STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105672	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 30599 Based on record review, residents and staff interviews, the facility failed to act promptly upon grievances expressed during resident council meetings. The findings included: The facility policy Grievance/Concern Policy created on 2/2010, last revised on 10/21, read, . Grievances can be filed verbally or in writing using the Grievance/Concern Form . The facility will make prompt efforts to resolve grievances . Grievances will be routed and tracked by the Grievance Officer/social services/Residence Director . Grievance Official in long term care is the social service director . Grievances will be responded to with 7 days for nonemergency concerns. The facility will notify the complainant to provide updates on resolution of the complaint . The manager responsible for investigating and resolving the grievance will complete the Grievance/ Concern Form, including the plan of resolution . Grievance Official/Resident Director will utilize a tracking system of all complaints to ensure proper follow-up. Review of the Resident Council Minutes dated 7/30/24 showed residents attending the meeting complained about not having enough staff to assist them back to their rooms from the bistro after their meals in a timely manner. The Resident Council Minutes dated 8/27/24 showed residents complained of lack of assistance from staff to and from meals on the weekends. Residents also complained of staff on the evening shift not answering call lights promptly. The Resident Council Minutes dated 9/24/24 and 10/30/24 showed residents at the meeting complained about call lights not being answered promptly on the night shift. The Resident Council Minutes do not list the names of the residents who attended the meeting or the names of the residents making the complaints. The Resident Council Minutes did not list resolutions to the complaints voiced at the meetings. Review of the Grievance Log for July, August, September and October 2024 showed no documentation of the grievances voiced during the resident council minutes. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 10:54 a.m., in an interview Resident #201's spouse complained staff at times did not answer the call light in a timely manner. On 11/5/24 at 9:12 a.m., in an interview Resident #148 said, At night I wait an hour or two hours for the aide to respond. I have got to where I just get up and go by myself. Resident#148 stated she had a history of falls with fracture. On 11/5/24 at 12:59 p.m., in an interview Resident #202's son said the facility was short staffed on the weekend. He said his mother sat in feces for over an hour. She is incontinent and has dementia and not able to use the call light. He said on Saturday she was soiled. They turned on the call light and it was an hour before someone came to change her. They said they were short staffed. On 11/7/24 at 12:56 p.m., in an interview the Social Worker said grievances voiced at resident council were not being logged on the Grievance Log. The Social Worker said he was not sure of the process for tracking and resolving grievances voiced during resident council meetings. On 11/7/24 at 1:17 p.m., in a follow up interview the Social Worker said the Activity Director reports the grievances voiced during the resident council meetings about call light response time and staffing issues to the Nurse Manager. He said there was no current process to document and track resolution of resident council grievances. On 11/7/24 at 1:56 p.m. in an interview the Administrator said she could not provide documentation of how the facility tracked and documented the resolution of grievances voiced during the resident council meetings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 30599 Based on record review, review of facility policy and procedures and staff interview, the facility failed to complete an accurate level I Preadmission Screening and Resident Review (PASRR) for 1 (Resident #38) of 1 sampled resident with a diagnosis of severe mental health requiring treatment. The failure to obtain a PASRR has a potential to prevent the resident form obtaining appropriate specialized treatments for residents with severe mental health issues. The findings Included: The Policy Preadmission Screening and Resident Review created 03/2019 and last revised on 10/2022 read, The purpose of the Preadmission Screening and Resident Review (PASRR) is to ensure individuals who are being considered for placement in a Medicaid-certified Skilled Nursing Facility (SNF) regardless of payor source are as follows: Evaluated for an intellectual or related (ID), serious mental Illness (SMI) . Offered the most integrated setting appropriate for long- term care needs (including determining whether a Skilled Nursing Facility is appropriate. Able to receive specialized services as indicated .1) The Licensed Nursing Home will obtain a level one PASRR on all new residents prior to admission to the Licensed Nursing Home . In the event, the resident is admitted from another nursing facility or acute care facility. The sending facility will send the Level I PASRR to the Licensed Nursing Home . The Licensed Nursing Home will complete a Level I PASSR on a current resident if the resident: a. Exhibits behavioral, psychiatric or mood related symptoms suggesting SMI . Review of the clinical record for Resident #38 revealed