STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105371	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Nursing Center	3075 NW 35th Ave Lauderdale Lakes, FL 33311

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to treat residents in a dignified manner for 3 of 3 sampled residents during mealtime observations, Resident #140, Resident #75, and Resident #100; and failed to provide grooming for 1 of 1 sampled resident, Resident #139. The findings included: 1. In an observation conducted on 01/13/25 at 12:22 PM, Staff H, Certified Nursing Assistant (CNA), was passing the lunch tray on the 2nd floor South unit. She turned to another staff member on the unit and said, She is a feeder. A few minutes later, at 12:27 PM, Staff I, CNA, asked another staff member, How many feeders do we have? 2. Continued observation on the 2nd floor South unit at 12:30 PM revealed Staff I stated to another staff member, She is a feeder as well. She then turned to the surveyor and said, I need to wait with some of the trays in the meal cart because I need to finish feeding the other residents. 3. In an observation conducted on 01/13/25 at 12:22 PM, Resident #140's roommate ate her lunch while Resident #140 waited. At 12:40 PM, Resident #140's roommate finished her lunch meal while Resident #140 was still waiting on her lunch tray. At 12:50 PM, no lunch tray was noted for Resident #140. At 12:55 PM, about 35 minutes later, the lunch tray was brought to Resident #140. 4. Record review revealed Resident #75 was admitted to the facility on [DATE] with diagnoses of Weakness, Anemia, Failure to Thrive, Sacral Wound, Iron Deficiency and Dementia. The admission 5-day Minimum Data Set (MDS) assessment dated [DATE] documented Resident #75 has a Brief Interview Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Section GG for eating showed that Resident #75 needed partial to moderate assistance during eating. In an observation conducted on 01/13/25 at 5:02 PM, Staff B, Certified Nursing Assistant, was standing over Resident #75 while feeding him the dinner meal. A continued observation at 5:45 PM showed Staff C, sister, standing over Resident #75 while feeding him the dinner meal. In an interview conducted on 01/16/25 at 7:45 AM, Staff J, Certified Nursing Assistant, stated that when assisting a resident during mealtimes, she needs to sit down at eye level while feeding the resident. She further said that she uses the word Feeder only when she talks to other staff members. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 01/16/25 at 11:00 AM with the Administrator, she was informed of the above findings. 50370 5. Record review documented Resident # 100 was admitted on [DATE] with diagnoses including Unspecified Dementia, Diabetes Mellitus, Gastroesophageal Reflux Disease, Hypertension, Benign Prostatic Hypertrophy, and Unspecified Psychosis. Review of quarterly Minimum Data Set (MDS), section C, dated 11/02/24, revealed a Brief Interview for Mental Status Score (BIMS) of 03 indicating severe mental impairment. Review of physician orders dated 01/01/25 revealed an order for regular dietary restrictions, and a radiology test for peg (percutaneous endoscopic gastrostomy) tube placement on 01/02/25. Review of dietary notes dated 01/01/25 revealed Resident #100's primary source of nutrition and hydration is from the PEG tube, but receives meals by mouth of the following: dysphagia mechanical, soft liquids, no added salt (NAS), and concentrated sweets (NCS) diet restrictions remain in place. Further review of the Certified Nursing Assistant's (CNA's) notes revealed the resident consumes zero to 25 % of pleasure meals. During a hallway dinner observation on 01/13/25 at 5:20 PM, Staff M, CNA, was going in and out of residents' rooms and was heard calling a resident a feeder. When asked when Resident #100 was going to eat his meal, since the dinner tray had been sitting in front of the resident for 10 minutes, Staff M, CNA stated. He is a feeder; someone has to feed him.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interview and record review, the facility failed to ensure the residents' call devices were in reach for 3 of 33 sampled residents reviewed for call light accessibility, Residents #85, #153 and #51. The findings included: Review of the facility's policy, titled, Call Bells-Lights, effective date 08/12/19 and reviewed date 10/16/24, included the following: Call bells will be available to facilitate care and to enhance safety for all residents. Procedure: 1.Staff will ensure that call buttons are within the reach of the resident at all times. 1. Record review for Resident #85 revealed the resident was admitted to the facility on [DATE] with the diagnoses that included Gastrointestinal Hemorrhage, Dementia, Hypertension, History of Falling, and Diabetes Mellitus. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. Review of Section GG of the same MDS revealed Resident #85 had no upper extremity impairment and was dependent on staff for his activities of daily living (ADLs), including personal hygiene. During the initial observational tour of the facility's 3rd floor conducted on 01/13/25 at 11:11 AM, Resident #85 was observed in his room, in bed. Further observation revealed Resident #85's call light cord was wrapped around the bed rail and the call light button was dangling and not within the resident's reach. Resident #85 was asked if he could reach for the call light. It was observed that Resident #85 was unable to reach and just shrugged his shoulders. Photographic Evidence Obtained. An interview was conducted on 01/16/25 at 10:36 AM with Staff CC, third floor Nurse Manager, who stated she has worked at the facility for 8 years. She stated the nursing staff is aware to clip the resident's call light on the bed to make sure it is accessible for the resident. Staff CC confirmed that staff are not to wrap the call light cord around the bedside rail. At this time, a side-by-side observation was conducted with Staff CC of Resident 85's room. She confirmed Resident #85's call light was wrapped around the bedside rail and the push button was dangling out of reach of Resident #85. 2. Record review for Resident #153 revealed the resident was admitted to the facility on [DATE] with the diagnoses that included Sequelae of Cerebral Infarction, Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), and Type 2 Diabetes Mellitus. Review of Section C of the MDS assessment dated [DATE] revealed Resident #153 had a BIMS score of 11, indicating moderate cognitive impairment. Section GG revealed that Resident #153 had upper extremity impairment on one side and required substantial assistance for ADLs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial observational tour of the facility's 3rd floor conducted on 01/13/25 at 11:15 AM, Resident #153 was observed in bed. Further observation revealed Resident #153's call light cord was wrapped around the bed rail with the call button dangling off the bed and not within the resident's reach, Resident #153 was asked if he could reach the call light button, and he stated no. When asked how often his call light button is unreachable, Resident #153 stated often. Photographic Evidence Obtained. On 01/15/25 at 9:35 AM, an observation was conducted on the facility's 3rd floor and noted Resident #153 in his bed. Again, Resident #153's call light cord was observed wrapped around the bedrail and not accessible to Resident #153. 3. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Sepsis, Urinary Tract Infection, Clonic Hemifacial Spasm, and Acute Kidney Failure. Review of Section C of the MDS assessment dated [DATE] revealed Resident #51 had a BIMS of 08, indicating moderate cognitive impairment. Review of Section GG of the same MDS assessment revealed Resident #51 had upper extremity impairment on one side and requires substantial assistance for some of his ADLs including toileting hygiene. On 01/15/25 at 10:11 AM, an observation was conducted on the facility's 3rd floor and noted Resident #51 sitting in his bed. Further observation revealed Resident #51's call light cord was wrapped around the bed rail and dangling from the bed and was not within the resident's reach. Resident #51 stated he can never find the call light. He stated if he needs something he uses his cell phone to contact his daughter because the call light button is not around. Photographic Evidence Obtained. An interview was conducted on 01/16/25 at 9:27 AM with Staff W, LPN, who stated she has worked for the facility for 4 1/2 years. She stated any staff member can respond to the call lights. Staff W stated the call light cord has a clip that can be used to securely attach the call light button to the sheet or pillow to be within reach and accessible for the resident. An interview was conducted on 01/16/25 at 10:26 AM with Staff AA, Certified Nursing Assistant (CNA), who stated he has worked at the facility for 2 years. He stated call lights are answered as soon as possible, and residents' call light button should be available to the resident to contact someone for help. An interview was conducted on 01/16/25 at 10:32 AM with Staff BB, CNA, who stated she has been working at the facility for [AGE] years. She stated the call light button is to be within reach of the resident and depending on the resident's strong side (left or right). An interview was conducted on 01/16/25 at 10:36 AM with Staff CC, third floor Nurse Manager, who stated she has worked at the facility for 8 years. She stated the nursing staff is aware to clip the resident's call light on the bed to make sure it is accessible for the resident. Staff CC confirmed that staff are not to wrap the call light cord around the bedside rail. An interview wasmconducted on 01/16/25 at 11:09 AM with the Director of Nursing (DON) who was informed of the call lights wrapped around the bedside rails.