STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105262	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records and an interview with staff, the facility failed to notify the resident and/or the resident's representative of an emergency hospital transfer and the reasons for the transfer in writing, and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman (LTCO) for one (Resident #103) of two residents reviewed for transfer/discharge, from a total survey sample of 34 residents. The findings include: A review of Resident #103's medical record revealed that she was admitted to the facility on [DATE] and was discharged on [DATE]. Her diagnoses included type 2 diabetes mellitus, schizoaffective disorder, dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, and seizure disorder. A nursing progress note dated 10/23/23 at 9:16 a.m., revealed that Resident #103 was pacing and becoming increasingly aggravated with other residents for no apparent reason. She was yelling and threatening to hit another resident as well as raising her fists. Resident #103 was removed from the area but she returned. (Photographic evidence obtained) A progress note dated 10/23/23 at 1:31 p.m., noted Resident #103 was admitted to the psychiatric ward at a local hospital. Resident #103 left willingly with a police officer and the daughter was notified via telephone. (Photographic evidence obtained) A review of a Certificate of Professional Initiating Involuntary Examination completed by the Clinical Psychologist on 10/23/23 at 11:15 a.m., revealed that Resident #103 had diagnoses including schizoaffective disorder, bipolar type and unspecified dementia with psychotic disturbance and agitation. Because of her mental illness, Resident #103 refused a voluntary examination and without care/treatment, was likely to cause serious bodily harm to others. She was delusional and extremely aggressive. She had become aggressive with the clinician and threatened to kill everyone who knocked her. (Photographic evidence obtained) (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #103's medical record revealed that there was no AHCA(Agency for Health Care Administration) Transfer/Discharge Notice informing the resident or her representative of the reason for the transfer, the location where she would be transferred, her appeal rights, or the contact information for the LTCO. Additionally, there was no evidence that the facility notified the LTCO in writing of the transfer. An interview was conducted with the Social Services Director (SSD) on 7/18/24 at 2:35 p.m. She recalled Resident #103 who went out under a [NAME] Act (involuntary psychiatric admission). This resident was then transferred to another facility. The SSD was asked who was responsible for notifying the resident or her representative in writing of the transfer to the hospital. The SSD said that was the assigned nurse's responsibility. She explained that the Administrator at that time was notifying the LTCO of transfers and discharges. The SSD reviewed the records and confirmed that there was no written notice of the transfer and no evidence that the LTCO was advised of Resident #103's emergent transfer to a psychiatric unit. .

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records and an interview with staff, the facility failed to provide written information to the resident and/or the resident's representative on the facility's bed-hold policy and the duration the resident's bed would be held while she was in the hospital for one (Resident #103) of two residents reviewed for transfer/discharge, from a total survey sample of 34 residents. The findings include: A review of Resident #103's medical record revealed she was admitted to the facility on [DATE] and was discharged on [DATE]. Her diagnoses included type 2 diabetes mellitus, schizoaffective disorder, dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, and seizure disorder. A review of a Certificate of Professional Initiating Involuntary Examination completed by the Clinical Psychologist on 10/23/23 at 11:15 a.m., revealed that Resident #103 had diagnoses including schizoaffective disorder, bipolar type and unspecified dementia with psychotic disturbance and agitation. Because of her mental illness, Resident #103 refused a voluntary examination and without care/treatment, was likely to cause serious bodily harm to others. She was delusional and extremely aggressive. She had become aggressive with the clinician and threatened to kill everyone who knocked her. (Photographic evidence obtained) A nursing progress note dated 10/23/23 at 9:16 a.m., revealed that Resident #103 was pacing, aggravated with other residents and yelling; she threatened to hit another resident and raised her fists. Resident #103 was removed from the area but she