STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045446	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at West Dixon Rehab & Nursing Center	2821 W Dixon Rd Little Rock, AR 72206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37925 Based on observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter bag was covered to promote dignity for 1 (Resident #42) of 1 sampled resident who was reviewed for an indwelling catheter. The findings are: Resident #42's Order Summary dated 08/19/2024 was reviewed and indicated the resident had diagnoses of Alzheimer's disease and an obstruction in urine flow. The Order Summary indicated an order dated 07/24/2024 to change the [brand name] catheter tubing and bag as needed. An admission Minimum Data Set with an Assessment Reference Date of 07/31/2024 was reviewed and indicated Resident #42 had a Brief Interview for Mental Status score of 10, which indicated moderate confusion and for bladder and bowel appliances an indwelling catheter. A Care Plan dated 08/01/2024 was reviewed and indicated Resident #42 required a [brand name] catheter and a privacy bag. On 08/19/2024 at 8:53 AM, Resident #42 was sitting in a chair in the hallway with a catheter bag hooked on the right side of the chair. The contents of the catheter bag were visible, and a yellow liquid was observed inside the bag. On 08/22/2024 at 10:56 AM, Certified Nursing Assistant (CNA) #8 was interviewed and confirmed she knows how to care for residents by looking at their care plan. She confirmed no one should be able to see inside of the bag. A Resident Dignity policy, with an effective date of 04/2021 and provided by the Director of Nursing on 8/22/2024, was reviewed and indicated staff shall promote dignity by helping the resident to keep urinary catheter bags covered.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on record review, and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) accurately reflected on section O0110, Special Treatment, Procedures, and Programs the resident received dialysis on admission or while a resident for 1 (Resident #31) of 1 sampled resident. This failed practice had the potential to inaccurately represent Resident #31's health status, impacting his care plan, reimbursement levels, and the ability to properly identify necessary interventions. Findings include: Review of the Medical Diagnoses revealed Resident #31 had diagnoses of end stage renal disease, right lower lobe cancer, and type II diabetes mellitus. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/16/2024 indicated a Brief Interview for Mental Status (BIMs) score of 06 (0-7 indicates severely cognitively impaired). Section I8000 revealed an active diagnosis of dependence on renal dialysis. a. A review of the Progress Notes, dated 07/08/2024 revealed Resident #31 had a port to the right chest, and received dialysis on Monday, Wednesday, and Friday. b. A review of Resident #31's Care Plan, dated 07/11/2024, revealed the resident was at risk for fluid volume excess related to fluid accumulation since last dialysis treatment, and was to be monitored for fluctuations in weight. c. A review of the Admission MDS, revealed under section O0110 J1, and J2 that Resident #31 was not on hemodialysis on admission, or while a resident. d. On 08/21/24 at 01:42 PM, the MDS Nurse was asked to check Resident #31's admission MDS dated [DATE], section O0110. The MDS Nurse confirmed that dialysis was forgotten on the MDS. The MDS Nurse was asked if she had a guide for coding to the MDS? The MDS Nurse revealed she uses the discharge summary from a resident's hospital stay, and the RAI (Resident Assessment Instrument) Manual. The Surveyor asked why is it important to code services like dialysis to the MDS? The MDS Nurse replied to ensure the residents were getting the proper plan of care it is important to code the MDS correctly. e. On 08/21/24 at 02:55 PM, the MDS Nurse provided O0110: Special Treatments, Procedures, and Programs, from the Resident Assessment Instrument (RAI) Manual, revealed documenting special treatments, procedures, and programs within a resident's 14 day look back period is important to ensure continuous appropriateness of procedures, treatments, or programs that residents receive. Staff should provide education and monitoring.