STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105481	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Del Mar Nursing and Rehab Center	375 NW 51st Street Boca Raton, FL 33431

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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** 01948 Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of quality of life that included; 1 (Resident #33) of 5 residents sampled for nutrition/dining and 1 (Resident #82) of 1 residents sampled for personal preferences. The findings included: 1) Observation conducted on 07/16/24 at 8 AM noted tray served to the room of Resident #33. Review of tray card documented Pureed/Carbohydrate Controlled/High Protein. Further observation of the meal noted that the CNA (Staff H) mixed the pureed Scrambled Eggs, Pureed Pancakes, and Pureed Cooked Cereal together into a homogenous mixture on the main entree plate. Staff H then proceeded to feed the dependent visually impaired resident the pureed food mixture. The surveyor questioned Staff H at the time of the observation why the pureed foods were mixed together and stated to the surveyor that the resident likes and requests all pureed foods to be mixed together. Interview with Resident #33 at the time of the feeding noted she she was not alert and would not answer the pureed food questions. Staff H continued to feed Resident #33 the pureed mixture even though the surveyor requested to the facility's Registered Dietitian that the resident be sent a new pureed breakfast tray. A second observation of the breakfast meal on 07/17/24 at 8:30 AM noted the tray served to the room of Resident #33. The breakfast tray served include Controlled /High Protein Diet. Continued observation noted that the CNA (Staff I) was feeding the visually impaired resident. Further observation noted that Staff I did not mix the pureed foods together and fed the resident individually pureed portions. Staff I stated to the surveyor that she cares for and feeds Resident #33 on a daily basis and never mixes the resident's pureed foods together. She further stated Resident #33 has never requested the pureed foods to be mixed together on the main entree plate and that Staff H was incorrect about mixing pureed foods together. Staff I did stated that the resident does like the Nepro (liquid supplement) be mixed with the cooked cereal in the bowl for the breakfast meal. During the review of the clinical record of Resident #33, the following were noted: * Date of Admission: 10/12/22 * Re-admission: 6/17/23 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Diagnoses: ESRD/ Pneumonia Due to Inhalation of solids and liquids, Dysphagia, Diabetes. * Current MD Orders: 6/21/23 - Carbohydrate Controlled, High Protein Renal , Pureed Diet. 7/16/23 - Nepro BID - M/W/Sun. 7/16/23 - Nepro QD Tue, Thur, Sat. A review of MDS dated [DATE] noted the following: Section C : BIMS = 15 Section GG: Eating = Dependent on Staff * Review of the resident's weight history noted: 7/3/24 = 117.5# 6/3/24 = 117# 5/1/24 = 116# 4/5/24 = 115.7# 1/5/24 = 114.6 # BMI = 18.4 (underweight/malnourished) Height = 67 * Current Care Plan 5/15/24 noted: ADL Self Care: Assist with eating as needed and provide total feeding. 50895 2) In an interview on 07/17/24 at 12:38 PM, Staff B, a Certified Nursing Assistant (CNA), explained that Resident #82 was in the recliner chair because she was going to the dining room. Staff B was asked if this resident usually eats in the dining room. She answered she was a floating CNA, and that this surveyor should ask the nurse. She added that the resident was in a group of people who eat in the dining room. The surveyor asked Resident #82 Do you want to eat in the dining room? Resident #82 answered, No, I like to eat in my room. When Staff B was asked if she understood this resident, Staff B responded yes. The surveyor looked at the CNA and asked Why is she going to the dining room if she wants to eat in her room? Staff B suggested the surveyor talk to the nurse. The CNA brought Resident #82 to the dining room for lunch. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/24 at 12:50 PM, the Unit Manager, Staff C was asked if Resident #82 usually eats in the dining room. Staff C said that this Resident was dependent on assistance for feeding and that she ate 1 meal, lunch, in the dining room on most days. Staff C checked a Dining Room List that was posted at the nurses' station ([NAME]). Staff C confirmed that Resident #82's name was listed on the dining room list. Staff C added They take her to the dining room except if she doesn't want to go, or if something prevented her from going. Staff C continued She's not cognitive enough to say if she wants to go or not. She doesn't normally refuse. They will tell her it's time to go to lunch. When asked if Resident #82 has problems with pain, Staff C responded: The nurse would have to assess non-verbal cues. In an interview on 07/17/24 at 03:10 PM the social worker, Staff A, was asked how she determined if a resident is appropriate to take a Brief Interview for Mental Status assessment (BIMS). She explained that she begins with the first question, and if the resident answers the question, then she continues with the BIMS assessment. This surveyor requested that Staff A attempt to perform a BIMS assessment on Resident #82. On 07/17/2024 at 3:15 PM, Staff A performed a BIMS assessment. The results showed a score of 6. When Staff A was asked if she understood what Resident #82 said, she answered yes. When Staff A was asked if Resident #82 understood what Staff A said, she answered yes.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observations, interviews and record review, the facility failed to inform a resident's guardian of proposed medical care and treatment options in advance, to choose the option she prefers. This affected 1 of 1 resident reviewed for planning and implementing care with a resident representative (Resident #40). The findings included: Resident #40 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, Chronic kidney disease, Other obstructive and reflux uropathy, Dementia, Bipolar disease and Schizophrenia. Review of the resident's face sheet indicated the resident had a legal guardian. The resident's Brief interview for mental status (BIMS) score was 8 on the admission Minimum Data Set (MDS) with an assessment reference date of 05/24/24. This indicated the resident had mild cognitive impairment. On 07/15/24 at 11:15 AM, an interview was conducted with Resident #40. The resident stated he wanted surgery for his left hip because he was having a lot of pain. He stated he was not sure if the surgery was already planned or not. The surveyor asked him if he still had a Foley catheter (an indwelling urinary catheter), and he stated he did but could not explain why he had the Foley catheter. He repeatedly asked about the hip surgery and when it was going to be done during the interview. Resident #40 was asked if he had seen a urologist for the Foley catheter and he was unable to recall if he did or not. Review of the medical record for Resident #40 revealed the resident was admitted to the facility with a Foley catheter. There were no urology visit notes in the medical record. An interview was conducted with the Infection Preventionist on 07/17/24 at 4:10 PM regarding the Foley catheter. The resident was admitted with ESBL (Extended-spectrum beta-lactamases) in the urine and had been on intravenous antibiotics so the Infection Preventionist had been aware the resident had a Foley catheter. ESBL infections are caused by bacteria that produce an enzyme called Extended-Spectrum Beta-Lactamase (ESBL). This enzyme makes the bacteria resistant to many common antibiotics, such as penicillins and cephalosporins. During the interview with the Infection Preventionist, she was asked if the resident had seen a urologist. She stated his physician said the Foley was chronic and the resident refused the urology consult. The surveyor asked if she had spoken to the physician and she stated the acting Director of Nurses (DON) spoke with him. The surveyor asked to speak with the acting DON and was told she had left for the day. A telephone call was placed to the acting DON on 07/17/24 at 4:38 PM. She stated she spoke with the resident's physician who stated the resident refused follow up appointments, and refused the urology consult. The surveyor asked the acting DON if the resident's guardian was aware of this and she said typically the guardian is aware and this would be documented under miscellaneous in the electronic medical record. The surveyor reviewed the miscellaneous record and there was no record that the guardian was informed of this. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 4:50 PM the Administrator handed the surveyor his phone that had the resident's physician on the line. The physician stated that the resident did not need any further treatment for the ESBL in the urine. He stated that the Foley catheter was removed in another facility he was in prior to this facility and he retained urine so the Foley was chronic. The resident initially refused hip surgery but now he agreed to it. A urology consult was postponed until after the hip surgery was done and the guardian was in agreement to this. A voicemail was left for the resident's guardian on 07/17/24 at 4:54 PM, 07/18/24 at 9:30 AM and 07/18/24 at 11:44 AM. She returned the call on 07/18/24 at 12:39 PM. She stated that no one in the facility told her that they were holding off on a urology consult until after the surgery. She stated that she was aware that the resident was planning to have hip surgery but was unaware that he refused a visit to urologist. She was also unaware that the physician said they are holding out on a urology consult until after the surgery. The guardian stated she would like the resident to see a urologist before the surgery and she will call and tell them and she will go to the appointment with him.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation and interview it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 4 residential areas that included: Williamsburg Unit, [NAME] Unit, Cambridge Unit, and [NAME] Unit. The findings included: 1) During the initial environment tour conducted on 07/16/24 at 1:30 PM and accompanied with the Administrator and Corporate Maintenance Director, the following were noted: (a) Williamsburg Unit: Soiled Utility Room - The specimen refrigerator was noted to have a large build-up of ice. It was discussed with the Administrator that the unit was not being defrosted on a regular basis and could result in inaccurate lab analysis of specimens. room [ROOM NUMBER] - The room windows were visibly soiled. room [ROOM NUMBER] - The room windows were visibly soiled. room [ROOM NUMBER] - The window screen was noted to have a large tear (12 X 12). Hallway: One of one wall mounted light fixture was broken and was falling off of the wall. Community Shower #2 - The room floor was heavily soiled, and a broken wall electrical cover. Laundry Chute Room - The laundry catch cart located at the bottom of the chute was noted to be overflowing with non -bag soiled resident linens. Further noted that many of the soiled linens were located on the floor of the room. The administrator stated that the soiled laundry needs to picked up more frequently. The ceiling vent was noted to be heavily dust laden. (b) [NAME] Unit: Pantry: The door gaskets of the refrigerator (freezer/refrigerator were heavily soiled and evidence of dead insects. Unidentified large containers (2) of frozen foods failed to be labeled. Following the 07/16/24 observation the findings were again reviewed confirmed with the Administrator. 2) During a second environment observation tour conducted on 07/17/24 at 1 PM with the Corporate Maintenance Director the following were noted: (c) Cambridge Unit: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cambridge Hallways : The exteriors of the wall mounted hand rails and wall mounted chair rails were heavily worn and areas of peeling paint. The areas included the 3 hallways located on the Cambridge Unit (Rooms #200 through #248). Community Shower #1: Missing privacy curtain, broken ceiling light cover, and exterior of entry/exit door was worn and in disrepair. Trash/Laundry Chute Room - The ceiling vent was soiled and dust laden, and ceiling tiles (x 2) discolored and evidence of a roof leak. room [ROOM NUMBER] - Exterior of room entry door was damaged and in disrepair. room [ROOM NUMBER] - Exterior of room entry door was damaged and in disrepair. room [ROOM NUMBER] - Room windows (X 3) noted to be heavily soiled and unable to view through the windows. (d) [NAME] Unit: [NAME] Hallway - The exterior of the wall mounted handrails and wall mounted chair rails were heavily worn and areas of peeling paint. The areas included the one hallway (Rooms #249 through #267). Pantry: The ceiling vent was dirt/dust laden, refrigerator interior soiled, and exterior of entry/exit door was damaged and in disrepair. Lounge/Dining Room - Large holes in window screens (x 3) , and window surfaces were soiled (x 6). Following the 07/17/24 observation tour the findings were reviewed and confirmed with the Administrator.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948 Based on observation , interview, and record review, it was determined that the facility failed to provide 2 (Resident #19, and #28) of five sampled residents for nutritional review with appropriate treatment and services to maintain or improve ability eat independently. The findings included: 1) During the observation of the breakfast meal on 07/17/24 at 8 AM, it was noted that the meal tray was served to the room of Resident #19. Continued observation noted that the resident was lying in bed and asleep, and the tray was just left on the resident's overbed table by the Certified Nursing Assistant (CNA). Observations conducted every five minutes from 8:05 AM through 8:40 AM noted no at no time staff entering the room to attempt to awaken the resident and to provide assistance with eating. During the 5 minute observations,specifically at 8:10 AM the resident was noted to be awake and pleasant and asked the surveyor to open the Nutritional Treat (Frozen Chocolate Supplement) that was on the tray and give to her with a spoon. The resident was noted to attempt to eat the frozen supplement while lying down in the bed. The resident appeared very hungry and tried to consume the supplement but spilled the majority onto the front of her night gown. Another observation conducted on 8:20 AM again noted the resident to state she is thirsty and requested the surveyor to open and served her Nectar thick Orange Juice. The surveyor opened the juice and the resident took it into her hand and attempted to drink but spilled the majority due to laying flat in the bed. The surveyor asked the resident if she would eat some of the hot pureed foods but the resident stated she did not like the pureed foods. On 07/17/24 at 8:45 AM, which was 40 minutes after the first meal observation of Resident #19, the meal tray was taken away from the resident