returned. At 1:31 p.m., a follow-up note indicated she was transported by police and admitted to the psychiatric unit at a local hospital. (Photographic evidence obtained) Resident #103's record did not contain any evidence that she or her representative was notified in writing of the facility's bed-hold policy prior to her transfer, as required. During an interview with the Social Services Director (SSD) on 7/18/24 at 2:35 p.m., she confirmed that Resident #103 had been transferred out of the facility under a [NAME] Act (involuntary psychiatric admission). She reviewed the resident's record and confirmed there was no written notice of the facility's bed hold policy or of the duration the facility would hold Resident #103's bed in her absence.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records and an interview with staff, the facility failed to comprehensively assess residents' strengths, needs, preferences, and goals within the required timeframes for five (Residents #18, #21, #23, #24, and #38) of nine residents whose Minimum Data Set (MDS) assessments were reviewed, from a total survey sample of 34 residents. The findings include: A review of Resident #18's medical record revealed that she was admitted to the facility on [DATE]. Her diagnoses included, but were not limited to, congestive heart failure, dementia with behavioral disturbances and schizoaffective disorder. Resident #18's most recently completed minimum data set (MDS) assessment was a quarterly assessment (QMDS) dated [DATE]. Resident #18's annual MDS assessment (AMDS) was started by Licensed Practical Nurse (LPN) J on 5/15/24, but was still in progress and was never finalized or electronically submitted. (Photographic evidence obtained) A review of Resident #21's medical record revealed that she was admitted to the facility on [DATE]. Her diagnoses included encephalitis, encephalomyelitis, and hemiplegia/hemiparesis following a cerebral infarction. Resident #21's most recently completed MDS assessment was a quarterly assessment dated [DATE]. The AMDS dated [DATE] was initiated by LPN J, but was incomplete and still in progress at the time of survey. (Photographic evidence obtained) A review of Resident #38's medical record revealed that he was admitted on [DATE] with diagnoses including metabolic encephalopathy. His most recently completed MDS was a quarterly MDS dated [DATE]. Resident #38 had an AMDS dated [DATE], which was initiated by LPN J, but was never completed and was still in progress. (Photographic evidence obtained) A review of Resident #23's medical record revealed an admitted [DATE] with a diagnosis of diffuse traumatic brain injury. His most recently completed MDS assessment was a quarterly assessment dated [DATE]. The AMDS initiated by LPN J and dated 5/12/24 was still in progress. (Photographic evidence obtained) A review of Resident #24's medical record revealed and admitted [DATE]. She had a primary diagnosis of schizoaffective disorder. The most recently completed QMDS was dated 2/19/24; however, her AMDS, dated [DATE], was still in progress. It had been initiated by LPN J. (Photographic evidence obtained) LPN J was interviewed on 7/16/24 at 3:56 PM. She confirmed that she had assisted with MDS assessments for about 90 days. The Director of Nursing reviewed and locked the assessments. LPN J was the person responsible for transmitting the MDS assessments electronically. When asked about her awareness of outstanding or overdue assessments or submissions, she said she didn't know; she would have to look. LPN J was advised of the overdue assessments. She acknowledged the finding, stating she would review the list. LPN J said she was doing the best she could to help. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 2:16 PM, LPN J confirmed the late submissions for the MDS assessments and said she was working on it. .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on a review of resident records and an interview with staff, the facility failed to comprehensively assess residents' strengths, needs, preferences, and goals quarterly for four (Residents #15, #14, #9, and #42) of nine sampled residents whose Minimum Data Set (MDS) assessments were reviewed, from a total survey sample of 34 residents. The findings include: A review of Resident #15's medical record revealed that she was admitted on [DATE]. Her diagnoses included unspecified dementia with behavioral disturbance, unspecified psychosis, metabolic encephalopathy, major depressive disorder, and insomnia. Resident #15 had a quarterly Minimum Data Set (QMDS) assessment completed on 2/28/24; however, the most recent QMDS initiated on 5/30/24 by Licensed Practical Nurse (LPN) J was never completed, and was still in progress. A review of Resident #14's medical record revealed that she was admitted