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure an uncapped razor was not left unattended in a resident's room to prevent accidents or injuries for 1 (Resident #44) of 1 sampled resident reviewed. to prevent accidents or injuries. The findings are: Review of the Medical Diagnoses revealed Resident #44 with diagnoses of schizoaffective disorder, dementia, and stroke. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 0f 02/28/2024 suggested a Brief Interview for Mental Status (BIMs) score of 4 (0-7 indicates severe cognitive impairment). Section GG 0130 indicated the resident was dependent for personal hygiene, and Section B1000 indicated the resident had impaired vision. a. Review of a facility policy titled, Shaving the Resident, (revised, October 2010) indicated after a resident is shaved the razor should be discarded in a designated sharps container labeled For Disposable Razors Only, located outside the resident rooms. b. Review of Resident 44's Care Plan, dated 03/28/2024, revealed the resident had complications related to impaired vision, with a change in the ability to perform activities of daily living. c. Review of Resident 44's Care Plan, dated 03/28/2024, revealed a self-care deficit related to weakness and cognitive deficit and Resident 44 was encouraged to use a call light for assistance, and staff to monitor for skin integrity and report cuts and scratches to the nurse. d. On 08/19/24 at 09:01 AM, the surveyor opened the door to Resident #44's room and observed an uncapped razor resting to the left of the in room sink on a brown napkin with a toothbrush and toothpaste. e. On 08/19/24 at 02:17 PM, an uncapped razor was observed resting to the left of the sink on a brown napkin with a toothbrush and toothpaste in Resident #44's room. f. On 08/20/24 at 08:52 AM, Resident #44 confirmed he had a razor in the room. g. During an interview with Licensed Practical Nurse (LPN) #4 on 08/21/24 at 10:30 AM, LPN #4 confirmed that residents should not have uncapped shaving razors in their room to prevent injuries. h. During an interview the Director of Nursing (DON) on 08/21/24 at 10:54 AM, the DON was asked the process for male residents to get shaven. The DON stated residents should be offered a shave on shower day. The DON was asked if a resident should have uncapped razors in their room. The DON replied, No, that residents could accidentally cut themselves with a razor, or another resident could take the razor and injure themselves.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure oxygen was set at the physician ordered rate for 1 (Resident #67) of 1 sampled resident with oxygen orders to prevent the potential for respiratory complications. Findings include: Review of Medical Diagnoses revealed Resident #67 had diagnoses of chronic obstructive pulmonary disease, acute respiratory failure, and pulmonary emphysema. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/24/2024 suggested a Brief Interview for Mental Status (BIMS) score of 12 (7-12 indicates moderately impaired). Section 0110 C1 indicates Resident #67 has been on oxygen while a resident. a. A review of Physician Order, dated, 07/03/2024, indicated Resident #67 receives oxygen at 2 liters as needed for shortness of breath. b. A review of the Care Plan, dated 06/08/2023, showed Resident #67 had chronic obstructive pulmonary disease and to give aerosol, bronchodilators, and oxygen 2 liters as needed per physician orders. c. On 08/19/24 at 07:43 AM, Resident #67 was observed resting in bed on 3 liters of oxygen by nasal cannula. Resident #67 said he/she is on 2 liters. d. On 08/19/24 at 01:25 PM, Resident #67 was observed wearing a nasal cannula with the concentrator set on 2.5 to 3 liters. A nebulizer with the mask stored was resting at Resident #67's feet. e. While checking Resident #67's oxygen on 08/20/24 at 09:00 AM, the concentrator was found to be on 2.5 to 3 liters. f. Licensed Practical Nurse (LPN) #4 accompanied Surveyor to Resident 67's room on 08/21/24 at 10:16 AM and confirmed the oxygen concentrator was set on 2.5-3 liters. LPN #4 pulled up the resident's orders and confirmed he was supposed to be on 2 liters as needed, and stated a concern for getting more oxygen than ordered is confusion, and a resident's body may not be capable of processing it, and it could make it harder to breath. g. During an interview on 08/21/24 at 10:50 AM, the Director of Nursing (DON) confirmed nursing should check each oxygen settings every shift while in a resident's room, because a few residents change their own oxygen and need checked behind, and not getting the ordered dose can affect their health including the heart rate. h. On 08/21/24 at 01:44 PM, the DON provided a policy titled, Oxygen Administration, the policy revealed unless otherwise ordered, oxygen flow should be started at the ordered rate.