STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105320	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on interviews, observations, and record reviews, the facility failed to ensure two residents (#79 and #213) were assessed for self-administration of treatments and medications out of forty sampled residents. Findings included: An interview was conducted with the Director of Nursing (DON) on 4/24/24 at 5:01 p.m., the DON stated she did not believe any residents in the facility were able to self-administer medications. 1. Review of Resident #79's Admission Record showed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to Type 2 Diabetes Mellitus with diabetic chronic kidney disease, cellulitis of left lower limb, and End Stage Renal Disease. An observation on 4/23/24 at 3:02 p.m. revealed Resident #79 lying in bed after returning from dialysis. The observation showed a bottle of nasal spray, a spray bottle of wound cleanser, and a bottle of a dark liquid the resident stated was Betadine. The resident reported an undated foam dressing on the left upper extremity and the open wound on the inner thigh of the left upper leg was dressed by the resident. The resident stated the presence of the collagen pad in the room was used to dress the left leg wound. During an observation and interview on 4/24/24 at 5:33 p.m., with Resident #79 and the Director of Nursing (DON), the DON informed the resident the observed wound cleanser and Betadine would need to removed and the resident refused to allow the removal of items. The DON left the room without any of the treatment items observed on the over-bed table, including the nasal spray. Review of Resident #79's care plan did not reveal the resident was assessed for the self-administration of medications or treatments. The care plan showed the resident had an Activities of Daily Living (ADL) self-care performance deficit related to impaired mobility, preferred to have facial hair at times, (and) preferred to have belongings/toiletries left in bathroom and at bedside. This focus was initiated/created on 1/30/24 and revised on 4/23/24. The interventions did not reveal the resident was able to keep medications at bedside. The resident's care plan did not show the resident was assessed and allowed to self-administer medications and/or medicated treatments. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/22/24 at 11:34 a.m., Resident #213 was observed lying in bed, with a bedside dresser/bookcase next to the bed. An opened bottle of Nystatin Topical Powder and a medication cup with a powder substance was observed on the top of the bookcase. The bottle of antifungal powder revealed it was to be applied to the groin/scrotum twice daily for 5 days. Photographic evidence was obtained. Review of Resident #213's Admission Record showed an original admitted [DATE] and a readmission on 4/15/24. The record included diagnoses not limited to encounter for orthopedic aftercare following surgical amputation and Type 2 Diabetes Mellitus with hyperglycemia. Review of Resident #213's April 2024 Treatment Administration Record (TAR) showed the treatment for Nystatin External Powder was to be applied twice daily to the groin/scrotum from 4/16/24 to 4/21/24. Review of Resident #213's medical record did not reveal the resident had been assessed for self-administration of medications. A request was made to the facility on [DATE] for a copy of the resident's Self-Administration Assessment and it was not provided. During an interview with the Director of Nursing (DON) on 4/25/24 at 1:12 p.m., the DON reported being aware of the (name brand) antifungal powder was at Resident #213's bedside, They had to have been in (pronoun) possessions. Review of the policy - Resident Self-Administration of Medication, implemented 11/2020, revealed the following: It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facilities interdisciplinary team has determined which medications may be self-administered safely. The compliance guidelines revealed: 1. Each resident has the right to be assessed for self-administration of medications. 2. Resident's preference will be documented on the appropriate form and placed in the medical record as indicated. The results of the interdisciplinary team assessment are recorded on the Self-Administration of Medication Evaluation, which is located in the resident's medical record. 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of the policy and procedures regarding resident self-administration when necessary. 13. The care plan must reflect resident self administration and storage arrangements for such medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on observations, interviews, and record review, the facility failed to complete the smoking assessment for one resident (#364) out of four residents sampled. Findings included: An observation on 04/22/24 at 9:45 a.m. revealed Resident #364 actively smoking a cigarette on the designated smoking patio during a facility specified smoking time. An interview was conducted on 04/24/24 at 12:09 p.m. with Resident #364. She stated she smokes during designated smoking times daily and has been smoking at the facility since she was admitted on [DATE]. An interview was conducted on 04/25/24 at 10:43 a.m. with the Director of Nursing (DON). She stated the smoking assessment process is completed when residents are admitted to the facility. She said there is a section in the admission assessments to address smoking. She stated the expectation is for staff to complete the smoking assessment immediately along with all assessments that are part of the admission. She said smoking assessments are completed at admission to determine resident safety and provide education on the facility policy, and safe smoking practice. She stated all the residents are to be supervised when smoking. She stated Resident #364's smoking assessment was completed on 04/23/24 after she was made aware it had not been done. She stated, It was overlooked and should have been completed at admission. Review of the medical record revealed Resident #364 was admitted on [DATE] with diagnoses that included Bipolar Disorder, generalized anxiety and major depressive disorder, cellulitis of right lower limb, lymphedema, and unspecified cirrhosis of liver. Review of the facility provided list of the residents who smoke, dated 04/22/24 at 7:58 a.m., had Resident #364 as #19 of 20 residents listed on the form. Review of the medical record revealed Resident #364 had no smoking assessment completed. Review of care plan, dated 04/17/2024, showed Resident #364 a focus of Must smoke with supervision. Establishes own choices related to declining to adhere to smoking policy. The care plan was initiated on 04/17/24, and revised on 04/22/24. Review of the Smoking Policy section in the admission packet revealed each resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include, Ability to smoke safely with supervision. Review of the facility policy titled Resident Smoking, implemented 07/25/22 and revised on 09/07/22, revealed the following: Residents who smoke will be further assessed using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking or if resident is safe to smoke at all.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on interviews and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) was accurate upon admission for ten residents (#19, #48, #13, #17, #34, #33, #16, #97, 78, and #73) out of 24 residents sampled for PASRR review. Findings included: Review of the Admission record showed Resident #16 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, major depressive disorder recurrent, moderate, localization- related symptomatic epilepsy and epileptic syndromes with simple partial seizures, and generalized anxiety disorder. Review of the PASRR, dated 11/15/22, revealed under Section A: MI (Mental Illness) or suspected MI check all that apply showed Depressive Disorder was checked and Anxiety Disorder was not checked. A second PASRR not dated revealed under Section A: MI or suspected MI check all that apply showed Depressive Disorder was checked but Anxiety Disorder was not checked. During an interview on 04/25/24 at 1:52 p.m., the Director of Nursing (DON) stated Resident # 16's PASRR was not correct and should have been updated to reflect the current status. Review of the Admission Record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Epilepsy unspecified, intractable with out status epileptics, generalized anxiety disorder, and major depressive disorder, recurrent, moderate. Review of the PASRR, dated 08/21/22, revealed under Section A: MI or suspected MI check all that apply Anxiety Disorder and Depressive Disorder was not checked. Under Section B. ID (Intellectual Disorder) or suspected ID (check all that apply) Related Conditions Epilepsy and Cerebral Palsy was not checked. During an interview on 04/25/24 at 1:52 p.m., the Director of Nursing (DON) stated Resident #34's PASRR should have been updated to reflect current status. Review of the Admission Record revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, current depressed, severe, without psychotic features, and generalized anxiety disorder. Review of the PASRR, dated 02/29/24, revealed under Section A: MI or suspected MI check all that apply showed Anxiety Disorder and Depressive Disorder was checked and Bipolar Disorder was not checked. During an interview on 04/25/24 at 1:53 p.m., the Director of Nursing (DON) stated Resident #48's PASRR was not correct and should have been updated upon admission to reflect current status. 49497 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of medical record revealed Resident #13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include acute and chronic respiratory failure with hypoxia, schizoaffective disorder bipolar type, anxiety disorder, major depressive disorder. Review of a Level I PASRR, dated 4/15/2024, showed qualifying diagnoses were not checked or indicated and no Level II PASRR was required. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including dementia, other persistent mood disorders, and anxiety disorder. Review of a Level I PASRR, dated 12/11/17, showed qualifying diagnoses were not checked or indicated and no Level II PASRR was required. Review of the medical record revealed Resident #78 was admitted on [DATE] with diagnoses including dementia, major depressive disorder, and Bipolar Disorder. Review of a Level I PASRR, dated 12/05/22, showed qualifying diagnoses were not checked or indicated and no Level II PASRR was required. Review of the medical record revealed Resident #97 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, anxiety disorder, and depression. Review of a Level I PASRR, dated 10/17/23, showed qualifying diagnoses were not checked or indicated and no Level II PASRR was required. An interview was conducted on 4/25/24 at 1:40 p.m. with the Director of Nursing (DON). She stated their process is when a resident is admitted to the facility, she receives PASRR paperwork in the admission packet to review. If the PASRR is incorrect she will attempt to have the hospital correct it, if unable to get corrected, she will complete a new Level I PASRR. She said, she will also update PASRR during resident stays when a new diagnosis is added that pertains to PASRR. She stated Resident #13, #33, #78, and #97's PASRR's were all incorrect as diagnoses should have reflected the diagnoses in their medical record and not left blank. She stated the PASRR's should have been updated with admitting diagnoses to have a correct Level I PASRR in medical record and to determine if a Level II PASRR was warranted. 