on [DATE]. Her diagnoses included hemiplegia/hemiparesis following a non-traumatic subarachnoid hemorrhage. Her annual MDS (AMDS) assessment was completed on 3/11/24; however, the most recent QMDS, dated [DATE], and initiated by LPN J was still in progress. A review of Resident #9's medical record revealed an admitted [DATE] and diagnoses including spondylosis with radiculopathy, lumbosacral region. Resident #9's QMDS, dated [DATE], was completed and submitted; however, the most recent QMDS, dated [DATE], and initiated by LPN J was still in progress. (Photographic evidence obtained) A review of Resident #42's medical record revealed that he was admitted on [DATE]. He had a primary diagnosis of intracranial injury with loss of consciousness. His last complete MDS assessment was an annual assessment dated [DATE]. The QMDS, dated [DATE], and initiated by LPN J was still in progress. (Photographic evidence obtained) LPN J was interviewed on 7/16/24 at 3:56 PM. She confirmed that she had been assisting with MDS assessments over the last 90 days. Once the assessments were done, the Director of Nursing reviewed and locked them, then LPN J transmitted them electronically. She was asked if she was aware of any outstanding or overdue assessments. She said she didn't know and would have to look. When advised of the findings, she acknowledged the late submission and said she would review the list. LPN J explained that she was doing the best she could to help. In a second interview at 2:16 PM, LPN J confirmed the late submissions and said she was working on it. .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30969 Based on record reviews, staff interviews, and facility policy review, the facility failed to refer residents with newly diagnosed serious mental illnesses to the state-designated authority for a new Pre-Admission Screening and Resident Review (PASRR) Level II screening, to ensure appropriate care and services were prescribed for three (Residents #25, #40, and #47) of four residents reviewed for PASRR compliance, from a total survey sample of 34 residents. The findings include: 1. A review of Resident #25's medical record revealed an initial admitted [DATE] with a re-entry date of 4/18/24, and diagnoses including schizoaffective disorder (dated 9/4/20), major depressive disorder (dated 7/11/21), and generalized anxiety disorder (dated 12/5/22). Resident #25 had an initial PASRR Level I Screening that was completed on 9/1/20. Section 1: PASRR Screen Decision Making asked under section A. to check all boxes that applied if there were any mental illnesses (MI) or suspected mental illnesses including, but not limited to, anxiety disorder, depressive disorder and/or schizoaffective disorder. Further review of the record revealed that another PASRR Level I Screening was completed on 8/29/23. Section 1 A. had none of the corresponding MI or suspected MI boxes checked off. Further review of Resident #25's medical record revealed no evidence that he was referred for a PASRR Level II screening for his diagnosis of schizoaffective disorder on admission, or for the respective newly diagnosed major depressive disorder or generalized anxiety disorder. 2. A review of Resident #40's medical record revealed that she was admitted to the facility on [DATE] with an admitting diagnosis of major depressive disorder, recurrent moderate (dated 12/30/22). A diagnosis of generalized anxiety disorder was also noted (dated 10/5/23). Resident #40 had a PASRR Level I screening dated 2/27/22, ten months prior to her admission. Section 1: PASRR Screen Decision Making asked under section A. to check all boxes that applied if there were any mental illnesses or suspected mental illnesses including, but not limited to, anxiety disorder and depressive disorder. None of the corresponding boxes were checked. Further review of Resident #40's medical record revealed no evidence that she was referred for a PASRR Level II screening for her admitting diagnosis of major depressive disorder, or after a diagnosis of generalized anxiety disorder was assessed on 10/5/23. 3. A review of Resident #47's medical record revealed an admitted [DATE] with a diagnosis of generalized anxiety disorder. Resident #47's PASRR Level 1 screening dated 3/25/24, indicated there was no diagnosis or suspicion of mental illness (MI). Furthermore, there was no evidence that a Level 2 screening referral had been made, as the Level 1 screening omitted the MI diagnosis. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Services Director (SSD) on 07/18/24 at 11:43 AM. She stated she used to be responsible for monitoring PASRRs and submitting the Level II review requests. A while back, a former Administrator told her nursing would be handling the PASRRs from that point on. At the time, she was responsible for checking the PASRRs on admission as well as checking the cumulative diagnoses list to determine whether a Level II screening was needed. According to the state-designated authority who does the PASRR level II determinations, a new PASRR was needed if there was a significant change. If that change involved psychiatric diagnoses, then the request for the Level 2 screening would be made. She reviewed the information for Residents #24, #40, and #47. She reported that at this time, no one in the facility was reviewing the Level I screenings to determine whether there were new or existing diagnoses warranting a Level II review. The SSD said that as of today, she had been told she would resume that responsibility. The SSD acknowledged the need for a system to review newly admitted residents' PASRRs and cumulative diagnoses for accuracy, as well as physician communication of newly diagnosed mental illness so Level II screenings could be requested. A review of the facility's policy titled PASRR (effective 2/1/24) revealed: Policy Statement: It is the policy of this facility to screen all potential admissions on an individualized basis. As part of the pre-admission process, this facility participates in the PASRR screening process (Level I) for all new and readmissions per requirements to determine if the individual meets the criterion for mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide specialized services determined in the Level II screen . Section 4.4 under the Coordination of Care section stated the facility will refer all residents with newly evident or possible SMI or possible serious mental disorders or intellectual disability for Level II review upon a significant change in status assessment to the state [PASRR] representative. (Photographic evidence obtained)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on record review, observations, and interviews with staff, the facility failed to identify and minimize the risk of accidents, and provide supervision to prevent accidental injury, for one (Resident #18) of one resident reviewed for accidents, from a total survey sample of 34 residents. The findings include: A review of Resident #18's medical record found she was admitted to the facility on [DATE] with diagnoses including, but not limited to, unspecified dementia with other behavioral disturbances; schizoaffective disorder, bipolar type; signs and symptoms involving cognitive functions and awareness, and cognitive/communication deficit. Resident #18 had a quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 2/13/24, that assessed her with a brief interview for mental status (BIMS) score of 4 out of 15 possible points, indicating severe cognitive impairment. Rejection of care was noted on 1-3 days over the assessment look-back period. Resident #18 was care planned on 5/14/22 with a last review date of 7/5/24 for Activities of Daily Living/Self-Care Performance Deficit related to her diagnosis of dementia. The goal was to maintain her current level of functioning. Interventions included checking nail length, trimming and cleaning nails on bath day and as needed, as well as reporting changes to the nurse. (Photographic evidence obtained) There was no assessment in the record regarding the resident's ability to safely perform her own nail care. The Podiatrist saw Resident #18 on 5/8/24 for thick elongated toenails. Resident #18 was noted to have a history of onychomycosis (a nail fungus causing thickened, brittle, crumbly or ragged nails). The Podiatrist noted that in addition to the pain associated with her toenails, there was also concern about soft tissue damage caused by her toenails snagging on her sheets and socks. Resident #18's toenails were described as grossly hypertrophic (increased soft tissue volume at the end edge of the nail), onychauxic (an overgrowth or thickening of the nail that often leads to discoloration), and discolored yellow with subungual debris (crusty material that forms on the nail as a result of the fungal infection) on both feet. The affected toenails were painful to palpitation, and there was periungual erythema (redness of the skin around the nail) of the affected toenails on each foot. Debridement of the nails was performed which would reduce the likelihood of further soft tissue infection and damage, but also reduce symptoms of pain. (Photographic evidence obtained) An observation of Resident #18 was made on 7/14/24 at 12:00 PM in her room. She was in bed and under her covers, which were pulled up over her head. Her exposed hands were visible, and Resident #18 had latex gloves on each hand. She was playing with her gloves. A return visit and attempted interview on 7/14/24 at 12:58 PM, found Resident #18 still in her room and eating lunch from an overbed table. The gloves were still on. An interview was attempted, but Resident #18 was highly confused and unable to interview. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 9:14 AM, Resident #18 was again observed in her room on her bed. She had a metal nail clipper and was trimming her own toenails. There was no staff member present in the room. (Photographic evidence obtained) On 7/16/24 at 9:40 AM, a second interview was attempted with Resident #18, who was again observed in bed curled up in her blanket. She responded to a greeting and after introduction, she was asked about her nail care in the facility. Resident #18 claimed she did her own pedicures, she did not need staff to do them. Resident #18 displayed her toes, which were observed with thickened nails. The quick was also thickened and ragged. A strong cheese-like odor emanated from her toes. The nail clippers were observed in a pocket of her handbag, which was at the foot of her bed. (Photographic evidence obtained) The Activities Director (AD) entered Resident #18's room on 7/16/24 at 9:43 AM and was interviewed about resident nail care. She stated she had a nail care activity yesterday and they did the residents' fingernails. She tried to hold that activity several times a week in order to get everyone taken care of. The AD did not do toenails; she thought only the nurses or the podiatrist did toenails. The AD did not know of any residents who trimmed their own toenails. Licensed Practical Nurse (LPN) B was interviewed at 9:45 AM on 7/16/24. When asked if Resident #18 was under the care of a podiatrist, she stated she was not sure but would look. LPN B was accompanied to Resident #18's room and was advised of the observation. LPN B observed Resident #18's toenails and confirmed they looked diseased. She then saw the nail clippers in the resident's handbag. LPN B confirmed that Resident #18 should not be in possession of nail clippers, explaining that outside of the podiatrist, only certified nursing assistants (CNAs) and nurses could trim residents' toenails. Nurses must trim diabetic residents' toenails. LPN B did offer that Resident #18 had been known to reject assistance with activities of daily living. An interview was conducted with the Director of Nursing (DON) on 7/16/24 at 9:50 AM. She was shown the photographs of the nail clippers in Resident #18's purse. The DON said neither this resident nor any other resident should have nail clippers in their possession. She had never seen them before and had not been advised that Resident #18 had nail clippers. The DON speculated that Resident #18 must keep them in her purse, which she always kept close to her. The DON said she would have to determine a way to remove them from Resident #18's possession. When asked for a facility policy or protocol for resident use of nail clippers, she was not sure there was one but would look. The DON was asked if residents were assessed for safe use of nail clippers or other sharp grooming implements. She stated residents were assessed on admission, but she was not sure there was a specific sharps use assessment. Some residents were permitted to use razors, if assessed as a safe to do so, under staff supervision. The DON was unable to locate a policy or protocol for resident use of nail clippers. On 7/16/24 at 11:41 AM, Resident #18's guardian was interviewed. She explained that she typically did not have issues with Resident #18's care, but knew she was very non-compliant with grooming. The observation of Resident #18 cutting her toenails was shared with the guardian. CNA D was interviewed on 7/17/24 at 1:19 PM. She stated Resident #18 was sometimes noncompliant. In those cases, the CNAs returned at a later time to offer care again. The Activities department did nail care but CNAs could also. CNA D had not been permitted to do resident toenails, and she preferred not to. CNA D had never seen Resident #18 clip her own toenails. Had she seen her with clippers, she would have removed and disposed of them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA C stated in an interview on 7/17/24 at 1:32 PM that she had never seen Resident #18 with nail clippers. CNA C assisted with nail care but not toenails. The nurse or Podiatrist did that. CNAs dried between residents' toes after showers but that was as far as toenail care went. On 7/18/24 at 2:34 PM, LPN B and LPN J reported that they attempted to retrieve the toenail cutters from Resident #18, but she refused to give them up. Resident #18 slept with her purse and they had been unable to retrieve them. The clinical record had been noted and she had been care planned for her refusal to give staff the nail clippers. The LPNs were asked if they were aware of the podiatrist's findings and potential for soft tissue damage noted on his last visit. They stated they were not aware. LPN J looked up the podiatry report, acknowledged the risks and said, I wish they (the practitioners) would tell us these things before they leave.