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on interviews and records review, the facility failed to honor 1 of 22 sampled residents, Resident #130's rights for self-determination, as evidenced by the facility's infringement on Resident #130's right to refuse and discontinue nursing home care services. The findings included: On 01/13/25 at 11:44 AM, Resident #130 stated he was asked in the month of October 2024 to come to the nursing home while his assisted living facility's (ALF) apartment was being renovated. He said that they told him that he would return to the ALF in two months. Yet, he has not heard from anyone, he does not know what is going on, and it has been three months. The resident stated they have ignored all his concerns. Resident #130's electronic record documented the following diagnoses: Chronic systolic heart failure; Hypertensive Heart disease; Bacteremia; Hyperlipidemia; presence of Cardiac Pace Maker; Glaucoma bilateral unspecified and gait abnormalities. On the Brief Interview of Mental Status (BIMS) Resident #130 obtained a score of 15/15. That BIMS score is indicative of someone whose cognitive abilities were intact. An interview was conducted with the Social Services Director (SSD) on 01/14/25 at 03:08 PM to obtain clarification on the cause of Resident #130 being at a nursing home. The SSD stated that Resident #130 would be returning to the ALF tentatively, on Monday, the 20th of January 2025. However, the SSD could not provide the rationale for the resident's admission to the Nursing Home. She said, she did not know why this resident was admitted to the facility. The SSD said, they were processing Resident 130's Medicaid application and he would return to the ALF soon. On 01/14/25 at 03:25 PM, Employee JJ, a Social Worker (SW) informed that Resident #130 was at the facility because of financial reason. Employee JJ said usually when Residents of the ALF, which is owned or operated by the same organization, have their Medicaid cases pending, they transfer them to this nursing home, while the process is ongoing. Employee JJ said she received correspondence from the Business Office Manager (BOM), and the SW from the ALF informing her that Resident #130 was eligible for Medicaid and that he could now go back to his previous residence in the ALF. The SW also said that she did not have any documentation to support the legitimacy of Resident #130 being admitted to the nursing home, other than perhaps the agreement that Resident #130 had signed to be admitted to the nursing home. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee KK, a Resident Navigator, informed on 01/14/25 at 03:43 PM, her role at the nursing home was to tour the nursing home with prospective residents, before and after their admission to the facility. Employee KK also assigned rooms to the residents, and ensured residents signed the admission packet. Employee KK said that she gave Resident #130 a tour of this facility prior to his admission. Employee KK said Resident #130 was transferred to the nursing home because there was some kind of billing issue at the ALF. He came here to wait for his Medicaid approval before he could return to the ALF. Employee KK further stated that she gets a few residents from the ALF who ended up in the nursing home when their funds run out over there in the ALF. She said that Resident #130 agreed to be admitted to the nursing home. Review of the Admission Packet showed Resident #130 was admitted to the facility on [DATE]. He signed the document as presented. The Resident Navigator said that Resident #130 came to the facility by himself since Resident #130 does not have a power of attorney (POA). On 01/14/25 at 04:11 PM, the Director of Nursing (DON) informed she has been working at this facility for three years. she said they have a centralized admission team who screen residents who are supposed to be admitted to this facility. However, she would occasionally screen resident, especially if the resident was going to be admitted for long-term care. She said she screened Resident #130 prior to his admission to the facility and he had gait disorder, memory loss, and history of falls. She said Resident #130 could no longer take care of himself at the ALF, so they transferred him to this facility. Review of the health assessment form (AHCA form 1823) provided by the DON and dated 5/24/2024 documented that Resident #130 did not require 24-hour nursing care. Review of the AHCA form 5000-3008 dated 9/19/2024 and completed by the Resident's Primary Care Physician confirmed that the resident did not require nursing facility placement services but needed Medicaid Waiver services. The DON said that she did not know that the physician had written that information. On 01/15/25 at10:19 AM, Resident #130 said, he never had any falls while in the ALF. The only physical problem he had was a subluxation of his spine many years ago before coming to the facility. Resident #130 said, they have not done anything for him in this nursing home but giving him his medications. He asked how much he would have to pay, for being at the nursing home? They told him they would take it from his account and they would leave some money for him in his account. He said since he was admitted to the nursing home, he never received any mails. Resident #130 said he was paying 1000.00 dollars at the ALF. Every time he wanted to go back to the ALF, they told him he could not go, he needed permission to do so although most of his belongings were left at the ALF. He felt deprived of his rights to handle his personal affairs. Resident #130 said at the ALF, all he had to do was sign out and he could go about his business. But, at the nursing home, he could not do anything. He said that he has been complaining about going back to the ALF for a long time. On 01/15/25 at 10:53 AM, the Physical Therapist (PT) Director said that Resident #130 did not receive any rehabilitation services. He said that he was not familiar with the resident's name. The PT Director said that Resident #130 was only screened for long term care on 11/13/2024. The patient showed no indication that he needed rehabilitation services, said the PT Director. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Business Office Manager (BOM) said on 01/15/25 at10:59 am, that Resident #130 would soon be going back to the ALF. The BOM said that Resident #130's Medicaid application for long-term care was approved. She said she did not open an account for Resident #130's stay in the nursing home because they knew Resident #130 was supposed to go back to the ALF. The BOM said Resident # 130 had a patient liability for the month of October 2024 in the amount of $11423.00 dollars and $1175.00 dollars for the months of November and December 2024. The BOM said they did not expect the Medicaid application to take that long that is why Resident #130 ended up staying so long at the facility. On 01/15/25 at 3:40 PM, the Administrator said that they had obtained other medical assessment/evidence verifying that Resident #130 needed nursing home care services. The Administrator provided a hospital transfer form which was signed by the nursing home Medical Director on 10/4/2024. The Administrator also attested to the fact that Resident #130 had been complaining about his stay at the nursing home. The Administrator acknowledged that Resident #130 wanted to go back to the ALF since he came to the nursing home. The Administrator declared that she was also the assisted living facility's (ALF) Administrator where Resident #130 came from. The Administrator said that the rent increased in the ALF and Resident #130 could not afford the rate increase, when he was transferred to the Nursing Home. However, upon Surveyor intervention, the Administrator decided to send Resident #130 back to the ALF on the same day. She said that she would immediately arrange the transfer of Resident #130 back to the ALF. On 1/16/2025, it was observed that Resident #130 was relocated back to the assisted living facility as he desired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 31746 Based on observation, records review, and interview, the facility failed to provide assistance with Activites of Daily Living (ADLs) for 1 of 22 sampled residents, Resident#139, related to removal of facial hair. The findings included: Review of Resident #139's facesheet and section A of the Minimum Data Set (MDS) assessement documented the resident's admitted to the facility to be 06/08/23.Review of on the Brief Interview for Mental Status (BIMS) for Resiident #139 noted a score of 3 of 15 indicating severe cognitive impairment. Section GG of the MDS. titled Functional Abilities and goals. documented the resident required total assistance for most ADLs. Review of the resident's ADL care plan (CP) dated 02/12/24 documented the resident has self-care deficits as evidenced by her decreased balance and endurance, safety awareness strength, and required maximum assistance with upper body dressing, total assistance with lower body dressing, total assistance with toilet transfer, total assistance with toileting hygiene, due to functional decline related to ADL dysfunction muscle weakness status post (s/p) cerebrovascular aneurysm (CVA). On 01/13/25 at 12:35 PM, Resident #139 was observed with overgrown facial hair under her chin. The resident answered basic questions but could not provide any feedback regarding her personal care needs. In an interview conducted with Staff II, Certified Nursing Assistant (CNA), on 01/13/25 at 1:01 PM, right after exiting Resident #139's room, Staff II said that she has been working at the facility for 2 years. Staff II said she had ten residents assigned to her to assist with activities of daily living (ADLs), of whom Resident #139 was one. Staff II stated Resident #139 had a colostomy bag and could not perform any personal care. Staff II said that she gave Resident #139 a bed bath in the morning and assisted her with oral hygiene care, confirming that she had noticed the resident's overgrown facial hair but took no action. On 01/16/25 at 2:21 PM, a follow-up observation revealed that after a couple of days, Resident #139 was nicely groomed, and the overgrown facial hair was removed. Resident #139 could not say when on that day or the night before she was shaved, nor who might have done it. During an interview with the fourth floor Unit Manager, Staff T, on 01/16/25 at 2:24 PM, he said that he did not know who shaved Resident #139. His interviews with the staff who worked the mornings of 01/15/25 and 01/16/25 provided no definitive answers as to who might have shaved the resident. Until the time of the exit meeting with the facility on 01/16/25 at 5:45 PM, no answer was provided as to who might have shaved the resident between the days of 01/13/25 and 01/16/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to follow Physician orders for urinary care for 1 of 1 sampled resident, Resident # 152, reviewed for urinary care. The findings included: Review of a document, titled, Foley Catheter Care, with policy # 2032, and reviewed on 08/22/22, revealed catheter care will be provided to all residents with indwelling catheters at least daily. An additional statement revealed the purpose of catheter care is to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. Record review documented Resident #152 was admitted on [DATE] with diagnoses that included Atrial Fibrillation, Heart Failure, Benign Prostatic Hypertrophy, Chronic Urinary Retention, Diabetes Mellitus, Thyroid Disorder, Malnutrition, Sacral Wounds, and Asthma. Review of the Minimum Data Set (MDS) assessment, Section C, dated 01/05/25, revealed a Brief Interview for Mental Status (BIMS) score of 10 of 15 indicating moderate