14161 Review of the medical record for Resident # 19 revealed he was originally admitted to the facility in 4/14/13 with diagnoses including of brief psychotic disorder, generalized anxiety disorder, mood disorder. In 2022 a diagnosis of unspecified dementia, unspecified severity with other behavioral disturbance was added to his diagnoses. A PASRR, dated 2/6/24, revealed under Section A: MI or suspected MI check all that apply Anxiety Disorder, Depressive Disorder, Psychotic Disorder, and Substance Abuse was checked and revealed the finding was based on documented history. Section II: Other Indications for PASRR Screen Decision Making item 5 revealed Resident (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#19 had no primary diagnosis of Dementia or Related Neurocognitive Disorder (including Alzheimer's disease). Item 6 indicated Resident #19 did not have a secondary diagnosis of dementia, related neurocognitive disorder and the primary diagnosis is an Serious Mental Illness or Intellectual Disability. No Level II PASRR was required. A PASRR, dated 3/7/24, revealed under Section A: MI or suspected MI check all that apply Anxiety Disorder, Depressive Disorder and Mood Disorder were checked. Section II : Other Indications for PASRR Screen Decision Making, item 5 revealed a yes check mark for having a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's Disease), and the Primary diagnosis is an Serious Mental Illness or Intellectual Disability No Level II PASRR was required. An interview was conducted with the DON, on 4/25/24 at 1:54 p.m The DON stated both PASRR's were incorrect and she needed to redo them again. 48223 Review of the Admission Record showed Resident #17 was admitted on [DATE] and readmitted on [DATE] with diagnoses of Bipolar Disorder, Anxiety disorder, Major Depressive disorder, Vascular Dementia, and other comorbidities. Review of the Physician's history and physical, dated 01/18/2023, showed Resident #17 with a diagnosis of schizoaffective disorder. Review of Resident #17's PASRR Level I Assessment, dated 03/15/2024, did not reveal the qualifying mental health diagnosis schizoaffective disorder marked in section I A. nor was the diagnosis of Vascular Dementia. A Level II PASRR should be submitted due to the qualifying diagnoses. During an interview on 04/25/2024 at 01:40 PM, the DON confirmed the diagnoses should be listed on the PASRR. The DON confirmed the PASRR was inaccurate, and a new PASRR should be completed. Review of Resident #73's Psychiatry Subsequent Note, dated 03/27/2020, showed Resident #73 with the following diagnoses of Psychotic Disturbance, Anxiety disorder, Schizophreniform disorder, Dementia, and other comorbidities. Review of Resident #73's PASRR Level I Assessment, dated 06/20/2023, did not reveal the qualifying mental health diagnosis marked in section I A. nor was the diagnosis of Dementia. A Level II PASRR should be submitted due to the qualifying diagnoses. During an interview on 04/25/2024 at 01:40 PM, the DON confirmed the diagnoses should be listed on the PASRR. The DON confirmed the PASRR was inaccurate, and a new PASRR should be completed. Review of the facility's policy, dated 9/18/2023, showed the following: Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders (MD) or intellectual disabilities (ID) and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and or rehabilitative services the individual needs. 2. The facility will only admit individuals with a MD or ID who the State mental health or ID authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the resident's medical record. 4. Exceptions to the preadmission screening program, dependent upon State requirements, include those individuals who: a. Are readmitted directly from a hospital. b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Service Director or designee shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASARR Level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transition of care. 8. Any Level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Examples include: a. A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms. b. A resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment. c. A resident who experiences an improved medical condition - such that the residents' plan of care or placement recommendations may require modifications. d. A resident whose significant change is physical, but has behavioral, psychiatric or mood-related symptoms, or cognitive abilities, that may influence adjustment to the altered pattern of daily living. e. A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASARR Level II evaluation and determination. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not a primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, interviews, and record reviews, the facility failed to assess, obtain physician orders, and provide treatments for one resident (#79) out of one resident sampled for skin conditions unrelated to pressure injuries. Findings included: On 4/23/24 at 3:02 p.m., Resident #79 was observed lying in bed with a bottle of wound cleanser and a bottle of dark liquid, which the resident stated was Betadine, on the over-bed table within reach of the resident. The observation revealed an undated foam dressing located to the outer aspect of the resident's upper left arm. The resident was observed with two areas on the upper left thigh, one area was approximately dime-size, opened with yellowish-white substance attached to the indented wound bed, and the other area was raised, approximately quarter-sized, with a purplish-red coloration to it. The open area to left thigh had a knuckle bandage next to the area. The resident reported dressing the left thigh by himself, having wound cleanser, Betadine, and collagen. The resident reported the facility's Wound Care Nurse probably started out good but has declined. A review, on 4/23/24 at 3:49 p.m. of Resident #79's medical record revealed staff had noted a left arm skin tear on the resident's Weekly Skin Evaluation, dated 4/17/24, with no further information. A review on 4/23/24 at 3:47 p.m., of Resident #79's Long-Term Care (LTC) Nurse's Note, dated 4/23/24 at 3:33 p.m., revealed the resident did not have a surgical wound, had Left (L) leg wounds and dialysis port, dressing(s) to wound(s) were clean, dry, and intact, and there was no signs or symptoms of infection which included foul odor, redness, increased and/or purulent drainage or warmth. The nurse's note did not reveal the resident had a skin tear to upper left arm. Review of Resident #79's April Medication and Treatment Administration Records (MAR/TAR) did not show the facility had obtained or had been following physician orders for the application of dressing to the resident's upper left arm or inner left thigh. Review of the facility's Incident Log did not reveal Resident #79 had any skin tear or skin condition non-pressure incidents during the time period of 11/22/23 to 4/22/24. An interview was conducted with Staff L, Wound Care Nurse (WCN)/Licensed Practical Nurse (LPN), on 4/24/24 at 5:38 p.m. The staff member stated the resident had surgical wounds a couple months ago and they were healed as far as she knew. The WCN reported she would not have followed up with the wounds, stated the assigned nurse would have assessed the area, notified the physician, gotten treatment orders, and do the treatments. Staff L stated multiple times that she would not have followed up on any wounds for Resident #79 then admitted that after the nurse had obtained orders and did treatment she would have seen the resident for any wounds. She stated she was not aware of Resident #79 having any current wounds. An interview was conducted with Staff R, agency LPN, on 4/24/24 at 5:50 p.m. The staff member reviewed the TAR for the resident and stated no dressings were scheduled for the shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 5:51 p.m., Resident #79 was observed lying in bed with an undated foam dressing to the left upper arm, the left thigh's open area had a tan-colored undated foam dressing stained with drainage and was partially attached to thigh. The resident pulled up on corner of the dressing covering the left thigh and stated the staining was from the open area. The area was open with yellow slough covering the wound bed. Resident #79 stated the facility had not dressed the area, he had done the dressing and the facility Should do it tonight. On 4/24/24 at 5:53 p.m., Resident #79's left upper arm (LUE) dressing, left thigh open area, and raised area to left thigh was observed with the Director of Nursing. The resident confirmed the area under the LUE dressing was a skin tear occurring when coming through front door and thought Staff S, LPN, had put the dressing on it. The resident pulled his short leg up and revealed both the open and raised areas to the DON. The resident stated the outside facility Wound Care physician had informed the resident not to allow anyone to touch it, so the resident has been dressing it. The DON attempted to remove wound care treatment supplies (Wound Cleanser, Betadine, and Collagen) from the room, which the resident refused to allow. Immediately following the observation, the DON stated the open area to left thigh appeared to be infected and the resident was difficult due to trying to be independent. During an interview on 4/25/24 at 8:36 a.m., the DON reported Staff L had reported to her (on 4/24/24) of being aware of Resident #79's open area and had dressed the area on left thigh of Resident #79. Review of Resident #79's Admission Record revealed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to cellulitis of left lower limb, Type 2 Diabetes Mellitus with diabetic chronic kidney disease, idiopathic aseptic necrosis of left femur, and dependence on renal dialysis. Review of Resident #79's care plan revealed the following focuses related to the resident's skin conditions: - Is at risk for skin breakdown related to (r/t) impaired mobility, initiated and created 1/30/24. The included interventions instructed staff to observe skin during bathing and daily, especially over bony prominences; report abnormalities to nurse and wound care as ordered, see current treatment record and physician's orders; monitor effectiveness of / response to treatment as ordered, initiated 1/30/24. - Has actual skin breakdown related to: surgical sites to left inner thigh, left groin, initiated and created on 1/30/24. The interventions included but was not limited to Monitor for signs/symptoms (s/s) infection or delayed healing and report to physician as needed (PRN): Redness / Erythema Drainage - purulent or bloody, separation of incision. The interventions instructed Wound care as ordered, see current treatment record and physician's orders; monitor effectiveness of / response to treatment as ordered, initiated: 1/30/24. The policy - Skin Assessment, implemented 11/2020 and reviewed/revised 10/1/2022, revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is our policy to performing full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. The explanation and compliance guidelines instructed staff: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 2. Procedure: e. Begin head to toe, thoroughly examining the resident skin for conditions. Pay close attention to pressure points, bony prominences, and underneath medical devices. g. Remove any dressings, using clean technique, unless contraindicated or ordered to remain in place, and note findings. h. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions. 7. Documentation of skin assessment: a. Include the date and time of the assessment , staff name and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etcetera). c. Document type of wound. d. Describe the wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated order appropriate. The policy - Clean Dressing Change, undated as to implementation and/or reviewed, revealed the following: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/ or cross contamination. Physician orders will specify type of dressing and frequency of changes. 