the resident transferred from another skilled nursing facility on 6/14/24. Admitting diagnoses included Psychotic Disorder with delusions due to known physiological condition, and Schizoaffective Disorder, Bipolar Type. The Psychiatric Progress Note dated 6/25/24 read, A moderate level of medical decision-making was necessary due to the patient's multiple psychiatric conditions specifically major depressive disorder, schizoaffective disorder d/o, and psychotic disorder. This necessitates regular clinical evaluations and places them at a moderate risk of deteriorating mental health and adverse health outcomes without adequate care. Review Of the Level I PASRR which was transferred with Resident #38 on 6/14/24 was dated 6/7/18 and documented at that time Resident #38 had no diagnosis of SMI. The Admission Record documented from the transferring facility showed Resident #38 was diagnosed with Psychotic Disorder with Delusions on 10/25/2018. She was diagnosed with Schizoaffective Disorder on 10/27/20. She did not have a diagnosis of Major Depressive Disorder noted in her medical record until 6/25/24 when she was seen for a psychiatric assessment at the current facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/9/24 at approximately 10:30 a.m., in an interview the Minimum Data Set (MDS) Coordinator verified the PASRR from the previous facility dated 6/7/18 was not accurate. It was not updated to reflect Resident #38's diagnoses of Psychotic Disorder with delusions (10/25/18), Schizoaffective Disorder (10/27/20). The MDS Coordinator verified Resident #38 was currently being treated for SMI and the facility and did not have an accurate Level I PASSR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interview and record review, the facility failed to conduct a drug regimen review identified on the care plan interventions for 1 (Resident #252) of 7 residents reviewed receiving psychotropic medications and sustained multiple falls at the facility. The findings included: Review of the clinical record for Resident #252 revealed an admitted [DATE]. Diagnoses included pleural effusion, generalized muscle weakness, and left rib fracture. A Daily Progress Note dated 10/16/24 noted prior to admission, Resident #252 fell at home, resulting in left rib fractures. The fall risk assessments completed on 10/17/24 and 10/21/24 noted the resident was a high fall risk. Review of the Medication Administration Record (MAR) for October 2024 and November 2024 revealed Resident #252 received the following physician ordered medications: Xanax (Alprazolam) 0.25 mg, one tablet by mouth every morning and at bedtime for anxiety on 10/26/24 and 10/27/24. Alprazolam 0.25 mg one tablet by mouth every six hours as needed for anxiety for 14 days on 10/19/24, 10/20/24 and 10/21/24. Zolpidem Tartrate 10 milligrams (mg), one tablet by mouth at bedtime for insomnia from 10/19/24 through 11/5/24. The MAR noted potential side effects included increased falls, dizziness, and weakness. Lorazepam 2 mg, one tablet by mouth every 8 hours for anxiety from 10/18/24 through 11/6/24. Oxycodone 5 mg one tablet by mouth every 6 hours as needed for moderate to severe pain. The Oxycodone was administered on 10/24/24 (once), 10/25/24 (twice), 10/27/24 (once), 10/28/24 (twice), 10/29/24 (twice), 10/31/24 (once), 11/2/24 (once), 11/3/24 (once), and 11/6/24 (once). An Order Progress Note Warning dated 10/17/24 at 4:26 p.m., noted the following drug interaction warnings triggered for coadministration of Oxycodone Oral Capsule 5 milligrams (mg), Alprazolam Oral Tablet 0.25 mg, and Lorazepam Oral Tablet 2 mg. The drugs (taken together) may cause additive central nervous system (CNS) depression. CNS depression side effects range from mild drowsiness to a profound stupor and can lead to coma or death. CNS depression can be caused by misuse of CNS depressants, such as sedatives and hypnotics. Further review of the clinical record revealed Resident #252 sustained seven falls at the facility between 10/19/24 to 11/6/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/19/24 at 10:38 p.m., Resident #252 rolled out of bed onto the floor while changing position in bed. On 10/24/24 at 10:30 a.m., the nurse was helping Resident #252. The resident slid out of the wheelchair onto the tile floor. On 10/26/24 at 6:00 p.m., Resident #252 fell while attempting to transfer unassisted. On 10/27/24 at 11:00 a.m., Resident #252 thought she could transfer unassisted and fell . On 10/29/24 at 6:00 p.m., Resident #252 was found lying on the floor under the sink in her room. On 10/30/24 Registered Nurse (RN) Staff Z added a medication regimen review to the comprehensive care plan. On 11/1/24 at 6:50 p.m., Resident #252 tried to reach for the bed unassisted and fell . On 11/5/24 at 4:14 p.m., in an interview Resident #252 appeared upset and said she did not know why she keeps falling. On 11/6/24 at 3:00 p.m., Resident #252 could not wait, attempted to transfer to the bathroom unassisted and fell . On 11/6/24 complete review of the clinical record, including nursing and physician's progress notes, consultant pharmacy reviews, and physician's orders failed to reveal documentation of a drug regimen review per the care plan intervention dated 10/30/24. On 11/6/24 at 5:00 p.m., in an interview the Transitional Care Unit (TCU) Manager RN Staff V verified Resident #252 sustained multiple falls. She verified the lack of documentation the drug regimen review was