STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045478	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arkansas Continued Care Hospital of Jonesboro	3024 Red Wolf Blvd, Suite 1 Jonesboro, AR 72401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36821 Based on observation, record review and interview the facility failed to ensure a urinary fluid drainage bag was concealed in a privacy bag to maintain dignity for 2 of 2 (Residents #203, and #206) sampled residents who had a urinary fluid collection bag. This failed practice did not ensure patient dignity and had the likelihood to affect 2 residents who had a urine collection bag. The findings follow: A. On 07/17/24 at 3:30 PM,the facility staff training competency on Peri care & Foley Care CAUTI (Catheter Associated Urinary Tract Infection) provided by the Director of Nursing (DON) was reviewed and did not adress privacy or dignity. B. The CAUTI prevention Policy and Procedure approved May 1, 2023, was reviewed and did not address privacy or dignity. C. Resident # 203 was admitted on [DATE] with Diagnoses of Stage 4 Pressure Ulcer with osteomyelitis of vertebra, sacral, and sacrococcygeal region. The comprehensive Minimum Data Set (MDS) with assessment reference date (ARD) of 07/09/2024 showed a Brief Interview for Mental Status (BIMS) of 13 (13-15 suggests cognitively intact). Section H of the comprehensive MDS showed Indwelling catheter use and frequently incontinent of bowel. 1. On 07/15/24 at 11:19 AM Resident # 203 was observed in her room. A foley catheter and the indwelling catheter drainage bag were hanging from the right side of bed and not in a privacy bag. The drainage bag was visible from the hallway. The drainage bag contained approximately 480 cc (cubic centimeters) of yellow urine. 2. On 07/16/24 at 8:53 AM, Resident # 203 was observed with the foley catheter drainage bag hanging from the right side rail and visible from the hallway. The drainage bag was not in a privacy bag. 3. On 07/16/24 at 8:53 AM, Licensed Practical Nurse (LPN) # 1 was asked if there was any problem observed with resident # 203's catheter. She stated, . it needs to be in a privacy bag. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Resident #206 had diagnoses of Cerebrovascular disease, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Aphasia. The Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024 documented the resident scored 0 (0-7 severely impaired) on a brief interview for mental status (BIMS), required dependent assistance of personnel for bed mobility, toileting and transfers. 1. On 07/15/24 at 11:17 AM, Resident #206 was observed lying in hospital bed with eyes closed. Registered Nurse (RN) # 1 stated, [Resident #206] is nonverbal . Urinary Fluid collection bag was observed hanging on the right side of bed frame with bright yellow urine, visible to the hallway. No visible privacy bag was present. 2. On 07/15/24 12:26 PM, observed Resident #206 lying in bed with their urinary fluid collection bag hanging on the right side of bed with bright yellow urine, visible to the hallway. No visible privacy bag was present. 37145

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30601 Based on observation, record review and interview, the facility failed to ensure baseline care plans were developed and implemented that included the instructions needed to provide effective person centered care for five (5) (Residents #202, #203, #204,# 205 and #206) of five (5) sampled residents. The failed practice had the likelihood to affect all 5 residents who were admitted in the past 30 days, as documented on a list provided by the Administrator on 7/15/24 at 10:50 AM. The findings follow: A. On 07/18/24 at 9:26 AM the Director of Nursing (DON) provided a form titled, Policy and Procedure . Description: Baseline Care Planning documented, .It [baseline care plan] will include interim approaches for meeting the resident's immediate needs and will reflect changes to approaches, as necessary, that occur before the development of the comprehensive care plan This Baseline Care Plan will include, but not limited to this information needed to care for the resident: a. Initial goals based on admission orders: b. Instruction needed to provide effective and person-centered care that meets professional standards of quality care; c. Resident's immediate health and safety needs; d. Physician orders; e. Dietary orders; f. Therapy orders; g. Social Services and h. PASARR [Preadmission Screening and Resident Review] recommendations (when applicable) This facility will provide the resident and representative, if applicable, with a written summary of the baseline care plan or baseline care plan including, but not limited to: a. Initial goals of the resident; b. Summary of the resident's medications; c. Summary of the resident's dietary instructions; d. Any services and treatments that will be administered to the resident and e. Any updated information based on details of the admission comprehensive assessment . B. Resident #202 was admitted [DATE] with diagnoses of Type 2 Diabetes Mellitus, Chronic Atrial Fibrillation, Atherosclerotic Heart Disease of native Coronary Artery, and Heart failure. The Admission Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 7/08/2024 showed the resident scored 15 (12-15 indicates cognitively intact) on a Brief Interview for Mental Status, and required supervision assistance for eating, toileting, grooming, and bathing. 1. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/08/2024 section K0300 weight loss showed Resident #202 had .Loss of 5% or more in the last month or loss of 10% or more in the last 6 months . 2.The Medication Administration record (MAR) showed Megestrol Acetate (Megace), give 40 mg (milligrams) tablet by mouth four times a day was administered beginning on 07/11/24. 3. The care plan dated 07/08/24 documented problems, goals and interventions to address diet, cardiovascular status, safety related to risk for falls and injury, infection related to osteomyelitis of the jaw, anticoagulant, and code status, The Care Plan did not address the resident's need for supervision of Activities of Daily Living (ADLs), or interventions for identified weight loss. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident # 203 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus with other specified complications, Chronic Respiratory Failure with Hypoxia, and Stage four (4) Pressure Ulcer with osteomyelitis of vertebra, sacral, and sacrococcygeal region. The admission Minimum Data Set (MDS) with assessment reference date (ARD) of 07/09/2024 showed a Brief Interview for Mental Status (BIMS) of 13 (13-15 suggests cognitively intact) . Section H of the admission MDS showed Indwelling catheter use. Section O of the admission MDS showed continuous oxygen therapy. 1.On 07/15/24 at 11:19 AM, Resident #203 was observed with 02 (oxygen) at 2 LPM (liters per minute) via NC (nasal cannula) and had a CPAP (Continuous Positive Airway Pressure) machine on the bedside table with the nosepiece draped off the back of the table and not stored in a bag. A urinary collection bag was hanging from the right side of bed and not in a privacy bag. The drainage bag was visible from the hallway. 2. On 07/15/24 at 11:30 AM, Registered Nurse (RN) # 1 was interviewed and asked how the CPAP nosepiece should be stored. RN #1 stated, Respiratory Therapy takes care of all of that. I am not sure she is using it but it should be stored in a bag. 3. On 7/15/24 at 3:19 PM, Resident # 203 was observed with O2 at 2 LPM via nasal cannula connected to wall 02 flow, the oxygen tubing was not dated. The CPAP nose piece was hanging down beside the bedside table and not stored in a bag. 4.On 07/16/24 at 8:53 AM, during medication pass observation with Licensed Practical Nurse (LPN) # 1, Resident # 203 was observed in her room. The urinary drainage bag was hanging from the right side rail that was in the lowered position and was touching the floor. 5. Review of the baseline plan of care dated 07/10/24 noted the care plan did not address the size of the indwelling catheter, when to change it, or any measures to prevent complications such as , excessive urethral tension, accidental removal, or obstruction of urine outflow, keeping the drainage bag below the level of the bladder, and potential psychosocial issues related to urinary catheter use. 6. Review of the baseline plan of care dated 07/10/24 noted the care plan did not address respiratory equipment functioning and cleaning, or procedures for emergencies. 7. On 07/17/24 at 2:30 PM, the DON was interviewed and was asked to locate a physician's order for the indwelling catheter. She could not locate an order. She was asked if there should be a physician's order and she stated, Yes. She was asked what the facility protocol would include for residents admitted with an indwelling catheter. She stated, We would change it on admission and then per physician's orders. 36821 D. Resident #204 with an admitted [DATE] had a diagnosis of Sepsis, Rectal Abscess, Type 2 Diabetes Mellitus, and Cutaneous Perineal Abscess. The Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/24 documented the resident scored 15 (13-15 cognitively intact) on the Brief Interview Mental Status (BIMS), required partial assistance and set up help with some of their Activities of Daily Living (ADL), and had surgical wound care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A baseline care plan dated 07/03/24 documented, .Pain . Medicate daily as per MD [Medical Doctor] . Glucose Metabolism . Give (Specify Medications) for diabetes as per MD order . There was no baseline care plan for Activities of Daily Living (ADL) for this resident, no specific wound care instructions, and no specific medications listed in the care plan to indicate pain control interventions and specific medication or special diet for Diabetes Mellitus. There was no care plan regarding the resident's code status. 