2. Multi-use wound care supplies will be dated and initialed when opened. They will be maintained as clean after initial use. [NAME] items will not be used at the sterility cannot be assured at time of initial use (i.e. open package, broken seal). 13. Measure wound using disposable measuring guide. (Note: if performing photo documentation, remove gloves and wash hands. Photograph wound being careful to avoid any contamination of the camera equipment). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15. Apply topical ointment or creams and dress the wound as ordered. Protect surrounding skin as in indicated with skin protectant. 16. Secure dressing. [NAME] with initials and date. (Add time if dressing is more than once daily.)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, interviews, and record review, the facility failed to ensure one resident (#416) out of two residents sampled for pressure ulcers, received necessary care and services to promote healing, prevent infection, and prevent new ulcers from developing. Findings included: During an interview on 04/22/24 at 9:05 a.m., Resident #416 stated, My heel hurt last night so I asked {Staff B, Licensed Practical Nurse, (LPN)} if she could put the pressure ulcer medicine and bandage on my heel so it could sooth the pain. Resident #416 stated Staff B, LPN responded, No she did not do this at night as she was the only nurse in the facility, she was too busy and the facility was understaffed. Resident #416 stated there should be a bandage on my pressure ulcer at all times. Resident #416's right heel did not have a bandage over the pressure ulcer. Resident #416 gave permission to take photographic evidence of the pressure ulcer located on her right heel. (Photographic evidence obtained). A second observation was conducted on 04/22/24 at 10:26 a.m., with both the State Agency (SA) Surveyor and the SA Nurse Surveyor. Resident #416 had a pressure ulcer located on the right heel. Resident #416 had a black non-skid sock over the right foot. Staff C, Certified Nursing Assistant (CNA) removed the black non-skid sock from Resident #416's right foot. The pressure ulcer had no bandage or protection over Resident #416's right heel. An interview was conducted on 04/22/24 at 10:26 a.m., with Staff C, CNA. Staff C stated the pressure ulcer on Resident #416's right heel was usually covered under the non-skid socks and did not know why it was not today. A review of the Admission Record revealed Resident #416 was admitted to the facility on [DATE] with diagnoses that included Type II Diabetes Mellitus, Chronic Respiratory Failure, Presence of right artificial knee, Chronic Obstructive Pulmonary Disease and extended spectrum beta lactamase (ESBL) resistance. Review of a physician order, dated 04/08/24, revealed, Clean Right heel with n/s (normal saline), apply collagen sheet and cover with bordered gauze daily. Every day shift for Stage 3 pressure wound. A review of the Medicare 5-Day Minimum Data Set (MDS), dated [DATE] revealed Resident #416 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Review of the care plan showed the following: Focus: [Resident #416] has actual skin breakdown related to: Pressure wound right heel. Goal: Risk for further skin breakdown and complications with current skin impairment will be minimized through the next review date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Interventions included: - Complete Weekly Skin Evaluation. - Consult wound physician as needed. - Discuss non-compliance issues with resident/responsible party. - Monitor for pain and medicate PRN [as needed] per physician's order. - Monitor for sign and symptoms of infection or delayed healing and report to physician PRN: Redness / Erythema Drainage - purulent or bloody Separation of incision. - Observe skin during bathing and daily, especially over bony prominence, Report abnormalities to nurse. During an interview on 04/25/24 at 8:20 a.m., Staff B, LPN stated Resident #416 did ask to have her bandage replaced the other night. Staff B, LPN stated, I had already changed it 2 nights in a row. Staff B, LPN stated Resident #416 kept snatching it off (the bandage) and because I was the only one here and was in the middle of a tube feed, Staff B, LPN stated she told Resident #416, I just did not have the time. Staff B, LPN stated Resident #416 told me she was going to report me for not providing care and I told her to just go ahead and do that. Staff B, LPN stated, I never had the time to go back and replace the bandage, plus wound care comes in at 7:00 a.m. During an interview on 04/25/24 at 2:36 p.m., the Director of Nursing (DON) stated if a resident asked to have wound/pressure ulcer care then it would be expected the nurse on duty to have complete the care. The DON stated at very least, I would have expected the nurse on duty to have passed the information along to morning shift nurses so the wound care could be completed first thing in the morning. A review of the facility's policy Pressure Injury Prevention and Management with reviewed date 07/25/22, revealed, This facility is committed to the prevention of avoidable injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37999 Based on observations, record reviews, and interviews the facility failed to adhere to the smoking assessment of one resident (#79) out of the twenty smoking residents, and allowed three residents (#79, #9, and #213) to possess unsecured smoking paraphernalia outside of the supervised smoking times. Findings included: 1. On 4/22/24 at 6:30 a.m., Resident #79 was observed sitting at the main entrance of the facility, next to a trash bin/ashtray alone. The resident informed team of having to use the doorbell to get back into the facility. The entrance area smelled of fresh cigarette smoke and a pack of cigarettes was observed sitting on top of the trash bin. The resident entered the building with the survey team. On 4/23/24 at 3:02 p.m., Resident #79 was observed lying in bed and stated the facility started taking away smoking materials about 7-8 months ago, but have gotten lax about it. The resident stated Staff P, Activity Assistant, informed residents' today of having to take the cigarettes away again, saying it was policy. The resident reported not feeling it was right to take them away, feeling other residents who don't have any are given cigarettes from other residents'. Resident #79 confirmed being at the main entrance smoking when the survey team entered the building at 6:30 a.m. on 4/22/24. The resident stated staff let the resident out and sometimes it takes 45-60 minutes to be let in after ringing the doorbell. On 4/24/24 at 5:53 p.m., Resident #79 was observed, with the Director of Nursing (DON), the resident unzipped a case to obtain the business card from an outside Wound Care Physician and a purple pack of cigarettes fell out of the case. The resident acknowledged he was not supposed to have them the cigarettes. Review of Resident #79's Admission Record showed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses of uncomplicated unspecified nicotine dependence, unspecified respiratory failure with hypoxia, unspecified chronic obstructive pulmonary disease, and unspecified pulmonary hypertension. Review of the Quarterly Minimum Data Set, dated dated [DATE], showed Resident #79's Brief Interview of Mental Status (BIMS) score was 12 out of 15, indicating moderate cognitive impairment. Review of Resident #79's Smoking Evaluation, dated 4/17/24, showed the resident did not have a history of smoking-related incidents, smoked 5-9 times per day, did not exhibit signs of confusion, vision was adequate with glasses, has fine-motor dexterity, was able to extinguish cigarette safely, and understood the policy related to smoking times and storage of smoking materials. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #79's care plan revealed the resident Must smoke with supervision. Establishes own choices related to declining to adhere to smoking policy, initiated 1/30/24 and revised 4/22/24. The goals regarding the residents smoking was the resident would smoke safely with supervision, initiated 1/30/24, and would understand risks and benefits of choices made through next review date, initiated 4/22/24. The goals target date was 7/22/24. The interventions included: - Notify charge nurse if it is suspected resident has violated facility smoking policy, date Initiated 1/30/24. - Resident oriented to smoking procedures and areas, date Initiated: 1/30/24. - Resident will demonstrate the ability to verbalize understanding that smoking materials are for use only in designated smoking areas, date Initiated 1/30/24. - Explain risks and benefits of resident's choices date Initiated 4/22/24. - Respect resident choices, date Initiated 4/22/24. During an interview on 4/25/24 at 1:12 p.m., the DON stated Resident #79 was supposed to be supervised while smoking. She stated the resident's non-compliance with smoking policy has been addressed. The smoking issue regarding others smoking other residents' cigarettes was an ongoing battle. 2. On 4/22/24 at 10:14 a.m., Resident #9 was observed and interviewed while lying in bed. The resident reported the facility does not allow resident's to smoke unattended. The resident reported having personal cigarettes and a lighter due to missing cigarettes if kept in facility box and if not keeping lighter the resident's would not be able to light cigarettes as the facility does not provide lighters. Resident #9 acknowledged not suppose to have lighter and hoped (pronoun) wasn't getting facility in trouble. The resident confirmed being the Resident Council President. On 4/23/24 at 2:08 p.m., Resident #9 was observed smoking with other residents' in the area designated as the smoking patio. Review of Resident #9's census showed the resident was admitted on [DATE]. The medical diagnoses of the resident included chronic systolic (congestive) heart failure, unspecified chronic obstructive pulmonary disease, and functional quadriplegia. Review of Resident #9's Quarterly Minimum Data Set, revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating an intact cognition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's Smoking Evaluation, dated 3/5/24, revealed the resident was a current smoker, had no history of smoking-related incidents, did not exhibit signs of confusion, verbalizes or demonstrates an understanding of the times and place to smoke, able to communicate if lit materials fall on them, has the fine-motor dexterity to hold a cigarette safely and dispose of ashes without a device, and able to extinguish safely. The evaluation showed the resident had the policy related to smoking times and storage of smoking materials and understands the policy. Review of Resident #9's care plan revealed the resident Must smoke with supervision. Establishes own choices related to declining to adhere to smoking policy created 7/25/22, initiated 8/3/23, and revised on 4/22/24 by Unit Manager. The goals for showed the resident will smoke safely with supervision throughout next review date created 7/25/22, initiated 8/3/23, and revised on 9/21/23 with a target date of 6/9/24. An additional goal initiated and created on 4/22/24 revealed the resident Will understand risks and benefits of choices made through next review date with a target date of 6/9/24. The interventions regarding Resident #9's smoking included: - Notify charge nurse if it is suspected resident has violated facility smoking policy, created 7/25/22, initiated and revised on 8/3/23. - Remind resident not to share smoking materials with other resident who may be unsafe created 7/25/22, initiated and revised on 8/3/23. - Explain risks and benefits of resident's choices, initiated and created by Staff T, Unit Manager on 4/22/24. - Respect resident choices, initiated and created by Staff T on 4/22/24. 