with 0% meal intake. Following the observation the meal issues were discussed with the facility's Registered Dietitian who agreed with the surveyor's findings. Review of the clinical record noted the following: * Date of Re-admission 3/31/23 * Diagnoses: COPD, Parkinson's Disease, Schizophrenia, Dementia, Dysphagia. * Current Physician Orders: 4/3/23 - Pureed/Enhanced/ Moderately Thick Liquids 4/3/23 - Nutritional Treat - Three Time per Day 6/21/24 - ProSource 30 ml Daily - Supplement Current MDS: dated 6/20/24 noted: Section C: BIMS = 00 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sec D : No response to Mood questions Section E: No Hallucinations, no Delusions , no Behaviors Sec GG: Eat = Requires Set up /Clean Up Sec K : No Swallow Disorder 66/108 # Therapeutic Diet Section M : NO Pressure Ulcer * Weight History: 7/8/24 = 105# 6/26/24 = 111 # 5/1/24 = 115 # 3/6/24 = 118# BMI = 16.9 Height = 66 Weight loss of 13 pounds in 4 months. * Review of Care Plan Review: Date 7/5/24 < Nutritional Status Actual /Pot Wt Loss -Parkinson's/Dementia Thickened Liquid Fluctuating Intake ADL Self Care- Assist with eating Assist with Eating * Nutrition Assessments: conducted on 4/3/23 Decrease in food intake Psychological Stress (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BMI less than 23 Dementia Score = 5 - Malnourished 2) Observation of the lunch meal conducted on 07/16/24 at 12:30 noted meal tray served to the room of Resident #28. Continued observation noted the CNA put the meal tray on the overbed table which was located on the right side of the resident. Only the lid was taken off the entree plate and staff left the room without supervision or assisting the resident to eat the lunch meal. Resident noted to not be able to reach the food tray located on the overbed table and was attempting eating with hands resulting in spilling of foods over the tray, floor and onto the resident. Meal tray taken away with the resident not receiving supervision or assistance with the meal. Resident consumed less than 25% of the lunch meal. Second observation of the breakfast meal on 07/17/24 at 8:30 AM noted the tray served to the room of Resident #28. The tray was put on top of the resident's overbed table which was located to the right side of the resident's bed. The lid taken off the main plate and staff left the resident to attempt to self feed. Further observation noted the alert resident struggling to eat independently and was noted to put the bowl of Cheerios (no milk) on her neck and drop pieces of the cereal into her mouth which resulted in the cereal spilling all over the resident. Further observation noted the resident attempting to eat foods from the main plate (eggs, toast) with hands and spilling over the floor and overbed table. The silver ware was noted to be out of reach for the resident to utilize to self feed. Resident in poor eating position throughout the meal. At 8:50 AM nursing staff was noted to take the breakfast tray away from the resident without the resident able to receive assist to complete the meal. The intake of the meal was noted to be less than 50%. During the meal observation the surveyor requested the facility's Registered Dietitian to view the resident during the meal. The Dietitian confirmed all the surveyor's findings and stated that the issue was unacceptable. Review of clinical record of Resident #28 noted the following: * Date Of Admission: 9/12/22 1/24/23 - Hospice * Diagnoses: ASHD, Parkinson's Disease, Muscle Wasting, Dementia * Current MD Orders: 0/12/22 - (revised 1/24/23) - No Added Salt - Enhanced Foods for Lunch & Dinner 9/16/23 - Nutritional Treat Daily 3/2/23 - Vitamin C 500 mg BID 3/2/23 - Zinc 50 mg BID - Wounds 3/28/24 - ProSource 30 ml Daily - Wound (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Weight History: 7/15/24 = 99# 7/9 = 98# 5/2 = 103.8# 4/8/24 = 106.4# BMI = 19.3 Ht = 60 * Current MDS dated [DATE]: Section C : BIMS = 9 Section D : No Mood Issues Sec GG : Eating - Set Up with Assistance Sec K : NO Swallowing Disorder Height/Weight = 60/106# Sec M : Pressure Ulcer Present (1) - Stage III * Care Plan: Review dated 5/8/24 noted: Requires Assistance with eat - Position Resident Upright Set up Meal ** Provide assistance and encourage with feeding - Feed resident slowly

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observation, record review and interview, the facility failed to ensure that a resident receives wound care/dressing changes consistent with professional standards of practice for 3 of 3 residents sampled for skin conditions review (Resident #12, #20 and #47) and failed to administer topical skin medication as per physician orders for Resident #12. The findings included: 1) Review of Resident #12's clinical record documented an admission on 06/29/22 with no readmissions. The resident diagnoses included Malignant Neoplasm Of Bladder, Neoplasm Of Uncertain Behavior of Skin, Personal History of Other Malignant Neoplasm of Skin, Allergic Contact Dermatitis, Blepharitis Left Eye, Upper and Lower Eyelids, Basal Cell Carcinoma of Skin of Other Part of Trunk, Basal Cell Carcinoma Of Skin Of Scalp And Neck, Methicillin Resistant Staphylococcus Aureus Infection-Unspecified Site. Review of Resident #12's Minimum Data Set (MDS) annual assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 14 indicating that the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent on the staff for bathing and showering activities of the daily living (ADL's). On 07/15/24 at 10:05 AM, during an initial tour to the facility, observation revealed Resident #12 in bed. An interview was conducted with the resident who stated he had a rash and added the doctor wanted him to have some ointments put on and nothing had been done about it. The resident lifted up his gown and showed an undated foam dressing on his chest and stated it was put on yesterday (07/14/24). Observation revealed skin redness, straight lines, the resident stated he did not know what it was. On 07/16/24 at 8:31 AM, observation revealed Resident #12 in bed. An interview was conducted with the resident and showed the undated foam dressing on his chest continues in place. An interview was conducted with the resident and he stated he was not sure when the dressing was changed. On 07/17/24 at 11:08 AM, an interview was conducted with Staff M, Registered Nurse (RN) who stated Resident #12 went to a dermatologist appointment on 07/16/24 and that no new orders were received. Staff M stated he looked at the resident this morning and noticed dressing on his head, forehead and did not check his chest. A side by side review of the resident's clinical record was conducted with Staff M; the review revealed the resident had multiple skin treatments to be done on all shift, not a dressing change order noted. Staff M was apprised that Resident #12 had a dressing on his chest noted on 07/15/24 that was not dated. Staff M stated all dressings had to be dated. Subsequently, a side by side observation of Resident #12's skin was conducted with Staff M, RN. During the observation, Resident #12 stated the dermatologist changed his chest dressing on 07/16/24, the dressing was not dated. Staff M was asked to submit the dermatologist consult for 07/16/24. 2) Review of Resident #20's clinical record documented an admission on 08/08/23 with no readmissions. The resident diagnoses included Metabolic Encephalopathy, Protein-Calorie Malnutrition, Heart Failure and History of Falling. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Del Mar Nursing and Rehab Center	375 NW 51st Street Boca Raton, FL 33431