cognition impairment. Review of the physician orders dated 12/13/24 revealed: to provide Foley [Inventor's name of a urinary tubing] catheter care for Obstructive Uropathy every shift. Review of the nursing care plan dated 01/10/25 revealed a problem of increased risk for infection related to indwelling catheter due to Obstructive Uropathy. The interventions included to monitor urine for sediment, cloudiness, odor or blood, and to notify MD promptly when changes occur. Record review of the nurses notes dated 01/13/25 at 11:33 AM revealed Staff Q, Licensed Practical nurse (LPN), documented the following: resident poor appetite, assistance with meals, and fluids encouraged. In bed, head of bed (HOB) elevated, weakness and decline. Family aware, will continue to monitor. There was no documentation regarding Foley catheter care for Obstructive Uropathy. Review of the nurses notes dated 01/13/25 at 11: 44 PM revealed another LPN documented the resident in no acute distress, alert to self, and surrounding, assistance with meals, appetite remains poor, per orem fluids encouraged, will continue to monitor. There was no documentation regarding providing Foley catheter care for Obstructive Uropathy. Review of the nurses notes dated 01/14/25 at 10:48 PM revealed the type of Infection: Urinary Tract Infection (UTI), Vital signs: Pulse = 66/min, Temperature = 97.4, blood pressure = 118/68, respiration = regular. There were no notes regarding the color of urine, the urinary tubing, and the urinary bag. An observation on 01/13/25 at 10:25 AM revealed Resident #152's urinary tubing had a reddish tinged color with whitish sediments, and the urinary drainage bag did not have a privacy cover. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/14/25 at 11:25 AM revealed the urinary bag had no privacy covering, and the urine was reddish tinged, both in the tubing and the urinary drainage bag. An additional observation on 01/14/25 at 5:20 PM revealed the urine in the urinary drainage bag and tubing was dark red tinged to dark brown in color, and no privacy bag covering was noted over the urinary bag. Observation on 01/15/25 at 1:24 PM revealed the urine had brownish color inside the urinary drainage bag, and it was covered with blue privacy bag. An observation on 01/16/25 at 9:45 AM revealed a red-orange colored urine in urinary bag, and it was covered with a blue privacy bag. In an interview with Staff Q, LPN, on 01/15/25 at 8:58 AM, when asked if she observed a red colored urinary tubing or urine on resident's urinary catheter, she responded she would document it. She stated she would make sure the Foley catheter was still attached to resident; if resident is male, she would check the penis, the Foley anchor, date, tag and any changes she observed on the urinary tubing, urinary bag and urinary anchor. She added that she would observe for mucus and bleeding. When asked regarding bleeding, she stated she would contact the resident's doctor and notify her or him immediately, would talk to Certified Nursing Assistants (CNAs) and ask them if they notice bleeding or red coloration in urinary tubing and urinary bag. She added that she would document in nurses notes including the date and time red colored urine was observed. She added that she would also document when MD (Medical Doctor) was notified, the orders received from MD, laboratory orders which she would put in the laboratory order book, the date and time she talked with MD, and pass on all information during report to the next shift.

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St Johns Nursing Center	3075 NW 35th Ave Lauderdale Lakes, FL 33311

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to identify weight loss and provide nutritional interventions in a timely manner for 2 of 8 sampled residents reviewed for nutrition, Resident #7, and Resident #140. The findings included: Review of the facility's policy titled Nutrition Assessment and Monitoring, revised on 09/08/24, revealed the following: A systematic approach will be used to optimize a resident's nutritional status. The process includes identifying and assessing each Resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing the effectiveness, monitoring pertinent approaches and interventions, and revising them as necessary. Review of the facility's policy titled Resident Weights reviewed on 10/16/24 showed the following: The Weight Team will be responsible for weighing Residents and entering weight into the EMR. Weight Fluctuations shall be re-weighed and then reported to the Nurse/Dietitian/Diet Tech if there is a +/- 5-pound change in weight. Appropriate Documentation shall be entered into the Resident's Medical Record, and proper interventions shall be implemented. Residents shall be weighed within 24 hours of admission and re-admission; they will be re-weighed again within 24 hours. All admissions and re-admissions are to be weighed for four consecutive weeks after admission. Significant weight deviations of +/- 5 pounds shall be re-weighed within 24 hours and then shall be notified to the Nurse Manager/Dietitian/Diet Tech via Resident weight loss form. The Nurse Manager/Dietitian/Diet Tech shall notify the Physician/ARNP/Physician Assistant in a timely manner. All Resident weight gains or losses shall be properly documented in the EMR. Proper interventions shall be put into place and monitored. All weight deviations are to be brought up at NIPS/Care Plan Meetings and discussed with the Interdisciplinary team. 1. Record review showed that Resident #75 was admitted to the facility on [DATE] with diagnoses to include Weakness, Anemia, Failure to Thrive, Sacral Wound, Iron Deficiency and Dementia. The admission 5-day Minimum Data Set (MDS) assessment dated [DATE] showed that Resident #75 has a Brief Interview Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Section GG for eating showed that Resident #75 needed partial to moderate assistance during eating. Review of the weight log for Resident #75 showed the following: On 01/08/24, a weight of 155.6 pounds. On 11/14/24, a weight of 164 pounds. On 11/22/24, a weight of 156.4 pounds. On 12/08/24, a weight of 144.3 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25, a weight of 136.3 pounds. This showed a significant weight loss of 7.7% from 11/22/24 to 12/08/24 and a significant weight loss of 5.5% from 12/08/24 to 01/08/25. In an interview conducted on 01/13/25 at 4:40 PM, Resident #75 stated that he has a good appetite and that he eats enough. When asked if he was aware that he lost weight he stated, it's because he does not eat much. When asked if he would like nutritional supplements, he said yes. An interview was conducted on 01/13/25 at 5:02 PM, with Staff B, Certified Nursing Assistant (CNA), who stated that Resident #75 usually eats 100% of his meals. In an observation conducted on 01/14/25 at 8:23 AM, Resident #75 consumed 100% of his breakfast meal. A bottle of Glucerna (nutritional supplement), which had been provided the night before, was 100% consumed. In this observation, Resident #75 said that he ate 100% of his breakfast meal and has a good appetite. He further stated he likes the Glucerna supplements and drinks them all when provided. An interview was conducted on 01/14/25 at 8:30 AM with Staff L, Licensed Practical Nurse (LPN), who stated Resident #75 gets his nutritional supplements twice a day: at 10:00 AM and at 9:00 PM. The supplements are provided by the Nurse assigned to the resident. They are brought into the pantry on the floor from the Dietary department. The Initial Nutrition Assessment was completed on 11/16/24, 9 days after Resident #75 was admitted . The assessment showed the following: Resident was at high nutritional risk secondary to stage 3-4 pressure ulcers. Resident #75 has increased nutritional needs with interventions added for Pro T Gold (protein supplement), vitamin C, and Zinc. The protein supplements were ordered on 01/14/24 and added 7 days after Resident #75 was admitted . The next follow-up nutritional progress note was dated 12/31/24, about three weeks after the significant weight loss of 7.7% was identified on 12/08/24. This note revealed the following: The Resident was eating 100% of his meals with a 7.3% (clinically significant) weight loss in one month. The goals were to provide Glucerna (nutritional supplements) twice a day and to monitor weekly weights for three weeks. Further review of the nutritional progress notes did not show that a follow-up progress note was completed on Resident #75, identifying the significant weight loss of 5.5% from 12/08/24 to 01/08/25. Record review of the hospital records dated 11/5/24 revealed Resident #75 had a 6 centimeters gastric mass highly concerning for malignancy. The hospital nutritional note dated 11/02/24 showed Resident #75 was 145 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/14/25 at 3:56 PM with Staff D, Consultant Dietitian, who stated she started working in the facility on 12/16/24. They have 5 to 7 days to complete an initial nutrition assessment but are told to complete them within 5 days. If a resident has a weight loss, the nursing staff would also let her know if it is between the resident's quarterly assessments. A monthly weight report is run, and that is done monthly. They are in the process of initiating a new weight policy that could overlap nursing and nutrition. Staff D stated she runs the weekly weights report weekly and attends the weekly Weights and Wounds meetings. The last Consultant Dietitian left around December 5th, and the Regional Clinical Manager covered the period between December 5th and December 16th. She would try to address any significant weight loss on the same day, and for any discrepancies in weight, she would ask for a reweight. Staff D was aware that Resident #75 had a significant weight change of 5.5%, and she was in the process of writing a follow-up note to address the weight loss. An interview was conducted on 01/14/25 at 5:13 PM with the Director of Nursing who stated the Consultant Dietitian attends the Wounds and Weights meeting weekly. In these meetings Staff D would be notified of any weight changes. The Restorative Certified Nursing Assistants oversees weighting the residents, and they would notify the Unit Manager, Director of Nursing or the Assistant Director of Nursing of any changes. In an observation conducted on 07/15/25 at 7:22 AM, Staff E, Restorative Certified Nursing Assistant, used a Hoyer Lift to take the weight of Resident #75. The Hoyer lift scale showed a weight of 141.4. In this observation, Staff E said she gets a list of the weekly weights and the monthly weights that are needed to be taken from Staff D. For any significant weight changes, she would inform the Unit Manager. In an interview conducted on 01/15/35 at 10:50 AM with Resident #75's Primary Physician, he stated Resident #75 has a tumor in his stomach, and at one point, Hospice services were considered and was denied by the family. Resident #75 has severe osteomyelitis and a sacrum wound. According to the Primary Physician, Resident #75's weight loss is unavoidable, and his weight was around 145 pounds in the hospital. 