3. On 4/22/23 at 11:34 a.m., Resident #213 was observed with a green-colored pack of cigarettes on top of bedside dresser. The resident reported not being outside to smoke since being here. Resident #213 stated being in room [ROOM NUMBER] and having belongings brought over recently. Photographic evidence was obtained. Review of Resident #213's Admission Record revealed an admitted [DATE] and re-admitted [DATE]. The record included diagnoses of unspecified uncomplicated nicotine dependence, and chronic respiratory failure with hypoxia. Review of Resident #213's Quarterly Brief Interview of Mental Status, dated 3/15/24, revealed a score of 13 out of 15, indicating an intact cognition. Review of Resident #213's Smoking Evaluation, dated 4/17/24, revealed the resident currently smoked, did not have a smoking-related incidents, smoked 1-2 times per day, did wish to quit smoking, did exhibit signs of confusion, and was able to communicate the need for help if lit materials fell on them. The evaluation showed the resident had the fine-dexterity to hold cigarette safely and properly dispose of ashes, had the ability to extinguish cigarette safely, acknowledged the understanding of the smoking policy, and did not require a protection device while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #213's care plan revealed the resident Must smoke with supervision. Establishes own choices related to declining to adhere to smoking policy initiated and created 10/2/23 and revised on 4/22/24 by Staff T, Unit Manager. The revision showed the statement of Establishes own choices related to declining to adhere to smoking policy was added on 4/22/24 by Staff T. The goals regarding the residents smoking included Resident will smoke safely with supervision throughout next review initiated and created on 10/2/23 with a target date of 6/17/24 and Will understand risks and benefits of choices made through next review date initiated and created on 4/22/24 by Staff T with a target date of 6/17/24. The interventions included: - Notify charge nurse if it is suspected resident has violated facility smoking policy, initiated and created 10/2/23. - Resident oriented to smoking procedures and areas initiated and created 10/2/23. - Resident will demonstrate the ability to verbalize understanding that smoking materials are for use only in designated smoking areas, initiated and created 10/2/23. - Respect resident choices, initiated and created on 4/22/24 by Staff T. During an interview on 4/25/24 at 1:12 p.m., the Director of Nursing reported being aware of the presence of Resident #213's cigarettes at bedside, They had to have been in (pronoun) possessions. An interview was conducted with Staff P, Activities Assistant on 4/23/24 at 2:08 p.m., while the staff member was supervising smokers on the smoking patio. The observation revealed one unknown female resident lighting her own cigarette with lighter that was placed on the cigarette pack lying on table in front of her. The staff member stated about 50% of the residents, approximately 10-12 residents, currently on the porch keep their cigarettes and lighters. Staff P stated the resident's inform the staff member the cigarettes and lighters are their property. The staff member reported allowing the resident's to keep the materials because Doesn't want to argue with them and the job on the smoking patio was ensuring residents did not fight with each other. A review of the facility's list of smokers showed all twenty (20) current smokers Must smoke with supervision and included Resident #79, #9, and #213. The facility revealed the daily smoking times for residents was at 9:30 a.m., 2:00 p.m., 4:00 p.m., and 7:00 p.m. Review of the facility's policy - Resident Rights, implemented on 11/3/23 and revised on 3/8/23, revealed the following: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy addressed the Respect and dignity of residents revealing the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident for other residents. The facility acknowledged The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Review of the facility policy - Resident Smoking, reviewed/revised on 9/7/22, revealed the following: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. The compliance guidelines included: 1. Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted. 6. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, in and accordance with his/ her care plan. 12. If a resident or a family does not abide by the smoking policy or care plan (e.g. Smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. 13. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. 15. Documentation to support decision making will be included in the medical record, including but not limited to: - d. Compliance with smoking policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on interviews, observations, and record reviews the facility failed to provide medications ordered by the physician at the time of admission for one resident (#212) out of one resident sampled for new admissions and failed to notify the physician of the unavailability of the those medications. Findings included: During an interview on 4/22/24 at 12:51 p.m. with Resident #212 and a family member, the family member stated the facility could not get a nebulizer medication from the pharmacy. The resident was lying in bed and wearing oxygen via nasal cannula at the time of the interview. Review of Resident #212's Admission Record revealed the resident was admitted on [DATE] with the primary diagnosis of Chronic Obstructive Pulmonary Disease with (acute) exacerbation (COPD). The record included additional diagnoses of acute and chronic respiratory failure unspecified whether hypoxia or hypercapnia and personal history of other malignant neoplasm of bronchus and lung. Review of Resident #212's Admit/Readmit Screening, effective 4/18/24 at 6:54 p.m., revealed the resident had wheezing in bilateral upper lobes, had reported increased shortness of breath while lying flat, and was utilizing 4 liters per minute (lpm) of oxygen to aid the respiratory system. The evaluation showed the medication orders had been verified and reconciled with the physician, patient, and family/responsible party with no issues identified or changes needed. Review of Resident #212's Discharge Instructions from an acute care facility, dated 4/18/24 at 3:30 p.m., revealed new medication orders for: - Budesonide 0.5 milligram (mg)/2 milliliter (mL) inhalation suspension - 2 mL of nebulized inhalation every 12 hours. - Formoterol 20 microgram (mcg)/2 mL inhalation solution - 2 mL every 12 hours Review of Resident #212's Medication Administration Record (MAR) showed the following orders and administration documentation: - Budesonide Inhalation Solution 0.5 mg/2 mL - 2 mL inhale orally every 12 hours for COPD, started 4/18/24 at 9:00 p.m. The MAR showed the resident was to start receiving the medication at 9:00 p.m. on 4/18/24 and to continue receiving at 9:00 a.m. and 9:00 p.m. The administration information showed staff had administered the medication on 4/19, 4/20, and 4/22/24 at 9:00 a.m. and documented 9 (per chart code: Other/See Progress Notes) on 4/21, 4/23, and 4/24 at 9:00 a.m. and at 9:00 p.m. on 4/18, 4/19, 4/20, 4/21, 4/22, and 4/23/24. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Formoterol Fumarate Inhalation Nebulization solution 20 mcg/ 2 mL - 2 mL inhale orally via nebulizer every 12 hours for COPD, start 4/18/24 at 9:00 p.m. The MAR revealed the resident had received this medication at 9:00 a.m. on 4/19, 4/20, and 4/22. The review showed staff had documented 9 (per chart code: Other/See Progress Notes) for the 9:00 a.m. administration on 4/21, 4/23, and 4/24 and at 9:00 p.m. on 4/1, 4/19, 4/20, 4/21, 4/22, and 4/23/24. Review of Resident #212's progress notes, showed the following: - 4/18/24 at 8:38 p.m., Budesonide new admission on order. - 4/18/24 at 8:39 p.m., Formoterol new admission on order. - 4/19/24 at 8:39 p.m., Budesonide Awaiting pharmacy. - 4/19/24 at 9:02 p.m., Formoterol Awaiting pharmacy. - 4/20/24 at 9:47 p.m., Formoterol awaiting pharmacy. - 4/20/24 at 9:47 p.m., Budesonide awaiting pharmacy. - 4/21/24 at 10:34 a.m., Budesonide awaiting pharmacy. - 4/21/24 at 10:35 a.m., Formoterol awaiting pharmacy. - 4/21/24 at 8:53 p.m., Budesonide awaiting pharmacy. - 4/21/24 at 8:53 p.m., Formoterol awaiting pharmacy. - 4/22/24 at 8:50 a.m., Formoterol on order Advanced Practical Registered Nurse (APRN) aware, no new orders (NNO) - 4/22/24 at 8:13 p.m., Formoterol (no other documentation - per MAR medication was not administered) - 4/22/24 at 8:14 p.m., Budesonide (no other documentation - per MAR medication was not administered) - 4/23/24 at 10:26 a.m., Budesonide awaiting delivery. - 4/23/24 at 10:27 a.m., Formoterol awaiting delivery. - 4/23/24 at 10:00 p.m., Budesonide not in stock, contacted pharmacy who stated it will arrive soon. - 4/23/24 at 10:01 p.m., Formoterol not in stock, contacted pharmacy who stated it will arrive soon. - 4/24/24 at 8:24 a.m., Budesonide on order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/24/24 at 8:24 a.m. Formoterol on order. - 4/24/24 at 1:57 p.m. Resident discharged to another skilled nursing facility. Review of progress notes revealed the only Physician/APRN notification was on 4/22/24 at 8:50 a.m. that Formoterol was not available for administration (3.5 days after the order) and the MAR revealed the 9:00 a.m. on 4/22/24 dose of Budesonide and Formoterol had been administered. The notes did not show the Physician/APRN had been notified Budesonide was also not available. Review of Resident #212's care plan revealed the resident exhibits or is at risk for respiratory complications related to diagnosis (dx) of: COPD, initiated, created, and revised on 4/19/24. The interventions included: Provide respiratory treatment as ordered and monitor effectiveness, initiated 4/19/24. Review of medications available in the electronic dispenser did not show either Budesonide or Formoterol was available. During an interview on 4/24/24 at 5:01 p.m., the Director of Nursing (DON) stated medications for new admissions should be received within 24 hours or if available be accessed from the automatic medication dispenser. The DON reviewed the medications showing Budesonide and Formoterol were not received or administered. The staff member stated the pharmacy should have been notified, if an issue the Unit Manager or herself should have been notified and if an insurance reason the facility could authorize a couple days worth, the physician should be notified of the non-delivery so an alternative could have been used. The DON stated the resident had been discharged to another facility to be closer to family. The policy - Admission of a Resident, revised 11/16/23, revealed The admission process is intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable in the facility. Residents are admitted to the facility under orders of the attending physician. The pre-admission preparation for a resident showed: b. Once the resident/family has selected the facility, pre-admission information should be gathered. Preadmission information may include, but is not limited to: - iii. Physician's orders - iv. Medication and/or Treatment Records. 2. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. Information gathered will be placed into the resident's medical record via the facility's means of recordkeeping (i.e. paper, electronic).