2. The medication list provided by the Director of Nursing (DON) indicated the resident had orders for pain medicine. An interview with the resident on 07/15/24 noted he was routinely premedicated for pain control prior to dressing changes. The medication list also included insulin administered routinely and a consistent carbohydrate diet. E. Resident #205 had Diagnoses of non-pressure ulcer wound to foot, Hypertension, and Cerebral Palsy and was admitted [DATE]. Observations on 7/15/24 and 07/16/24 noted the resident to be bedbound but had a boot to wear when she gets out of the bed, per resident interview. 1. The medication list provided by the DON noted orders for Protonix for GI (Gastrointestinal) prophylaxis, Gabapentin for nerve pain, and Ultram for acute pain. 2. There were no baseline care plans for the use of high risk medications Protonix, Gabapentin, and Ultram. There was no care plan for Activities of Daily Living (ADL), and dietary. There was no care plan regarding the resident's code status. F. Resident #206 had diagnoses of Cerebrovascular Disease, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Aphasia, Seizure Disorder, Tube feeding, Contractures, Anticoagulant therapy and side rails were in use. The Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024 documented the resident scored 0 (0-7 severely impaired) on a brief interview for mental status (BIMS), required dependent assistance of personnel for bed mobility, tube feeding, toileting and transfers. 1.On 07/15/24 at 3:20 PM, Resident #206's current orders were received from DON which documented, . Enoxaparin Sodium 40 mg.(milligrams)SYR (Enoxaparin Sodium 40 mg. SYR)40mg/0.4 ML(milliliters)Subcutaneously DAILY HIGH ALERT DVT (Deep Vein Thrombosis) Prophylaxis .order date 07/01/2024 . Levetiracetam 500 mg (milligram)/5ml (milliliter) UD (Unit Dose)Solution(Keppra-UD) Administer 500 mg. (milligrams) (5 ml) via tube a day .Jevity 1.5 Calories/ Enteral TF (tube feeding) Continuous .per tube., Rate 65 ml/hr (hour).Enhanced Barrier Precautions . 2. On 7/15/24 at 3:06 PM, Resident #206 Baseline Care Plan provided by the DON was reviewed. The records did not contain a complete baseline care plan addressing the following: Tube Feedings, Contractures, Seizures, Anticoagulation Therapy, Side rails, Alternating Pressure Mattress, nor ADLs (Activities of Daily Living), nor Code Status. G. On 07/18/24 at 8:15 AM, the DON stated, A baseline care plan should include everything needed to take care of that patient. It should include all the diagnoses. She was asked, Who is responsible for ensuring the staff complete the baseline care plans? She stated, . That would be me. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 07/18/24 at 8:21 AM, the MDSC (Minimum Data Set Coordinator) was asked about the baseline care plan and she stated the care plans for insulin and pain should include the specific medication to be used. She was asked how the staff would know how to perform specific care for each resident. She stated the aides have access to information in the computer system. She stated they could look at the Physical Therapy notes to see how the therapists were able to work with them including transfer assistance. She stated they do not have a basic and specific ADL care plans that would be available for the direct care aides and nurses to view. I. On 7/18/24 at 8:27 AM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. She was asked, Who is responsible for completing the Baseline Care Plans? She stated, The nurses put their information in. She was asked, What are the potential negative outcomes of anticoagulants not being on the Resident's Care Plan? She stated, Bleeding, they should be monitored for bleeding, check labs. She was asked, Should there have been a care plan for side rails for [Resident #206]? She stated, Yes, to check for gaps, limbs could get caught in them and to monitor to see if they can use them to get up, if they shouldn't (should not) be using them. She was asked, Should there have been a care plan for their Tube feeding? She stated, Yes, when to check for residual .care of site. She was asked, Should [Resident #206] have contractures care planned? She stated, Yes, to check for pressure points, and hands. She was asked, Should Seizures be care planned for [Resident #206]? She stated, Yes, Side rails should be padded, bed low, no flashes on the television . 37145

