (3) foods stored in the freezer, refrigerator and dry storage area were covered, sealed, dated and were stored in accordance with the manufacturer's instructions for residents who received meals from the kitchen in Cottage #7, (4) that 1 of 7 ice scoop holder was maintained in a clean and sanitary condition to prevent potential contamination of residents' beverages for residents who received meals from the kitchen in Cottage #7, and dietary staff washed their hands before handling clean equipment to prevent potential food borne illness for residents who received meals from the kitchen in Cottage #2. The failed practices had the potential to affect 12 residents who receive meals from the kitchen in Cottage #1; 12 residents who receive meals from kitchen on Cottage #2; 12 residents who received meal trays from the kitchen in Cottage #3; 12 residents who received meal trays from the kitchen in Cottage #4; 11 residents who received meal trays from the kitchen in Cottage #5; 12 residents who received meal trays from the kitchen in Cottage #6; and 12 residents who received meal trays from the kitchen in Cottage #7. The findings are: 1. On [DATE] at 09:44 AM, the following observation was made in the refrigerator located in the kitchen in Cottage #7. a. An opened gallon of milk was on a shelf with no open date on it. b. An open bottle of prune juice was on a shelf, with no open date on the bottle. c. A packet of sliced oven roasted turkey was on a shelf and had sell by date of [DATE]. d. An opened bottle of lemon juice with no open date on the bottle. e. A bottle of caramel sauce. There was no date on the bottle to indicate when it was opened. f. A bottle of cocktail sauce. There was no open date on the bottle. g. Two bottles of Worcestershire sauce. No date on the bottle to indicate when it was opened. h. A bottle of chocolate syrup with no open date on it. i. Three opened bottles of tomato ketchup. j. A container of parmesan cheese with no open date on it. k. A bottle of Italian dressing with open 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	l. A bottle of traditional tomato sauce with no open date on the bottle. m. An opened bottle of tartar sauce. No date on the bottle to indicate when it was opened. n. An opened bottle of real mayonnaise with no open date on it. o. A bottle of apple cider vinegar on shelf that had an expiration date of [DATE]. p. A box of nectar sweetened tea with lemon flavor. There was no received or opened date on the box. q. A gallon of medium picante sauce with no open date on the gallon. 2. On [DATE] at 10:01 AM, the following observations were made in the kitchen cabinet in Cottage #7: a. An opened bottle of lemon juice. Some of the juice has been used from it. The manufacture specification on the bottle documented, Refrigerate after opening. The surveyor asked Certified Nursing Assistant (CNA) #2 what they use lemon juice for? She stated, We use it when we make lemon pie. b. An opened bottle of Italian dressing and an opened bottle of thousand land. The manufacturer specifications on the bottles documented, Refrigerate after opening. The surveyor asked CNA #7 if Italian dressing and an opened bottle of thousand island be refrigerated after opening. She stated, Yes. Someone must have put them there. c. A box of raisins and a box of baking soda with no received or opened dates on them. d. A container of ground cumin. e. A box of iodized salt. f. Ground cinnamon. g. A container of lemon pepper seasoning salt. h. A container of rubbed sage. 3. On [DATE] at 10:13 AM, the following food items stored on a shelf in the freezer were not covered, sealed and or dated when opened or received: a. An opened bag of cheese omelets. b. Two bags of chicken tenders. c. An opened bag of hash brown. d. An opened bags of chicken tenders. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. An opened bag of bread sticks. f. An opened bag of sausage. g. An opened box of biscuits. h. A box of chicken pot pie had no received date on it. i. A box of beef pot pie and a box of turkey pot pies have no received date on them. 4. On [DATE] at 10:16 AM, the following observations were made in the refrigerator and on the rack in the storage room: a. A container of sour cream on a shelf in the refrigerator had an expiration date of [DATE]. b. A container of cottage cheese on a shelf in the refrigerator had an expiration date of [DATE]. c. An opened container of chopped garlic was on a shelf, there was no open date on the container. d. An opened bag of potato chips was on the rack in the storage room. The bag was not sealed and did not have a date when it was opened. e. An opened bag of tornillos chips was on the rack in the storage room. The bag was not sealed. There was no date to indicate when it was opened. f. A 8 count bag of hamburger buns was on the rack with an expiration date of [DATE]. g. Two of 2 bags of bread on the rack had an expiration date of [DATE]. h. An opened box of fish fry crumbs was on the rack. The box was not covered or sealed. The lead CNA stated, We normally check the dates on the bread and if they have expired, we pull them out and throw them away. We have done it this morning. 