STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075263	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cromwell	385 Main Street Cromwell, CT 06416

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 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51182 Based on Resident Council interviews, staff interview, and a review of the Food Committee minutes, the facility failed to act on the Food Committee concerns. The findings include: On 7/24/24 at 1:15 PM, during the Resident Council meeting, Resident #29 and Resident #65 reported that the Food Committee meets monthly, and attendees give feedback for correction, and nothing ever gets done. An interview and review of the Food Committee minutes with the Dietary Manager and the Regional Dietary Manager on 7/25/24 at 11:15 AM identified that on 4/24/24, Resident #93 wanted small portions and didn't want bread on his/her tray and Resident #42 disliked pork and requested gravy on the side. Review of the Food Committee Minutes Review/Follow Up dated 5/25/24 failed to identify a response from the Dietary Department. Food Committee minutes dated 6/25/24 identified Resident #13 requested more scrambled eggs at breakfast and Resident #97 requested 2 boiled eggs twice a week. Review of the Food Committee Minutes Review/Follow Up dated 7/5/24 failed to identify a response from the Dietary Department. The Regional Dietary Manager performed a review of resident food tickets, within the Food Service computer program, to verify if a note had been placed on their food ticket after a request or complaint had been placed in the January of 2024 through July of 2024 Food Committee minutes. The Regional Dietary Manager was unable to identify that resident requests from the Food Committee meeting minutes resulted in a note being placed on their food ticket. Although requested, the Dietary Manager identified the facility did not have a policy for responding to Food Committee concerns.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46953 Based on observations, interviews, and review of facility documentation, for 4 of the rooms/resident areas on the Elm Unit, 7 of the rooms/resident areas on the Maple Unit, 9 of the rooms/resident areas on the Oak Unit, and 2 of the rooms/resident areas on the Hickory Unit, the facility failed to ensure the residents' rooms and furnishing were maintained in a clean, safe, homelike and sanitary manner and in good repair. The findings included: 1. On 07/19/24 and 07/24/24, observations throughout the day of the Bathroom between rooms [ROOM NUMBERS] on the Elm Unit identified the following: a. The surface of the wall underneath the sink had the drywall and tile removed. The plumbing and wall studs were exposed with tile debris falling from the wall. An interview and tour with the Director of Maintenance (DOM) on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the drywall had been missing. At one point there was a leak that required the drywall and tile to be removed. 2. On 07/19/24 and 07/24/24, observations throughout the day of the Bathroom between rooms [ROOM NUMBERS] on the Elm Unit identified the following: a. The ceiling tile appeared discolored and had a buildup of a black substance. An interview and tour with the DOM on 07/24/24 from approxmately 9:00 AM to 10:00 AM identified he was unsure of how long the ceiling tile had been like that but identified concerns with water dripping down from the 2nd floor. 3. On 07/19/24 and 07/24/24, observations throughout the day of the Bathroom in room [ROOM NUMBER] on the Elm Unit identified the following: a. The surface of the wall had paint which appeared to be peeling. b. Underneath the sink there was a hole in the drywall and tile. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the hole was there. 4. On 07/19/24 and 07/24/24, observations throughout the day of the 2nd floor Shower room on the Maple Unit identified the following: a. The faceplate of the radiator had fallen off and was on the ground. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the cover had been off, but it would be identified on an environmental round. The DOM fixed this while the tour was conducted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER]A in the Maple Unit identified the following: a. The window blinds had broken and/or missing slats. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long it had been broken, but it is common for residents to take the slats out so the residents can see out the window. 6. On 07/19/24 and on 07/24/24, observations throughout the day of room [ROOM NUMBER]B in the Maple Unit identified the following: a. The Bathroom door handle was permanently locked. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was not aware of the problem with the handle, but that it would have been identified on an environmental round. 7. On 07/19/24 and on 07/24/24, observations throughout the day of the Bathroom in room [ROOM NUMBER] in the Maple Unit identified the following: a. The ceiling tile appeared discolored and had a stain. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure how long the stain was there. 8. On 07/19/24 and on 07/24/24, observations throughout the day of the Bathroom in room [ROOM NUMBER] in the Maple Unit identified the following: a. The ceiling tile appeared discolored and had a stain. An interview and tour with the DOM on 07/24/24 from approximately 9:00AM to 10:00 AM identified he was unsure of how long the stain was there. 9. On 07/19/24 and on 07/24/24, observations throughout the day of the Bathroom between rooms [ROOM NUMBERS] in the Oak Unit identified the following: a. The toilet bowl had a reddish-brown stain. An interview and tour with the DOM on 07/24/24 from approximately 9:00AM to 10:00 AM identified he was unsure of how long the stain was there. 10. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] in the Oak Unit identified the following: a. The wall at the doorway under the light switch had exposed sheet rock. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and tour with the DOM on 07/24/24 from approximately 9:00AM to 10:00 AM identified he was unsure of how long the sheetrock had been exposed. 11. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER]B in the Oak Unit identified the following: a. The call bell light outlet had a cover plate and a 3x5 gap with exposed wires. An interview and tour with DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the cover plate had been missing. 12. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] A/B on the Oak Unit identified the following: a. The bathroom vent had a large accumulation of dust and debris. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified the vent was last cleaned in May of 2024. 13. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] in the Oak Unit identified the following: a. The ceiling tile appeared discolored and was stained. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the stain was there. 14. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] in the Oak Unit identified the following: a. The ceiling tile appeared discolored and was stained. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long the stain was there. 15. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] in the Oak Unit identified the following: a. The wall had a small hole in the sheetrock behind the window blinds. b. The radiator had a large hole in the grate. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified it had been there for a little while and the hole in the radiator was probably missed on the last environmental round. 16. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] A/B on the Oak Unit identified the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The privacy curtain was falling off the ceiling An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long it had been like that; however, he hooked the curtain to the hooks. 