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and the facility recipe to meet the nutritional needs of the residents for 1 of 1 meal observed. The findings are: 1. A facility recipe for the fortified oatmeal indicated, for 24 resident's use: 8 cups =2 quarts of water. Whole milk 6 ounces. Rolled oats 6-1/2 cup. Non-fat dry milk 2-1/4 cup. Margarine 3/4 cup. [NAME] sugar 1-1/4 cup. Granulated sugar 1-1/4 cup. Whole milk 6 ounces. 2. On 8/19/24 at 8:10 AM, during the breakfast meal service. Dietary [NAME] (DC) #1 was asked how he prepared oatmeal. DC #1 stated, I used a bag of brown sugar and 2 sticks of butter. 3. On 8/19/2024, a facility breakfast menu indicated residents on pureed diets were to receive 1/2 cup of pureed grits, and a #16 scoop (1/4) cup of pureed coffee cake. a. On 8/19/24 at 8:49 AM, DC #1 served regular grits to the residents on pureed diets, instead of pureed grits. b. There was no pureed coffee cake served to the residents on pureed diets. d. On 8/19/24 at 12:29 PM, DC #1 was asked if residents on pureed diets should receive pureed coffee cake. DC #1 stated, They did not get it. I was in a rush. DC #1 was asked if residents on pureed diets should receive regular grits. DC #1 stated, We have never served pureed grits. DC #1 was asked if he looked at the menu before preparing pureed food items. DC #1 stated, No ma'am.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observation, record review, and interview, the facility failed to ensure the meals were prepared in a method that maintained nutritive value and taste that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal preparation observed. The findings are: 1. A facility titled recipe for pureed sausage not dated and provided by the Dietary Manager on 8/19/2024 at 11:30 AM, indicated for 7 residents, place 7 portions of prepared sausage in food processor with hot broth and blend to a smooth consistency. On 8/19/24 at 8:12 AM, Dietary [NAME] (DC) #1 placed 12 servings of sausage into a blender, added 2 cups of hot water from the coffee maker, instead of hot broth, added 6 tablespoons of thickener and pureed. 2. A facility titled recipe for pureed scrambled eggs not dated and provided by the Dietary Manager on 8/19/2024 at 11:30 AM, indicated for 7 residents, place four #8 scoop (1/2 cup) prepared scrambled eggs in food processor with hot milk and blend to a smooth consistency, adding a small amount of hot milk as needed. On 8/19/24 at 8:20 AM, DC #1 used a #12 scoop (1/3 cup) to place 4 servings of scrambled eggs with no ham into a blender, added 2 cups of hot water from the coffee maker, instead of hot milk, added 5 tablespoons of thickener and pureed. 3. On 8/18/24 at 9:15 AM, DC #1 was asked how scrambled eggs and sausage pureed with water taste. DC #1 stated, They will taste like nothing.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 37925 Based on observation, record review, and interview, the facility failed to ensure a mechanical soft diet was provided during the lunch meal service for 1 (Resident #7) of 1 sampled resident reviewed for a therapeutic diet. The findings are: Resident #7's Order Summary dated 08/21/2024 was reviewed and indicated a diagnosis of type two diabetes and an order dated 05/21/2024 for a mechanical soft texture diet. A quarterly Minimum Data Set with an Assessment Reference Date of 06/14/2024 was reviewed and indicated Resident #3 had a Brief Interview for Mental Status score of 9, which indicated moderately confused. A Care Plan dated 06/27/2024 was reviewed and had no indication that Resident #7 required a mechanical soft texture diet, or the resident did not have upper teeth or dentures. A Dietary Progress Note dated 05/20/2024 was reviewed and indicated Resident #7 was recommended to be offered a mechanical soft diet related to difficulty chewing. On 08/19/2024 at 10:26 AM, Resident #7 was observed lying in bed awake and stated, I need my top teeth fixed. Resident #7 stated the breakfast meal could not be eaten due to no top teeth. On 08/21/2024 at 12:50 PM, Resident #7 was observed lying in bed and the lunch meal tray was on the over bed table. Resident #7 stated the resident did not have any top teeth in and began crying. The lunch