done as per the care plan intervention dated 10/30/24. She said she would provide a drug regimen review the next day. On 11/7/24 at 2:11 p.m., in an interview the Minimum Data Set (MDS) Coordinator Licensed Practical Nurse (LPN) Staff W said falls are reviewed in morning meetings. When new interventions are appropriate, they decide who will update the care plan and who will implement new interventions. She said the Unit Manager is responsible to implement new interventions. On 11/7/24 at 2:46 p.m., in an interview the Director of Nursing (DON) said she started employment at the facility on 11/4/24 and was still learning policies. Resident #252's multiple falls were discussed with the DON. The DON said the resident had the right to fall. On 11/7/24 at 3:06 p.m., LPN Staff V provided a physician order summary the Advanced Practice Registered Nurse signed and dated 11/1/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review, review of facility policy and procedure, resident and staff interviews, the facility failed to implement an ongoing resident centered activities to meet the needs of 2 (Residents #250 and #251) of 3 residents of the Transitional Care Unit (TCU) reviewed for activities. The findings included: Review of the facility policy for Activity and Lifestyle Program revised October 2022 noted the facility will provide an ongoing program to support residents in the choice of activities. The facility will plan and conduct daily activities and events. The facility will encourage residents and families to participate. The facility will provide activities off campus. The facility will engage residents in various levels of physical, intellectual, social and spiritual involvement, both active and passive individually and in groups. Review of the November 2024 TCU Life Enrichment Calendar: 11/4/24 2:00 room visits; 2:30 coffee and trivia (volunteer). 11/5/24 Puzzle books, card games, books, adult coloring books, newspaper are available in the TV room. 11/6/24 10:00 a.m. Pet Therapy with Rocky; 2:00 Room Visits; 2:30 Big Pin Bowling (Volunteer). 11/7/24 Puzzle books, card games, books, adult coloring books, newspaper are available in the TV room. 11/8/24 2:00 p.m. Room Visits; 2:30 p.m. Coffee and Trivia (Volunteer). Review of the clinical record for Resident #250 revealed an admitted [DATE]. The Admission Minimum Data Set (MDS) assessment with a target date of 11/1/24 noted the resident's cognition was intact with a Brief Interview for Mental Status score of 15. The MDS noted it was very important to the resident to do things with groups of people, do her favorite activities, go outside to get fresh air when the weather is good, have books, newspapers and magazines to read, participate in religious activities. The resident's activity preferences were also noted on the Therapeutic and Recreation Data assessment completed on 10/30/24. On 11/4/24 at 2:45 p.m., Resident #250 was observed lying in bed. In an interview, the resident said there were no activities in the TCU. She said participated in Physical and Occupational therapy for one in the morning. She said, The rest of the day, there is nothing to do. Resident #250 said she loves to play Bridge but they did not offer any card games. She said she did not know the facility had staff to provide activities. On 11/4/24 at 3:00 p.m., observation of the TCU unit revealed a long dining room table with word search and coloring books and pencils, a bookcase with reading materials, and a cabinet with an assortment of puzzles and games. A small wall mounted television in a small room next to the dining room was on with the volume muted . There was no afternoon activity staff or activity in progress. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/5/24 between breakfast, lunch, and dinner, no organized activities or activity staff were observed in the TCU. Several residents were sitting around the dining room table looking at each other making small talk. There were 3-4 word search and coloring books in the center of the dining room table. On 11/5/24 at 3:35 p.m., in an interview a family member said she visited her loved one every day and there were no activities for the residents in the TCU. She asked the Unit Manager (UM) about BINGO for the TCU residents. The UM told her BINGO was in the main building. She asked the UM to bring the BINGO over to the TCU, she would call the numbers and residents could play. The UM never brought the BINGO game over. On 11/6/24 at 3:06 p.m., in an interview the Life Enrichment Volunteer Coordinator Staff X, said she fills in for activity staff when they are on leave. Staff X said the TCU has its own separate activity calendar, and it is posted on the wall in the resident's room. Staff X said the facility offers live entertainment, BINGO, chair exercise, crafts, baking cookies next week, trivia, and sing-a longs. On 11/6/24 at 4:46 p.m., during an interview in the room, Resident #250 said therapy is finished around 9:30 a.m., and there is nothing to do after that except eat lunch and dinner. The resident said no one comes to say anything about activities. The activity calendar was taped on the wall in the room. The resident said, I can't read that. The Resident said they don't offer transport to the main building for activities. The resident said she did not know there was a cabinet with games and puzzles. The resident said she pushed her wheelchair over to the area near the cabinet one time and