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's MDS quarterly assessment dated [DATE] documented a BIMS score of 0 indicating that the resident had severe cognition impairment. The assessment documented under Functional Abilities and Goals that the resident was dependent from the staff to complete most activities of daily living. On 07/15/24 at 10:02 AM, observation revealed Resident #20 being wheeled by Staff C, Unit Manager (UM). The resident was confused, calling mama, mama. The resident was not interviewable. Further observation revealed the resident had an uncovered skin tear to her right forearm. On 07/16/24 at 10:17 AM, observation revealed Resident #20 sitting at the edge of the bed with an undated dressing to her right forearm. The resident was confused. On 07/17/24 at 10:47 AM, a side by side observation of Resident #20 was conducted with Staff M, RN. Observation revealed the resident in bed, lying over her right side, right arm had a loose and undated dressing. The dressing had a small amount of serous sanguinolent secretions, the open skin was touching the sheet. During the observation, Staff M stated he was aware of the resident's skin tear to the right arm, it happened about a week ago, the resident was agitated and was banging her arms. Staff M added that he believed the evening shift did the dressing change. Staff M stated the dressing was supposed to be dated. Resident #20 asked to go to the bathroom, observation noted an offensive urine like odor and the resident's sheet right sided where she was lying on had a mark of possible urine. Staff M confirmed a strong urine like odor in the room and the sheet mark was urine. On 07/17/24 at 11:04 AM, an interview was conducted with Staff O, Certified Nursing Assistant who stated she had not done Resident #20's care yet but changed her brief earlier. Staff O did not know if the resident had a dressing on her arm or not. Observation revealed Staff O transporting the resident into the bathroom for care with her skin tear uncovered, no dressing noted. On 07/17/24 at 11:06 AM, a side by side review of Resident #20's clinical record was conducted with Staff M who stated a documented physician order dated 07/09/24 as Right Forearm open skin: cleanse with normal saline, pat dry, apply xeroform and cover with dry dressing every day shift Tuesday, Thursday, Saturday for 14 days On 07/17/24 at 12:14 PM, observation revealed Resident #20 wheeling herself down the hallway, yelling mama and bleeding from her undressed right arm skin tear. Observation revealed a Dietary staff walking by who stated she (resident #20) is bleeding. Surveyor asked the administrator who was nearby to call the wound care nurse. The resident skin tear was undressed since side by side observation with Staff M at 10:47 AM. 3) Review of Resident #47's clinical record documented an admission on 08/10/23 with no readmissions. The resident diagnoses included Muscle Wasting and Atrophy, Diabetes Mellitus Type II, Anxiety Disorder, Heart Failure, Peripheral Vascular Disease, Acquired Absence of Left Leg above knee, and Alzheimer's Disease. Review of Resident #47's MDS quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 4, indicating that the resident had severe cognition impairment. The assessment documented under Functional Abilities and Goals that the resident needed partial to moderate assistance from the staff to complete the activities of daily living. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's physician orders lacked a written order for skin dressings. Review of Resident #47's nursing note dated 06/13/24 documented .writer noticed skin tear while Aide was changing Pt (patient). Writer asked Pt if she was ok and asked Pt what happened and Pt stated, I don't know. Writer asked Pt if she knew when skin tear occurred and Pt stated today .Writer cleaned up skin tear and applied a bordered dressing. Call placed to Doctor (name) and no new orders were given. On 07/15/24 at 11:41 AM, observation revealed Resident #47 sitting up in a wheelchair by the activities lounge and had two undated dressings on her right lower leg. The resident was answering Yes and No to questions asked. On 07/17/24 at 9:25 AM, entered Resident #47's room with Staff K, Licensed Practical Nurse (LPN). Observation revealed Resident #47 was in bed lying over her left side with her right leg hanging down from the edge of the bed. Further observation revealed the resident had one undated foam dressing to her right lower leg and one undated foam dressing to her right elbow. An interview was conducted with Staff P, CNA who stated the resident had a skin tear. On 07/17/24 at 9:41 AM, a joint interview was conducted with Staff K, LPN and Staff P, CNA. Staff K was asked about Resident #47's dressing on her right lower leg and right elbow and replied she did not know why the resident had those dressings. Staff P stated she saw the dressing on Sunday, her last day working with the resident and added the resident had fragile skin. Staff K stated the dressings should be dated. Staff K confirmed Resident #47's undated dressing to right lower leg and right arm close to the elbow. Staff K was asked to call the wound care nurse (WCN). On 07/17/24 at 9:55 AM, a side by side review of Resident #47's clinical record was conducted with Staff K, LPN who stated the resident usually has skin tears, added she did the last nursing note on file on 06/13/24 and documented the resident's right lower leg skin tear, added she call the doctor and no new orders were given. Staff K was asked for the facility protocol/policy regarding what to do when a resident sustained a skin tear and replied they will clean it with normal saline solution, put a xeroform and bordered dressing, then the WCN was supposed to come and look at it. Staff K was asked who will put the skin tear dressing changes order in the record and stated usually the WCN put the treatment on the TAR (treatment administration record). Staff K was asked to pull up Resident #47's TAR for dressing changes to skin tears and stated she did not see one, stated the resident did not have a physician order for wound/dressing care. Staff K stated she was not given report about the resident dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 10:01 AM, while Staff K and surveyor were walking towards Resident #47's room, observation revealed the facility's administrator, the Regional Nurse and Staff L, Unit Manager coming out of Resident #47's room. Consequently, a joint interview was conducted with the administrator, the Regional Nurse, Staff L and Staff K. The Regional Nurse stated that they were informed about the resident dressing and came to look at it. Staff K assigned nurse stated she informed Staff L that the resident had undated dressings. Observations revealed Resident #47's dressings were removed. Staff L stated she removed the dressings to see what was underneath. Staff L was asked what was underneath and stated nothing. A side by side observation of Resident #47's right lower leg and right forearm was conducted with Staff L, UM, Staff K, LPN, and Regional Nurse. The observation revealed Resident #47 had a skin tear on her right forearm, and dry skin on her right lower leg. Staff L stated the right arm skin tear was probably when they pulled the dressing off. They were all informed that Resident #47 had an undated dressing on her right lower leg observed since 07/15/24 with no evidence of a written physician orders on file. On 07/18/24 at 10:42 AM, during an interview, the WCN stated that residents skin tear care was done by the floor nurses and that she was not aware of Resident #47's dressings. 