meal tray had a slice of meat loaf, not ground, covered with a brown sauce, macaroni and cheese, green peas and a cookie. On 08/21/2024 at 1:26 PM, the Dietary Manager was interviewed and asked for a list of foods considered to be mechanical soft. He confirmed for a mechanical soft diet, foods were placed in the blender and ground. He was asked about the lunch meal today and if those foods were okay for a person on a mechanical soft diet to eat. He stated the spreadsheet indicates which foods should be ground and he needed to look at his spreadsheet to answer the question. He was asked to provide a copy of the spreadsheet for the lunch meal served today. The Daily Spreadsheet Week 3 Wednesday provided by the Dietary Manager on 08/21/2024, with no date, was reviewed and indicated the meatloaf should be ground for a mechanical soft diet with gravy on top. A Therapeutic and Modified Diets policy, dated 05/25/2012 and provided by the Administrator on 08/22/2024, was reviewed and indicated therapeutic diets would be prepared and served according to physician orders using standardized recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation and interview, and facility policy review, the facility failed to ensure the kitchen air vent was cleaned to provide a sanitary environment for food preparation; the dish washer, and kitchen walls, the door frames and baseboards were free of chipped, debris, dirt, rust, stains, and wall tiles were replaced; leftover food items were used in manner to maintain food quality; food items stored in the freezer were covered or sealed to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen; the ice machine on the 300 Hall was maintained in clean and sanitary condition; dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meal trays from 1 of 1 kitchen; and manufacturer's instructions were followed to prevent potential for food spoilage and or bacteria growth. The failed practices had the potential to affect residents who received meals from 1 of 1 kitchen (total census: 85), as indicated on a list provided by the Dietary Manager. The findings are: 1.On 8/19/24 at 7:44 AM, an opened box of salt was on a spice rack in the kitchen. The box was not covered. 2. On 8/19/2024 at 7:45 AM, zip top bags dated 8/18/2024 that contained leftover pureed sausage and leftover pureed eggs were on the counter to be reheated and served to the residents who required pureed diets. Dietary [NAME] (DC) #1 was asked what the leftover pureed sausage and pureed eggs were for. DC #1 stated, They were both for the pureed diets. On 8/21/24 at 9:19 AM, during an interview the Dietary Manager stated, We don't use left over food for anything. We make it fresh every day. 2. On 8/18/24 at 7:48 AM, the following observations were made in the kitchen area: a. At the entrance door to the kitchen, the wall was chipped, exposing the concrete and was covered with a brown residue. b. The door frames leading to the kitchen, dish washing machine, and storage room were chipped, the chipped areas were covered with rust. c. The wall in the dishwashing machine room had black and rusty stains. d. The floor around the door frames leading to the storage room were chipped, the area had an accumulation of dirt and debris. e. The wall below the hand washing sink was chipped. The chipped areas were covered with a yellow/black matter. f. The wall below the window by the spice rack in the kitchen was chipped, exposing the concrete. The area exposed was covered with brown dirt. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. The legs of the preparation counter between the 3-door refrigerator and the stove were chipped and had black stains on them. h. The wall below the window in the storage room was chipped and was covered with black stain. i. The wall by the door in the storage room leading to the outside was chipped, exposing the concrete. The area that was chipped had a rust stain on it. j. The door leading to the outside, between a metal rack where clean pans were stored, and the 3-door refrigerator was chipped, exposing the wood. 3. On 8/19/24 at 8:06 AM, there was an opened box of biscuits on a shelf in the freezer. The box was not covered or sealed. 