staff gave her an evil look. The resident said she thought residents were not allowed to go over there. On 11/5/24 9:40 a.m. Resident #251 pushed the wheelchair outside for an interview. Resident #251 said there are no activities that suit her interest and there was no staff offering activities. Resident #251 said, All we do is sit around the dining room table with a few word search and coloring books. There is no activity director that she knows of and never an outdoor activity. She said she likes to play cards, and didn't know another resident liked card games. The resident said she missed her husband who passed away a while ago and she thinks about him every day. The resident said an activity would keep my mind off my sorrow about losing him. The resident's eyes began to fill with tears. On 11/7/24 at 12:36 p.m., in an interview Resident #251 said a dog visited the TCU once. The resident said, Maybe trivia once in the TCU, but it was like nothing. The resident said no one announces, invites, or coordinates activities in the TCU, so how would you know there is anything going on? The resident said someone's husband brought in the word searches and coloring books at the dining room table because there was nothing to do. She said, For activities over here, there is basically nothing. On 11/7/24 at 3:37 p.m., in an interview Activity Assistant Staff Y said the TCU is a rehabilitation-focused unit. The activities for those residents is the rehabilitation therapy.

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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** 41905 Based on observation, record review, review of facility policy and procedure, resident and staff interviews, the facility failed to have justification for continued use of an indwelling urinary catheter (catheter inserted in the bladder to drain urine) for 1 (Resident #252) of 3 residents sampled for review of urinary catheter and bladder management. The findings included: Review of the facility policy for Bowel and Bladder Incontinence/Catheter/Urinary Tract Infection (UTI) reviewed 10/2022 noted a resident who enters the facility with an indwelling catheter is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. Residents that admit to the facility with an indwelling catheter will be assessed by the Interdisciplinary Team (IDT) and determine if the catheter has a valid medical justification for the catheter. The catheter is discontinued as soon as clinically warranted. Review of the clinical record for Resident #252 revealed an admitted [DATE] from an acute care hospital. Resident #252 was admitted with an indwelling urinary catheter. The form 3008, Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 10/17/24 noted diagnoses included acute cystitis (inflammation of the bladder) and the primary reason for transfer was Rehab. The form noted Resident #252 was incontinent of urine. A urinary catheter was inserted on 10/1/24. The indication for use was urinary retention. The form did not list the cause of the urinary retention. The nursing admission assessment dated [DATE] at 2:45 p.m., noted the resident had an indwelling urinary catheter for retention. The Admission Minimum Data Set (MDS) Assessment with a target date of 10/17/24 noted a diagnosis of neurogenic bladder (problem with central nervous system or peripheral nerves involved in the control of urination). The assessment noted the resident's cognition was intact with a Brief Interview for Mental Status score of 15. The clinical record, including physician progress notes, physician's orders, nursing progress notes, nursing progress notes, bladder data collection and interventions did not document urology referral or an assessment for catheter removal. On 11/5/24 at 9:20 a.m., Resident #252 was observed in her wheelchair. A urinary catheter drainage bag was hooked below the seat. On 11/5/24 3:12 p.m., in an interview Resident #252 said she never needed a urinary catheter before her recent admission to the hospital. She said no one at the facility asked to take it out. She said it was removed once at the hospital when she had a urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 4:17 p.m., in an interview Registered Nurse (RN) Unit Manager Staff V said Resident #252 failed a voiding trial at the hospital and admitted with the urinary catheter. She said the normal course was to attempt another void trial to see how the resident does. She verified there was no record of a voiding trial and no record of a urology consultation. On 11/7/24 12:52 p.m., in an interview RN Staff T said they removed the catheter on 11/6/24, it went well and the resident voided. On 11/7/24 12:59 p.m., Unit Manager Staff V said Resident #252 has been voiding in sufficient quantities from 11/6/24 at about 11:30 a.m. On 11/7/24 at 2:31 p.m., in an interview the concern related to the use of the indwelling urinary catheter was discussed with the Director of Nursing. She did not offer additional information related to the use of the indwelling catheter for Resident #252.