17. On 07/19/24 and 07/24/24, observations throughout the day of the Bathroom in room [ROOM NUMBER] in the Hickory Unit identified the following: a. There were 4 approximately 1/4 inch holes stuffed with pieces of what appeared to be paper towels. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long it has been like that. 18. On 07/19/24 and 07/24/24, observations throughout the day of room [ROOM NUMBER] in the Hickory Unit identified the following: a. There was a hole in the wall above Resident 164's bed which appeared to be missing a faceplate cover. An interview and tour with the DOM on 07/24/24 from approximately 9:00 AM to 10:00 AM identified he was unsure of how long it has been like that. In addition, an interview and tour with the DOM on 07/24/24 from approximately 9:00 AM until 10:00 AM indicated he does conduct environmental rounds to identify any possible issues quarterly. He also indicated each unit has a maintenance log which is routinely reviewed and helps address any issue or concern with environmental areas. The DOM did identify that all environmental concerns identified were unacceptable.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on staff interviews, review of the clinical records, facility documentation, and facility policy for 5 of 6 sampled residents (Residents #20, Resident #80, Resident #140, Resident #153, and Resident #668) reviewed for a resident-to-resident altercations, the facility failed to ensure an allegation of mistreatment was reported to the appropriate agencies. The findings include: A.1. Resident #20s diagnoses included dementia, hallucinations, and obesity. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was severely cognitively impaired, required substantial/maximum assist for personal hygiene, was independent/set up for eating, toileting, and transfers. The Resident Care Plan (RCP) dated 2/8/24 identified that Resident #20 had the potential to demonstrate physical behaviors related to dementia. Interventions included that when Resident #20 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and redirect Resident #153 away from Resident #20. 2. Resident #153's diagnoses included dementia, anxiety, and visual hallucinations. The Admission MDS assessment dated [DATE] identified Resident #153 was severely cognitively impaired, required substantial max assist for personal hygiene, and was dependent for eating, toileting, and bathing. The Resident Care Plan dated 2/8/24 identified that Resident #153 had the potential to demonstrate physical behaviors related to dementia. Interventions included redirecting Resident #153 from Resident #20, and behavior monitoring every shift. A Reportable Event form dated 2/8/24 identified, at approximately 12:30 PM, a staff member yelled for help and LPN #9 went to intervene. Resident #153 went into Resident #20's room, held onto Resident #20's walker and told him/her to let it go. Resident #153 did not let go of the walker and Resident #20 then slapped Resident #153 on the cheek. The staff member separated both residents and neither was injured at the time. The care plans were updated, the Advanced Practice Registered Nurse (APRN), Police, and responsible parties were notified. Both residents were placed on 1 to 1 until cleared by psychiatric services. Adult Protective Services was not identified as being notified. A second Reportable Event form dated 6/12/24 identified, at approximately 11:20 AM identified that Resident #153 was outside Resident #20's room, saw a rollator walker and seated his/herself on the rollator walker seat. Resident #20 looked out his/her door, saw Resident #153 sitting on his/her rollator, and walked over to him/her and hit Resident #153 in the face. Resident #20 was yelling he/she was in my chair and in my stuff. The nurse on the unit heard the commotion and ran to the area to separate the residents. Neither resident appeared injured. The Advanced Practice Registered Nurse (APRN), Police, and responsible parties were notified. Resident #153 was placed on 1 to 1 until cleared by psychiatric services. Resident #20 was sent to a behavioral unit at another facility. The Reportable Event failed to identify that Adult Protective Services were notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director Nursing Service (DNS) 7/23/24 at 1:18 PM identified that she did not notify Adult Protective Services regarding the incident on 2/8/24 and 6/12/24 because she did not know she was required to do so for a resident-to-resident altercation. B. 1. Resident #80 diagnoses included dementia, diabetes, and muscle weakness. The Quarterly MDS assessment dated [DATE] identified Resident #80 had long and short term memory problems and required partial to moderate assistance from staff with upper body dressing and was independent with ambulation and transfers. The Resident Care Plan in effect on 7/1/24 identified Resident #80 with risk for impaired cognitive function related to dementia. Interventions included administering medications as ordered, monitoring and documenting any changes in cognitive function and engaging in simple structured activities. 2. Resident #140's diagnoses included dementia, hypertension, depression, and anxiety. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #140 was severely cognitively impaired, and was independent with bed mobility, transfers, and ambulation. The Resident Care Plan in effect on 7/1/2024 identified Resident #140 with risk for impaired cognitive function related to dementia. Interventions included engaging the resident in simple structured activities that avoid overly demanding tasks, monitoring and documenting any changes in cognitive function, and using task segmentation to support short memory deficits. Review of the DNS nurse's note dated 7/8/24 at 4:04 PM identified that Resident #140 was observed with a new behavior of touching Resident #80 on top of her chest over her clothing. Review of the Reportable Event dated 7/8/24 identified that Resident #140 placed an open hand on the chest of Resident #80 over his/her clothing. The Reportable Event had a state classification of an E indicating that the event was not Reportable to the State Agency. Review of the Psychiatric and Consultation note dated 7/8/24 identified that Resident #140 was observed by staff touching the chest area of a resident of the opposite gender outside of his/her clothes. When Resident #140 was being reviewed by the psychiatric physician, Resident #140 became agitated over the conversation and stated that Resident #80 put his/her hands over there. Interview with the DNS on 7/23/24 at 11:23 AM identified that LPN #1 contacted her and reported an allegation of mistreatment between Resident #80 and Resident #140. The DNS indicated that she immediately went to the unit and started an investigation of the incident. The DNS identified that she did not report the incident to the state survey agency after she determined that Resident #140 briefly touched Resident #80 on the chest area over his/her clothing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the investigative statement with LPN #1 on 7/24/24 at 10:15 AM identified that on 7/8/24 during her shift, NA #5 reported to her that she was walking in the hallway when she observed Resident #140 sitting in the doorway of his/her room with Resident #80 standing over him/her. Resident #140's hands were noted to be on the outside of Resident #80's clothing, and he/she was holding Resident #80's breasts. LPN #1 further identified that NA #5 had already separated the Residents prior to reporting the issue to her. Additionally, LPN #1 identified that she informed the DNS of the allegation. Interview and review of the investigative statement with NA #5 on 7/24/24 at 10:25 AM identified that she was walking in the hallway when she observed Resident #140 sitting on a chair in the doorway of his/her room with Resident #80 standing over him/her with Resident #140's hands on the outside of Resident #80's clothing and he/she was holding Resident #80's breasts. NA #5 stated that she told Resident #140 to stop, separated Resident #140 from Resident #80 and reported the issue to LPN #1. Interview with the Administrator, DNS, and Clinical Regional Director (RN #3), on 7/24/24 at 11:30 AM identified they did not notify the state agency of the allegation of mistreatment between Resident #80 and Resident #140 because both Residents' Brief Interview for Mental Status (a cognitive test) were low, (cognitive impairment). They further identified that after the facility's internal investigation, it was determined that there was no malintent because Resident #140 did not know what he/she was doing due to severe cognitive impairment. The Administrator identified that he would have reported the allegation of mistreatment to the State Agency had he known that this type of situation still needed to be reported. C. 1. Resident #20's diagnoses included dementia, hypertension, and depression. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was moderately cognitively impaired, independent with bed mobility and transfers, and required supervision with ambulation. The Resident Care Plan (RCP) in effect on 5/1/23 identified Resident #20 had the potential to demonstrate physical behaviors related to dementia. Interventions included intervening before agitation escalates, guiding away from source of distress, engaging calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. 2. Resident #668's diagnoses included dementia, anxiety, and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #668 was moderately cognitively impaired and independent with bed mobility, transfers and ambulation. The Resident Care Plan in effect on 5/1/23 identified Resident #668 had behavior issues related to physical altercation with peers and staff. Interventions included to provide a psychiatric consultation as needed and redirection from other residents' personal space. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Reportable Event form dated 5/4/23 at 10:00 AM, identified an unwitnessed event had occurred. A staff member was walking in the hallway when she saw Resident #20 sitting on the ground near the doorway of his/her room while Resident #668 was noted to be holding Resident #20's phone in his hand leaving Resident #20's room. Staff responded and separated Resident #20 and Resident #668. Resident #20 stated that Resident #668 entered his/her room and attempted to take his/her cellphone. Resident #20 tried to take his/her cell phone back but in the process both Residents struck each other, and Resident #20 was pushed to the ground. Review of the resident interviews identified that Resident #668 stated he/she hit Resident #20 while Resident #20 stated that he/she hit Resident #668. Resident #20 and Resident #668 were placed on 1 to 1 observation until they were cleared by the psychiatric physician. Nursing Assessments were completed, and Resident #20 was noted to have an open area on his/her right elbow and left hand. Resident #668 was noted to have a skin tear on the left knee. Advanced Nurse Practitioner (APRN), resident's responsible party, and the police were notified of the altercation. Psychiatric and Social Services were provided. Adult Protective Services was not identified as being notified. Interview with the Director of Nursing Services (DNS) on 7/13/24 at 1:18PM identified that she did not notify the Adult Protective Services about the resident-to-resident altercation. She identified that she was unaware of the state guidelines regarding notifying Adult Protective Services. She further identified that had she been aware of the guidelines, she would have notified Adult Protective Services. Review of the Abuse Reporting and Investigation policy, in part, identified that the facility will not permit residents to be subjected to abuse by anyone including other residents. An investigative report will be conducted to identify the incident, identify staff members responsible for the initial reporting, investigation of alleged violations and reporting results to the proper authorities. Should the investigation reveal that suspected or actual abuse occurred, the administrator/designee must report such findings to the resident representative, Department of Public Health and others that may be required within the mandated time frames. Review of the Abuse: Reporting and Investigation policy, in part, identified that the facility will not permit residents to be subjected to abuse by anyone including other residents. An investigative report will be conducted to identify the incident, identify staff members responsible for the initial reporting, investigation of alleged violations and reporting results to the proper authorities. Should the investigation reveal that suspected or actual abuse occurred, the administrator/designee must report such findings to the resident representative, Department of Public Health and others that may be required within the mandated time frames. 50250

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on staff interviews, clinical record review, and facility policy for 1 of 5 residents (Resident #98), reviewed for Preadmission Screening Assessment Resident Review (PASRR), the facility failed to refer Resident #98 to the appropriate state-designated authority for a Level II PASRR evaluation and determination when a new psychiatric diagnosis was identified. The findings include: A PASRR Level I screen dated 3/4/20 identified that Resident #98 needed no further Level I screen unless you have or are suspected of having a serious mental illness of an intellectual or developmental disability and exhibit a significant change in the resident's treatment needs. Resident #98 diagnosis included dementia, congestive heart failure and a new diagnosis of schizoaffective disorder, which was diagnosed in September of 2020. A Psychological Services Progress Note dated 9/13/20 identified that Resident #98 had a psychotic disorder. A Psychological Services Progress Note dated 5/23/22 identified that Resident #98 had schizoaffective disorder. The Annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 was severely cognitively impaired, required substantial/ moderate assist for personal hygiene, was dependent for toileting, and bathing, and was independent with eating. Additionally, Resident #98 was noted with diagnoses including psychotic disorder and schizophrenia. The Resident Care Plan dated 1/23/24 identified Resident #98 had a psychosocial wellbeing problem related to schizoaffective psychotic disorder. Interventions identified when a conflict arises, remove Resident #98 to calm, safe environment and allow to vent/share feelings. Also to assist, supervise, and support Resident #98 to identify problems that cannot be controlled. Interview with Social Worker (SW)#1 on 7/23/24 at 10:09 AM identified that she only started working at the facility in 2023 and she was unsure why a PASRR Level II had not been completed for Resident #98 but that the notification for a Level II should have been submitted to the appropriate agency. SW#1 identified that she was in the process of learning how to run audits, that it must have gotten overlooked. Subsequent to surveyor inquiry, SW #1 indicated that she will resubmit for PASRR Level II. (continued on next page)

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	The Facility Policy for Resident Assessment -Coordination with PASRR program identified that the facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disease, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have a mental disease, intellectual disease or a related condition to the appropriate state-designated authority for a Level II PASRR evaluation and determination. The Social Service Director shall be responsible for keeping track of each resident's PASRR screening status, referring to the appropriate authority.