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to ensure the medication error rate was less than 5.00%. Thirty medication administration opportunities were observed and six (6) errors were identified for four residents (#67, #48, #415, and #24) of six residents observed. These errors constituted a 20% medication error rate. Findings included: 1) On 4/23/24 at 4:51 p.m., an observation of medication administration with Staff O, Licensed Practical Nurse (LPN), was conducted with Resident #67. The staff member scanned the resident's implantable glucose monitor and received a blood glucose level of 190. Staff O, LPN dispensed the following medications: - Insulin Aspart - Staff O applied needle to insulin pen, primed the pen with 2 units holding it parallel to the floor, applied another needle due to insulin not coming out, dialed the pen to 2 units, while holding the pen at approximately 45 degrees tapped the cartridge. The staff member returned to Resident #67's room, obtained a pulse of 73 via pulse oximeter, injected insulin into left upper extremity and immediately removed the needle. Returning to the medication cart Staff O dispensed: - Carvedilol 3.125 milligram (mg) tablet - Docusate sodium 100 mg softgel capsule The staff member confirmed one tablet and one capsule. An interview was conducted with Staff O on 4/23/24 at 5:27 p.m., the staff member reported the reason for priming insulin pens was to get the insulin to the top. Staff O stated the air bubble in cartridge was in the middle of the cartridge if held in 45 degree angle. During an interview on 4/25/24 at 12:59 p.m., the Director of Nursing stated the insulin should be held upright (needle pointing up) to prime. According to https://www.novo-pi.com/novolog.pdf, accessed on 4/26/24, revealed the following for priming of an Insulin Aspart pen: Giving the airshot before each injection. -Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your NovoLog(R) FlexPen(R) with the needle pointing up. Tap the cartridge gently with your (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog(R) FlexPen(R) and contact Novo Nordisk at [PHONE NUMBER]. A small air bubble may remain at the needle tip, but it will not be injected. The policy - Insulin Pen, reviewed 5/3/22, revealed It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. The policy revealed the insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. The facility failed to provide page 2 of the policy. 2) On 4/24/24 at 8:34 a.m., an observation of medication administration with Staff A, Licensed Practical Nurse (LPN), was conducted with Resident #48. The staff member dispensed the following medications: - Nicotine 7 mg topical patch - Acetazolamide 250 mg tablet - Amiodarone 200 mg tablet - Carvedilol 3.125 mg tablet - Furosemide 40 mg tablet - Losartan 25 mg tablet - Ferric X-150 tablet - Potassium chloride 20 milliequivalent (meq) Extended Release (ER) tablet - Budesonide 0.5 mg/2 mL inhalation vial - Norco 10-325 mg tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff member confirmed 8 tablets, signed off narcotic, and entered the resident room. Staff A handed the medication cup to Resident #48, poured Budesonide into the nebulizer medication cup, removed Nicotine patch from left front shoulder, and placed the new patch onto the right upper chest. Staff A handed nebulizer mask to resident who held it and machine was turned on. The staff member returned to the medication cart and documented a previously obtained blood pressure of 131/54 and a pulse of 70, which was the pulse of the resident in the room next to Resident #48's. During the medication administration for the resident's roommate on 4/24/24 at 9:02 a.m., Resident #48 was observed with the nebulizer machine turned off and nebulizer mask on the machine. Review of Resident #48's Medication Administration Record (MAR) revealed - Budesonide inhalation suspension 0.5 gm/2 milliliter - 2 mL inhale orally two times a day for shortness of breath/wheezing (SOB). Rinse mouth after use. Staff A did not instruct/ensure or encourage the resident to rinse mouth after use. The policy - Nebulizer Therapy, revised 12/23/22, showed It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. The compliance guidelines included the following instructions for staff: 6. Obtain resident's vital signs and perform respiratory assessment to establish a baseline. 14. Observe resident during the procedure for any change in condition. 16. Disassemble and rinse the nebulizer cup and mouthpiece with water and allow to air dry. The policy revealed staff were to document the date, time, and duration of therapy, vital signs and respiratory assessment, and the resident's response to treatment. During an interview on 4/25/24 at 1:00 p.m., the Director of Nursing stated the staff should wash hands, let resident know what was happening, obtain lung sounds, and pulse. The nebulizer mask should be in a plastic bag, and do a (respiratory) assessment afterwards. 3) On 4/24/24 at 8:51 a.m., an observation of medication administration with Staff A, Licensed Practical Nurse (LPN), was conducted with Resident #415. The staff member obtained a blood glucose level of 335 from an implantable glucose monitoring system and the resident refused oral medications. The resident informed Staff A of not eating any breakfast and did not want any. The staff member obtained a Humalog Kwikpen from the medication refrigerator, rubbing it in between hands to warm the insulin. Staff A applied a needle, primed with 2 units, primed again with 2 units, dialed the dose selector to 3 units and injected the insulin into Resident #415's right lower quadrant. Review of Resident #415's MAR revealed the Humalog (Insulin Lispro) was scheduled to be administered at 7:30 a.m., one hour and 21 minutes prior to the observation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 4/24/24 at 9:17 a.m., an observation of medication administration with Staff N, Licensed Practical Nurse (LPN), was conducted with Resident #24. The observation revealed the resident's Gabapentin was scheduled for 8:00 a.m. and the medication was colored red (showing it was late). The staff member stated They scheduled it for 8. Staff N obtained a blood pressure of 113/63 and pulse of 57. Staff N reported not giving Amiodarone because of the resident's pulse was low. The staff member dispensed the following medications: - Gabapentin 100 mg capsule - Baclofen 10 mg tablet - Losartan potassium tablet- 1/2 of 25 mg tablet (12.5 mg) - Lactobacilli probiotic 500 million cells - Sucralfate 1 gram tablet - Sulfasalazine 500 mg tablet - Sertraline 100 mg tablet - Oxycodone Acetaminophen 10-325 mg tablet Review of Resident #24's MAR revealed the following: - Amiodarone 200 mg - Give 1 tablet by mouth every morning and at bedtime related to personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits in the morning and before bedtime. The medication was held for Vitals outside of parameters for administration. The order did not reveal any parameters to hold the medication. - Probiotic Oral Capsule (Saccharomyces boulardii) - Give 1 capsule by mouth every 12 hours for Urinary Tract Infection (UTI). - Gabapentin 100 mg- Give 1 capsule by mouth three times a day for neuropathy. Review of Resident #24's progress notes revealed on 4/24/24 at 9:36 a.m., (thirty-six minutes after hour before/hour after) Staff N had notified MD of the late administration of Gabapentin which the MD stated ok, no new orders was obtained. The progress note did not reveal the physician was notified of holding Amiodarone due to pulse. According to Webmd.com (accessed on 4/26/24), Saccharomyces boulardii (S. boulardii) is a type of probiotic (friendly organism). It's a yeast that is actually a strain of Saccharomyces cerevisiae. Review of Webmd.com revealed Lactobacillus acidophilus (L. acidophilus) is a type of probiotic (good bacteria) found in the human gut, mouth, and vagina, and also in certain foods. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24 at 1:07 p.m. the Director of Nursing revealed liking that Staff N had held the Amiodarone, and when holding a medication, (staff should) contact the physician and ask if they want to continue to hold. The DON stated the Lactobacillus (administered) was not the same medication as Saccharomyces (ordered). The policy - Medication Administration, reviewed 5/24/23, revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, any manner to prevent contamination or infection. The compliance guidelines included the following: 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc) with MAR to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Class III

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49497 Based on interviews and record review, the facility failed to ensure physician ordered lab work was completed accurately and in a timely manner for one resident (#33) out of five sampled residents. Findings included: Review of Resident #33's Power of Attorney (POA) correspondence on 04/20/24 at 12:20 p.m. revealed she made nursing staff aware of Resident #33 not acting herself and requested urinalysis (UA) be completed due to resident's history of recurrent urinary tract infections (UTI). The medical record revealed it took over a week to have the UA completed and when it was, the culture and sensitivity (C&S) was not requested as ordered and had to be redone, delaying treatment. An interview was conducted on 04/25/24 at 10:43 a.m. with the Director of Nursing (DON). She stated the process for receiving physician orders is I expect any order to be acted upon immediately, documented and followed through when received. She said if the resident refused the lab there needs to be documentation in the medical record explaining the reason for refusal. She stated she and the doctor are to be notified. She stated the order was missed for Resident #33's UA and it should have been addressed on 04/05/24 the day the order was received along with the request for C&S to ensure no delay in treatment. An interview was conducted on 04/25/24 at 11:16 a.m. with Staff N, Licensed Practical Nurse (LPN). She stated when she receives any order from the doctor or nurse practitioner she puts the order in the system immediately. She said she fills out a lab sheet in the lab book to schedule pick up, typically within 24 hours. She said if it is a stat (urgent) lab request, then she puts it in for immediate pick up. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses to include dementia, other persistent mood disorders, and anxiety disorder. Review of the Medication Administration Record (MAR) for April 2024 revealed: -04/24/24 11:17 AM 04/23/24 11:59 AM Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 100 mg by mouth two times a day for ENTEROCOCCUS FAECALIS for 5 Days. Review of a physician order by hospice on 04/05/24 showed UA [urinalysis] and C&S [culture and sensitivity]. Review of lab orders showed urinalysis completed on 04/11/2024 and urinalysis with reflex to culture/urine culture completed on 04/16/24. Review of a hospice note, dated 04/05/24, revealed Received order for UA and C&S; order faxed to facility. Review of the nurse's progress notes revealed: (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/24 Resident presents confusion and agitation. Ativan re-ordered for anxiety. Urine sample re-collected via straight catheter, approximately 30 cc moderate orange color urine collected. Resident tolerated well. sample placed in sterile specimen cup with name, DOB [date of birth], date, and time on the label. Placed in bio room refrigerator for lab p/u [pick up]. Requisition for lab completed and entered in to book. Residents remain afebrile with dysuria reported. Will pass on in report for f/u [follow up]. On 04/11/24 Hospice order received for UA C&S; straight catheter due to dysuria. 40 cc moderate yellow urine collected via straight catheter. Tolerated well. Urine sample placed into sterile specimen cup with name, date, DOB, time on label. Placed in bio room refrigerator for lab p/u. will pass on in report for f/u. Review of Physician Services policy and procedure dated 01/03/24 revealed: -A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the resident 's immediate care and needs. -All physician or other health care professional verbal orders, including telephone orders, will be immediately recorded, dated and signed by the person receiving the order. -All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during the shift.