2. Record review revealed Resident #140 was admitted on [DATE] with diagnoses to inlcude Dysphagia and Dementia. The Quarterly MDS assessment dated [DATE] showed that Resident #140 has a BIMS score of 01, indicating severe cognitive impairment. Section GG for eating showed that Resident #140 needed substantial to maximum assistance. Review of Resident #140 ' s weight record showed the following: 04/12/24: 105 pounds. 05/13/24: 106 pounds. 06/11/24: 108.3 pounds. 07/11/24: 109.6 pounds. 08/12/24: 103.8 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/13/24: 102.4 pounds. 08/19/24: 104.4 pounds. 08/26/24: 100 pounds. 10/1/24: 103.7 pounds. 11/12/24: 102 pounds. 12/08/24: 90.8 pounds. This showed a severe weight loss of 10.9% from 11/12/24 to 12/8/24. A follow-up nutritional note dated 12/27/24 was completed by Staff D, addressing the severe weight loss, which was about 3 weeks later. In this note, Staff D stated Resident #140 was eating 26% of the last 12 meals recorded and met less than 75% of her estimated calorie needs. She was receiving superfoods with all meals and was also receiving Glucerna (nutritional supplements) 3 times a day. Resident #140 has a stage 3 sacral wound and was on Protein supplements as well. In this note, Staff D recommended decreasing the Glucerna to twice a day and adding Magic cup (nutritional supplement) at supper time. In an observation conducted on 01/13/25 at 5:10 PM, Resident #140 was eating her dinner meal with Staff F, Activities, at the bedside. She stated Resident #140 eats between 75% and 80% of her meals and that she likes to drink a lot. The meal ticket did not have a Magic cup listed, and the dinner meal did not have any nutritional supplements on the tray. In an observation conducted on 01/14/25 at 8:34 AM, Resident #140 was in her room with the breakfast tray. Staff G, Unit Secretary, was in the room helping Resident #140 with her breakfast meal. Staff G stated Resident #140 eats between 25% and 75%, depending on what she gets. Resident #140 likes to drink and gets a nutritional supplement twice a day. If you open the supplement bottles for the resident, she will drink them. According to Staff G, if Resident #140 does not eat her meals, they make sure that she drinks the supplements to compensate for the incomplete meals. In an observation conducted on 01/14/25 at 12:24 PM, Resident #140 was in the room waiting on her lunch tray. A bottle on Glucerna date 01/14/25 at 10:00 AM was noted unopened and untouched at the bed side. In an observation conducted on 01/15/25 at 8:15 AM, Resident #140 was in the room. A bottle of Glucerna, dated 01/14/25 at 2:00 PM, was noted unopened and untouched at the bedside. In an observation conducted on 01/15/25 at 9:04 AM, Staff F sat near Resident #140, assisting her with the breakfast meal. The surveyor asked if she would try to give Resident #140 a Glucerna supplement. A new bottle of Glucerna was brought from the kitchen and was given to Staff F. Staff F brought the Glucerna bottle to Resident #140's mouth and held the bottle for the resident to drink. Resident #140 was observed drinking the Glucerna, and Staff F said, She loves drinking, as she proceeded to hold the Glucerna supplement for Resident #140. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 01/16/25 at 8:57 AM, Staff D stated that in her note on 12/27/24, she recommended decreasing the Glucerna supplements from 3 times a day to 2 times a day because she was told that Resident #140 was only drinking two cans a day. She added a Magic Cup nutritional supplement to the dinner tray, which comes from the kitchen on the tray. The Magic Cup was added to Resident #140's dinner meal tickets. Review of Resident #140's meal tickets from 12/29/24 to 01/13/25 did not show that a Magic Cup supplement was added to the dinner meals. In an interview conducted on 01/16/25 at 9:30 AM with Staff D, she acknowledged that the Magic Cup supplements were never added to the meal tickets for Resident #140.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to follow physicians orders for fluid restriction for 1 of 1 sampled resident, Resident #42, reviewed for Dialysis. The findings included: Review of the policy document provided, titled Dialysis Residents, with a policy #2008, and reviewed on 10/16/24, revealed the purpose is to ensure that all needs / services of residents on dialysis are met while at the Facility. Recor review revealed Resident #42 was admitted on [DATE] with diagnoses including End Stage Renal Disease on Dialysis, Anxiety Disorder, Anemia, and Hypertension. Review of quarterly Minimum Data Set (MDS) assessment, Section C, dated 12/11/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of physician orders dated 09/11/24 revealed to monitor intake every shift as per fluid overload prevention protocol: 24-hour fluid restriction in milliliters (ml). 1200 ml (nursing 480 ml and dietary 720 ml). The order documented: 120 ml fluid restriction for night shift, 120 ml fluid restriction for evening shift, and 240 ml fluid restriction during the day shift. Review of a document, titled Week at a glance customized for resident #42, and provided by Staff HH, Regional Dietician, on 01/15/25 at 4:30 PM, revealed 780 milliliters (ml) daily average fluid provided by the Dietary Department on resident's meals. At this time, Staff HH stated she added the value in mls opposite the fluid served on breakfast, lunch and dinner. Review of the Certified Nursing Assistant (CNA) intake records dated 01/06/25 to 01/16/25 revealed several dates when Resident #42 received more than the 480 ml fluid from nursing, except on 01/07/25 (220 ml); on 01/09/25 (100 ml), and on 01/13/25 (360 ml). The amount of fluid nurses provided were documented as follows: 610 ml on 01/08/25, 880 ml on 01/09/25, 630 ml on 01/11/25, 420 ml on 01/12/25, 360 ml on 01/13/25, 960 ml on 01/14/25, and 840 ml on 01/15/25. Review of the Medication Administration Records (MARs) dated 01/01/25 to 01/14/25 revealed 2 times for the night shifts, fluid intake documentaion with the exception on 01/11/25 when a 120 ml being documented. In an observation on 01/13/25 at 2:00 PM, Resident #42 had a pitcher filled with water on a meal table (bedside) next to the right side of her bed. When asked if staff told her about the fluid amount she is allowed to drink, she stated I do not drink that much. An observation on 01/14/25 at 4:20 PM, revealed Resident #42 was seen with a pitcher of water and a styrofoam cup on the meal table on the right side of her bed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff GG, Certified Nursing Assistant (CNA), on 01/16/25 at 1:58 PM, when asked regarding the care of the resident with fluid restriction, she stated, to put the resident head high, to give little water to resident, and to inform the nurse on how much fluid resident consumed. In an interview with Staff HH on 01/16/25 at 1:27 PM, she stated Resident #42 has a fluid restriction order of 1200 ml daily, where dietary provides 840 milliliters (ml), and nurses provide 360 ml daily. When asked how much the actual daily resident fluid consumption was and if data were recorded, she responded the Nutrition department provided the fluids on the meal tray, but the nurses document the total amount consumed. She added that fluid restriction in served meals are provided by the Nutrition department, but they do not keep records of daily resident's fluid consumption.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, interview, observation and record review, the facility failed to address social services responsibilities regarding missing personal items and clothing for 1 of 1 sampled resident, Resident #223. The findings included: Review of undated facility's licensed Social Worker job description on [DATE] at 11:17 AM provided by the Administrator documented, Summary & Objective: The Social Worker coordinates and provides medically related Social Services to attain or maintain the highest practicable, physical, mental, and psychosocial wellbeing of each resident . Essential Functions: Complete progress notes/assessments as required . Participates in daily management team meetings to discuss resident status, census changes, and resident complaints or concerns if applicable . Other Duties: Comply with all policies, local, state, and federal laws and regulations and Perform other duties as assigned . Review of the facility's policy and procedure, titled, Handling of Valuables, provided by the Administrator, reviewed [DATE], documented in the Policy Statement: The facility will ensure the safekeeping of resident's personal property by identification processes . Purpose: The facility will establish processes that will maintain and respect the resident's rights to retain and use personal possessions, . and appropriate clothing as space permits, . Identification of Personal Items: 1. On admission and on an ongoing basis, Nursing staff will document, on the inventory of Personal Effects Form that is part of the medical record, all personal items including but not limited to: Clothing . And, all other personal items . Missing Items: In the event that items logged onto the Inventory of Personal Effects form are missing, the resident/family will inform nursing of this situation. Nursing shall endeavor to locate the missing items. If the situation cannot be resolved to the resident's/family's satisfaction, a formal grievance may be filed, as per facility policy. Investigation 1. Anyone receiving a report of a missing item will inform the Charge Nurse. 2. The Charge Nurse will contact appropriate departments, i.e. Environmental Services, Food/Nutritional Services, Security, etc. 3. Departments will also search and investigate. 4. An unusual Occurrence/Incident Report will be completed by Nursing if the item is not located. Record review revealed Resident #223 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus, Anxiety Disorder, Pulmonary Embolism, Acute Lymphadenitis of lower limb, Hypertension, Cystitis, History of falling, Fracture of Sacrum with generalized muscle weakness. The documented Brief Interview of Mental Status (BIMs) score was indicative of moderately impaired, decisions poor, cues/supervision required. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:27 AM, a telephone interview was conducted with Resident #223's son, who stated that subsequent to the time that his Mother had a missed medical appointment at this facility, he said that he had spoken with one (1) of the staff in the facility who asked him to bring some clothes into the facility so that they could put them on his Mother when she gets her up. Resident #223's son stated that in the beginning, he took home a bag of dirty clothes to wash that the resident already had in the facility. The resident's son stated he remembers later signing-in some clothing that he had personally brought in, but he said that he did not sign out any clothing. Photographic Evidence Obtained. The son stated that Resident #223 also had some miscellaneous personal items to include: 1) approximately $30 in cash, kept in a wallet in the purse itself which could not later be located and when he checked for this money and mentioned it to the Nun and one of the nurses, it was not addressed and nothing was done, He stated no action was ever taken on it. 2) a handbag containing a gate card to the resident's condominium, which was present when Resident #223 was admitted to this facility and it remained there, but the gate card was missing from her gray pocketbook and disappeared. He also said that he had some pictures of the resident's clothing spread out on her couch at home, before he packed them, so they could be viewed clearly. There were also some pictures of personal items and clothing hanging inside of the facility's closet dated [DATE] which he reiterated were signed in, but he never signed any out. Resident #223's son explained to the surveyor the reason why the family had previously taken pictures of the resident's clothing, while still at her home, prior to bringing them into the facility, was due to the ongoing concerns that they had previously encountered regarding other missing items. Resident #223's son stated that he brought in a new set of clothes after this. Resident #223's son stated that he sent an e-mail on [DATE] to Staff V, Sister/Master of Social Work, regarding some of the above clothing and personal items and she acknowledged with a return e-mail response on the same day. Review was conducted of the e-mail dated and sent on Tuesday [DATE] at 2:22 PM from the Resident #223's son to Staff V. This email was forwarded to the surveyor on Wednesday [DATE] indicating, Hello, please find attached photos of pocketbook, gate card from ,d+[DATE] and the clothing hanging in the closet. Clothes are also laid out for your review. 1. The first photo is of the items spread out on her couch at home before I packed them so they could be viewed clearly. I took the time documenting this due to the other missing items we had encountered. 2. The second photo is the missing gate card that was in her gray pocketbook and disappeared. The bag and card are photographed on the rolling table in her room at St [NAME]. 3. The third photo is the clothes hanging in the closet/wardrobe that was in her room. I was asked to bring the clothes by Staff V . I also reported missing case from my Mother's wallet .I also forwarded Staff V's response to me acknowledging receipt of the below email . The response back to me on Tuesday [DATE] at 2:45 PM was: Received. Thanks; same day. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:45 PM, a telephone interview was conducted with Resident #223's daughter, regarding the resident's clothing and personal items. She stated that her Mother was transferred to the hospital and from there she went onto Hospice where she subsequently expired. She stated she was told by someone in the facility that they could not find her Mother's belongings, and this was before 30 days. She stated she spoke with the Administrator and was told they had thrown out the gate card. Resident #223's daughter said the resident's purse was missing some items to include some money and stamps. She said the facility told her to bring in some clothing for the resident to be able to wear for when she gets up, for therapy, etc., she spoke with Staff V but the belongings were never found. She also stated she spoke with the Director of Nursing (DON) who told her she was imagining this, even with pictures being provided. Resident #223's daughter stated none of the belongings were found and she suspected that they had lost the belongings. Resident #223's daughter stated the Administrator said she believes that the items were thrown away. The daughter stated there was no recourse provided to replace by the facility and the Administrator offered to call the Condo association, but she told the Administrator that this was not necessary. During an interview conducted on [DATE] at 12:21 PM with Staff V, regarding the resident's clothing and personal items, she stated that the Unit Manager had spoken to her following a conversation that she earlier had with Resident #223's family about bringing in some clothing for Resident #223 to wear, since she was usually always in a hospital gown, and did not have clothing for an upcoming medical appt. After this appointment, Staff V revealed the resident's son brought in some clothing and no other personal items were brought in, at that time for the resident. Staff V proceeded to show the surveyor some colored photos of the clothing items in Resident #223's closet that were brought in by the resident's son. Staff V presented a copy of both the Inventory List of Personal Effects forms dated [DATE] and of the Changes to Inventory form dated [DATE]. Staff V revealed she had received an e-mail(s) from Resident #223's family during the time frame of [DATE] until [DATE], regarding the resident's clothing and personal items. Staff V was able to locate the e-mail that was sent directly to her on [DATE] at 2:22 PM from the resident's son regarding the resident's clothing and other personal items. She indicated that she did recall previously speaking with the resident's daughter regarding the resident's clothing as well as e-mailing a response back to the resident's son. Staff V stated none of those items were ever found. During this interview, Staff V and the surveyor were joined by the Regional Director of Care Coordinator for the Social Work and Utilization Management Division. At this time, Staff V briefly explained the process/protocol of what to do when a resident has missing clothing and personal items as: when it is learned that a resident has missing clothing and/or personal items they would confirm if it is on the inventory form; they would check the resident's room and laundry, if the item could not be located; the facility would ask the family if they have a receipt or an estimated monetary value, it would go to the Administrator in the form of a grievance and she would make the determination of what happens from there; she would speak with the family, the floor/unit manager, the Social Worker, Unit Secretary, Business office to see if it is a credit card; and a grievance would be completed within a maximum of a one (1) week time-frame. Staff V stated she does not recall speaking with any of the family members after that time, and did recall documenting any further information regarding this in Resident #223's record. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation found to show that any other pertinent staff members had been informed or notified of these ongoing issues and concerns involving the clothing and personal items for Resident #223's in the record. There was no further documented efforts by the facility, per their protocol, to follow-up with locating Resident #223's clothing and other personal items or belongings, after Staff V's two (2) previous documented telephone conversations on [DATE] and [DATE]. A side-by-side record review was conducted with Staff V, of both Resident #223's Inventory of Personal Effects log dated [DATE], which listed all of the following items: one (1) cell phone and charger, one (1) small hand bag, an unidentified Identification (ID) and two (2) unspecified cards. Photographic Evidence Obtained of above; and of Resident #223's Changes to Inventory log dated atop as [DATE] at 2:15 PM, in which it was documented the resident had all of the following items listed: two (2) pair black and white pants, two (2) shirts black and red, three (3) pair underwear and one (1) black bra. Photographic Evidence Obtained. Both of the inventory forms ultimately had Resident #223's signature at the bottom of the page. There was also an incomplete section at the bottom of the Inventory of Personal Effects log, and on the Discharge section on the bottom of the Changes to Inventory log indicating, receipt of valuables from the facility in good condition, as listed on this form, was also incomplete, unsigned and undated by both the Resident/Relative and the facility employee. There was no clarity or documentation on either of the above forms to indicate or authenticate as to whether or not the signature of Resident #223's son on the two (2) forms were signed at the time of drop-off, or at the time of pick-up, of any of the resident's clothing or personal items. Record review of the Social Worker notes by Staff V, dated [DATE], [DATE], [DATE], in which it was noted that, .SW took a small black purse from the resident's handbag that contained two credit cards ([name] Visa card and [Name] Credit Union Card), one [name] medical card, Driver's License and two [name] cards and some papers. Stored in SW office. Will contact family to pick up Credit Cards . The writer spoke with resident's son regarding resident's wallet. He will arrange pick up with the writer. He reported that he visited and picked up resident's Iphone and signed inventory with a nurse Resident collected his Mother's purse that contained her ID, two credit cards. Further record review of the last two (2) SS notes by Staff V, dated [DATE] and [DATE], documented, Resident is still in the hospital Writer followed up with .resident's daughter who also mentioned that she will stop-by soon to pick up resident's belongings. Writer informed floor staff and business; there was no documentation reviewed to support this .SW contacted resident's family .resident's daughter .stating that she will come during the week to pick up resident's stuff. There was no evidence reviewed in the transfer nurses' progress notes dated [DATE] at 5:26 PM by Staff W, LPN, referencing the status of Resident #223's clothing nor personal items, upon discharge from the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Social Services [DATE] at 4:03 PM regarding the resident's clothing and personal items and she stated that, the last communication she had with Resident #223's family members was on [DATE] involving the issuance of the Notice of Non-Medicare Coverage (NONMC). The Director of Social Services revealed she had not had any communication with the family during the resident's facility stay regarding the resident's clothing or personal items, as documented in the record. The Director of Social