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Autumn Lake Healthcare at Cromwell	385 Main Street Cromwell, CT 06416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility policy, and interviews for the only resident (Resident #103), reviewed for incontinence, the facility failed to provide timely incontinent care to a dependent resident. The findings include: Resident #103's diagnoses included hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) and chronic pain syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #103 was mildly cognitively impaired, was totally dependent on staff for bed mobility and toileting hygiene and did not transfer out of bed. Resident #103 was always incontinent of bowel and bladder. The Resident Care Plan dated 5/15/24 identified Resident #103 had bowel and bladder incontinence and is at risk for complications with yeast in the urine. Interventions included washing, rinsing, and drying the perineum and changing clothing after incontinence episodes every 2 hours and as needed. Continuous observations of Resident #103 on 7/24/24 from 9:00 AM to 11:39 AM identified that at 11:39 AM, NA#1 and NA #2 entered Resident #103's room to perform incontinent care. After obtaining permission from the resident to observe care, Resident #103, was identified to have had a small liquid bowel movement. Dried fecal material was noted to be adhering to the outside ring of fecal material on his/her buttocks which required NA #2 to apply friction to remove the fecal matter. Interview with NA #1 and NA #2 on 7/24/24 at 11:45 AM identified that incontinent care is given every 2 hours and as needed. NA #2 identified she had last given Resident #103 care at 7:45 AM. Although NA #2 indicated she went in at 11:00 AM and checked Resident #103 for incontinence, constant observation by the surveyor failed to identify NA#2 had entered Resident #103's room. Interview with LPN #3 on 7/24/24 at 1:26 PM identified that incontinent care is given every 2 hours and when the residents use their call bell. The NA's get the residents up and change them if the residents are soiled and then transfer the residents back to their chairs. LPN #3 stated that NA #2 indicated care was provided to Resident #103 at 8:45 AM. LPN #3 additionally stated that NA#2 should have provided Resident #103 with an incontinent check/care at 10:45 AM (within approximately 2 hours) and further stated she would have expected Resident #103 to be checked/care given sooner than the surveyor observed. In a second interview with NA#2 at 1:37 PM she confirmed she was responsible for Resident #103's incontinent care and that she had last provided Resident #103 incontinent care at 7:45 AM (approximately 4 hours prior to the observation of care). Interview with Resident #103 on 7/24/24 at 1:58 PM identified that he/she could not recall being checked earlier than when the surveyor observed his/her care. Interview with Director of Nursing Services (DNS) on 7/25/24 at 8:55 AM identified that incontinent care is given 4 times a shift and when a resident needs to be changed. The DNS indicated that incontinent care is not given exactly every 2 hours but is given more frequently than every 4 hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Perineal care policy dated 12/14/2022 directed, in part, to provide perineal care to all incontinent residents during routine bath and as needed to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Although requested, a facility policy for incontinence care was not provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on review of the clinical record, facility policy, and interviews for 2 of 2 residents, (Resident #94 and Resident #152), reviewed for kidney failure who receive specialized services and who were on a fluid restriction, the facility failed to have a systematic approach in place to assess daily fluid intake amounts on consecutive days. The findings include: 1. Resident #94 's diagnoses included chronic kidney disease Stage 4 (severe) and Diabetes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #94 was moderately cognitively impaired and independent with eating, bed mobility, transfers, and toileting. The Resident Care Plan dated 6/17/24 identified renal insufficiency related to end stage chronic kidney disease now on a specialized service. Interventions included providing the specialized service as ordered by the provider, monitor, document and report any complications every shift, and due to a fluid restriction, to check with the charge nurse before bringing fluids between meals. A physician's order dated 6/18/24 directed a fluid restriction of 1200 milliliters (ml) per day: 480 ml to be given by nursing and 720 ml to be given by dietary. The Medication Administration Record (MAR) identified a fluid restriction of 1200 ml per day beginning on 6/19/24 with amounts noted for each shift but the MAR failed to indicate a total fluid intake for each 24-hour period. The Documentation Survey Report indicates fluids given by staff on each shift as follows: 7/14/24 120 ml on evening shift, 7/15/24 360 ml on evening shift, 7/16/24 360 ml on evening shift, 7/17/24, 420 ml on the evening shift and 120 ml on the overnight shift, 7/18/24 360 ml on evening shift, 7/19/24 480 ml on evening shift, and on 7/20/24 360 ml on evening shift. Review of the intake and output worksheets identified there was an intake and output book at the nurse's station but lacked an entry for 7/14/24, on 7/15/24 a 300 ml intake, on 7/16/24 a 480 ml, on 7/17/24 a 480 ml, on 718/24 a 480 ml, on 7/19/24 360 ml, and on 7/20/24 480 ml. Review of the clinical record failed to indicate that total fluid intake amounts were calculated from 7/14/24 through 7/20/24. Interview with RN #3 on 7/25/24 at 12:50 PM identified that when a resident were to show symptoms of dehydration, an assessment would be conducted, and the practitioner would be notified. RN #3 indicated that the facility failed to have a mechanism in place to total fluid intake every 24 hours. RN #3 identified that the Dietician assessed residents for total fluid needs/goals, but if the resident failed to meet that goal, there were no designated staff who would look at the 24-hour total each day to make the determination if the fluid goal was met or exceeded. Further, per the standard of practice, RN#3 indicated that if a resident did not meet their 24 hour fluid goal for 3 consecutive days, a dehydration assessment should be conducted, and the Dietician and medical practitioner should be notified. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #152's diagnoses included end stage renal disease, moderate protein-calorie malnutrition, and congestive heart failure. The admission Minimum Data Set assessment dated [DATE] identified Resident #152 was moderately cognitively impaired, was independent with eating, dependent on staff for personal hygiene, and dependent for chair/bed-to-chair transfers. The Resident Care Plan dated 6/4/24 identified Resident #152 was at risk for dehydration or potential for fluid deficit related to his/her fluid restriction, end stage renal disease, and congestive heart failure. Interventions included monitoring and document intake and output amounts. A physician's order dated 7/3/24 directed to maintain a fluid restriction of 1200 milliliters (ml) in 24 hours every shift with 480 ml from nursing (days: 180 ml, evenings: 180 ml, nights: 120 ml) and 720 ml from dietary. Observation of Resident #152 on 7/19/24 at 11:41 AM identified him/her with dry mucous membranes. Intake and output record flowsheets dated 7/7/24 through 7/20/24, from Resident #152 ' s paper chart, identified Resident #152 was on a 1200 ml fluid restriction in 24-hours and had intake and output documentation that did not exceed 480 ml per day with no 24-hour total documented. On 7/7/24 120 ml on night shift and 360 ml on evening shift; on 7/8/24 120 ml on night shift; 7/9/24 60 ml on night shift and 360 ml on evening shift; 7/10/24 60 ml on night shift and 360 ml on evening shift; 7/11/24 60 ml on night shift and 360 ml on evening shift; 7/12/24 60 ml on night shift and 360 ml on evening shift; 7/13/24 60 ml on night shift and 360 ml on evening shift; 7/14/24 no entries; 7/15/24 360 ml on evening shift; 7/16/24 60 ml on night shift and 360 ml on evening shift; 7/17/24 60 ml on night shift and 350 ml on evening shift; 7/18/24 60 ml on night shift and 360 ml on evening shift; 7/19/24 360 ml on evening shift; 7/20/24 60 ml on night shift and 360 ml on evening shift. Intake amounts documented in the MAR from 7/7/24-7/20//24 were as follows: 7/7/24 100 ml on night shift, 420 ml on day shift, and 360 ml on evening shift; 7/8/24 60 ml on night shift, 360 ml on day shift, and 360 ml on evening shift; 7/9/24 60 ml on night shift, 180 ml on day shift, and 180 ml on evening shift; 7/10/24 60 ml on night shift, 480 ml on day shift, and 360 ml on evening shift; 7/11/24 60 ml on night shift, 360 ml on day shift, and 360 ml on evening shift; 7/12/24 60 ml on night shift, 180 ml on day shift, and 360 ml on evening shift; 7/13/24 60 ml on night shift, 120 ml on day shift, and 360 ml on evening shift; 7/14/24 60 ml on night shift, 360 ml on day shift, and 300 ml on evening shift; 7/15/25 60 ml on night shift, 360 ml on day shift, and 360 ml on evening shift; 7/16/24 60 ml on night shift, 180 ml on day shift, and 360 ml on evening shift; 7/17/24 60 ml on night shift, 360 ml on day shift, and 360 ml on evening shift; 7/18/24 60 ml on night shift, 80 ml on day shift, and 360 ml on evening shift; 7/19/24 60 ml on night shift, 280 ml on day shift, and 360 ml on evening shift; and 7/20/24 60 ml on night shift, 240 ml on day shift, and 360 ml on evening shift. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 7/25/24 at 9:20 AM identified that the intake and output record flowsheets in the paper chart are not part of the official clinical record, are used only as a worksheet, and should not be in the resident ' s chart. All intake and output documents are located in the electronic clinical record where the nurse for each shift documents the total intake for that shift. The DNS further identified that a total intake for 24 hours is not documented, however each nurse can see the entries of the previous two shifts so that they could see if the resident went over their physician prescribed fluid restriction. If the fluid restriction was exceeded, the staff could notify the Advanced Practice Registered Nurse (APRN). The DNS failed to identify what the nurse ' s actions would be taken if the resident intake was below the fluid restriction or how staff would know if the resident was not meeting their fluid goal for 3 days consecutively. Interview with Nurse Aide (NA) #1 on 7/25/24 at 10:09 AM identified that fluid intake amounts are not documented by them in the electronic record, however when she sees an intake and output record flowsheet in the intake and output book, she will write the intake on the sheet for the nurse to review. Interview with LPN #11 on 7/25/24 at 11:20 AM identified that she documents the total intake for her shift in the electronic record, which includes what the NA ' s document on the intake and output sheets added to what she provides during the shift. LPN #11 stated that she does not look at the entries of the previous two shifts and can only be responsible for the intake on her shift, and that her goal for residents on a fluid restriction is 500 ml on the day shift. Interview with the Clinical Regional Nurse (RN #3) on 7/25/24 at 12:50 PM identified that the facility does not a have a process to tally 24-hour totals for residents who are on intake and output. RN #3 further identified that the facility would report to the provider when a resident was symptomatic for a lack of hydration and that an assessment would be conducted, but there was no system to identify when a resident did not meet their 24-hour fluid total that had been determined by the Dietician. RN #3 identified that if a resident showed signs and symptoms of dehydration the physician would be notified, but that there was not a process to identify when a resident did not meet their fluid goal for consecutive days according to standards of practice. Additionally, RN #3 indicated that the Dietician and provider should be notified, and an assessment should be completed. Intake and output should be documented and totaled to identify any deviations from estimated fluid goals or fluid restrictions. Review of the clinical record for Resident #152 failed to reflect documentation of the total amount of fluid intake meeting the fluid restriction of 1200 ml without exceeding it. Between 7/5/24 through 7/21/2024, there were 14 days where the documented amounts for each shift did not total over 800 ml for 24 hours and there was no corresponding nursing staff documentation/assessments/notes to indicate Resident #152's hydration status when his/her fluid intake did not meet 800 ml since the initial readmission dehydration risk screener conducted on 7/4/24. Review of the intake measuring and recording, and hydration and prevention of dehydration policy directed, in part, to record the fluid intake after the resident consumed the fluids at the end of your shift total the amounts of all liquids the resident consumed and record the intake and output on the intake and output record. Physician orders to limit fluids will take priority over calculated fluid needs. The Dietitian may refer calculated needs to the physician if restrictions potentially increase the risk of dehydration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50179 51183

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on review of the clinical record, facility policy, and interviews for 2 of 8 residents, (Resident #25 and Resident #107), reviewed for unnecessary medications, the facility failed to follow physician orders for obtaining a blood pressure before administration of a medication (Resident #25), and failed to correctly input an order for medication administration and failed to follow a physician's order for medication administration (Resident #107). The findings include: 1. Resident #25's diagnoses included hypertension, atrial fibrillation, and schizoaffective disorder. Physician order dated 1/3/24 directed Atenolol (a medication for high blood pressure) 50 milligrams (mg) by mouth twice a day, hold for systolic blood pressure (SBP) less than 100, and hold for a heart rate (HR) of less than 60 beats per minute. The annual Minimum Data Set assessment dated [DATE] identified Resident #25 had moderately impaired cognition and was independent with eating, oral hygiene, toilet use, showering, and personal hygiene. The Resident Care Plan dated 1/9/24 identified Resident #25 had an alteration of cardiac/respiratory status related to hypertension and chronic obstructive pulmonary disease. Interventions included administering medications as ordered, monitor for side effects, document and report cardiac distress, and obtain vital signs as ordered. Review of the Medication Administration Record and the clinical record with Licensed Practical Nurse (LPN) #4 on 7/23/24 at 12:40 identified that although Resident #25 received Atenolol 50 mg twice daily beginning in February 2024, the resident's blood pressure was taken once in February on 2/5/24, once in March 2024 on 3/6/24, once in April 2024 on 4/5/24, once in May 2024 on 5/5/24, once in June 2024 on 6/5/24, and once in July 2024 on 7/4/24, equating to greater than 340 missed blood pressure readings. Interview and record review with Licensed Practical Nurse (LPN) #4 on 7/23/24 at 12:40 PM identified that although Resident #25's heart rate was checked before the 7/23/24 medication administration, the blood pressure was not being taken per the provider medication order with each Atenolol administration twice daily. Interview with LPN #5 on 7/23/24 at 12:45 PM identified that Resident #25's heart rate was taken before the 7/22/24 medication administration but the blood pressure was not being taken per provider medication order. LPN #5 stated the reason the resident's blood pressure was not taken per the provider's order, was that the electronic system did not prompt for a blood pressure to be taken. Review of the facility's Administering Oral Medications Policy, dated March 2019, identified that any pre-administration assessments should be performed before a medication is administered 2. Resident #107 's diagnoses included anemia, chronic myeloid leukemia in remission, depression, and a history of left femur fracture. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5 day Minimum Data Set assessment dated [DATE] identified Resident #107 was moderately cognitively impaired, was independent with eating, required substantial/maximal assistance to roll left and right, and substantial/maximal assistance for sit to stand transfers. The Resident Care Plan dated 12/12/23 identified Resident #107 had a nutritional problem related to diabetes, a history of chronic myeloid leukemia, chemotherapy, and a significant weight loss. Interventions included administering medications as ordered. A. A pharmacy consultant recommendation for Resident #107 dated 1/16/24 suggested that the prescriber consider changing Vitamin D to Vitamin D3 50,000 units once a month. An APRN order (APRN #1) dated 1/18/24 directed to discontinue the administration of Cholecalciferol (Vitamin D3) oral tablet 1,000 units, 1 tablet once daily and start the administration of Vitamin D3 oral tablet 50,000 units 1 tablet once a day starting on the 23rd and ending on the 24th every month. A review of the Medication Administration Record (MAR) identified that Resident #107 received Vitamin D3 50,000 units for 2 days in January, February, March, April, May, June and July on the 23rd and 24th of each month. In an interview with Pharmacist #1 on 7/24/24 at 12:44 PM it was identified that his recommendation dated 1/16/24 was for Vitamin D3 once per month. Pharmacist #1 was not aware how the Advanced Practice Registered Nurse (APRN) #1 had written the order dated 1/18/24 resulting in Vitamin D3 50,000 units being administered twice a month. In interview with APRN #1 on 7/24/24 at 12:25 PM she identified when she wrote the order for Vitamin D3 oral tablet 50,000 units on 1/18/24, her intention was to administer Vitamin D3 50,000 units per month per the pharmacy recommendation. APRN #1 was unaware that due to the way she had written the order, she had directed facility staff to administer the Vitamin D3 for 2 days concurrently every month, on the 23rd and 24th, since January 2024 (over 6 months' time). B. The Resident Care Plan dated 12/12/23 identified that Resident #107 had an alteration in gastrointestinal status related to anemia and history of gastrointestinal hemorrhage. Interventions included obtaining and monitoring laboratory work, and giving medications as ordered. 1. An APRN order (APRN #1) dated 2/28/24 directed facility staff to inject 1 application of Procrit 10,000 units per milliliter (units/ml.) intramuscularly (IM) once daily every Tuesday, and to hold the medication if the laboratory result for hemoglobin was over 10. Review of the clinical record, laboratory result dated 6/3/24 identified that Resident #107's hemoglobin was 11.1. Review of the Medication Administration Record (MAR) identified that on 6/4/24 LPN #10 had administered Procrit 10,000 units/ml IM despite the physician order to hold the Procrit if the hemoglobin was over 10 (11.1). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An APRN order (APRN#2) dated 6/4/24 directed facility staff to discontinue Resident #107's weekly laboratory work for hemoglobin levels and to start obtaining hemoglobin levels monthly. Further, APRN #2 directed Resident #107's Procrit be held on 6/11/24, 6/18/24, 6/25/24, and 7/2/24. APRN #2's progress note dated 6/4/24 directed facility staff to discontinue the Procrit, however, APRN #2 failed to write a physician's order for discontinuation and instead, ordered the Procrit to be held from 6/4/24 through 7/2/24. Review of the clinical record, laboratory result, dated 7/2/24 identified that the Resident #107's hemoglobin was 10.1. Review of the July MAR identified the Procrit was correctly held on 7/2/24 and 7/9/24, according to the laboratory results obtained on 7/2/24, but that on 7/23/24 LPN #5 had administered Procrit to Resident #107, despite a hemoglobin level of 10.1. In an interview and review of the clinical record with LPN #10 on 7/25/24 at 9:40 AM she identified that Resident #107's Procrit had parameters, per the physician's order, to hold the medication if the laboratory value for hemoglobin was greater than 10. Review of the laboratory data with LPN #10 identified that on 6/3/24 Resident #107's hemoglobin was 11.1 and that she had signed that she had administered the medication on 6/4/24 despite the parameter to not administer. LPN #10 identified that if she had held Resident #107's Procrit she would have written a nursing note, however, no note was identified. Further LPN #10 indicated that if the medication was checked off (as it was on 6/4/24), that indicated the medication was administered. Although LPN #10 had signed off giving the medication on the MAR on 6/4/24, she was unable to recall if she had actually administered the Procrit to Resident #107. In an interview with APRN #1 on 7/25/24 at 10:43AM, she identified that her expectation for the administration of Procrit would be for facility staff to follow the physician order as written. APRN #1 indicated that the medication had parameters not to administer when the hemoglobin was above 10 and that on 6/4/24 and 7/23/24 the medication should not have been administered to Resident #107. Although attempted, an interview with LPN #5 was not obtained for the administration of Procrit on 7/23/24. Although requested, a facility policy for physician orders was not provided. Review of the Administering Medications Policy directed, in part, that medications must be administered in accordance with the physician orders. 51183

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F 0761 Level of Harm - Potential for minimal 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. 51102 Based on observations, interviews, review of the clinical records and facility policy for 3 of 4 of medication rooms reviewed for medication storage, the facility failed to date a multi-dose vial upon opening and failed to discard expired medications in a timely manner. The findings include: During a review of the facility Medication Storage Rooms on 7/25/24 at 9:00AM, the following was identified: a. On the Maple Unit a vial of Tuberculin purified protein derivative (PPD) was stored in the refrigerator. The vial was noted to have been opened, was half full, and was dated 2/28/24. b. On the Maple Unit a vial of Lidocaine was stored in the cabinet. The vial was noted to have been opened, was less than half full, and failed to indicate the date the medication was opened. c. On the Oak Unit a bottle of Biotin 1,000 milligrams (mg) was stored in a cabinet. The bottle was noted to have been opened, with an expiration date of 1/2024 (6 months previous). d. On the Oak Unit a bottle of Omeprazole 2 mg suspension was stored in the refrigerator, noted to be a quarter full. The bottle was noted to have a label that stated the medication expired 14 days after dispensing. The bottle was noted to be opened with an expiration date of 5/20/24 (66 days prior) e. On the Oak Unit a bottle of Omeprazole 2 mg suspension was stored in the refrigerator, noted to be full and sealed. The bottle was noted to have a label that stated the medication expired 14 days after dispensing. The bottle was noted with an expiration date of 7/18/24 (7 days prior) e. On the Elm Unit a bottle of Tuberculin PPD was stored in the refrigerator. The vial was noted to have been opened, was half full, and was dated 3/13/24. Interview with the ADNS (RN#2) on 7/25/24 at 9:00AM identified that when multi-use medication vials are opened, the facility policy was to place the date that the vial was opened on the container. Interview with the Infection Control Nurse (RN#1) on 7/25/24 at 9:20 AM identified that when a multi-use medication vial was opened, the facility policy was to place the date that the vial was opened and discard the vial after 30 days. Interview with Pharmacist #1 on 7/25/24 at 10:00AM identified a multi-use medication vial is good for 28-30 days after opening and administering the medication after that time is an infection control issue and might cause an infection under the skin (subcutaneous infection). Interview with LPN #8 on 7/25/24 at 10:20AM identified that he was not aware of the facility policy on dating multi dose vials. (continued on next page)

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	075263	A. Building B. Wing	07/25/2024

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with Pharmacist #2 on 7/25/24 at 11:41AM identified that the efficacy of medications can only be guaranteed until the expiration date. According to the FDA open vials of Tuberculin should be discarded 30 days after the open date. Review of the Storage of Medications Policy dated March 2019 directed the facility shall not use outdated drugs and medications must be labeled accordingly. Although requested, a policy for multi-use medication vials was not provided.