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37145 Based on observation, record review, and interview, the facility failed to ensure an indwelling catheter drainage bag was positioned off the floor for 1 (Resident # 203) of 1 sampled resident with an indwelling catheter. This failed practice had the likelihood to cause urinary complications, including a urinary tract infection and to have adverse effects for all future residents with physician's orders for an indwelling catheter. The findings follow: A. Resident # 203 was admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus with other specified complications, and Stage four (4) Pressure Ulcer with Osteomyelitis of vertebra, sacral, and sacrococcygeal region. The admission Minimum Data Set (MDS) with assessment reference date (ARD) of 07/09/2024 showed a Brief Interview for Mental Status (BIMS) of 13 (13-15 suggests cognitively intact). Section H of the annual MDS showed Indwelling catheter use. 1. On 07/17/24 at 3:30 PM the facility staff training competency on Peri care & Foley Care CAUTI (Catheter Associated Urinary Tract Infection) provided by the Director of Nursing (DON) was reviewed and showed, Foley bag placement Secure bag to bed frame where it will not touch the floor. Place bag on the bed frame towards the foot of the bed or in the middle and attached to the frame, (Not Rails). 2. The CAUTI prevention Policy and Procedure approved May 1, 2023, showed, Steps to CAUTI prevention will be posted and included in staff education. 1) Hand Hygiene before and after handling catheter 2) Foley tubing stabilization 3) Keep bag off of floor and avoid dependent loops 4) Catheter care once a shift and prn 5) Keep a closed system-Replace with a new catheter ASAP (as soon as possible) if the seal is broken. 6) Prevent backflow empty bag before transport and drain urine from tubing to bag before moving bag to opposite side of bed. 3. On 07/16/24 at 8:53 AM, during medication pass observation with Licensed Practical Nurse (LPN) #1, Resident # 203 was observed in her room. The urinary drainage bag was hanging from the right side rail that was in the lowered position and was touching the floor. LPN # 1 was asked if there was any problem observed with Resident # 203's drainage bag? She stated, Yes, it shouldn't be touching the floor . She was asked if a foley catheter drainage bag should ever touch the floor. She stated, No, that would be a source of infection. 4. On 07/17/24 at 2:30 PM, the DON was interviewed and was asked to locate a Physician order for the indwelling catheter. She could not locate an order. She was asked if there should be a Physician order and she stated, Yes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37145 Based on observation, record review, and interview, the facility failed to ensure professional standards of care in the care and storage of respiratory equipment was maintained and signage indicating No Smoking was posted on the door for 1 of 1 (Residents# 203) resident who received oxygen therapy. The failed practice did not ensure patient safety and the equipment was maintained in sanitary conditions. The findings follow: A. On 07/17/24 at 3:30 PM, review of the Respiratory Care Patient Care, Cleaning, Disinfectant Sterilizing Procedure policy and procedure showed .Equipment utilized shall be cleaned, disinfected and/or sterilized after each use and all other appropriate times to prevent cross contamination. Nasal cannula, drain condensation into drainage bag as needed; Change every Sunday; tag and dated. B. Resident # 203 was admitted on [DATE] with Diagnoses of Chronic Respiratory Failure with Hypoxia. The Annual Minimum Data Set (MDS) with assessment reference date (ARD) of 07/09/2024 showed a Brief Interview for Mental Status (BIMS) of 13 (13-15 suggests cognitively intact) . Section O of the annual MDS showed continuous oxygen therapy. 1. On 07/15/24 at 11:19 AM, Resident #203 was observed with 02(oxygen) at 2 LPM(liters per minute) via NC (nasal cannula) and had a CPAP (Continuous Positive Airway Pressure) machine on the bedside table with the nose piece draped off the back of the table and was not stored in a bag. 2. On 07/15/24 at 11:30 AM, Registered Nurse (RN) # 1 was interviewed and asked how the CPAP nose piece should be stored? RN #1 stated, Respiratory Therapy takes care of all of that. I am not sure she is using it, but it should be stored in a bag. 3. On 7/15/24 at 03:19 PM, resident # 203 was observed with O2 at 2 LPM via nasal cannula connected to wall 02 flow, the tubing was not dated. The CPAP nose piece hanging down beside the bedside table and was not stored in a bag. 4. Review of the Physician orders showed there were no current orders for the CPAP, oxygen therapy or flow rate. 5. Review of the Plan of Care dated 07/10/24 showed, Alteration in Respiratory function related to impaired gas exchange as evidenced by 02(oxygen) and CPAP. 6. On 07/16/24 at 10:05 AM, the Administrator was asked how CPAP nose pieces should be stored when not in use. She stated, They should be stored in a bag. She stated resident # 203's family had brought the CPAP in and had placed it in the room. Protocol is to order CPAP from DME(Durable Medical Equipment) company if this is needed for patient. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. On 07/17/24 at 1:35 PM, Respiratory Therapist (RT) #1 was interviewed and asked how often respiratory equipment was changed, how staff would know if it needed to be changed out and proper storage when not in use. She stated the CPAP nose piece and oxygen tubing are changed out when Respiratory Therapy assessed the resident on admission, if they came from home with them, and then every Sunday. Review of the respiratory documentation showed there was no evidence that the oxygen tubing was changed out on admission, nor on the first Sunday of admission (07/14/24). RT # 1 stated she didn't see any documented change of oxygen tubing or the nose piece for the CPAP on the admission assessment or on the Sunday after admission. She stated she would start using a date sticker when tubing is changed out on the patients. 8. RT # 1 was asked if she could locate any documentation of Resident # 203's CPAP being addressed with the Physician or an order for the CPAP. She said she couldn't find any order or documentation in the record.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36821 Based on observation, record review and interview, the facility failed to ensure that before side rails were installed on a resident's bed, an assessment for entrapment risk was conducted and documented, alternatives to side rail use were attempted, the potential risks and benefits of side rail use were discussed with the resident or representative and informed consent was obtained to ensure, to the extent possible, that side rails were a necessary, safe and effective intervention for 1 (Resident #5) of 5 sampled residents who had side rails in use. The failed practices had the likelihood to affect 5 residents who had side rails in use. The findings follow: A. Resident #206 had diagnoses of Cerebrovascular Disease, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Aphasia. The Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024 documented the resident scored 0 (0-7 severely impaired) on a brief interview for mental status (BIMS), and was dependent assistance of personnel for bed mobility and toileting.On 7/15/24 at 4:40 p.m., reviewed the documents titled, Nursing Shift assessment dated [DATE] documented, .ADL (Activities of Daily Living)/Functional Status . Bed mobility, . Total dependence .Dressing .one-person physical assist .toilet use .total dependence- full staff performance every time during entire 7-day period. 1. On 07/15/24 at 11:17 AM, Registered Nurse (RN)#1) stated, [Resident #206] is nonverbal. Resident #206 was observed lying quietly with their eyes closed on their left side with a pillow behind their back on a Proactive Aire 6000 hospital bed with all 4 side rails up. The mattress settings were set at alternating cycle every 10 minutes, lbs (pounds) of pressure 130-180. Tube feeding Jevity 1.5 cal (calories) was infusing at 65 cc/hr(cubic centemeters/hour). 2. On 7/15/24 at 12:20 PM, LPN #2 stated, We have to turn him every two hours .He does not talk . Resident # 206 was lying in the hospital bed with all four side rails up. She lowered the side rails at the foot of the bed. She stated, He cannot reposition himself. 3. On 07/15/24 at 2:06 PM received a policy from the Administrator titled Accident & Supervision Appropriate Use & Assessment of Bedrails that showed, .to ensure proper installation of side /bed rails to reduce chances of entrapment .1. Assess the resident for risk of entrapment from bed rails prior to installation.2. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation . 4. On 07/15/24 at 4:00 PM, the Director of Nursing (DON) was asked, Why does (Resident #206) have side rails? She stated, For repositioning. She was asked, What is a potential complication of him having all 4 side rails up? She stated, Entrapment. She was asked, Was there anything you tried before using the side rails? She stated, No, he is on Keppra for seizure disorder and at risk for pressure sore due to his braden score being a 7 . She stated there had been no incidents of entrapment at the facility. She was asked, Was there a consent for side rails signed by the guardian? She stated, No. She was asked, Was a risk assessment for entrapment completed prior to raising his side rails. She stated, No, because that is our standard of care for everyone.