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures, review of the clinical record , resident and staff interview the facility failed to obtain physician's orders upon admission for the care and management of a peripherally inserted central catheter (PICC) for 1 (Resident #84) of 1 resident receiving intravenous antibiotics through a PICC. The findings included: The facility policy Central Vascular Access Device Dressing Change noted, Perform sterile dressing changes: upon admission, if a transparent dressing is dated, clean, dry and intact, the admission dressing change may be omitted and scheduled for 7 days from the date on the dressing label . At least weekly . If the integrity of the dressing has been compromised (wet, loose or soiled). Review of the clinical record revealed Resident #84 had an admitted [DATE] with diagnoses including osteomyelitis (bone infection), bacteremia (bacteria in the blood), and methicillin susceptible staphylococcal aureus. The clinical record showed no documentation of physicians order for the care, including dressing change of the PICC. On 11/4/24 at 3:09 p.m., Resident #84 was observed lying in bed in her room. A PICC line was observed inserted in her right upper arm. In an interview, Resident #84 said she had an infected surgical wound on her back for which she was receiving intravenous antibiotics. The dressing covering the PICC was dated 10/21 and was heavily soiled with a brown substance at the border edges of the dressing. Photographic evidence obtained. On 11/4/24 at 3:21 p.m., in an interview Registered Nurse (RN) Staff B said Resident #84 was admitted with a surgical wound to her upper back. The incision separated and was infected. RN Staff B said the resident was still receiving antibiotics through the PICC. When asked about dressing changes to the PICC line insertion site, RN Staff B checked the clinical record and verified there was no physician's orders for the care of the PICC line. On 11/7/24 at 9:58 a.m., in an interview the Director of Nursing (DON) verified the lack of physician's orders for the care of the PICC. She said they identified it as a problem on the admission assessment. The DON said the Unit Manager was made aware Resident #84's PICC dressing had not been changed.

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Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 41155 Based on observation, review of facility policy and staff interviews, the facility failed to ensure all drugs and biological's were stored in locked compartments and under direct observation of authorized staff in an area where residents, visitors and staff could not access it in 1 (B wing) of 3 wings observed. The findings included: The facility policy Storage and expiration dating of Medications and Biological's documented, Facility should ensure that all medications and biological's, including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. On 11/5/24 at 10:07 a.m., observation of Resident #31's room revealed five unidentified pills in a plastic medication cup, and a sealed packet with a Lidoderm (topical anesthetic) unsecured and unattended on the resident's bedside table. Resident #31 was not in her room. Photographic evidence obtained. On 11/5/24 at approximately 10:10 a.m., in an interview Registered Nurse (RN) Staff A said Resident #31 was in the shower room getting her shower. Upon request, RN Staff A checked the resident's bedside table and confirmed the five pills and the Lidoderm patch were left unsecured unattended on the resident's bedside table. She said she should not have left the medications unattended on the resident's bedside table. On 11/7/24 from 9:20 a.m., to 9:35 a.m., continuous observation was made of four large, plastic pharmacy medications bags left unattended at the B wing nurses' desk. Photographic evidence obtained. The bags of medications were easily accessible to several staff, residents and visitors observed walking past the nurses' desk. On 11/7/24 at 9:35 a.m., the Regional Nurse Consultant (RNC) verified the four large plastic pharmacy bags were unattended at the nurses' desk. She verified the bags contained medications delivered by the pharmacy. The RNC said she would remove them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44824 Based on observation, record review and staff interviews, the facility failed to ensure dietary staff operating the low temperature dishwasher had the necessary training and competency to test the sanitizing solution to ensure the sanitation of dishes to prevent food borne illnesses of residents consuming an oral diet. The facility also failed to store food in a sanitary manner. The findings included: The facility policy Cleaning Dishes/Dish Machine stated, All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The facility policy Dish Machine Temperature Log stated, Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes. The facility policy for Food Storage #9 Stated, Food will be stored a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall with adequate space on all sides of stored items to permit ventilation. Racks and other storage surfaces will be clean and protected from splashes, overhead pipes, or other contamination. On 11/4/2024 at 9:30 a.m., during the initial tour of the kitchen with the Certified Dietary Manager (CDM), she explained the high temp dishwasher had not been working correctly and approximately two months ago had been converted to a low temp dishwasher requiring the use of a sanitizer. Dietary Aide Staff C was observed operating the dishwasher. In an interview Dietary Aide Staff A said he had been employed at the facility for approximately five or six months. He said he had never tested the sanitizer in the dishwasher. He did not know where the test strips were kept or that a sanitizer test was required. The CDM said the Head Chef was