5. On [DATE] at 10:23 AM, the ice scoop holder on the wall by the ice machine in the storage room had water standing with brownish residue floating on it. The ice scoop was directly resting on the residue. The Surveyor asked the lead CNA how much was in the ice scoop holder, to describe what was observed in the water, who uses the ice from the machine and how often it was cleaned. She stated, About a cup of water and had brownish substances floating on it. We clean it once a week. We use it to fill beverages served to the residents at mealtimes and also use it to fill the water cups in the residents' rooms. 6. On [DATE] at 10:00 AM, initial rounds in kitchen in Cottage #6 were conducted with the CNA #4. The microwave located on the food preparation counter had a gray finish peeling off the inside top. Certified Nursing Assistant #4 took a wet white towel and whipped it across the surface and dark particles came off onto the towel. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On [DATE] at 10:10 AM, Maintenance #1 came in Cottage #6 and looked at the surface, he peeled some of the surface off and said the unit needed to get a new one due to the paint peeling off. The Surveyor asked Maintenance #1 if he had received a work order on this microwave. Maintenance #1 stated, No. 8. On [DATE] at 10:07 AM, the following observations were made on a shelf in the refrigerator in the kitchen area in Cottage #6: a. A partial jug of milk that had expired [DATE]. b. A gallon jug with red liquid in it had not been dated. c. A quart of half and half had expired on [DATE]. d. A carton of (fortified nutritional shake oral supplement) expired on [DATE]. e. A box of orange juice expired on [DATE]. 3. On [DATE] at 10:20 AM, the freezer in the storage room contained 2 (Fast Food Business) cups of ice. CNA#4 stated it belonged to a staff member. When asked where the staff was to store their food items, CNA #4 stated, We store it in the refrigerators, indicating the same one with the resident food. 4. On [DATE] at 10:25 AM, a dented can of tomato soup was on the shelves where food intended to be used was stored. 5. On [DATE] at 10:44 AM, the utensil drawer had a spatula with several areas chipped off. The Surveyor asked CNA #4 what the spatula was used for. CNA #4 stated it was used for icing cakes. The Surveyor asked what problem she saw with the spatula. CNA #4 stated pieces could chip off in the icing. 6. On [DATE] at 04:15 PM, two cartons of nectar sweetened lemon flavor tea were on a rack in the storage room with an expiration date of [DATE]. CNA #2 stated, We threw all nectar thickened liquid away. We missed those 2 cartons. We don't even have anyone on nectar thickened liquid anymore. 7. On [DATE] at 04:18 PM, the following spices were stored in the cabinet above the food preparation counter with no open date on them: a. A container of chili powder. b. A container of lemon pepper seasoning. c. A container of ground cayenne pepper. d. A container of mediterranean style ground oregano. e. A container of ground cumin. 8. On [DATE] at 10:48 AM, the following observations were made in the refrigerator in Cottage #5. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. A small individual tub of tuna salad did not have a receive date on it. b. A quart of buttermilk that expired [DATE]. 9. On [DATE] at 10:55 AM, the following observations were made in the freezer in Cottage #5: a. A ham in the freezer in a large plastic bag on a shelf was freezer burned and contained white ice particles. b. Three bags of california blend vegetables did not have dates and were freezer burned with white ice particles on the vegetables inside the bag. c. Two packages of green beans are not dated. d. Two packages of zucchini had freezer burned containing white ice particles on the vegetables. The Surveyor asked CNA #6 how these foods appeared. CNA #6 stated they appear freezer burned. The Surveyor asked CNA #6 if these foods were usable. CNA #6 stated she did not know if she could use them. 10. On [DATE] at 11:05 AM, a #10 can of cherry pie filling was dented and stored on the shelves for food to be used. 11. On [DATE] at 11:15 AM, the following observations were made in the refrigerator in Cottage #5. a. A jar of relish on a shelf was not dated. b. A zip lock bag containing a head of cabbage not sealed. 12. On [DATE] at 11:17 AM, there was an open bag of tortilla chips on the rack in the storage room. The bag was not sealed. 13. On [DATE] at 10:34 AM, in Cottage #4 the following spices were stored in the cabinet above the food preparation counter with no open dates on them: a. An open box of iodized salt was not covered. b. A container of ground cumin. c. A container of ground pepper. d. A container of garlic powder. e. A container of ground mustard. f. A container of lemon pepper. g. A container of cinnamon. h. A container of ground oregano. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. A container spanish paprika. j. A container of light chili powder. k. Two containers of breadcrumbs. l. A container of rubbed sage. m. A container of traditional seasoned salt. n. A bottle of vanilla extract. o. An opened box of baking soda. The box was not covered. p. A bottle of worcestershire sauce. q. A container of cornstarch. r. A container of peanut butter. 