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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. 51182 Based on observation, interviews, and a temperature test, the facility failed to ensure that food was palatable, attractive, and at a safe and appetizing temperature. The findings included: Interview with Resident #34 on 7/19/24 at 1:30 PM identified the food was not good and he/she gets cold food. Interview with Resident #107 on 7/22/24 at 10:14 AM identified the food was not good, they don't like the vegetables. Interview with Resident #19 on 7/22/24 at 11:40 AM identified the food was not good and did not know he/she had options for different meals if they did not like what was on the menu Interview with Resident #46 on 7/22/24 at 12:14 PM identified in general the food was not that great. The food was not appealing. Resident #46 stated the kitchen does not separate portions and the vegetables were mushy. On 7/24/24 a test/temperature tray conducted with the Dietary Manager identified the lunch tray consisting of meatloaf with gravy, mashed potato, corn, roll, and cheesecake left the kitchen at 1:04 PM. The test tray arrived on the second floor at 1:08 PM and was delivered to residents starting at 1:10 PM. The last tray was delivered at 1:22 PM. The temperature of the test tray was conducted with the Dietary Manager at that time and identified the following: The meatloaf internal temperature was 120.4 degrees Fahrenheit (F) per the surveyor calibrated thermometer and 120.9 degrees F by the Dietary Manager's thermometer. The potatoes internal temperature was 131.4 degrees Fahrenheit (F) per the surveyor calibrated thermometer and 124.2 degrees F by the Dietary Manager's thermometer. The cheesecake was 77.7 degrees Fahrenheit (F) per the surveyor calibrated thermometer and 77.3 degrees F by the Dietary Manager's thermometer. An interview with the Dietary Manager on 7/24/24 at 1:22 PM indicated that a palatable temperature for the meatloaf should be at least 135 degrees F and a palatable temperature for the cheesecake should be 38 degrees F to 40 degrees F. The Dietary Manager stated a contributing factor for the high temperatures of the cheesecake was the trays of cheesecake came directly out of the refrigerator and were stored on an open metal cart throughout the entire time staff was plating all the meals (approximately 160 meals). A contributing factor for the low meatloaf temperatures was a non-functioning pellet plating system. Subsequent to surveyor inquiry an electrician was contacted for repair of the pellet plating system.

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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** 51182 Based on the tour of the Dietary Department, staff interviews, facility documentation, and facility policy, the facility failed to ensure open food items were dated to include dates opened/expired/use by and failed to ensure food was served under sanitary conditions. The findings include: Tour of the kitchen with the Dietary Manager on [DATE] at 10:56 AM identified the following: a. The threshold of the walk in refrigerator where the door meets the doorframe had a heavy accumulation of dust and debris. Interview with the Dietary Manager identified that floors were swept after every meal service. b. An opened package containing 5 hotdogs was wrapped in plastic wrap but failed to identify an open date or expiration date. c. A 48 ounce container of Ricotta Cheese with a received date of [DATE] (with approximately ,d+[DATE] of the contents removed) was observed with a black and orange-like appearing substance along the inner rim and encroaching into the Ricotta Cheese. d. A 25 gallon container/tub of Spanish Onions was observed to be visibly dirty with a brown-like substance on the inside and outside of the container/tub and the and container/tub was uncovered. The Dietary Manager stated the tubs were wiped weekly but the tubs were last wiped down a week and a half ago. e. The walk in freezer was found to have a 10.8 pound box of pancakes with 25 of 144 pancakes remaining. The package was not sealed and open to the air. Additionally the package was not dated or tied and no expiration date for the pancakes was listed on the box or the package. f. 1 box of omeletts with 8 of 34 omeletts remaining was found open to air. The package was not dated or tied and lacked an expiration date. g. Seven 13.5 pound boxes of French Toast failed to identify an expiration date. h. A 10 pound box of pork crumble was observed to be open with approximately a half bag of contents remaining. The bag was not dated with an open date or expiration date. Interview with the Dietary Manager identified that all staff were responsible for ensuring foods in the refrigerator were checked for closure and expiration date, with the cooks checking the refrigerator daily in the morning. i. The ice machine located outside of the freezer was observed to have a heavy accumulation of a white substance inside the machine above the ice and a dark substance on the machine above the ice. A heavy accumulation of dust was observed on the ice machine side vents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietary Manager stated the ice machine was last cleaned by her on [DATE]. The Dry Storage room was observed to contain the following: j. A 25 pound bag of dried cranberries, noted to be almost full, was not tied and open to air. k. Heavy dirt and debris was observed behind the can shelving near the air conditioner. [NAME] shavings and dirty insulation with black specks/debris were observed on the window sill, on the floor in front of the air conditioner, and behind the racks of cans on the far wall of the Dry Storage room. Interview with the Dietary Manager identified that she was not aware of the insulation and dirt. The air conditioners were installed two days ago and per the Dietary Manager, Maintenance was responsible for cleaning up after the air conditioner installation. l. The third floor Nourishment Room ceiling tile above the refrigerator was found to be visibly stained and was approximately 12 inches by 12 inches in size. Review of the Facility's Environment Policy HCSG Policy 028, dated revised ,d+[DATE], identified that all food preparation areas and food service areas will be maintained in a clean and sanitary condition. The Dining Services Director will ensure the kitchen is maintained in a clean and sanitary manner. The Dining Services Director will ensure that employees are knowledgeable in the proper procedures for cleaning and sanitizing of food service equipment and surfaces. Food contact surfaces will be cleaned and sanitized. The Dining Services Director will ensure that a routine cleaning schedule is in place for cooking equipment, food storage areas, and surfaces. Review of the Facility's Food Storage: Dry Goods Policy HCSG Policy 018, dated revised on ,d+[DATE], identified that dry goods will be appropriately stored in accordance with the FDA food code. Packaged and canned food items will be kept clean, dry, and sealed. Storage areas will be neat, arranged for easy identification, and date marked as appropriate.