4. On 8/19/24 at 8:17 AM, Dietary [NAME] (DC) #1 turned on the 3 compartment sink faucet and washed the blender bowl, blade and the lid. After washing the food processor equipment and sanitizing them, he turned off the faucet with his bare hands, contaminating his hands. He picked up a clean blade and attached it to the blender to be used in pureeing food items to be served to the residents on pureed diets. DC #1 was asked what he should have done after touching dirty objects and before handling clean equipment. He stated, I should have washed my hands. 5. On 8/19/24 at 8:32 AM, DC #1 was on the tray line serving the breakfast meal. DC #1 picked up tray cards and placed them on the trays. Without washing his hands, he picked up plates to be used in portioning foods to be served to the residents for breakfast with his fingers inside the plates. DC #1 was asked what he should have done after touching dirty objects and before handling clean equipment. She stated, I should have washed my hands. 6. On 8/19/24 at 8:34 AM, the following observations were made in the 3-door freezer in the storage room: a. An opened box of sausage patties. The box was not covered or sealed. b. An opened box of breaded cod fish. The box was not covered or sealed. c. An opened box of chicken nuggets. The box was not covered or sealed. 7. On 8/19/24 at 8:44 AM, an opened box of vegetable blend was on shelf in the freezer. The box was not covered or sealed. 8. On 8/19/24 at 8:53 AM, a bottle of lemon juice on a rack in the storage room was opened and partially used. The Dietary Manager was asked what they use the lemon juice for. The Dietary Manager stated, We use it when we bake lemon chicken. The manufacturer specification on the bottle indicated, Refrigerate after opening. 9. On 8/19/24 at 8:59 AM, the back of the oven had brown carbon build up on it. There were brown stripes of residue on it. The cart where clean plates were stored on the clean side of the dish machine was chipped exposing the metal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 8/18/24 at 9:23 AM, the ice machine on the 300 Hall had wet black residue on the panel and around the area where ice formed before dropping into the ice collector. The areas were pointed out to the Maintenance Man and he was asked if the residue build up could be wiped off. He used a rag and wiped it off. The wet black residue easily transferred to the rag. At 9:28 AM, the Maintenance Man was asked how often they cleaned it. He stated, I just cleaned it two weeks ago. At 9:31 AM, the Dietary Manger was asked who used the ice from the ice machine. He stated, CNAs [Certified Nursing Assistants] use it for the water pitchers in the residents' rooms. 11. On 8/19/24 at 11:20 AM, DC #1 wiped his face with tissue paper and threw them away, contaminating his hands. Without washing his hands, he picked up a pan and placed it on the counter with his fingers inside the pan. When DC #1 was ready to transfer the cooked pasta into the pan. DC #1 was asked what he should have done after touching dirty objects and before handling clean equipment. He stated, I should have rewashed my hand. 12. A facility policy titled, Hand Washing not dated, indicated, hand washing was to perform at the start of a shift and after engaging in other activities that contaminate the hands.

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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. 47916 Based on observation, record review, and interview it was determined the facility failed to practice hand hygiene during meal service between 2 of 21 sampled residents. (Residents #76 and #83); failed to ensure proper hand hygiene during perineal care to prevent cross contamination for 1 (Resident #81) of 2 (Residents #34 and #81) sampled residents who were observed for bowel and bladder care during 1 of 1 observation; failed to ensure the tubing of an indwelling urinary catheter bag was not directly on the floor and the catheter bag drainage valve was in the protective plastic sleeve on the bag to decrease the potential for contamination for 1 (Resident #42) of 1 sampled residents who were reviewed for an indwelling catheter; and the facility failed to ensure the water management program was consistently implemented to monitor for legionella and other water-borne pathogens in 1 of 1 facility. The findings include: On 08/19/2024 at 09:35 AM, Certified Nursing Assistant (CNA) #3 was observed feeding Resident #76, and handling used napkins then walked over to Resident #83, picked up a napkin and assisted in removing eggs from Resident #83's face, and hands. CNA #3 then returned to Resident #76 and reached over Residents #76's left shoulder touched their left