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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 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. 30969 Based on observations and interviews with staff, the facility failed to store refrigerated food in a manner to prevent contamination by airborne matter, by failing to ensure the evaporator fan was clean and free of build-up and debris. This had the potential to effect all 42 residents in the facility who ate by mouth, by potentially contaminating exposed food with the built-up matter on the fan. The findings include: During an intial tour of the kitchen on 7/14/24 at 11:34 AM, the walk-in refrigerator was inspected. The evaporator fan on the back wall of the unit was observed with a build up of thick, dark matter resembling dust on the grates of the fan cover. The debris was moving in response to the fan blowing the cold air around. During an inspection of the walk-in refrigerator on 7/18/24 at 3:24 PM, the fan was observed in the same condition and had still not been cleaned. There was visible build up of dust-like debris on all surfaces of the fan. There was a tray of sandwiches on the top rack, which had been covered in plastic wrap and parchment paper. The force of the fan had blown the plastic wrap off the entire edge of the tray, exposing the bread and meat to possible contamination by the debris on the fan. (Photographic evidence obtained) An interview was conducted with the certified dietary manager (CDM) at the time of the finding, who stated the Maintenance Department was responsible for cleaning this fan. The CDM looked at the fan and confirmed its soiled condition and the risk to the uncovered food in the refrigerator.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 45153 Based on a facility record review and a staff interview, the facility failed to maintain documentation to demonstrate evidence of its ongoing Quality Assurance Performance Improvement (QAPI) program. This failure could potentially affect all facility residents. The findings include: On 7/18/24 at 3:15 PM, during the Quality Assurance Performance Improvement (QAPI) review with the Administrator and the Director of Nursing, they could provide no current documentation to verify the development, implementation and maintenance of an effective, comprehensive, data-driven QAPI program focused on indicators of the outcomes of care and quality of life. When they were asked to share documentation of their QAPI program, they provided a form that read QAPI Plan Review (dated 1/13/2022), which was a sign-in sheet with a number of staff signatures on it, and policy and procedure manuals including a Comprehensive Federal Emergency Program (FEP), and a Comprehensive State and Local Emergency Management Plan/Disaster Manual. (Copies obtained) The Administrator stated the facility held a QAPI meeting monthly, but no evidence of that was produced. He stated the facility had two current performance improvement plans in place currently (antibiotic surveillance/infection preventionist and tuberculosis vaccinations, but no documented evidence was produced to corroborate that. The Administrator was asked about the annual review of facility policies and procedures. He stated that was completed and reviewed with the QAPI committee, but no documented evidence was produced to verify that this occurred. He was asked for the facility's QAPI policy, but it was not provided at the time of the survey.

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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** 48947 Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to implement a process for on-going infection control and prevention, including enhanced barrier precautions, to prevent the spread of infection for two (Residents #38 and #22) of five residents sampled during a review of the facility's infection prevention and control program, from a total of 34 residents in the survey sample. The finds include: 1. A review if Resident #38's medical record revealed he was admitted to the facility on [DATE] with an indwelling urinary catheter and diagnoses including multiple sclerosis, neuromuscular dysfunction of bladder, and reflex neuropathic bladder. A review of the resident's Progress Notes revealed that the resident completed a course of antibiotics on 6/29/2024 related to a complicated urinary tract infection (UTI). On 7/14/24 at 12:55 PM, Resident #38 was observed in his room with a urinary catheter collection bag hanging at the bedside. No enhanced barrier precaution (EBP) sign was observed on the resident's room door. (Photographic evidence obtained) On 7/15/24 at 10:34 AM, Resident #38's urinary catheter collection bag and catheter tubing were observed touching the floor. No EBP sign was observed on the resident's room door.