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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. 41015 Based on record review, observations, and interviews, the facility failed to store, prepare and appropriately document food temperatures in accordance with professional standards for food service safety in the facility kitchen area. Findings included: An observation on 04/22/24 at 7:00 a.m., revealed a walk in refrigerator that had bag of orange shredding solid substance and a metal container of fruit like half moon shaped substance not labeled or dated. Further observation showed a head of lettuce in a bag that was brownish/red color, a cucumber in a bag that when picked up has a mushy like feeling and an additional bag of lettuce that was left open to air and not properly sealed for food storage safety. (Photographic evidence obtained.) During an interview on 04/22/24 at 7:05 a.m., Staff H, Dietary Aide (DA) stated all food in the walk in refrigerator should be labeled and dated before storage. Staff H, DA stated the head of lettuce was turning and should have been thrown away and the cucumber was rotting and would also needed to be thrown away. Staff H, DA stated the fruit in the metal container was peach crisp that would be used today for lunch but the metal container should have been labeled and dated. An observation of the East Dietary Pantry on 04/22/24 at approximately 12:00 p.m., showed a pizza box that was not labeled and dated and a container of 46 flowing ounces of Prune juice with a use by date of 02/17/24. Photographic evidence obtained. An observation on 04/23/24 at 11:35 a.m., revealed Staff J, Dietary Manager (DM) preparing Residents' food trays on the tray line. During an interview on 04/23/24 at 11:35 a.m., Staff J, DM stated he took the food temperatures already and the spaghetti was 175 degrees, the spaghetti sauce was 175 degrees and the green beans were 170 degrees. Review of the facility's 04/23/24 lunch food temperature log showed no food temperatures were documented. An interview on 04/23/24 at 11:40 a.m., Staff J, DM stated he did not document the lunch food temperatures on the temperature log during completion. During an interview on 04/23/24 at 11:35 a.m., Staff I, Regional Dietary Consultant (RDC) stated the practice of not recording the food temperatures in the log book while tempting food was not the best practice. Staff I, RDC stated Staff J, DM had only been recently hired about a week ago and he would be sure to re-educate Staff J, DM on the best practices for the food tempting process. The RDC also confirmed all food located in both the walk in refrigerator in the kitchen area and all refrigerators in the pantries should be labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy Use and Storage of Food brought in by Family or Visitor with revised date 01/2023 revealed: Policy: It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. Policy Explanation and Compliance Guidelines: 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator b. The prepared food must be consumed by the resident within 3 days c. If not consumed within 3 days, food will be thrown away by the facility staff. d. The facility will not be responsible for maintaining and reusable items. Review of the facility's policy Food Storage: Cold dated October 2019, revealed, Policy Statement: It is the center policy to all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code. Action Steps .4. The Dining Services Director/Cook(s) insures that an accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures is recorded. 2. The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observation, interview, and record review, the facility failed to provide Quality Assurance and Performance Improvement (QAPI) practice that demonstrated identification, monitoring and implementation of an effective action plan to correct citations related to: 1.) failing to ensure a medication administration error rate of less than five percent. A total of ten medication administration opportunities were observed with two errors for one (Resident #8) of three residents observed. This resulted in a medication administration error rate of 20% (F759) and 2.) failed to ensure proper storage, labeling and dating of food and beverages in accordance with professional standards for food service safety in one pantry (East) of two pantries and one of one facility kitchen (F812) during the revisit survey conducted [DATE] to [DATE]. Findings included: 1.) A review of Resident #8's medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease and metabolic encephalopathy. A review of Resident #8's physician orders revealed an order, dated [DATE] for insulin glargine 100 units per milliliter (ml) via (brand name) pen injector, inject 40 units subcutaneously every morning and at bedtime for a diagnosis of type 2 diabetes mellitus. Resident #8's physician orders also revealed an order, dated [DATE] for insulin lispro 100 units per ml via pen injector, inject 18 units subcutaneously before meals and at bedtime for a diagnosis of type 2 diabetes mellitus. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of medication administration was conducted on [DATE] at 9:46 AM on the facility's Recovery Hall with Staff A, Licensed Practical Nurse (LPN). After removing Resident #8's insulin glargine pen injector from the medication cart, Staff A, LPN dialed the dosage selector on the injector pen to 2 units and pressed on the plunger without attaching an insulin needle to the pen injector. Staff A, LPN performed the same procedure with Resident #8's insulin lispro pen injector, dialing the dosage selector on the injector pen to 2 units and pressing on the plunger without attaching an insulin needle to the pen injector. Staff A, LPN also removed two insulin pen injector needles and alcohol preparation pads from the medication cart. Staff A, LPN cleansed the top of each of the insulin pen injectors with alcohol and applied an insulin needle to each pen injector. Staff A, LPN gathered the pen injectors and entered Resident #8's room. After explaining the procedure to the resident, performing hand hygiene, and donning clean gloves, Staff A, LPN dialed the dosage selector on the insulin glargine injector pen to 40 units and administered the insulin to Resident #8. Staff A, LPN dialed the dosage selector on the insulin lispro injector pen to 18 units and administered the insulin to Resident #8. After removing the gloves, disposing of the needles in the sharps container, and performing hand hygiene, Staff A, LPN exited Resident #8's room. An interview with Staff A, LPN was conducted following the observation. Staff A, LPN stated the purpose of priming the insulin injector pen was to ensure there were no air bubbles in the insulin pen prior to injecting the insulin to the resident. Staff A, LPN demonstrated again how to prime the insulin injector pen by dialing the dosage selector on the injector pen to 2 units and pressing on the plunger without attaching an insulin needle to the pen injector. Staff A, LPN addressed there was no way for air bubbles to escape the insulin pen injector without attaching an insulin needle and stated she was not aware a needle needed to be applied to the injector pen prior to priming the insulin injector pen. After the interview, Staff A, LPN attached an insulin needle to the insulin pen injector and primed the insulin injector pen by dialing the dosage selector on the injector pen to 2 units and pressing on the plunger. After pressing on the plunger to the injector pen and observing insulin come out of the insulin needle Staff A, LPN stated that does make more sense. Staff A, LPN stated she had been employed at the facility for just under two months and did not remember receiving education related to the use of insulin pens. An interview was conducted on [DATE] at 1:41 PM with the facility's Nursing Home Administrator (NHA) and Director of Nursing (DON). The NHA stated following the survey completed on [DATE], the facility's Interdisciplinary Team (IDT) met to discuss the findings of the survey and areas of concern identified by the survey team. The IDT discussed what immediate corrections needed to take place, education needing to be initiated, and audits needing to be implemented following the survey. The DON stated the main concern related to the F749 citation was related to the priming of the insulin pens prior to administration of insulin. The DON also stated the facility's pharmacy staff conducted education with the nursing staff to ensure they knew how to prime the insulin pens. The DON stated insulin injector pens should be primed prior to administration by applying the needle to the pen injector, dialing the dosage selector on the injector pen to 2 units and pressing on the plunger. The DON also stated it would not be correct to prime the insulin injector pen before applying the needle to the injector pen. A review of the facility policy titled Insulin Pen, last revised on [DATE], revealed under the section titled Policy it is the policy of the facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. The policy also revealed under the section titled Policy Explanation and Compliance Guidelines the procedure for using the insulin pen: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Gather supplies needed. - Perform hand hygiene. - Don gloves. - Verify resident identification using picture, ID bracelet, verbally, etc. - Examine the appearance of the insulin. - Attach pen needle: remove the pen cap from the insulin pen, wipe the rubber seal with an alcohol pad, screw the pen needle onto the insulin pen, and twist open and remove the outer cover from the pen needle. - Prime the insulin pen: dial 2 units by turning the dose selector clockwise, with the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. - Set the insulin dose. - Inject the insulin. - Remove gloves and perform hand hygiene. - Document the dosage, site, and time in the medication record along with nurse signature. 50570 2.) An observation on [DATE] at 10:25 a.m. revealed a walk-in refrigerator with a bag of lettuce heads with no open date or labeling and a quarter-size rip in the plastic packaging. An observation of the bag of lettuce heads revealed one lettuce head had a mushy, dark brown spot. Staff B, Certified Dietary Manager (CDM) observed the bag with the lettuce heads and stated he had not previously observed the rip or dark brown spot; he proceeded to discard the entire bag. Further observation of the walk-refrigerator revealed a half gallon of half and half milk with an expiration date of [DATE]. The Staff B, CDM observed the milk, read the date out loud and proceeded to discard the milk. Observations of the dry storage area revealed bread loaves with no opened date. Staff B, CDM stated he usually labeled when the bread was received and opened. Staff B, CDM pointed to the container holding various loaves of bread which revealed a blank label. He stated he didn't know why it was not labeled. Staff B, CDM proceeded to discard some bags and loaves of bread with no date of when they were received or opened. Further observation of the dry storage area revealed unlabeled, dry cereal bags that were not in their original packaging. Staff B, CDM proceeded to discard them and stated they should have been labeled with the date they were opened. An interview on [DATE] at 10:44 a.m. with Staff B, CDM revealed there are two dietary pantries. He stated he checks the East and [NAME] dietary pantry every day or every other day. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on [DATE] at 10:50 a.m. of the East dietary pantry revealed one carton of thickened orange juice and one carton of thickened cranberry juice with no labeling of when they were opened. Staff B, CDM proceeded to discard them and stated they were open and didn't have a date of when they were opened. (Photographic Evidence Obtained). An observation of the East dietary pantry refrigerator revealed multiple food and beverages with no label or date to include applesauce, hazelnut creamer, [vendor name] juice, and a [vendor name] cup of macaroni and cheese. (Photographic Evidence Obtained). An observation of the East dietary pantry freezer revealed a burrito with a use by date of [DATE]. (Photographic Evidence Obtained). Observation of the East dietary pantry counter revealed hamburger buns with no label of who it belongs do. (Photographic Evidence Obtained). An interview on [DATE] at 1:55 p.m. with Staff B, CDM and Staff C, CDM in the East dietary pantry revealed the items that were not labeled, dated or expired should be thrown away. The CDMs proceeded to discard the items observed with no label or date. Staff C, CDM stated the expectation is for CDMs to check the pantry refrigerator and freezer more often since the nursing staff are the ones who put the items in the refrigerator and freezer. Staff C, CDM stated she checks the pantries in the morning and during the nursing staff change of shift. Staff C, CDM stated the activities department shares the refrigerator as well and the creamer most likely belonged to them. An interview on [DATE] at 9:55 a.m. with Staff C, CDM revealed she conducts a daily walk through of the freezer, cooler and dry storage. Staff C, CDM stated during stock and delivery days she is hands-on and assists staff with dating and putting away items using the first in, first out (FIFO) method. Staff D, Regional Director of Operation (RDO)/CDM, was present during the interview and initially stated Staff B, CDM was supposed to be completing daily audits and reporting his findings to the Nursing Home Administrator (NHA). During the interview, Staff D, RDO/CDM, corrected himself and stated the expectation was that Staff B, CDM should be conducting weekly audits since the last annual survey. He stated the NHA started that process with Staff B, CDM and they planned the corrections and audits together. A review of the in-service signature sheet revealed the topic as, Temperature Control for Safety (TCS) food labeling, cold storage, dated ,d+[DATE], and signatures of staff who received the in-service. A review of the facility's policy titled, Food Storage: Cold, dated [DATE], revealed Policy Statement: It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the Food and Drug Administration (FDA) Food Code. Action Steps .5. The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. A review of the facility policy titled Quality Assessment and Assurance Committee, last revised on [DATE], revealed under the section titled Policy the facility will maintain a Quality Assessment and Assurance (QAA) committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through an interdisciplinary approach.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observations, interviews, and record review, the facility failed to implement facility wide procedures to maintain a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. 1) The facility failed to ensure hand hygiene was provided to five residents (#416, #102, #100, #97, and #22) prior to meal service out of five residents sampled. 2) The facility failed to ensure two residents (#214 and #416) was identified as isolation precautions at the room entrance out of two residents sampled. 3) The facility failed to ensure nebulizer masks were stored in appropriate storage bags for two residents (#16 and #48) of three residents reviewed for appropriate storage of nebulizer masks. 4) The facility failed to ensure reusable equipment was cleaned for two residents (#67 and #93) out of six residents sampled during medication pass. 5) The facility failed to ensure one resident (#214) out one resident with a catheter was stored in a sanitary manner. Findings included: 1) An observation on 04/22/24 at 8:16 a.m., revealed the morning breakfast tray pass for rooms 40- 52. Staff were not observed offering or providing any form of hand hygiene to residents prior to meal service. An observation on 04/22/24 at 11:33 a.m., revealed the preparation of lunch service in the dining room. There were four staff in the dining room assisting residents with hydration. Staff were not observed offering or providing hand hygiene to residents. An observation on 04/22/24 at 11:50 a.m., revealed staff in the dining room served nine residents food trays. Staff were not observed offering or providing hand hygiene to residents. During an interview on 04/22/24 at 12:45 p.m., Resident #416 stated, I was not offered hand hygiene before breakfast or lunch today. Resident #416 stated, I have never been offered hand hygiene here at the facility at all. A review of the Admission Record revealed Resident #416 was admitted to the facility on [DATE] with diagnoses that included Type II Diabetes Mellitus, Chronic Respiratory Failure, Presence of right artificial knee, Chronic Obstructive Pulmonary Disease and extended spectrum beta lactamase (ESBL) resistance. Review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #416 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). During an interview on 04/22/24 at 12:49 p.m., Resident #102 stated, No I have have never been offered any hand hygiene before meals. A review of the Admission Record revealed Resident #102 was admitted to the facility on [DATE] with diagnoses that included acute Diastolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Recurrent Moderate, Muscle Weakness and Unspecified Lack of Coordination. Review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #102 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/25/24 at 9:10 a.m., Resident #100 stated, No hand hygiene has never been offered to me since I have been here. A review of the Admission Record revealed Resident #100 was admitted to the facility on [DATE] with diagnoses that included Parkinsonism, Type II Diabetes, Pain in right shoulder, Cellulitus of left lower limb, Muscle weakness, Heredity and Idiopathic neuropathy and the need for assistance with personal care. Review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). During an interview on 04/25/24 at 9:15 a.m., Resident #97 stated, I have never been asked if I wanted hand hygiene. Resident #97 confirmed, she had never been provided hand hygiene before meals. A review of the Admission Record revealed Resident #97 was admitted to the facility on [DATE] with diagnoses that included Arthrodesis, Cellulitus, a breakdown (mechanical) of internal fixation of bones of foot and toes, unspecified fracture of unspecified lower leg, encounter for closed fracture with routine healing, Unspecified abnormalities of gait and mobility, lack of coordination and Neuralgia and Neuritis. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). During an interview on 04/25/24 at 9:20 a.m., Resident #22 stated, he had never been asked or offered hand hygiene before meals. A review of the Admission Record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses that included Peripheral Vascular Disease, Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Acute Pulmonary Edema, Type II Diabetes Mellitus, Muscle Weakness and Lack of coordination. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). During an interview on 04/25/24 at 9:25 a.m., Staff D, Certified Nursing Assistant (CNA) stated, they were supposed to provide hand hygiene to residents before and after meals. During an interview on 04/25.24 at 9:30 a.m., Staff E, Certified Nursing Assistant (CNA) stated she sometimes provided hand hygiene to residents. Staff E, CNA stated she made sure resident's hands that were visible dirty or sticky after meals were provided hand hygiene. During an interview on 9:35 a.m., Staff F, Certified Nursing Assistant (CNA) stated, I provide hand hygiene when the resident asks me, when I assist them to the restroom and when they are visibly dirty. During an interview on 04/25/24 at 3:44 p.m., the Director of Nursing (DON) stated that all residents should be provided hand hygiene prior to meals. Review of the facility's policy Hand Hygiene reviewed date on 05/21/22 showed, Policy: Staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors . The Hand Hygiene Table showed before and after eating soap and water hand hygiene should be performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 04/22/24 at 9:05 a.m., revealed Resident #416's room had no transmission based precautions signage posted on the door and no personal protective equipment (PPE) located near the door. During an interview on 04/22/24 at 9:05 a.m., Resident #416 stated, she had a pressure ulcer on her right heel. A second observation on 04/22/24 at 10:26 a.m., revealed Resident #416's room had no transmission based precautions signage posted on the door and no personal protective equipment (PPE) located near the door. An observation on 04/22/24 at 10:26 a.m., revealed Resident #416's pressure ulcer located on the right heel. Resident #416 had a black non-skid sock over the right foot and Staff C, Certified Nursing Assistant (CNA) removed the black non-skid sock for the observation. A review of the Admission Record revealed Resident #416 was admitted to the facility on [DATE] with diagnoses that included Type II Diabetes Mellitus, Chronic Respiratory Failure, Presence of right artificial knee, Chronic Obstructive Pulmonary Disease and extended spectrum beta lactamase (ESBL) resistance. Review of a physician order, dated 04/11/24, revealed, Contact Isolation. A review of the Medicare 5-Day Minimum Data Set (MDS), dated [DATE], revealed Resident #416 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). A review of the medical record page under physicians orders showed Special Instructions: Contact Isolation: [Extended Spectrum Beta-Lactamase] ESBL in urine. During an interview on 04/24/24 at 10:50 a.m., Staff A, Licensed Practical Nurse (LPN) stated Resident #416 was on Contact Precautions for ESBL and once the precautions were discontinued Resident #416 discharged on [DATE]. Staff A, LPN stated if a Resident had an active order for contact precautions or any other transmission based precautions, it was expected there be a sign on the door and PPE available at the door. During an interview on 04/24/24 at 1:30 p.m., Staff C, Certified Nursing Assistant (CNA) stated, I identify residents on transmission based precautions by the sign on the door and the PPE available in the bin outside the door. Staff C, CNA stated she was aware Resident #416 was on contact precautions because this information was given to her in morning report. Staff C, CNA stated she was aware Resident #416 was on contact precautions for ESBL in the urine and because she did not touch her urine she knew she was good when pulling her sock off on 04/22/24. Review of the facility's policy Transmission- Based (Isolation) Precautions reviewed date 08/15/2022 showed, 8. Contact Precautions- a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Make decision regarding private room on case-by-case basis, balancing infection risks to other residents, the presence of risk factors that increase the likelihood of transmission, and the potential of adverse psychological impact on the infected or colonized resident. c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the residents or potentially contaminated areas in resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. e. Resident experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggested an increased potential for an extensive environment before a specific organism has been identified. f. Contact precautions will be used for residents infected or colonized with [Multi-drug Resistant Organism] MDROs in the following situations: i- When a resident has wounds, secretions, or excretion that are unable to be covered, or contained; and ii- On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring. An observation on 04/22/24 at 8:25 a.m., revealed Resident #16's nebulizer mask sat on the nightstand next to Resident #16's bed beside the nebulizer machine. The nebulizer mask was not in the stored properly in the storage bag that hung on the nightstand right below the nebulizer machine. Photographic evidence obtained. An observation on 04/22/24 at 10:07 a.m., revealed Resident #48's nebulizer mask sat on the bedside table next to Resident #48's bed beside the nebulizer machine. The nebulizer mask was not stored properly in the storage bag that hung on the nightstand. Photographic evidence obtained. An observation on 03/23/24 at 10:00 a.m., revealed Resident #16's nebulizer mask sat on the nightstand next to Resident #16's bed beside the nebulizer machine. The nebulizer mask was not in the stored properly in the storage bag that hung on the nightstand right below the nebulizer machine. An observation on 04/23/24 at 10:10 a.m., revealed Resident #48's nebulizer mask sat on the nightstand next to Resident #48's bed