4) Review of Resident #12's clinical record documented an admission on 06/29/22 with no readmissions. The resident diagnoses included Neoplasm Of Uncertain Behavior of Skin, Personal History of Other Malignant Neoplasm of Skin, Allergic Contact Dermatitis, Blepharitis Left Eye, Upper and Lower Eyelids, Basal Cell Carcinoma of Skin of Other Part of Trunk, Basal Cell Carcinoma Of Skin Of Scalp And Neck, Methicillin Resistant Staphylococcus Aureus Infection-Unspecified Site. Review of Resident #12's physician orders documented the following topical skin medications: - Aveeno Anti-Itch External Lotion 1-3 % (Pramoxine-Calamine) Apply to Body topically every 8 hours as needed for Contact Dermatitis Avoid Fragrances or harsh chemicals-dated 11/22/23. - Triamcinolone Acetonide External Cream 0.1 % (Triamcinolone Acetonide (Topical) Apply to chest topically every day and evening shift for Rash- dated 11/30/23. - Hibiclens External Liquid 4 % (Chlorhexidine Gluconate) Apply to scalp of head and trunk topically every day shift for Dry Scalp please wash scalp and trunk daily- dated 02/21/24. - Mupirocin External Ointment 2 % (Mupirocin). Apply to nose and right neck topically two times a day for rash- dated 03/14/24. - Triamcinolone Acetonide Cr 0.1 % w/Ketoconazole Cr 2% (1:1) Cream 0.1 % Apply to Trunk and arms topically two times a day for red rash - dated 03/18/24. - Hibiclens External Liquid (Chlorhexidine Gluconate). Apply to skin topically one time a day for scabs wash skin daily with hibiclens, avoid eyes and mucous membranes-dated 04/03/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 10:05 AM, during an initial tour to the facility, observation revealed Resident #12 in bed. An interview was conducted with the resident who stated he had a rash and added the doctor wanted him to have some ointments put on and nothing had been done about it. The resident lifted up his gown and showed an undated foam dressing on his chest and stated it was put on yesterday (07/14/24). Observation revealed skin redness, straight lines, the resident stated he did not know what it was. The resident's scalp had some skin opening with some secretions oozing from it, no dressing on scalp noted. On 07/17/24 at 11:08 AM, an interview was conducted with Staff M, Registered Nurse (RN) who stated Resident #12 went to a dermatologist appointment on 07/16/24 and that no new orders were received. Staff M stated he looked at the resident this morning and noticed dressing on his head, forehead and did not check his chest. A side by side review of the resident's clinical record was conducted with Staff M; the review revealed the resident had multiple skin treatments to be done on all shift. Staff M stated he was applying some ointment to the resident skin. Subsequently, a side by side observation of Resident # 12's skin was conducted with Staff M, RN. During the observation, Resident #12 stated the dermatologist will fax new orders. Staff M stated he had not seen any new orders from the dermatologist and added that the night shift nurse told him there were no new orders. Observation revealed the resident had no dressing on his scalp, skin opening on top of his head noted with some ointment like on it, one undated dry dressing on his right lower cheek, and an undated sterile dressing on his chest. Subsequently, an interview was conducted with Resident #12 who stated he went to the Dermatologist yesterday (07/16/24) who was very upset because the staff did not put his ointment on as he wanted. The resident stated the dermatologist changed his current chest dressing. Staff M lifted up the chest dressing and two small open skin were observed. The resident stated they have to put an ointment on it. The resident stated again the staff was not putting his ointment on as the doctor wants. On 07/17/24 at 11:20 AM, a side by side review of Resident #12's topical ointments located in the treatment cart was conducted with Staff M, RN. The cart contained the following for topicals labeled for Resident #12: *one (1) undated and opened tube for Gentamicin sulfate 0.1%, the pharmacy label was dated 05/26/24 and read apply to scalp, face two (2) times a day, and abdomen topically. The tube was half full. *one (1) opened Gentamicin sulfate ointment 0.1% tube dated 05/22/24, the pharmacy label dated 05/21/24 (same directions as above). The tube was half full. *one Hibiclens-Chlorhexidine Gluconate solution 4% skin cleanser unopened bottle, with a pharmacy label directions that read apply to skin topically one time a day for scabs wash skin daily, pharmacy label was dated 05/20/24. During the observation, Staff M stated he used the green generic Hibiclens-Chlorhexidine Gluconate solution 4% skin cleanser, not the one the pharmacy sent and pointed to a Hibiclens bottle with an expiration date on 06/2024. The bottle was almost full and was not dated with the opening date. Further review revealed no evidence of Mupirocin External Ointment 2%, Triamcinolone Acetonide External Cream 0.1% or Aveeno anti-itch External lotion 1-3%, prescribed medications for Resident #12 in the treatment cart. Staff M confirmed the findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 12:11 PM, an interview was conducted with the Acting DON who was apprised of Resident #12's Aveeno, Mupirocin and Triamcinolone not readily available for the resident. The Acting DON was showed the almost full opened bottle of Hibiclens skin cleanser from the pharmacy. Review of Resident #12's dermatologist's letter dated 05/09/24 documented .please follow instructions regarding regular Hibiclens washes daily to scalp and trunk .use Triamcinolone to rash on trunk as instructed on prescription . Review of Resident #12's dermatologist's consult note dated 05/09/24 documented .the patient has chronic MRSA affecting scalp and it seems that despite instructions to his facility to apply gentamicin twice daily and to wash the scalp with Hibiclens, nothing is being done, and it has started crusting and oozing significantly again .bacterial infection-mid-parietal scalp . Review of Resident #12's dermatologist's consult note dated 07/16/24 documented .he (resident) is meant to have gentamicin ointment placed on the healing sores on the scalp and it was ordered to have the scalp washed with Hibiclens but yet again neither is being done .history of squamous cell carcinoma on .scalp . right lateral chest .it is unclear what the facility is doing at present to clean his trunk .