(Photographic evidence obtained) On 7/17/24 at 4:23 PM, Resident #38's urinary catheter collection bag and catheter tubing were observed resting on the floormat on the right side of the resident's bed. No EBP sign was observed on the resident's room door.(Photographic evidence obtained) On 7/18/24 at 11:26 AM, an interview was conducted with Certified Nursing Assistant (CNA) G. When she was asked about any training/education she received about how to care for urinary catheters, tubing, and drainage bags, she stated, They taught that in orientation. When she was asked what her role was in caring for a resident with a urinary catheter, she replied, I empty the catheter bag every 2-3 hours. I chart the amount of urine that I empty from the bag in the computer, and I make sure the catheter bag is covered and not touching the floor. I also clean the catheter tubing when I do patient care every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 11:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) H, who was the nurse taking care of Resident #38 this day. She she was asked what preventive interventions she would implement for Resident #38 to minimize complications such as urinary tract infection (UTI), she stated, I would make sure to check his Foley (urinary catheter brand) every two hours to make sure the Foley bag/tubing is not touching the floor, make sure he's drinking water, check to make sure the urine is not blood colored, and monitor him for pain. When she was asked about any training/education she had received related to urinary catheter care, she replied, Yes, I had it in orientation and about 2-3 months after I started. It was pertaining to a resident that had pulled the catheter out and had to have it replaced. The residents have as needed (PRN) orders to change the Foley catheter. It's at the judgement of the nurse if the tubing is blocked or if the resident is having several brief changes or leakage. Policy Review: Catheter Care-Indwelling (effective 2/1/2024): 19. Empty gravity drainage bag every shift or more frequently, as needed. Do not allow the end of drainage spout to touch floor, collection container, or other surface. 45153 2. On 7/14/2024 at 12:42 PM, Resident #22 was observed in his room with an enteral feeding tube but no EBP sign was posted on his door. On 7/15/2024 at 10:37 AM, Resident #22 was observed in his room with an enteral feeding tube but no EBP sign was posted on his door. On 7/17/2024 at 9:53 AM, Resident #22 was observed in his room with an enteral feeding tube but no EBP sign was posted on his door. On 7/18/2024 at 11:21 AM, Resident #22 was observed in his room with an enteral feeding tube but no EBP sign was posted on his door. (Photographic evidence obtained) On 7/18/2024 at 12:23 PM, LPN H was asked how staff were made aware that a resident was on EBP. She replied, I'm not sure. It pops up on the Medication Administration Record or Treatment Administration Record to alert staff about a resident precaution. A sign is usually placed on the door, stating see nurse before entering room. On 7/18/2024 at 12:34 PM, the Infection Preventionist/Director of Nursing was asked how staff knew which residents were on EBP precautions. She replied, There should be signage outside the door that indicates to use caution and see the nurse before entering. She also stated there was additional information in resident records and the information was passed from one nurse to the next through shift change report. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Infection Prevention and Control Policy (effective2/1/2024), revealed: Policy Statement: The facility strives to prevent transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community acquired infections. The goal of the program is to identify and reduce the risks of acquiring and transmitting infections among residents, employees, volunteers, and visitors. The program includes a system to monitor and investigate infection trends. The program is developed based on nationally recognized organizational standards and procedures. A coordinated process is established to reduce the risk of nosocomial infections in residents and employees. The infection prevention and control process is directed at lowering risk, and improving trends and rates of epidemiologically significant infections. The process includes but is not limited to: Prevention - standard precautions; transmission-based precautions: contact, droplet, airborne, special droplet, enhanced barrier precautions; personnel health; engineering and work practice controls; exposure control plans: tuberculosis, blood borne pathogens. (Copy obtained)