Services indicated she was not notified of any concerns or issues with missing clothing items or personal property for this resident at any time during the facility stay, by her own staff or by any other facility staff members. The Director of Social Services explained that the overall policy for following up with missing personal items and clothing involves: informing the Director, completing a grievance pending an investigation of the missing items, and a resolution being reached. This was not done. The Director of Social Services stated there was no report made and no grievance completed for such. An interview was conducted on [DATE] at 5:16 PM with the Director Of Nursing (DON) regarding Resident #223's clothing and personal items, who revealed she was not notified or informed of any concerns or issues with any missing clothing items or personal property at any time during the facility stay by her own staff or by any other facility staff members. The DON stated the facility has three (3) locked storage areas on-site for the resident's personal items and clothing (stored at a minimum of 30 days) on each nursing floor, and in each nurses' station / units there is a key to the storage room kept in an un-locked nurses' station desk (which is accessible to any staff member on the nursing floor). The DON further revealed that these three (3) storage rooms can go unattended for months without being checked. Photographic Evidence Obtained. The DON reiterated the procedure for following up with missing clothing and personal items reports from the resident or their representative as: a grievance would be filed pending an investigation of the missing items, the facility would check the inventory log to see if the items missing are on the inventory list, if they are there they would look for the missing items, but if they could not be located, then 3) the facility would ask the family to see what can be done e.g. reimbursement, 4) the Business office would follow-up, and 5) a resolution is reached, and the family would receive their reimbursement, if applicable. She acknowledged that none of the above steps had been followed in this case. On [DATE] at 5:35 PM, an observation was conducted of one (1) of three (3) storage rooms on the second (2nd) floor for resident's clothing and personal items in which it was noted there were numerous different types of bagged items, wheelchairs, etc. packed into the locked room, located in the community shower room. The key to this room is was accessible to anyone entering the nurses' station; and all of the staff members are aware of this key location, per the DON. The DON stated there was no master Inventory List of the facility's residents' personal belongings and items, only individual paper lists which are kept in each resident's chart. On [DATE] at 6:14 PM during an interview conducted with the Administrator, she stated she was not notified or informed of any issues or concerns involving missing clothing or personal items by any of her facility staff, for Resident #223. The Administrator revealed she had no prior knowledge or any idea about anything regarding Resident #223 personal items and missing clothing until the day of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews and record review, the facility failed to secure dispensed medications which were left unattended on a medication cart, and dispensed medications left at the bedside for a resident during initial observational tour, for 1 of 164 resiudents observed, Resident #374; failed to secure a treatment cart while unattended during wound care observation; and failed to secure an unlocked medication cart review in the facility's third floor wing. The findings included: Review of the facility's policy, titled, Drug Procurement/Storage/Inspection, effective date 12/03/04, reviewed date 10/24/24, included the following: Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the facility. Procedure: Medications are stored in a secure manner. Lockable medication carts are used to store unit-of-use medications in the resident medication dose system. These carts will be locked when not attended. Review of the facility's policy, titled, Bedside Medications, effective date 12/03/04, reviewed date 10/25/24, included the following: It is the policy of this facility that certain medications may be left at the bedside only on the specific order from the physician. Medications left at the bedside may be administered following the Self-Administration of Medications policy and procedure requirements. Procedure: Medications shall not be left at the bedside for self-administration, with the exception of the following which have been approved by the Interdisciplinary Team: Aerosols and/or bronchodilators used in the treatment of bronchospasms Antacids Eye drops Throat lozenges External preps for topical application (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All medications left at the bedside may only be administered following the Self-Administration of Medications policy and procedure requirements. If the tenets of that policy are not met, the medications may not be left at the resident's bedside for self-administration. Bedside medications must be kept in a locked cabinet or drawer. 1. During the initial tour conducted on 01/13/25 at 10:45 AM, Staff FF, Licensed Practical Nurse (LPN), was observed on the third floor administering medications. Staff FF was observed entering a resident's room with the vitals' machine. Further observation of the medication cart revealed two small medication cups left on top of the locked cart. One of the small medication cups contained a green/bluish liquid and the other cup contained a few hard substances mixed with apple sauce. Photographic Evidence Obtained. The surveyor observed a few staff members pass by the medication cart including the in-house pharmacist. Staff FF returned to the medication cart approximately 5 minutes later. At this time, Staff FF was asked about the two small cups. She confirmed the contents of the small medication cups were medications for a resident. She stated the resident did not want the medications and she was going to try to administer the medications to the resident later. Staff FF opened the medication cart and placed the two cups containing the dispensed medications in the top drawer of the medication cart. 2. Record review for Resident #374 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Displacement Intertrochanteric Fracture Femur, Traumatic Subdural Hemorrhage, History of Falling, Localized Osteoporosis, Hypomagnesemia, Hypertension, Hyperlipidemia, Neuralgia and Neuritis. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #374 had a Brief Interview for Mental Status (BIMS) of 15, indicating no cognitive impairment. Review of the Physician's Orders showed Resident #374 had orders dated 12/27/24 for Calcium Carb-Cholecalciferol 600mg -10mcg tablet by mouth daily for Vitamin Deficiency; for Docusate Sodium 100mg tablet by mouth twice a day for Constipation; for Gabapentin 300mg capsule by mouth twice a day for Neuropathic Pain; and for Magnesium Oxide 400 (240mg) mg by mouth daily for Hypomagnesemia. Review of Resident #374's January electronic Medication Administration Record (eMAR) revealed Resident #374 was scheduled to receive the above 4 medications and it was document by the nurse as administered at 9:00 AM. During an observation conducted on 01/13/25 at 11:25 AM of Resident #374, she was noted in her bed. Upon closer observation, there was a small medication cup with 4 unidentified pills on the over-bed-side table in front of Resident #374. Photographic Evidence Obtained. When asked what was in the small cup, Resident #374 stated they were her morning medications, and the nurse just left it for her to take. She also stated the nurse does this every so often. Review of Resident #374's form, titled, Evaluation for Self-Administration of Medications, dated 12/27/24, revealed the resident was not evaluated to self-administer her medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/16/25 at 9:27 AM with Staff W, LPN, who stated she has worked for the facility for 4 1/2 years. She stated dispensed medications that are refused by the resident are to be discarded or wasted in the drug buster. Then she stated that if the resident decides to take the medications afterwards, the medications are again dispensed and administered. She confirmed that the nurses cannot hold on to dispensed medications in the medication cart to be administered later. In addition, Staff W stated a resident can self-administer medications if the resident was assessed and there's an order from the physician stating the resident can self-administer the medications. She acknowledged that medications should never be left at the bedside, and the resident should be monitored even if they can self-administer. During an interview conducted on 01/16/25 at 10:36 AM with Staff CC, third floor Nurse Manager, who stated she has worked at the facility for 8 years. She stated nurses are to dispense and right away administer the medications to residents. Staff CC added that if the resident refuses the dispensed medications, the nurse is to document in the resident's chart and then destroy or waste the medications. She stated for residents to self-administer their medications, the resident would be evaluated by the nurse to see if resident can read the labels on medication bottles and demonstrate that they are able to administer medications properly. Staff CC stated a locked box would be placed at the bedside for the medications, the nurses will assist with the locked box and must be present when the resident takes the medication. During an interview conducted on 01/16/25 at 10:56 AM with Staff DD, 2nd floor nurse manager, who stated she has worked at the facility for 4 months. She stated that upon admission, a resident is assessed for self-administration of medications. Staff DD presented the self-administration medication form for Resident #374 and confirmed that the resident had not been assessed to self-administer her medications. An interview conducted on 01/16/25 at 11:09 AM with the Director of Nursing (DON). She stated the nurse is to document when the resident refuses their medication, contact the physician and destroy or waste the refused medications. The DON acknowledged hearing of the dispensed medications that were left on top of the medication cart and left on the bedside for the resident to be self-administered. 