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50250 Based on interview and review of facility documentation, the facility failed to ensure that Payroll Based Journal (PBJ) data (staffing information) for the third quarter (April, May, and June 2023) was submitted as required by the Centers for Medicare and Medicaid Services (CMS). The findings Include: Interview and review of facility documentation with the Administrator on 7/25/24 at 10:30 AM identified that he was aware that PBJ data for the third quarter of 2023 had not been submitted. The Administrator further indicated that the facility's corporate office was responsible for submitting PBJ data to CMS, however had failed to submit the information as required. Additionally, the Administrator identified that because of the failed data submission, the facility contracted a private based company to submit PBJ data on its behalf effective 1/1/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 Residents (Resident #77) reviewed for wound care, the facility failed to maintain proper infection control techniques for Enhanced Barrier Precautions (EBP) during wound care, and during a review of the facility laundry services in the facility's only laundry area, the facility failed to ensure a clean environment for laundry processing. The findings include: 1. Resident #77's diagnoses included subacute osteomyelitis and stage 4 pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #77 was cognitively intact and was dependent on staff with toileting hygiene, showering/bathing self, and chair to bed transfers. Additionally, the MDS identified that Resident #77 had an unstageable pressure ulcer. The Resident Care Plan dated 7/17/24 identified EBP. Interventions included appropriate Personal Protective Equipment (PPE) to be used per the Enhanced Barrier Precautions Protocol. A physician's order dated 7/19/24 directed EBP to be maintained at all times every shift. Observation of Resident #77's room on 7/24/24 at 11:00 AM identified EBP signage was posted on the door frame which directed that staff must wear gloves and a gown for wound care. LPN #6 was observed to enter Resident #77's room and complete wound care to the sacral pressure ulcer without the benefit of wearing a gown throughout the treatment. Interview and clinical record review with LPN #6 on 7/24/24 at 12:56 PM identified that she was not aware that Resident #77 was on EBP. Additionally, LPN #6 identified that she would look at the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) to verify if Resident #77 was on EBP. Upon further review of the MAR and TAR, LPN #6 identified that Resident #77 was on EBP and that she should have been wearing appropriate PPE. Interview with the Infection Preventionist (RN #1) on 7/24/24 at 3:17 PM identified that during wound care, the nurse should be wearing a gown and gloves per EBP. Additionally, RN #1 identified that staff can verify if a resident was on EBP by reviewing the EBP signage posted outside of the resident's room, the physician's order, the care plan, and the care card (used by Nurse Aides). Although EBP was a requirement per the Centers for Medicare and Medicaid Services effective 4/1/24, RN #1 identified that the facility was still working on education for the staff and the order for EBP was not created until 7/18/24 (effective 7/19/24). Review of the EBP policy directed, in part, that PPE for EBP is only necessary when performing high-contact care activities. High-contact care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care on any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation in the Laundry Room with the Infection Preventionist on 7/23/24 at 12:10 PM identified a moderate coating of white/gray debris on the tops of 4 of 4 washers and 5 of 5 dryers. Additionally, the washer room ceiling fan had a moderate buildup of a dark grey substance on all fan blades. On 2 of the washers exposed outer filters, a moderate buildup of a dark gray substance was present. The overhead pipes and wires in both the washer and dryer areas also had a moderate buildup/coating of a dark gray substance. Interview and observation with the Regional Environmental Services Manager on 7/23/24 at 12:15 PM, indicated he was unable to identify the substances on the washers/dryers, ceiling fan, washer filters, or overhead pipes and wires. He further identified that he visits the facility weekly and has seen similar conditions in the washer and dryer rooms on his prior visits. The Regional Environmental Services Manager indicated that the areas needed to be thoroughly cleaned and that he would have facility staff complete the necessary tasks. Interview and observation with the Environmental Services Director, on 7/23/24 at 12:20 PM, identified a window to the outside above 2 washers that had a thick buildup of a dark gray substance on the inside screen. The Environmental Services Director was unable to identify the substance clinging to the inside screen of the window. In addition, a window to the outside located in the dryer room was open approximately 8 inches, lacked a screen, and was coated with a a notable amount of a white substance. Dryers were venting to the outside and there was a large amount of white substances on the grass below the exhaust vent/pipe. The vent discharge area was directly adjacent to the open window and a considerable amount of warm air was venting back into the dryer room where clean, wet, laundry was stored uncovered in a laundry bin placed between two dryers. The Environmental Services Director indicated clean wash should be stored covered and that the outside window in the dryer room should have been closed to prevent the white substance from re-entering the dryer room. Interview, observation, and review of facility documentation with the Environmental Services Director and Laundry Assistant #1 on 7/23/24 at 12:30 PM identified all surfaces and machines in the washer and dryer rooms are cleaned daily. The Environmental Services Director indicated that it was the responsibility of the laundry staff to complete the laundry cleaning schedules as posted. Review of the Laundry Cleaning Schedule for June 2024 and July 2024 identified that clean and soiled area cleaning was to be completed daily, high dust cleaning was to be completed weekly, and light fixtures and windows were to be cleaned monthly (fan cleaning was not noted). Although the Regional Environmental Services Director indicated the areas needed to be thoroughly cleaned, the Laundry Cleaning Schedule had been signed indicating that all the cleaning tasks had already been completed. Observation of the laundry facility on 7/24/24 at 11:30 AM identified that all areas were free of dust and debris, the dryer window was closed, and clean laundry was not noted to be stored uncovered. Although a laundry policy was requested, the facility policy failed to include clean laundry operations for drying, folding, storage or cleaning of the laundry areas. 50249