in charge of training the employees so she didn't know what training the staff had received. Review of the dishwasher logs for the month of October 2024 and November 2024 revealed the water temperature was entered on the log. The log did not contain documentation the sanitizer was checked to ensure it was at the manufacturer's recommended concentration to ensure the sanitizing of the dishes. Photographic evidence obtained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/4/24 at approximately 9:45 a.m., the CDM said the dietary staff operating the dishwasher were checking the sanitizer before using the machine but not documenting it on the log. The CDM retrieved a bottle of test strips which she said were used to test the sanitizer in the dishwasher. The expiration date of the test strips was August 2024. On 11/4/24 at approximately 9:50 a.m., observation of the dry storage area showed a small flying insect on a bucket of chicken bouillon. Food items were observed stored on the floor. The CDM verified the observation of the flying insect on the bucket of chicken bouillon and the storage of food items on the floor. She said the facility had not had pest issues. Photographic evidence obtained. Observation of the walk-in refrigerator and freezer revealed black bio growth around the bottom of the freezer entry door and the refrigerator ceiling. Photographic evidence obtained On 11/5/2024 at 9:20 a.m., in an Interview the Director of Dining and Culinary said the dishwasher had been waiting on a booster (heater) from the contracted company for months now. He said that the Executive Chef was the person responsible to hire and train the kitchen staff. On 11/5/2024 at 9:40 a.m., in an Interview the Executive Chef said she has been employed at facility for seven years and has been the head chef for the past year. She said the booster needed for the high temp dishwasher has been on back order for seven months. They added the layer of sanitizer to the dishwashing process to ensure the sanitization of the dishes. The Executive Chef said she did not know that the dishwasher required daily monitoring/testing of the sanitizer. She said the contracted company came out and occasionally checked the machine to make sure it was working properly. She said the dietary staff who use the dishwasher were never trained to test the sanitizer, including herself. On 11/6/2024 at 11:00 a.m., in an interview the Administrator said the CDM informed her the sanitizer in the dishwasher was not being monitored but the facility had not had any incident of food borne illness in the past seven months. On 11/6/2024 at 12:30 p.m., in a follow up interview the Executive Chef she had not started training the kitchen staff since she was never taught how to test the sanitizer level. The Executive Chef said they had ordered replacement test strips. She said at this time there was no way to ensure the dishes were sanitized. On 11/6/2024 at 2:00 p.m., in an interview the executive chef said they started sanitizing the dishes in the three compartment sink since they had the appropriate strips for the three compartment sink. Review of the contracted company Regular Service Call report dated 11/4/2024 at 4:28 p.m. noted, The machine is currently in chemical sanitation mode until the back ordered parts for the booster heater arrive. The chemical line from the pump to the injector inlet was severed and sanitizer was being pumped on to floor. The line from the pump to the inlet has been replaced and the machine is properly sanitizing again. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The previous visit report was dated 9/12/2024 noted the sanitizer was checked at that time and was working. No other monitoring for appropriate sanitizer level documentation was provided. On 11/6/2024 at 2:45 p.m. in a telephone interview the contracted company representative said that he tests the dishwashing machine monthly when he comes out for service. He said everyone in the kitchen should know how to test the dishwasher. He said he was informed the dishwasher had not been tested since the booster went out in April because no one knew it was required. The facility contacted him for test strips and to provide training to the kitchen staff on testing the sanitizer of the dishwasher.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 30599 Based on record review and staff interview, the facility failed to submit the required staffing data to the Center for Medicare/Medicaid (CMS) Payroll-Based Journal (PBJ) system for the Fiscal Year Quarter three of 2024 (April 1-June 30). The findings included: Review of the facility's Staffing Data Report for April 1, 2024, through June 30, 2024, showed the facility triggered in the following areas: One star rating. Excessively low weekend staffing. No RN (Registered Nurse) hours. Failed to have licensed nursing staff coverage 24 hours a day. The facility provided supportive documentation verifying required staffing and nursing hours for the third quarter of April 2024, May 2024, and June 2024. On 11/7/24 at 12:53 p.m., in an interview the Administrator said the Corporate Office sent a digital file to upload with the staffing information for the third quarter. Staff at the facility attempted to upload the file and it would not upload. The Administrator said they could not explain what happened. She stated staff at the facility are currently working on the staffing file to upload for the 4th quarter.