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, record review, observation, and interview, the facility failed to prepare an appropriate environment for Wound Care for 1 of 1 sampled residents observed, Resident #108. The findings included: Review of the facility policy and procedure on 07/17/24 at 11:45 AM titled, Dressings, Non-Sterile provided by the Director of Nursing (DON) reviewed April 2019, documented in the Policy Statement: This procedure may involve potential/direct exposure to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals Purpose: The purposes of this procedure are to provide guidelines for non-sterile dressing changes to protect wounds from injury and to prevent the introduction of bacteria .Steps in Procedure 2. Assemble all necessary equipment and supplies to perform the procedure and take them to the resident's room .5. Place equipment on the bedside stand or overbed table. Arrange the supplies so that they can be easily reached 15. Observe the wound and surrounding skin . Resident #108 was admitted to the facility on [DATE] with diagnoses which included Pressure Ulcer. He had a Brief Interview Mental Status (BIM) score of 00 (cognition severely impaired). On 07/16/24 the physician's order documented for Sacral wound care: to clean with normal saline, apply Dakin's solution 0.25% to a moistened gauze and cover with a dry 4 x 4 dressing every day. Care plans dated 06/05//23 for Chronic Sacral ulcer and the care plan for at risk for alteration in skin integrity related to: impaired mobility, incontinence, malnutrition, skin failure and wounds documented to provide preventative skin care routinely and as needed PRN as an intervention with the goals to decrease/minimize skin breakdown risks with continued signs of healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 10:16 AM, an observation was conducted of a dressing change to the sacrum Stage IV (admitted with) for Resident #108. Resident #108 was readmitted to the facility on [DATE]; this wound care was performed by the Registered Nurse (RN)/Wound Care Nurse (WCN). Resident #108 was observed lying down in bed, at the time. The WCN retrieved a gown from her wound care cart. Resident #108 provided permission for this Surveyor to observe the wound care. The WCN checked the order and verified the resident's identity. She then prepared her supplies and placed them on the cleaned/covered bedside table after sanitizing her hands. The WCN then washed her hands. However, the WCN did not place a clean barrier down between Resident #108's skin and the dirty/contaminated brief and bed sheets, prior to beginning the dressing change. Resident #108 was already observed by this Surveyor as having a small amount of bowel movement (BM), which had already oozed out of the resident's rectum and which continued to slowly ooze out, just inches away from the Resident #108's exposed wound area, prior to and during the wound care. Nevertheless, the WCN continued to proceed with the resident's wound care without first temporarily covering up the wound with a clean dressing, cleaning up the resident's BM and then going back to change Resident #108's wound dressing, to avoid cross-contamination. Next, the WCN donned a pair of clean gloves then proceeded to remove the old dressing from the sacrum and washed her hands again. The nurse was assisted with the wound care by the DON. The wound is located on Resident #108's sacrum; it was (clean) in appearance. Next, the WCN cleansed the area (from the inner to the outer edges) with normal saline, after she sanitized her hands and donned a clean pair of gloves. The WCN then applied the Dakin's solution 0.25% with a moistened gauze cover and she then applied a dry 4x4 dry dressing. Lastly, the WCN dated the dressing and re-applied Resident #108's brief. The initial sacral wound measurements were: 1.5 cm depth tunneling at 0.5 cm with 10% slough 90% granulation per the previous Wound Care Nurse on 10/04/23. Record review of the skin assessment revealed that on 07/02/24, the sacral wound measurements were: 2.2 x 0.6 x 0.1 cm (centimeters). However, further record review of the skin assessment revealed that on 07/09/24, the sacral wound measurements were increased to 2.5 x 1.5 x 0.2 cm; a slight worsening/increase in the size of the wound bed over a period of one (1) week; without debridement. The BM was not cleaned off Resident #108's skin area, until after surveyor intervention. On 07/17/24 at 10:57 AM, an interview was conducted with both the WCN and the DON regarding Resident #108 receiving a wound care dressing while currently having a bowel movement, with no clean barrier placed between the resident's wound and the resident's dirty/contaminated brief and bed sheets. Both the WCN and the DON, acknowledged that a clean barrier should have been placed down first and that Resident #108 should have been cleaned appropriately, prior to the start/continuation of wound care; this was not done.

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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** 36057 Based on observation, interview and review of policy and procedure, the facility failed to: to discard expired medications and tube feeding formula observed during a medication storage review for 2 of 4 medication storage review; to discard an opened, unlabeled and expired bottle of Hibiclens skin care solution for Resident #12' skin care; to label an opened and undated tube of hydrocortisone cream and Therahoney gel and failed to properly secure medication for Residents #39 and #108 during a medication storage review for 1 of 4 medications cart. The findings included: Review of the facility's policy provided by management titled, Storage of Medications no effective or revised date noted documented .no discontinued, outdate, or deteriorated drugs or biologicals are available for use in this center. All such drugs are destroyed . 1) On 07/16/24 at 3:29 PM, a side by side review of the facility's medication room in the Cambridge unit was conducted with Staff C, Unit Manager (UM). The review revealed the following expired items: One (1) bottle of 100 tablets of Aspirin 325 milligrams (mg) with an expiration date on 01/2024. One (1) bottle of 100 tablets of Bisacodyl (stool softener) with an expiration date on 01/2024. One (1) opened and unlabeled 3/4 bottle of Milk of Magnesium. Twelve (12)- 237 millimeters (ml) containers of Osmolite (a tube feeding formula) with an expiration date on January 2024. During the review, Staff C stated that the nurses were supposed to check for expiration dates. On 07/18/24 at 11:45 AM, an interview conducted with the Dietitian revealed Resident #50 was receiving Osmolite formula bolus feedings four times a day via a tube feeding. 2) On 07/16/24 at 3:35 PM, a side by side review of the facility's medication room in the [NAME] unit was conducted with Staff L, UM. The review revealed two (2) 1500 ml of Glucerna 1.2 cal (tube feeding formula) with an expiration date on 01/06/24. During the review, Staff L stated Resident #110 currently receiving Glucerna 1.2 cal at 45 ml per hour via a tube feeding. Staff L stated they were responsible to check the medications in the medication room for expiration dates and central supply was checking on the tube feeding formulas expiration dates. 3) On 07/17/24 at 11:10 AM, a side by side review of the facility's Cambridge treatment cart was conducted with Staff M, Registered Nurse (RN). The review revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*one (1) opened, unlabeled and undated generic Hibiclens-Chlorhexidine Gluconate solution 4% skin cleanser with an expiration date on 06/2024. The bottle was almost full. *one opened, unlabeled and undated, tube of Hydrocortisone 1% cream. *one opened, unlabeled and undated Therahoney gel tube. During the review, Staff M stated he used the green generic Hibiclens-Chlorhexidine Gluconate solution and pointed to the expired bottle. Staff M stated all opened tubes, bottle in the cart must be dated with an opening date. On 07/17/24 at 12:19 PM, an interview was conducted with the Director of Nursing (DON) who stated an opened ointment tube should be dated and can be used for multiples residents. The DON was apprised of Resident #12's expired Hibiclens and the undated hydrocortisone cream and Therahoney tube in the treatment cart. 38349 Review of the un-dated facility policy and procedure on 07/17/24 at 2:05 PM titled, Medication Preparation for Dispensing provided by the Director of Nursing (DON) documented in the Policy Statement: All medications will be prepared .and administered in a manner consistent with the general requirements outlined in this policy. Procedure: A. 3. Prepare medications for one customer at a time only .Medication Administration: .J. 3. Medications are administered in a timely fashion as specified by policy K. 2. Dispose of wasted medication per policy . 4) Resident #39 was admitted to the facility on [DATE] with diagnoses which included Displaced Subcapital Fracture of the Right Hip with Right Bipolar Hemiarthroplasty done, Anemia, Muscle Wasting and Atrophy of the Right and Left Thigh, Gastroesophageal Reflux Disease, Hypertension, Recurrent Depressive Disorders, Adult Failure to Thrive and Dementia. He had a Brief Interview Mental Status (BIM) score of 3 (severely impaired). (continued on next page)