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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. 30601 Based on record review and interview, the facility failed to ensure a Proton Pump Inhibitor (PPI) was evaluated for appropriate use for1 (Resident # 205) of 5(resident # 202, #203, #204, #205, and #206) sample residents reviewed. This failed practice had the likelihood to affect all residents. The findings follow: A. Review of Resident #205's clinic record showed an orders for .Pantoprazole Sodium (Protonix) 40 mg, Give 40 mg (1 tablet) by mouth twice a day Indication: GI (Gastrointestinal) prophylaxis . 1. On 07/17/24 at 11:30 AM, the pharmacist was interviewed and stated the computer system prompts questions for high risk medications. This includes appropriateness of use but does not include specific dosage parameters and does not include PPI's (Proton Pump Inhibitors). 2. On 7/17/24 the Administrator was asked for the policy regarding medication regimen review. A policy was not provided.

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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. 30601 Based on observation, record review, and interview the facility failed to ensure items stored in the refrigerator were sealed completely to prevent potential food borne illness for residents who receive meals from 1 of 1 kitchen and failed to ensure food temperatures were maintained within required range while trays were served from the hall cart. These failed practices had the likelihood to affect all residents who received meals from the kitchen.The findings follow: A.On 07/15/24 at 10:52 AM, observed two (2) opened boxes of pork sausage covered with an opaque plastic wrapping that was not sealed in the refrigerator. In addition, there was one (1) opened box of cooked eggs with an opaque plastic wrapping that was not sealed in the refrigerator. During the initial tour, the Certified Dietary Manager (CDM) agreed these should have been sealed. 1. On 07/17/24 the Administrator provided a form which documented, Policy and Procedure Description: Food and Drink Each patient receives and the Recuperation Center provides: . Food and drink that is palatable, attractive, and served at a safe and appetizing temperature . 2. On 07/15/24 at 11:28 AM, Resident #204 stated the food could be warm when asked about any concerns he had about the meals. 3. On 07/15/24 at 12:30 PM, the food temperatures obtained by the CDM on the hall test tray were out of acceptable range. The salisbury steak was 119 degrees Fahrenheit, (F) mashed potatoes were 120 degrees(F) and the 3 bean salad (a cold food) was 95 degrees (F). The CDM stated, This is gonna kill us [as he took temperature of the 3 bean salad]. They were nervous and didn't put it in a separate bowl. That's what I would have done. The hot food should have been 135 degrees (F) or greater and the cold food should have been 41 degrees (F) or less.

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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. 30601 Based on observation, record review and interview, the facility failed to follow hand hygiene practices while providing wound care for 1 (Resident # 205) of 4 (Resident #202, #203, #204, and #205) sampled residents who required wound care, the dietary department did not have a hands-free trash receptacle at the handwashing station in the kitchen, the facility failed to provide documentation of implementation and monitoring of the water management plan to prevent Legionella and other waterborne pathogens, and failed to ensure environmental surfaces were being cleaned and disinfected with an EPA (Environmental Protection Agency)-registered disinfectant for the healthcare settings. The failed practices promoted the spread of infection. These failed practices had the likelihood to affect all residents. The findings follow : A. On 07/16/24 at 11:10 AM, during wound care observation with Resident #205, the treatment nurse did not wash hands before nor after completion of the wound treatment. The treatment nurse did not use hand sanitizer or wash hands after removing gloves and before applying new gloves when moving from a dirty to clean task during a wound dressing change. 1. On 07/16/24 at 11:25 AM, the treatment nurse was asked what should also occur when gloves are changed and she stated to wash her hands or use hand sanitizer. She agreed that the correct procedure would include washing her hands before and after the wound dressing change and to use hand sanitizer when gloves are changed and moving from dirty to clean tasks. 2. On 07/17/24 at 10:13 AM, the Director of Nursing (DON) was asked when would a nurse be expected to wash their hands and/or use hand sanitizer during a wound dressing change. She stated, They should wash their hands before they start, then glove up. They should change their gloves when they go from one wound to another and use the hand foam. She was asked what should happen when a soiled dressing is removed? She stated, When they change their gloves, use their hand foam and re-glove. Anytime they go from dirty to clean they should de-glove, use hand foam and put on new gloves. They need to wash their hands when they're done [with the treatment]. 