arm. On 08/16/2024 at 09:44 AM, CNA #3 confirmed that she did not perform hand hygiene between residents and there was a risk of cross contamination. The surveyor asked, what is the process staff follow when assisting between residents? CNA #3 replied their process was to sanitize hands between residents. On 08/21/24 at 12:11 PM, the Surveyor accompanied CNA #2 to Resident #81's room. The Surveyor observed CNA #2 using the right hand to pull out clean wipes, and wipe Resident #81's perineal area. The Surveyor asked CNA #2 if her right hand was the dirty hand and after confirming that it was CNA #2 was asked if she had any concerns using the right hand to pull out clean wipes and then wiping the perineal area with the right hand. CNA #2 replied that there is a concern for cross contamination and the right hand should not have been used to pull clean wipes from the package, and to clean the resident. During an interview with the Director of Nursing (DON) on 08/21/2024 at 11:05 AM, The DON confirmed that during perineal care, wipes should be used once going in one direction, and hand hygiene needs to be performed between clean and dirty tasks to prevent cross contamination. The DON stated that staff are expected to use alcohol gel or wash their hands between resident care. On 08/22/24 at 03:20 PM, the Administrator stated the facility did not have a policy for perineal care. Review of a provided Peri [Perineal] Care Audit, did not address cross contamination during peri care. 37925 (continued on next page)

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	045446	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at West Dixon Rehab & Nursing Center	2821 W Dixon Rd Little Rock, AR 72206

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #42's Order Summary dated 08/19/2024 was reviewed and indicated the resident had diagnoses of Alzheimer's disease and an obstruction in urine flow. The Order Summary indicated an order dated 07/24/2024 to change the [brand name] catheter tubing and bag as needed. An admission Minimum Data Set with an Assessment Reference Date of 07/31/2024 was reviewed and indicated Resident #42 had a Brief Interview for Mental Status score of 10, which indicated moderate confusion, and for bladder and bowel appliances, an indwelling catheter. A Care Plan dated 08/01/2024 was reviewed and indicated Resident #42 required a [brand name] catheter and catheter care per protocol. On 08/19/2024 at 8:53 AM, Resident #42 was sitting in a chair in the hallway with a catheter bag hooked on the right side of the chair. The catheter tubing was lying directly on the floor and the drainage valve was not in the protective sleeve on the bag but positioned down towards the floor. On 08/22/2024 at 10:56 AM, Certified Nursing Assistant (CNA) #8 was interviewed and stated she knows how to care for residents by looking at their care plan. She confirmed the tubing should not be positioned on the floor. An Infection Control policy, with a reviewed date of 01/2024 and provided by the Administrator on 08/19/2024. This document was reviewed and indicated that for the prevention of infection, staff would be educated to ensure they adhered to proper techniques and procedures. A Urinary Catheter Care policy, with an effective date of 04/2021 and provided by the Director of Nursing on 08/22/2024, was reviewed and indicated a closed drainage system should be maintained. It did not address placement of the catheter tubing. 4. On 08/19/2024 at 8:56 AM, the Midnight Census Report, dated 08/19/2024 and provided by the Director of Nursing, was reviewed and indicated the following rooms were empty on the 300, 400 and 500 Halls: 300, 411, 412, 503, 506, 507, 511, 513, 515, 517 and 519. On 08/22/2024 at 10:40 AM, the Administrator provided a binder which included the water management program. The information in the binder was reviewed and on page 14, it indicated control measures and corrective actions were to be completed by maintenance, housekeeping, or designee. Section Number 1 indicated the facility would conduct weekly water flushing on all identified key locations where the building may be at risk for the growth and spread of Legionella. There was a monthly log titled Weekly Water Run Flushing Log with the dates from January 2024 to August 2024. Each log identified which hall was flushed, but did not indicate the type of water outlet, such as a toilet or faucet, no dates were present on the columns to indicate which day of the week the flushing was performed. There were no temperature logs included to indicate if the water temperatures were checked. On 08/22/2024 at 11:40 AM, the Administrator was interviewed and asked who was responsible for completing the water management program. He stated the main maintenance guy quit two weeks ago and the assistant maintenance guy had not been employed at the facility long. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/2024 at 11:43 AM, the Assistant Maintenance Director was interviewed and when asked if he was familiar with the water management program, he replied he was not and he started working at the facility about six months ago. He added in his statement, the other maintenance guy had quit about 2 months ago. He was asked if he was included in the water management program, and he stated he was not. On 08/22/2024 at 11:50 AM, the Administrator was interviewed regarding the water management program. The Administrator confirmed the Maintenance Director, Regional Maintenance Consultant (no name provided) and the Administrator were included in the program. He confirmed the Regional Maintenance Consultant had monitored and documented the facility's water management program since the Maintenance Director left. The Administrator was asked if water temperatures were checked in resident rooms, and he confirmed he saw the maintenance guy checking them but did not know if/where he was documenting the information. He confirmed the Assistant Maintenance Director was not included in the water management program because he was new and needed training. He was asked to review the documentation on the Weekly Water Run Flushing Log in the Legionella Testing binder. He confirmed he could not tell which rooms on the halls were checked because no room was indicated on the log, only a hall. He confirmed he could not describe the date the flushing was performed on, or if the toilet and the water was flushed in the residents' rooms by looking at the documentation on the log because that information was not included. On 08/22/2024 at 1:03 PM, the Administrator provided Weekly Water Temp Log forms. The forms were reviewed, and the last form included dates with a month and day for July and August, but not the year. For the month of July on this form, the kitchen, an Assisted Living Facility (ALF), and halls 200, 300 and 400 were listed with documented water temperatures. There were no water temperatures documented for halls 100, 500 or 600 on this form for July and August. The forms did not include any water temperatures for the month of February 2024 or June 2024. There were no weekly water temperatures documented for the following weeks: January 28, 2024, to February 3, 2024; March 3, 2024, to March 9, 2024; March 10, 2024, to March 16, 2024; May 19, 2024, to May 25, 2024; May 26, 2024, to June 1, 2024, and June 30, 2024, to July 6, 2024. A Water Management Program policy, not dated and included in the binder for the water management program provided by the Administrator on 08/22/2024, was reviewed and indicated on page five, key elements of the water management program which included making sure the program was running as designated and all activities were documented. The program review section indicated the facility water management program would be reviewed by the Safety committee annually or when certain events occurred. There was no review date documented on the water management program.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37925 Based on record review and interview, the facility failed to ensure a pneumococcal vaccine was provided for 1 (Resident #44) of 5 (Resident's #11, #44, #48, #80 and #81) sampled residents. reviewed for immunizations. The findings are: Resident #44's Order Summary dated 08/22/2024 was reviewed and indicated the resident had diagnoses of dementia and an irregular heartbeat. An order dated 02/23/2024 indicated Resident #44 could receive Pneumovax (a pneumonia vaccine) unless contraindicated. An order dated 08/20/2024 indicated, may give pneumococcal vaccine unless contraindicated or refused, and one dose of Prevnar 20 - 0.5 milliliters (ml) was ordered to be administered intramuscular (IM). On 08/22/2024, Resident #44's immunization screen was reviewed and Prevnar 20 was listed as an immunization required under consent status. On 08/22/24 at 1:21 PM, the Infection Preventionist was interviewed and provided a copy of an