3. Wound care observation, on the 2nd floor, was conducted on 01/16/25 at 9:36 AM with Staff EE, LPN and wound care nurse, who stated she has worked at the facility for [AGE] years. She gathered all the supplies and placed them on top of the treatment cart, then she stated she would wash her hands in the resident's room. Staff EE walked away to the room, leaving the treatment cart unlocked, unattended and the supplies on top of the cart. She returned to the treatment cart and donned a gown, picked up the supplies and entered the resident's room. Staff EE again left the treatment cart unlocked and unattended in the hallway. The surveyor observed unlicensed staff members, therapy staff and residents walking and in wheelchairs ambulating by the unlocked treatment cart. During the wound care procedure, Staff EE returned to the treatment cart to retrieve additional tape and realized the cart was unlocked, but continued to retrieve the tape and don on a clean gown and went back into the room, leaving the treatment cart unlocked and unattended again. Upon completing the wound care procedure, an interview was conducted with Staff EE, who acknowledged leaving the treatment cart unlocked and unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the treatment cart revealed the wound cart contained ointments/creams labeled with residents' names, scissors, and wound supplies. 38349 4. Review of the facility policy and procedure, titled, Drug Procurement / Storage / Inspection, provided by the Administrator, reviewed 10/25/24, documented in the Policy Statement: Responsibility for control of medications within this facility rests with the facility and the Pharmacy. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the facility. These policies will be approved by the designated facility committee (s) .Procedure: Storage: Medications are stored under proper conditions as stated by the medication manufacturer to assure stability of that medication. Medications are stored in a secure manner. Lockable medication carts are used to store unit-of-use medications in the resident medication dose system. These carts will be locked when not attended. During an observation on the South wing hallway conducted on 01/14/25 at 10:47 AM, it was observed that the South Wing Medication cart #33 had been left unlocked and unattended; accessible to residents, staff members and visitors. An interview was conducted with Staff X, Licensed Practical Nurse (LPN), regarding the South Wing Medication cart #33 having been left unattended and unlocked. Staff X acknowledged that it was, but should not have been. Interview was conducted on 01/14/25 at 4:27 PM with the Registered Nurse / Unit Manager (RN UM) 3rd floor, working in the facility for [AGE] years, regarding the South Wing Medication cart #33 being left unattended and unlocked, and she also acknowledged that the medication cart should not have been left unlocked and unattended. Interview conducted on 01/15/25 at 11 AM with the DON, regarding the South Wing Medication cart #33 having been unattended and unlocked. She further acknowledged that the South Wing Medication cart #33 should have been secured.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure it honored the resident's food preferences during a lunch meal for 4 of 33 sampled residents observed, Resident #14, Resident# 151, and Resident #133. The findings included: Record review of the facility policy and procedure, titled, Nutritional Services Rounds, provided by the Administrator, reviewed 10/16/24, documented: Purpose: To determine resident's likes/dislikes and overall acceptance of meal service. Residents' cultural, religious and ethnic food preferences are honored when possible and when not contraindicated To identify any errors or deficiencies in the meal tray service. Policy: The Registered Dietician or Dietary Technician: Record as appropriate, nutrition information in the medical record on nutrition progress notes. 1. Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnosis to included Gastroesophageal Reflux Disease (GERD). The current Minimum Date Set (MDS) assessment documented a Brief Interview Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. On 12/19/24, the Physician's Order documented, Regular diet for Resident #14. Record review of the Resident #14's Dietary / Nutritional Care plan revised 12/29/23 indicated Interventions: Honor food preferences . On 01/13/25 at 1:29 PM, an observation was conducted of Resident #14's lunch meal of a mechanical soft diet of chicken chunks and rice. Photographic Evidence Obtained. At this time, the lunch meal ticket documented the resident was to have chopped chicken with rice, instead. An interview was conducted on 01/14/25 at 9:50 AM with Staff Y, Certified Nursing Assistant (CNA). According to the CNA, she said that the dietary knows this resident does love chicken. She acknowledged this should have been recorded on the resident's lunch meal ticket; but it was not. On 01/14/25 at 10:18 AM an interview was conducted with Staff Z, Licensed Practical Nurse (LPN). According to the nurse, she acknowledged the food recorded on the lunch meal ticket was not what the resident had actually been served for lunch. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #151 was admitted to the facility on [DATE] with diagnoses that included Acute Systolic (Congestive) Heart, Atherosclerotic Heart Disease and Chronic Kidney Disease. The current MDS documented a Brief Interview Mental Status (BIM) score of 10, indicating (moderate impairment). On 07/25/24, the Physician's Order documented, Mechanical Soft diet with minced / moist meats and thin liquids. Record review of the Resident #151's Dietary / Nutritional Care plan initiated 07/31/24 indicated Interventions: Honor food preferences . On 01/13/25 at 1:33 PM, the resident's lunch meal ticket documented the resident was to receive an Italian Beef Sandwich with potato tots. An observation conducted of the Resident# 151's lunch meal for the Dysphagia Mechanical diet revealed the meal tray with mashed potatoes and gravy only. There was no meat, no bread and no potato tots according to the resident. Photographic Evidence Obtained. Interview on 01/13/25 at 1:36 PM with the resident was conducted who stated she did not have a sandwich but received only mashed potatoes and gravy with no meat, no bread. She said that it bothers her that they prepare basically the same type of meals everyday, but not what she especially likes or prefers. The resident added that she recalls telling staff, but nothing changes. On 01/14/25 at 9:50 AM, an interview was conducted with Staff Y, CNA, who acknowledged that the food recorded on the lunch meal ticket was not what the resident had actually been served for lunch. During an interview conducted on 01/14/25 at 10:18 AM with Staff Z, Nurse, she acknowledged that the food recorded on the lunch meal ticket was not what the resident had actually been served for lunch. 3. Record review revealed Resident #133 was admitted to the facility on [DATE] with diagnoses that included Metabolic Encephalopathy, Folate Deficiency, Anemia and Vitamin Deficiency. The current MDS documented [added] a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognition. On 10/10/24, the Physician's Order documented, Regular diet with cut up meat/mechanical soft meats and thin liquids. Record review of the Resident #133's Dietary/Nutritional Care plan reviewed 12/23/24 indicated Interventions: .Honor food preferences. On 01/13/25 at 1:41 PM, the lunch meal ticket documented the resident was to have a peanut butter and jelly sandwich. An observation at this time was conducted of the Resident #133's lunch meal for the Regular diet, showed that he had received a beef sandwich with tater tots, fruit and soup. Photographic Evidence Obtained. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/13/25 at 1:45 PM, an interview was conducted with Resident #133 who was asked about his care and services. He voiced that everything was ok, but the food here is not good, no taste; and it is usually been that way. He stated he did eat some of the soup for lunch today and he took a few bites of the sandwich, but it bothered him because it was very dry and tough. He said he did not want to even ask the staff again for anything else since it might not be any better. On 01/14/25 at 9:50 AM, an interview was conducted with Staff Y, CNA, who acknowledged the food recorded on the lunch meal ticket was not what the resident had actually been served for lunch. On 01/14/25 at 10:18 AM, an interview was conducted with Staff Z, Nurse, who acknowledged the food recorded on the lunch meal ticket was not what the resident had actually been served for lunch. An interview was conducted with the Director Of Nursing (DON) on 01/15/25 at 3:59 PM who acknowledged there was an incorrect discrepancy between what the resident's lunch meal tray had on it and what was actually recorded on the lunch meal ticket.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food according to professional standards for food service safety and sanitary conditions and to prevent foodborne illnesses for 2 of 2 observations to the main kitchen. The findings included: In an initial tour of the central kitchen conducted on 01/13/25 at 9:00 AM, the following were noted: 1. The Food Service Director did not have a facial hair covering in the food production area. 2. A dirty used rag was noted in the food production counter that was not placed in a sanitation bucket. 3. One (1) light of 3 lights under the hood was not working. 4. A 16-ounce private plastic drinking cup was noted under the food production area. 5. A large bag of cooked pork in the walk-in refrigerator had a date of 01/04/25 with a used by date of 01/07/25. 6. A large metal container of [NAME] sauce in the walk-in refrigerator had a date of 01/07/25 with a used by date of 01/09/25. 7. A large metal container of Marinara sauce in the walk-in refrigerator had a date of 12/31/24 and a used-by date of 01/03/25. 8. A large metal container of cooked eggs in the walk-in refrigerator had a date of 01/7/25 and a used-by date of 01/09/25. 9. A large metal container of cream of broccoli soup noted in the walk-in refrigerator had a date of 01/01/25 with a used-by date of 02/03/25. In this observation, the Food Service Director was not sure as to why the used-by date for the soup was about one month later. 10. A large metal container with pieces of raw fish was noted with a date of 01/09/25 and a used-by date of 01/11/25. 11. A large metal container with pieces of raw chicken noted with date of 01/09/25 and a used by date of 01/12/25. 12. A review of the Diet Spreadsheet week 2, day 2, showed the following menu for the Regular diet: 3 ounces of pork and 2 ounces of salsa sauce. (continued on next page)

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	105371	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Nursing Center	3075 NW 35th Ave Lauderdale Lakes, FL 33311