3. On 07/17/24 at 11:30 AM, the Administrator stated the facility did not have a wound care policy that includes infection control specifics. B. On 07/15/24 at 10:52 AM, during the initial tour of the kitchen, there were no foot-pedal, hands-free operated trash cans at the handwashing station. The CDM (Certified Dietary Manager) stated, Oh, do we need one so we don't touch the tops of the trash barrels? Informed that they would re-contaminate their hands after just washing their hands. No policy regarding trash cans at the handwashing stations was provided. 36821 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 7/17/24 at 11:00 a.m., the Director of Nursing (DON) provided a policy titled, Maintenance and Monitoring of Water Systems to Reduce Legionella growth & Spread showed, .To provide a water system management program to reduce the potential for nosocomial infections caused by biological agents in aerosolizing water systems. The program will include the monitoring and maintenance of the facility's water system to reduce Legionella growth and spread .will perform and review at a minimum annually and whenever indicated a LTACH (Long Term Acute Care Hospital)Water Management Risk Assessment .The policy will be in accordance with State, federal, local CDC (Center for Disease Control), and regulatory guideline recommendations to reduce the risk of growth and spread of Legionella .water quality should be measured throughout the system .monitoring tap fixtures close to and far from the central distribution point 1. On 07/17/2024 at 11:16 AM, the DON was asked, Does the facility have the measures to prevent growth of Legionella? The DON stated, (Maintenance Director) deadheads all unoccupied rooms .State came out here last year from the Health Department because they said a resident ,who had Legionella's, was here and had been to four other hospitals and we sent them to the nursing home. We were never given their name . 2. On 7/17/2024 at 2:13 PM, a review of the State's Legionella Investigation was provided by the DON. The Investigation showed, On October 5, 2023, State Plumbing Inspector . conducted an investigation related to a confirmed Legionella case . 3.On 07/18/24 at 8:12 AM., the Maintenance Director was asked what the facility was doing to prevent Legionnaires disease. He stated he has been flushing the bathrooms, showers, and sinks in the patient rooms weekly that are not in use on the third floor, and another employee was treating the water. He was asked for documentation of the implementation and monitoring of their water management system. He stated, I haven't (have not) been documenting it . He was asked, What are the potential negative outcomes of not ensuring dead water is flushed from the water pipes? He stated, Sewage odor, stagnated water. He was asked again and he stated, We try to prevent Legionnaires. 4. On 7/17/24 the Administrator was asked for documentation of water testing results. No results were provided as of 7/23/24. D. Review of a facility policy titled, Infection Control surveillance, Prevention and Control of Infection dated June 1, 2017, showed, Purpose: The goal is to identify and reduce risks of endemic and epidemic health-associated infections (HAI) and communicable diseases in patients and health care workers (HCW) . 1. On 7/17/24 at 11:00 AM, the DON provided a graph titled admitted Infections. The graph showed patients admitted with cdiff (clostridium difficile) colitis in January, and June of 2024. 2. On 07/17/2024 at 12:21 PM, the housekeeper was observed in the hallway pushing his housekeeping cart. He was asked what cleaning chemicals he was directed to use. He picked up a container labeled Peroxy and stated that was what he cleaned the floors with. 3. On 07/17/24 at 2:04 PM, a walkthrough of the cleaning supplies was completed with the Director of Infection Control. Observed several unopened containers of Peroxy in the storage room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 07/17/2024 at 2:39 PM., the Director of Infection Control provided manufacture's recommendations for Peroxy cleaning solution and stated, it did not have an EPA number and she was not sure when or why it was being used. She was asked what the potential negative outcomes could be for using a cleaner that was not an EPA registered disinfectant. She stated, It doesn't kill cdiff (Clostridium difficile colitis) .