14. On [DATE] at 10:37 AM, the following observations were made on a shelf in the refrigerator and on the rack in the storeroom with no open date on them: a. An opened container of chopped garlic in water. b. A gallon of enchilada sauce. c. A bottle of italian dressing. d. A container of kosher dill spears pickles. e. A container of sour cream on a shelf in the refrigerator had an expiration date of [DATE]. f. A bag of bread on the rack had an expiration date of [DATE]. g. Two of 2 bags with 8 counts of hot dog buns each had an expiration date of [DATE]. h. A box of nectar thickened flavor water on the rack in the storage room had an expiration date of [DATE]. i. A bottle of prune juice on the rack with an expiration date of [DATE] j. An opened box of fish fryer crumbs was on a shelf in the storage room. The box was not covered or sealed. 15. On [DATE] at 10:39 AM, the following observations were made in the freezer in the storage room: a. Two bags of opened pie shells were on a shelf in the freezer. The bags were not sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. An opened bag of biscuits was in the freezer compartment. The bag was not sealed. 16. On [DATE] at 11:30 AM, the following spices were stored in the cabinet above the food preparation counter in Cottage #3 with no open dates on them. a. A container of ground lemon pepper. b. A container of mustard. c. A container of garlic powder. d. A container of ground mustard. e. A container of cinnamon. f. A container of creole seasoning. g. A container of celery seasoning. h. A container of light chili powder. i. A container of rubbed sage. 17. On [DATE] at 11:33 AM, the following observations were made on a shelf in the refrigerator with no open date. a. A bottle of worcestershire sauce. b. A bottle of cocktail sauce. c. A bottle of ranch dressing. d. A container of parmesan cheese. e. A gallon of enchilada sauce. f. A plastic bag of shredded cheese was not sealed. g. A container of cottage cheese had an expiration date of [DATE]. h. A bottle of prune juice had expiration date of [DATE]. 18. On [DATE] at 02:32 PM, a container of cottage cheese was on a shelf in the refrigerator in the storage room with an expiration date of [DATE]. 19. On [DATE] at 02:33 PM, three bags of hamburger buns with 8 counts in each bag were on the rack in the storage room 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	20. On [DATE] at 02:27 PM, the following observations were made in the refrigerator of Cottage #1: a. An opened resealable bag of mozzarella cheese was on a shelf. The bag was not sealed. There was no date to indicate when the bag was opened. b. A container of cottage cheese had an expiration date of [DATE]. 21. On [DATE] at 02:29 PM, the following spices were stored in the cabinet above the food preparation counter with no open date on them: a. A container of garlic powder. b. A container of ground black pepper. c. A container of onion powder. d. A container of celery salt. e. A container of cinnamon. f. A container of ground cumin. g. A container of ground mustard. 22. Two bags with 8 hamburger buns in each bag were on the rack in the storage room with an expiration date of [DATE]. 23. On [DATE] at 01:43 PM, the following spices were stored in the cabinet above the food preparation counter in Cottage #2 with no open date on them. a. A container of parmesan grated cheese. b. A container of garlic powder. c. a container of celery seed. d. A container of ground mustard. e. A container of mediterranean style ground oregano. f. A container of ground cayenne pepper. g. A container of rubbed sage. 24. On [DATE] at 01:51 PM, the following observations were made in the refrigerator compartment: a. An opened package of oven roasted turkey was in the compartment with no open 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	b. An opened package of smoked ham was in the compartment with no open date indicated on the package. c. An opened bottle of strawberry jelly was on a shelf in the refrigerator and there was no open date on it. d. An opened bottle of grape jelly was on a shelf and there was no open date on it. 25. On [DATE] at 02:01 PM, the following observations were made in the freezer compartment: a. An opened bag of sausage. The bag was not sealed. b. An opened bag of biscuits. The bag was not sealed. 26. On [DATE] at 02:03 PM, the following food items stored on a shelf in the freezer in the storage room did not have a received date on them: a. A bag of battered sweet corn nuggets. b. Carrots. c. Breaded okra. 27. On [DATE] at 02:07 PM, a container of cottage cheese on a shelf in the refrigerator had an expiration date of [DATE]. 28. On [DATE] at 02:09 PM, the following observations were made on the rack in the storage room: a. An opened bag of corn chips was on the rack. There was no open date on the bag. b. A bag of bread was on the rack with expiration date of [DATE]. 