immunization record from a website. The document was reviewed and did not indicate if the pneumonia vaccine was administered to Resident #44. She was unable to explain why the pneumonia vaccine had not been administered once consent was given on 02/23/2024. A Pneumococcal Vaccine policy, with an effective date of 03/2020, provided by the Administrator on 08/19/2024, was reviewed and indicated all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to provide a call light for 1 of 2 residents in a shared room, and failed to ensure a call light was in reach of 2 (Residents #40 and #66); failed to ensure the call light was in safe working condition for 1 (Resident 76) to ensure residents could communicate with staff, and prevent accidents, or injury during 1 of 1 observation. Findings include: 1. A review of Medical Diagnosis revealed Resident #40 had diagnoses of Alzheimer ' s, left eye blindness, and failure to thrive. A review of the Medical Diagnosis revealed Resident #66 diagnoses of schizophrenia, dementia, and anxiety. a. A review of a policy titled, Answer the Call light, (Revised, 10/2010) revealed the call light should be within easy reach of the resident. b. Review of an in-service Answering Call lights, dated 08/21/23, indicated, call lights must be on residents when they are in their room or lying in bed, and to ensure call lights are answered in a timely manner. c. Review of an in-service titled Call Lights, dated, 06/17/2024, indicated all nursing staff should respond promptly to call lights because it could have a critical means for pain, discomfort or emergencies. d. On 08/19/24 at 08:06 AM, Resident #40 was observed standing in his/her room on a rollator (a walker with wheels on the front two legs) and stated he/she recently fell on the sidewalk. One call light was observed in Resident #40's shared room, resting on the direct floor behind a brown recliner. e. Resident #44 was observed standing near the bed on 08/19/24 at 11:52 AM, with the right hand wrapped in gauze. Resident #40 revealed being right-handed and cannot even get to the call light. f. On 08/20/24 at 03:08 PM, the Surveyor observed Resident #40's call light resting directly on the floor behind a brown recliner. g. During an interview with Certified Nursing Assistant (CNA) #6 on 08/20/24 at 03:16 PM, CNA #6 was asked how Resident #40, and Resident #66, could call for help if they needed assistance. She checked and located the call light behind a brown recliner and said it should have been in reach of Resident #40 and on closer inspection CNA #6 revealed that there is only one call light in the room to share between Resident #40, and Resident #66. CNA #6 confirmed that there should be two call lights so both residents could call if they needed assistance. 2. A review of Medical Diagnosis revealed Resident #76 with diagnoses of respiratory failure, schizoaffective disorder, and anxiety. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 08/21/24 at 09:10 AM, Resident #76 was heard from the doorway, I need help changing my brief. I need help. Resident #76 was asked several times if the call light button was pressed. The Surveyor observed that the call light alarmed but did not light up above the doorway. b. On 08/21/24 at 09:12 AM, Licensed Practical Nurse (LPN) #7 was asked if the call light above Resident #76's room should light up when the call light is pushed, and LPN #7 said Yes, it should, so that staff can see the light and know that she needs help. c. During an interview with the Director of Nursing (DON) on 08/21/24 at 11:00 AM, the DON stated that call lights should be available and in reach of residents and confirmed that if a call light is not working properly, it should be added to the maintenance log. The Surveyor asked if there is a procedure for checking call lights to make sure they are working. The [NAME] stated that maintenance goes through and periodically checks to make sure call lights are working, but she cannot remember how often at this time. The Surveyor asked who was responsible for making sure call lights are in reach, or working for residents The DON said nursing, CNAs, and really all staff members are responsible because residents may need their call light to call for help, and to prevent falls. d. On 08/21/24 at 01:35 PM, the Administrator provided the Maintenance Repair Log, showing a call light check was done at the facility on 07/12/2024, revealing Resident #40's room had no cord.