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 36821 Based on record review and interview, the facility failed to ensure a certified or a qualified through education, training and experience Infection Preventionist (IP) was employed at the facility and available at least 20 hours a week, to establish and maintain the infection prevention program to help prevent the development and transmission of communicable diseases and infections. This failed practice had the likelihood to affect all 5 residents. The findings follow: A. On 7/17/24 at 3:30 PM., a review of the policy Antimicrobial Stewardship Program did not address the hours the Infection Preventionist must work at the facility each week. 1. On 7/17/24 at 11:16 AM, the Director of Nursing (DON) was asked, Who is your Infection Preventionist (IP)? She stated, [name of IP]. She was asked, Does she work here at this facility part time? She stated, No, but she is available at any time. We can call her . 2. On 7/17/24 at 11:18 AM, the Infection Control Director was asked if she had completed the Infection Prevetionist training and she stated she was scheduled for a class in September of 2024. She was asked to provide any education she had received in infection prevention. No documentation was provided. 3. On 7/17/24 , the Administrator was asked if she had an Infection Preventionist on staff at this facility and she stated, She is available for us to call her at any time . She was asked, Does she work at this facility at least part time. The Administrator stated, No. 4. Review of a facility policy titled, Infection Control surveillance, Prevention and Control of Infection dated June 1, 2017 showed, Purpose: The goal is to identify and reduce risks of endemic and epidemic health-associated infections (HAI) and communicable diseases in patients and health care workers (HCW) .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 36821 Based on interview and record review, the facility failed to ensure the medical record included documentation of the resident's decision to obtain or refuse the Pneumonia vaccine and that the resident or resident representative was provided education regarding the benefits and potential risks associated with the Pneumonia vaccine for 3 (Resident #202, #204 and #206) of 5 (Resident #202, #203, #204, #205 and #206) sampled residents who were over the age of 65 who were reviewed for immunization administration. This failed practice had the likelihood to affect all 5 residents. The findings follow: A. Review of a facility policy titled, Infection Control surveillance, Prevention and Control of Infection dated June 1, 2017, showed, Purpose: The goal is to identify and reduce risks of endemic and epidemic health-associated infections (HAI) and communicable diseases in patients and health care workers (HCW) . 1. On 7/23/24 a form titled Vaccination Status showed, Our hospital policy & protocol approved by our physicians allows the Pneumococcal and Influenza vaccine to be administered to patients aged 65 and older unless contraindicated or otherwise declined by the patient or patient representative. Pneumococcal vaccine is available year-round and Influenza vaccine is available every flu season October thru December. 2. The Immunization Records provided by the Director of Nursing (DON) on 7/17/24 did not contain documentation of Resident #202, #204 and #206 receiving the Pneumococcal vaccine, nor did it show education provided or a signed declination. 3. On 7/17/24 at 2:44 PM, the DON was asked, Did [Resident #202, #204, #206] receive a Pneumococcal Vaccine, education of risk, or declination forms signed? She stated, No, we used to have a declination form, but we are not using it anymore . The nurse fills those out on admission.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 36821 Based on interview and record review, the facility failed to ensure the medical record included documentation of the resident's decision to obtain or refuse the COVID vaccine and that the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine for 4 (Resident #202, #203, #204 and #206) of 5 (Resident #202, #203, #204, #205 and #206) sampled residents who were reviewed for immunization administration. This failed practice had the likelihood to affect all 5 residents. The findings follow: A. Review of a facility policy titled, Infection Control surveillance, Prevention and Control of Infection dated June 1, 2017, showed, Purpose: The goal is to identify and reduce risks of endemic and epidemic health-associated infections (HAI) and communicable diseases in patients and health care workers (HCW) . 1. The Immunization Records provided by the Director of Nursing (DON) on 7/17/24 did not contain documentation of Resident #202, #203, #204 and #206 COVID-19 vaccine, nor did it show education provided or a signed declination. 2. On 7/17/24 at 2:44 p.m., the DON was asked, Were [Residents #202,#203, #204, #206] offered a COVID-19 Vaccine, education of risk, or declination forms signed? She stated, No, we used to have a declination form, but we are not using it anymore . The nurse fills those out on admission, but we stopped it.