29. On [DATE] at 03:46 PM, CNA #8 turned on the sink faucet and obtained water in a pot. After obtaining the water, she turned the water faucet off with her gloved hands, contaminating them. She then placed the pot of water on the stove. She opened a bag of tator tots that was on the counter. Without changing gloves and washing her hands, she removed tator tots from the bag and placed them inside the deep fryer basket to be fried and served to the residents for the supper meal. The Surveyor asked CNA #8 Should you have used the same glove that you wore when you turned and on and turned off the faucet to remove tator tots? She stated, I should have removed the gloves and washed my hands. 30. On [DATE] at 07:59 AM, CNA # 9 picked up glasses by their rims and placed them on the counter to be used serving beverages to the residents for breakfast. The Surveyor asked CNA #9 what should you have done after touching dirty objects and before handling clean equipment? She stated, Washed my hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	31. A facility policy titled Handwashing: Follow these five steps every time documented, Wet your hands with clean, running water (warm or cold), and apply soap. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them.

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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. 37925 Based on observation, interview and record review, the facility failed to ensure staff used proper hand hygiene while passing medication and providing perineal care for 2 (Resident #16 and #25) sampled residents. The findings are: 1. On 04/24/2024 at 07:24 AM, Licensed Practical Nurse (LPN) #3 prepared medications for Resident #16. At 07:32 AM, she put on gloves, administered eye drops, inhaler, and injected scheduled insulin into the abdomen of Resident #16. She then applied cream to Resident #16's arms and hands. At 7:36 AM, LPN #3 discarded the gloves and retrieved a clean pair and, without washing or sanitizing her hands, put on the clean pair of gloves and administered a second dose of eye drops in each eye of Resident #16. a. On 04/25/2024 at 07:59 PM, the Infection Preventionist (IP) was interviewed by telephone and was asked what should a nurse do before changing gloves during medication administration. She asked what the scenario was and was informed the nurse was changing administration routes. The IP then answered, Use hand sanitizer. She was asked why and stated, To prevent contamination. b. A policy provided by the Administrative Assistant on 04/25/2024 titled, Specific Medication Administration Procedures documented, .Policy To administer medications in a safe and effective manner .Cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning a med pass, before handling medication, and before contact with resident . 2. Resident #25 had diagnoses of Urinary tract infection and Candidiasis. a. According to the Admission Minimum Data Set with an Assessment Referenced Date of 02/13/2024, Resident #25 scored 15 (13-15 indicates cognitively intact) on a Brief Interview of Mental Status and was occasionally incontinent of bowel and bladder. b. A Care Plan with a review date of 02/23/2024 documented Resident #25 required assistance with functional abilities related to muscle weakness, lack of coordination, and fracture to left femur and shaft of right tibia. c. On 04/22/2024 at 12:20 PM, Certified Nursing Assistant (CNA) #2 and #3 provided incontinence care to Resident #25. The Resident's incontinence brief, blue disposable incontinence pad, and sheet were saturated with urine as evidenced by yellow discoloration. Resident #25 had visible skin irritation in the form of reddened excoriation in the areas that contacted the wet brief. When cleaning Resident #25's perineal area, CNA #3 did not properly clean all affected areas of the skin. CNA #2 and #3 did not perform proper hand hygiene or gloves changes after completing incontinence care, after disposing of soiled linens, after applying clean linens, or before applying topical skin barrier cream to the resident's perineal area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 04/22/2024 at 12:37 PM, CNA #3 stated that neither CNA that performed incontinence care for Resident #25 had performed hand sanitation while performing glove changes. CNA #2 confirmed that the Resident's perineal area had been incompletely cleansed, and that soiled gloves had been used to apply the clean sheets, incontinence pad, brief, and topical barrier cream. e. On 04/25/24 at 10:37 AM, the Assistant Director of Nursing (ADON) stated every part of the body that comes in contact with urine should be cleaned, and that it is important to clean all areas that come in contact with urine, so their skin doesn't become irritated, or any skin breakdown occur. The ADON stated that staff should sanitize or wash their hands between glove changes, and that clean items should not be touched with soiled gloves to prevent the spread of infection. f. On 04/25/2024 at 11:39 AM, a policy titled, Hand Hygiene, documented, Perform Hand Hygiene .When . After removing gloves. g. On 04/25/2024 at 11:39 AM, the Surveyor was provided a policy titled, Peri Care Check Off, documented the proper procedure for providing incontinence care, which included to change gloves after touching a soiled area and to change gloves after providing incontinence care to the front of the resident and the back. 48977