beside the nebulizer machine. The nebulizer mask was not stored properly in the storage bag that hung on the nightstand right below the nebulizer machine. An observation on 03/24/24 at 12:43 p.m., revealed Resident #16's nebulizer mask sat on the nightstand next to Resident #16's bed beside the nebulizer machine. The nebulizer mask was not stored properly in the storage bag that hung on the nightstand right below the nebulizer machine. Photographic evidence obtained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 04/24/24 at 12:46 p.m., revealed Resident #48's nebulizer mask sat on the nightstand next to Resident #16's bed beside the nebulizer machine. The nebulizer mask was not stored properly in the storage bag that hung on the nightstand right below the nebulizer machine. Photographic evidence obtained. During an interview on 04/24/24 at 12:50 p.m., Staff A, Licensed Practical Nurse (LPN) stated nurses were responsible for storing all unused nebulizer masks into the storage bags after treatment. Staff A, LPN stated Resident #48 did not wish to have the nebulizer mask placed in the storage bag and refused. Staff A, LPN stated any resident who refused to have their nebulizer mask placed in the storage bag would have a care plan for refusal. Staff A, LPN stated Resident #48 was not care planned for the refusal of nebulizer mask storage yet. Staff A, LPN stated Resident #16 had never refused to have the nebulizer mask stored in the storage bag so the mask should be been placed in the storage bag after treatment was administered. During an interview on 04/24/24 at 12:55 p.m., Resident #48 stated that she had never refused to have the nebulizer mask placed in the storage bag. Resident #48 stated, There would be no reason why I wouldn't want it in the bag. Resident #48 stated staff have never stored the nebulizer mask in the bag, it was just always stored in open are next to the nebulizer machine. A review of the Admission Record revealed Resident #48 was admitted to the facility on [DATE] with diagnoses that included Cellulitus of chest wall, Chronic Obstructive Pulmonary Disease and Type II Diabetes with Diabetic Neuropathy. Review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A review of the facility's policy Nebulizer Therapy reviewed date 12/23/22 showed, Policy: It is the policy of the facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. Policy Explanation and Compliance Guidelines: . Care of Equipment 7. Once completed dry, store the nebulizer cup and the mouthpiece in the zip lock bag. 48223 2) On 04/23/2024 from 7:30 AM to 8:30 tray pass observation of breakfast for the residents in their rooms for all six wings, staff did not offer resident's hand hygiene prior to leaving the room after tray set up. On 04/23/2024 at 12:35 PM to 12:50 PM, tray pass observation of lunch for the residents in their rooms for the Heritage Wing, staff did not offer resident's hand hygiene prior to leaving the room after tray set up. An interview was conducted with Staff A, Certified Nursing Assistant (CNA) on 04/23/2024 at 7:50 AM. Staff A, CNA stated, I did not offer hand sanitation to the residents when I pass trays, I never thought about it. An interview was conducted with Staff D, CNA on 04/23/2024 at 8:15 AM. Staff D, CNA stated, no hand hygiene was provided to residents when passing trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with Staff CC, CNA on 04/23/2024 at 7:50 AM. Staff CC, CNA stated, no hand hygiene was provided to residents when passing trays. An interview was conducted with Staff E, CNA on 04/23/2024 at 8:25 AM. Staff E, CNA stated, no hand hygiene was provided to residents when passing trays. An interview was conducted with Staff C, CNA on 04/23/2024 at 7:50 AM. Staff C, CNA stated, no hand hygiene was provided to residents when passing trays. An interview was conducted with Staff B, License Practical Nurse, (LPN) on 04/23/2024 at 8:25 AM. Staff B, LPN stated, no hand hygiene was provided to residents when passing trays. 37999 3) On 4/22/24 at 7:22 a.m., an observation was made of the room for Resident #214. A Personal Protective Equipment (PPE) caddy was hanging from the door which was posted with one sign Please Stop, See Nurse Before Entering, Thank You. The observation revealed the caddy held one box of large gloves and one box of medium glove, and no other PPE. The sign on door did not reveal the type of precautions staff or visitors should observe when entering the resident's room. An unknown staff member brought gowns to the caddy reporting (Resident #214) had MRSA. The staff member reported the resident was under contact precautions and required staff to wear gowns, gloves, and mask. On 4/23/24 at 11:31 a.m., Resident #214's room continued to have a PPE caddy hanging from the door without signage showing the type of precaution staff/visitors should observe when entering the room. On 4/23/24 at 10:08 a.m, an observation revealed Resident #214's urinary catheter drainage bag attached to the bed frame which was in the lowest position and was lying on the floor. An observation and interview was conducted with Staff Q, Certified Nursing Assistant (CNA) on 4/23/24 at 11:49 a.m., the staff member confirmed the catheter was on the floor due to the bed being in the low position and began raising the bed till the catheter was no longer on the floor. Review of Resident #214's Admission Record showed the resident had been admitted on [DATE] and included a diagnosis of Methicillin Resistant Staphylococcus Aureus infection as the cause of disease classified elsewhere. Review of Resident #214's Clinical Physician Orders, showed the resident was to be observed and cared for under Contact precautions, revised on 4/23/24. The dashboard special instructions revealed Contact Precautions through 4/25 then Enhanced Barrier Precautions. A physician order, dated 4/24/24 at 3:00 p.m. revealed Enhanced Barrier Precautions every shift for Peg Tube. The facility provided a list of residents on Transmission-Based Precautions which included one resident, Resident #214. Review of Resident #214's care plan showed the following concerns with associated interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105320	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dade City Health and Rehabilitation Center	37135 Coleman Ave Dade City, FL 33525

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident #214 has active infection' g-tube site, initiated 4/14/24. The interventions included: Observe facility policies for infection control. The care plan did not document the resident's urinary catheter. Review of the policy - Catheter Care, revised 1/6/23, revealed It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. The policy did not show how the catheter bag should be stored. During an interview on 4/25/24 at 11:16 a.m., the Infection Preventionist (IP) stated a urinary catheter soul be in a privacy bag and not on the floor, should be clipped to the frame of the bed, never on the floor but can be stored in a basin (sitting on floor). The IP stated PPE should be available in the door caddy at all times, when running low, we can restock, and the type of precaution should be posted on the resident's door. Photographic evidence was obtained. On 4/23/24 at 4:51 p.m., Staff O, Licensed Practical Nurse (LPN) was observed preparing and administering medications with Resident #67. The staff member removed a manual blood pressure cuff and stethoscope from the cart and entered the resident's room. Staff O attempted to place the cuff around the upper left arm of resident, revealing it did not fit, the staff member placed the cuff above the left wrist obtaining a blood pressure of 124/74. The staff member returned to the medication cart in the hallway and placed both the cuff and stethoscope on the medication cart. Staff O administered insulin and oral medications to the resident before returning to the cart. On 4/23/24 at 5:07 p.m., the observation of medication administration continued with Staff O. The staff member dispensed medications for Resident #93, removed the previously manual cuff and stethoscope from the end of the medication cart, and entered the resident room. The staff member assisted resident with medications, placed cuff on left upper arm, laid meter on the underpad next to the resident and obtained a blood pressure of 101/60. The staff member returned to the cart and laid the cuff and stethoscope on the handle of the medication cart. An interview was conducted on 4/23/24 at 5:27 p.m. with Staff O after the administration of medications with Resident #93. The staff member confirmed not cleaning the manual cuff or stethoscope in between using them for Resident #67 and #93. During an interview on 4/25/24 at 11:16 a.m, the IP stated the blood pressure cuff and stethoscope should be cleaned between residents. Review of the policy - Transmission-Based (Isolation) Precautions, revised 8/15/22, revealed It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. The compliance guidelines revealed: 7. Initiation of Transmission-Based Precautions (Isolation Precautions)- (continued on next page)

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	105320	A. Building B. Wing	04/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the Centers of Disease Control and Prevention (CDC) category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage. f. The facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. g. Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use. 8. Contact Precautions- c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. The policy - This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The compliance guidelines revealed All reusable items and equipment requiring special cleaning, disinfection, or sterilization be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a Compliance and Ethics Program. 41015 Based on observations, interviews, and record review, the facility failed to ensure the accuracy of documentation presented for two of two pantry refrigerator temperature logs. Findings included: An observation on 04/22/24 at 11:30 a.m., revealed a Refrigerator/Freezer temperature log that hung on the wall next the free standing refrigerator in the [NAME] Dietary Pantry. The temperature log was incomplete with blank spaces on the form for the dates 04/05/24-04/14/24 and 04/16/24- 04/21/24. Photographic evidence obtained. An observation on 04/22/24 at approximately 12:00 p.m., revealed a a Refrigerator/Freezer temperature log that hung on the refrigerator in the East Dietary Pantry. The temperature log was incomplete with blank spaces on the form for the dates of 04/06/24, 04/12/24, 04/13/24, 04/17/24, 04/18/24 and 04/19/24. An observation on 04/22/24 at 10:30 a.m., revealed the Refrigerator/Freezer temperature log located in the East Dietary Pantry was now fully completed with no blank spaces. Photographic evidence obtained. An observation on 04/23/24 at 12:05 p.m., revealed the Refrigerator/Freezer temperature log located in the [NAME] Dietary Pantry was now fully completed with no blank spaces. Photographic evidence obtained. During an interview on 04/23/24 at 4:52 p.m., the Director of Nursing (DON) stated it was the facility's nursing staff who were responsible for completing the refrigerator/freezer temperature log daily for the pantries. The DON reviewed the photographic evidence of the two pantry temperature logs with discrepancies. The DON stated the temperature logs should not have been completed with the blank spaces filled in, and the nursing staff should be completing them daily. The DON stated her staff should not completed the temperature logs, if they were not already completed. Review of the facility's policy, Principles and Rules of Conductwith reviewed date 01/01/2024 revealed: Employee Conduct: - Professional Standards- You are always expected to adhere to the highest professional standards. This includes behaving in a professional manner during work and at work related events. - Honest Communication: Lilac Health Group requires honesty from individuals in the performance of their responsibilities and in communication with the Lilac Health Group. No employee or contractor shall make a false or misleading statement. Each supervisor and manager are responsible for ensuring that the personnel within their supervision are acting ethically and in compliance with applicable law and this Code.