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	105481	A. Building B. Wing	07/18/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Medication Storage Observation conducted on 07/17/24 at 1:23 PM, with both the Director of Nursing (DON) and with Staff J, a Licensed Practical Nurse (LPN), it was noted that there were two (2) separate cups of previously pre-poured/prepared and un-packaged, medications found stored in the top drawer of the Williamsburg medication cart containing various different pills. The first medication cup had a hand-written room number on the side which, according to Staff J, was for Resident #39 in which there were fourteen (14) morning medications: Potassium Chloride ER oral tablet extended release 20 milliequivalents (meq) to be given one (1) tablet by mouth one time a day for Hypokalemia, Sennosides tablet 8.6 mg to be given two (2) tablets by mouth one time a day for Constipation, Multivitamin with Minerals oral tablet to be given one (1) tablet by mouth one time a day for Nutrition Support, Ferrous Sulfate oral Tablet 325 mg to be given one (1) tablet by mouth one time a day for Anemia, Sertraline HCl oral tablet 25 mg by mouth one (1) time a day for Depression, Finasteride oral Tablet 5 mg by mouth one time a day for Benign Prostatic Hypertrophy, Aspirin oral Tablet 325 mg to be given by mouth one time a day for pain, Memantine HCl oral tablet 10 mg by mouth two (2) times a day for Dementia, Docusate Sodium oral capsule 100 mg to be given by mouth two (2) times a day for Constipation, Famotidine oral tablet 20 mg by mouth two (2) times a day for Gastroesophageal Reflux Disease, Vitamin C/Ascorbic Acid oral tablet to be given 500 mg by mouth one (1) time a day for Supplement, Calcium Carbonate 600 oral tablet to be given one (1) tablet by mouth one time a day for Hypocalcemia, Potassium oral tablet to be given 20 milliequivalents (meq) by mouth two (2) times a day for Hypokalemia, and Allopurinol oral tablet to be given 300 mg by mouth one time a day for Gout. On 07/17/24 the Medication Administration Record (MAR) for Resident #39 documented that all fourteen (14) of the above oral morning medications had been due for administration previously for 10 AM. 5) Resident #108 was admitted to the facility on [DATE] with diagnoses which included Idiopathic Normal Pressure Hydrocephalus, Dysphagia, Sarcopenia, Unspecified Hydronephrosis, Anemia, Pressure Ulcer and Recurrent Depressive Disorder. He had a Brief Interview Mental Status (BIM) score of 00 (cognition severely impaired). The second medication cup had a hand-written room number on the side which, according to Staff J, was for Resident #108 in which there were nine (9) morning medications: Actigall/Ursodiol oral capsule 300 MG to be given by mouth one (1) time a day for Gallstones, Zenpep/Pancrelipase-Lipase-Protease-Amylase oral capsule delayed release articles 25000-79000 units to be given one (1) capsule by mouth before meals related to Gastroesophageal Reflux Disease without Esophagitis, Hiprex/Methenamine Hippurate oral tablet one (1) gm to be given one (1) tablet by mouth two (2) times a day for Recurrent Urinary Tract Infection, Docusate Sodium liquid 50 mg/5ml to be given 10 ml by mouth one (1) time a day for Constipation, Multivitamin with Minerals oral tablet to be given one (1) tablet by mouth one (1) time a day for Nutrition Support, Vitamin D/ Cholecalciferol oral tablet 50 mcg (2000 Units) to be given one (1) tablet by mouth one (1) time a day for Supplement, Zinc oral tablet 50 mg to be given 50 mg by mouth one (1) time a day for Sacral wound, Pantoprazole Sodium tablet delayed release 40 mg to be given 40 mg by mouth two (2) times a day for Gastroesophageal Reflux Disease, and Vitamin C/Ascorbic Acid oral tablet to be given 500 mg by mouth two (2) times a day for Sacral wound. On 07/17/24 the Medication Administration Record (MAR) for Resident #108 documented that all nine (9) of the above oral morning medications had been due for administration previously for 10 AM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff J, a Licensed Practical Nurse (LPN), stated to this Surveyor during a brief interview on 07/17/24 at 1:18 PM, in both instances, that she had been keeping/storing the oral pill medications there in the locked medication cart so that she could administer them individually, to both of the residents later since both residents had initially refused the medication dosage, when offered earlier. The DON further recognized and acknowledged that on 07/17/24 at 1:23 PM the medications stored in the Williamsburg medication cart #1 should not have been pre-poured/pre-pared for the residents and should have been promptly discarded when refused by the residents; this was not done.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01948 Based on observation and interview it was determined that the facility failed to store, prepare, distribute and serve food, in accordance with professional standards for food service safety for potentially 153 of the facility's 159 residents. The findings included: During the initial Dietary/Food Service Observation Tour conducted on 07/15/24 at 9:15 AM and accompanied with the facility's Corporate Food Service Director (CFSD), the following were noted: a) The door gasket of the walk-in refrigerator was torn and not attached properly, the entry door was noted to have a large area of peeling paint, and a rack of cooked foods that included chicken , pasta, and pies was not properly covered and the foods were exposed to the air. It was discussed with the CFSD that the door gasket must be properly attached to maintain refrigeration temperature, and there was a potential of peeling paint to contaminate foods. b) Observation of the Ice Cream Freezer noted a heavy build-up of ice on all interior walls, the door gasket was heavily soiled, and a thermometer could not be located within the unit. It was discussed with the CFSD that the unit was not being properly maintained and that a working thermometer is required inside the unit at all times. c) Observation of the Dry Goods Storage Room was noted to have 1/1 can storage rack that was heavily soiled and not being properly cleaned. It was also noted that an employee soiled clothing (jacket) was being stored on a food transportation cart. Noted that a 2 pound plastic container of Crystal Light Lemonade Powder was located on a food storage rack that was not properly secure (open to air) and no documentation of an opening date. The perimeter floor area was heavily soiled and not being properly cleaned on a regular basis. Three walls of the room were noted to have large areas of peeling paint. d) Observation of the commercial meal slicer noted that the slicer guide has pieces of dried food matter and that there was a build--up of brown grease around the top of the guide. It was discussed with the CFSD that the slicer was not being properly cleaned and sanitized after each use. e) Observation of the Chemical Storage Room noted to have 3 jackets hanging of the chemical storage racks. It was discussed with the CFSD that the jackets are worn by staff when frozen delivery foods are put into the freezer. It was discussed that there was the potential for the jackets to transfer chemical residue onto the cases of frozen foods. f) Observation of the Mop/Broom Storage Room noted the ceiling mounted vent to be soiled and dust laden. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) Observation of the bathroom noted that there was employee lockers (12) located in the vestibule. Observation of the open lockers (6) noted to be heavy soiled, soiled clothing, and unidentifiable foods were being stored within the lockers. It was discussed with the CFSD that the lockers need to be properly cleaned and cease the storage of foods within the lockers. h) Observation of the high temperature dish machine noted that the wash water gauge was at 120 degrees F. It was discussed with the CFSD that the wash temperature must be maintained at the regulatory temperature of 150-165 degrees F. It was discussed that the dish machine should not be utilized until regulatory temperature of the wash water is maintained during the dish machine cycles.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39026 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI) failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F584, safe, clean, comfortable, homelike environment; and F 812 food procurement, store, prepare and serve. These repeated deficient practices have the potential to affect all 159 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited F584 during the Recertification and Relicensure survey with exit dates of 04/2019, 01/2021, 01/2022 and 04/19/23. F812 was cited during the Recertification and Relicensure survey with exit dates of 1/2021, 01/2022, 04/19/23. During an interview with the facility's Administrator on 07/18/24 at 2:30 PM, the Administrator was apprised that these 2 deficiencies will be cited again on this current survey. The Administrator stated he will be working to remedy this.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142 Based on interview, record review, and observation, the facility failed to provide laundry services in a safe and sanitary manner and failed to appropriately use Personal Protection Equipment (PPE) as related to care provided to residents on Enhanced Barrier Precautions for 2 of 2 residents, Resident #40, and Resident #72, observed for Enhanced Barrier Precautions. There were 28 residents on Enhanced Barrier Precautions at the time of the survey. The findings included: The policy statement for the policy titled, Laundry dated March 2022, states: Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection and provide infection free laundry for residents. Staff should be familiar with the recommended equipment, application of supplies, equipment maintenance, and sound safety practices. The facility's policy titled, Infection Prevention and Control dated November 2019, revealed Enhanced Barrier Precautions expand the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities High-contact resident care activities .device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator 1) On 07/16/24 at 2:25P, a tour of the facility's laundry room was conducted with the Administrator and Regional Maintenance Director (RMD) attending. On the way to the laundry room an observation was made of the laundry chute room. In the laundry chute room it was noted that there were two bags of laundry on the floor. The laundry bin was overfull, which indicated the two bags had fallen from the bin. This caused an opportunity for cross contamination of laundry. In the laundry room on the dirty laundry side, an observation was made of a large, lidded bin where the lid was askew. The bin was full of dirty laundry, some of which was un-bagged. Laundry bins are supposed to be closed with a lid or covered with a non-permeable cover to prevent cross-contamination. In the clean laundry area an observation was made of three of three yellow, open topped, laundry bins where there was debris and dirt on the bottom of the bins. According to the RMD, these bins were used to transport clean laundry to the folding area. The dirt and debris would have caused cross contamination to clean laundry if the staff had proceeded to use the bins without cleaning them. The RMD had the staff clean the bins immediately. The RMD and Administrator both agreed that the observations made constituted infection control issues. Photographic evidence acquired. 36057 2) Review of Resident #72's clinical record documented an admission on 12/01/18 and a readmission on 12/03/20. The resident's diagnoses included Cerebral Infarction, Hemiplegia, Diabetes Mellitus and Aphasia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #72's physician order date 12/04/20 documented NPO (nothing by mouth) diet. On 07/16/24 at 9:30 AM, medication administration via a PEG (tube feeding) observation for Resident #72 performed by Staff M, RN was conducted. Staff M stated Resident #72 had a PEG tube and he had to crush all medications to be administered via the PEG tube. Observation revealed Staff M crushed the resident's Amlodipine, B-12 vitamin and Senna tablets. Staff M stated he will put gloves on and open the probiotic capsule. On 07/16/24 at 9:44 AM, Staff M entered Resident #72's room, without hand sanitation, donned gloves, opened the probiotic capsule and pour into a cup, pushed buttons on the feeding pump to flush the tube with water, repositioned the bed, poured water into the medications cups, retrieved the feeding tube syringe, and without donning a gown, connected the syringe to the PEG tube, checked for residual (0),then administered the medication via PEG without wearing a gown (barrier). Observation revealed a sign by the bathroom door titled, Enhanced Barrier Precautions. On 07/16/24 at 10:02 AM, during an interview, Staff M, was asked when they would wear a gown with Resident #72 and replied when they were doing care. Staff M was asked to review the Enhanced Barrier Precautions sign posted by the resident's bathroom door. Staff M stated he was supposed to wear a gown while he was administering the residents medication via PEG tube and he did not. 39026 3) Resident #40 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, Chronic kidney disease, Other obstructive and reflux uropathy, Dementia, Bipolar disease and Schizophrenia. The resident's Brief interview for mental status (BIMS) score was 8 on the admission Minimum Data Set (MDS) with an assessment reference date of 05/24/24. This indicated the resident had mild cognitive impairment. An observation of Foley catheter care was conducted with Staff E, Certified Nursing Assistant (CNA), on 07/17/24 at 1:30 PM. The enhanced barrier sign was visible on the bathroom door of the resident's room. Staff E performed Foley care wearing gloves but not wearing a gown per the enhanced barrier precaution policy. The surveyor asked Staff E if she was aware what enhanced barrier precautions meant and she stated she did. Reviewed with Staff E that she did not wear a gown during Foley care and she stated she did not see the sign. Reviewed with Staff E that even though she did not see a sign she should be aware that while doing Foley care she should have a gown and gloves on. Staff E acknowledged that this was correct.