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 01/15/25 at 11:35 AM in the main kitchen during the tray line, a large tray of pre-sliced pork pieces was noted. The Food Service Director plated a sliced pork for a Regular consistency diet meal ticket. The surveyor requested that the weight of the sliced pork with the salsa sauce be taken using a facility-calibrated scale. The sliced pork and the salsa sauce were noted to be 2-ounces in total and not the necessary 3 ounces as per the facility's menu. An interview was conducted on 01/15/25 at 11:40 AM with Staff K, Cook, who stated that he pre-slices the pork pieces for 4-ounces each.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to disinfect the vital signs machine between residents' usage for Residents #137, Resident #42 and Resident #428; and failed to follow droplet precaution protocol for residents' positive for Coronavirus Disease 2019 (COVID-19), for Resident #375. The findings included: Review of the facility document, titled, Guidelines for Isolation Precautions, policy #4022, dated 10/25/24, revealed standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infections in hospitals. Page 5 of the policy revealed droplet transmission is a form of contact transmission, where droplets are generated from the source person primarily during coughing, sneezing, talking, and during the performance of suctioning and bronchoscopy. Isolation precautions are designed to prevent transmission of microorganisms in healthcare facilities. Since agents and host factors are more difficult to control, interruption of the spread of infection is directed primarily at transmission. Further review of policy on page 6 revealed the fundamentals of isolation precautions with infection control measures such as hand hygiene per new Center for Disease Control and Prevention (CDC) guidelines and gloving; cleansing hands as promptly and thoroughly as possible, between resident contacts and after contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them, appropriate resident placement explaining resident with highly transmissible or epidemiologically important microorganism are placed in private room, and appropriate barriers like mask, impervious dressings are worn or used by the resident to reduce transmission of microorganisms to other residents, personnel and visitors, and to reduce contamination of the environment. Page 9 of the policy revealed resident care equipment and articles for noncritical equipment (equipment that touches intact skin) contaminated with blood, body fluids, secretions, or excretions is cleaned and disinfected after use. 1. a. Record review revealed Resident #137 was originally admitted on [DATE] and readmitted on [DATE] with the diagnoses that includrf Aftercare following Joint Replacement Surgery, Presence of Left Artificial Hip Joint, Pain Left Hip, and History of Falling. Review of Minimum Data Set (MDS) assessment, Section C, dated 01/02/25, revealed a Brief Interview for Mental Status (BIMS) score of 08 indicating moderately impaired cognition. b. Record review revealed Resident #424 was admitted on [DATE] with diagnoses that included Urinary Tract Infection, Urinary Retention, Anemia, Arthritis, Cerebral-Vascular Accident (CVA), Right Sided Weakness, Benign Prostatic Hypertrophy (BPH) with Chronic Foley (Inventor's name of a urinary catheter) catheter. Review of MDS Section C, dated 01/14/25 revealed a BIMS score of 03 indicating severe impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed the following orders: On 01/08/25 for Isolation Precautions, contact for positive urine culture Morganella and Pseudomonas. On 01/09/25, check placement of dressing, replace if soiled or dislodged per Medical Doctor (MD) daily. On 01/10/25, evaluate nonfunctioning right arm midline one time only 01/10/25; and IV protocols: change midline site dressing one time only within the first 24 hours after line insertion, clean site, allow air to dry and cover with transparent dressing. Review of Treatment Administration Record dated 01/09/25 revealed treatment for left dorsal foot 3x (times) a week and provide Foley care every shift with nurses signatures. Review of nurses notes dated 01/13/25 revealed urine clarity, and color was amber, with Foley (urinary) catheter of 20 French and no problems; and on 01/15/25 at 3:09 PM, urine amber with Foley catheter of 20 French with tubing seen on left groin. c. Record review revealed Resident #428 was admitted on [DATE] with diagnoses that included Acute Metabolic Encephalopathy, Dental Abscess, CVA, Hypertension (HTN), Cardiomyopathy, Diabetes Mellitus (DM), and Dementia. Review of the MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Review of physician orders dated 01/02/25 revealed an ordered mechanical soft diet, dysphagia treatment by speech therapy, and wound care consult. The physician orders dated 01/02/25 revealed: Cefdinir (antibiotic) 300 mg capsule by mouth every 12 hours for tooth abscess; and on 01/03/25 an order to avoid direct pressure to sacrum, turn left to right, with wedge pillow, and check dressing placement. During an observation on 01/14/25 at 4:24 PM, Staff O, Certified Nursing Assistant (CNA), left a room with an East labelled Hill-Rom 5-wheels, Spot vital signs machine. She was observed to not disinfect the machine or perform hand sanitizing after leaving the room. She went straight into Resident # 137's room. Upon entering, she was observed not to clean or disinfect the machine and/or sanitize her hands. Staff O put on gloves, touched resident's privacy curtains, applied blood pressure cuff to Resident #137, clipped the pulse oximeter to resident's right pointer finger, and placed the thermometer a few inches away from resident's forehead on 01/14/25 at 4:27 PM. While using her gloved hand, she wrote on her clipboard after taking a pen out of her pocket. Staff O removed the blood pressure cuff from resident's right arm, and with the same gloves used for resident, touched resident's phone, and meal table, and then removed both gloves. She performed ABHR (alcohol-based hand rub) on 01/14/25 at 4:29 PM but did not clean or disinfect the vital signs machine. The machine had a basket with 2 pressure (BP) cuffs with a long gray cord, a pulse oximeter clip with a white cord, and a thermometer with a white cord. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/25 at 4:30 PM, Staff O went to the next room and sanitized her hands. With the same vital signs machine that she had not disinfected, she then applied the BP cuff on the Resident# 428's left arm on 01/14/25 at 4:30 PM. She was observed touching her forehead with the same gloves she used to apply the resident's BP cuff. With the same set of gloves, she wrote on her clipboard on 01/14/25 at 4:30 PM. She stood next to the vital signs machine and her clipboard was touching the cord part of the BP cuff. She then touched her left ear using the same gloves, removed BP cuff from resident's arm, then removed her gloves, discarded them in trash, and sanitized her hands. Further observation revealed Resident #428's room had an EBP (Enhanced Barrier Precaution) sign on the door frame. Staff O, a CNA did not clean and disinfect the vital signs machine before and after leaving the EBP room. On 01/14/25 at 4:32 PM, observation revealed Staff O placed the vital signs machine in front of Resident# 424's room. The room had an EBP (Enhanced Barrier Precaution) sign posted. On 01/14/25 at 4:33 PM, Staff O donned a personal protective equipment (PPE) gown, put a mask over her other face mask. Staff O did not clean or disinfect the machine she used for Resident #137, Resident # 428 , and a random observed resident on 01/14/25 at 4:33 PM. Staff O put on gloves, then applied the bigger BP cuff (brown, and white in color) to the Resident # 424's arm. She took off the BP cuff shortly afterwards, put it back in the white basket of the Hill Rom machine. She then applied a bp cuff found on resident's meal table. She did not sanitize this resident's BP cuff before putting on resident's left upper arm on 01/14/25 at 04:37 PM. Staff O touched the left side of her eyeglasses, then touched resident's arm, BP cuff, and the bulb of sphygmomanometer with her left hand, and with her right hand touched Resident #424's arm again. She put the BP cuff on top of resident's table without disinfecting it. She took the resident's temperature by placing the thermometer a few inches away from resident's forehead, and with the same gloves she used on this resident touched her clipboard and pen. She continued and touched the resident's napkin on the meal table, then pushed the meal table closer to resident's bed with the same set of gloves. She wheeled the vital signs machine next to the bathroom, removed her PPE gown, performed handwashing in resident's bathroom, and left the room with the machine. She did not clean and disinfect the machine but placed and plugged it into an electrical outlet on 01/14/25 04:42 PM. She then walked away from the East labelled Hill-Rom machine. In an interview with Staff O on 01/14/25 at 4:44 PM, when asked regarding CNA's care of residents with EBP post, she stated staff must put on gown, mask, glove before caring for residents. When asked why staff must wear the mentioned items, she responded, To protect self. In an interview with the Administrator on 01/14/25 at 5 :10 PM, when asked regarding disinfection of the Hill-Rom machine, she stated the facility does not have any. When asked what disinfectant the facility uses for the Hill-Rom machine, she responded, Whatever the manufacturer recommends. 40153 2. Record review revealed Resident #375 was admitted to the facility on [DATE] with diagnoses that included Muscle Weakness, Hypertension, and type 2 Diabetes. Review of the Physician's order showed an order dated 01/10/25 for droplet, contact, for Coronavirus disease (COVID-19) positive. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 01/13/24 at 10:30 AM and 11:09 AM, Resident #375 was noted in his room with a droplet isolation precaution sign noted on the door. Continued observation at 12:15 PM revealed Staff A, Certified Nursing Assistant (CNA), was noted taking the lunch tray to Resident #375's room without practicing hand sanitizing before entering the room. She entered the room with a surgical mask but no gown or gloves. Staff A touched the side table and adjusted Resident #375's items on the side table before setting down his meal tray. She then walked around the bed and used the bed remote to help Resident #375 elevate his body and head. During this entire observation, Staff A used her bare hands. An interview was conducted on 01/16/25 at 7:20 AM with Staff J, CNA, who stated when a resident is on droplet isolation, she needs to make sure that she puts on a gown, mask, and gloves before going into the droplet isolation room. She then pointed out the Personal Protective Equipment (PPE) cart that was noted outside the room.