STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to ensure proper administration of medications for one of one resident assessed for self administration of medications, of a total sample of 44 residents, (#94). Findings: Review of the medical record revealed resident #94 a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Parkinson's disease, peripheral neuropathy, mixed anxiety disorders, neuralgia. On 4/14/25 at 1:44 PM, resident #94's spouse was observed assisting the resident with his lunch in his room. On the overbed table next to the lunch tray were two 30 milliliter (ml) medication cups with multiple pills inside the cups. The resident's spouse stated the medications included eight pills including Tylenol, Parkinson's medication, antihistamine medication, neuropathy medication, stool softener, and laxative. Resident #94's spouse stated, the nurse always left the medications with her to give to the resident with the meal. On 4/14/25 at 1:49 PM, Registered Nurse (RN) C observed the medication cups that held resident #94's medications on the overbed table. RN C acknowledged she had left the medications with resident 94's spouse. On 4/14/25 at 1:56 PM, the South Wing Unit Manager confirmed RN C should not have left medications at the bedside. She stated the nurse should always administer the medication, not leave it at bedside. On 4/14/25 at 1:52 PM, the Director of Nursing stated the nurse should have taken the pills with her if she had to leave the room. A review of the policy and procedure for Administering Medications dated December 2012 revealed, medications shall be administered in a safe and timely manner and as prescribed. The document read, Only persons licensed or permitted by the state to prepare, administer, and document the administration of medications may do so.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected resident's tobacco use for 1 of 1 residents reviewed for smoking (#511); reflected oxygen (O2) therapy for 1 of 1 residents reviewed for respiratory care, (#511); and accurately reflected active diagnoses for 1 of 1 residents reviewed for psychiatric diagnoses, (#93), of a total sample of 44 residents. Findings: 1. Review of resident #511's medical record revealed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, chronic respiratory failure, and dependence on supplemental O2. Review of resident #511's medical record revealed an Admission Observation Report form dated 3/24/25 which indicated he used O2 via nasal cannula (NC). Review of resident #511's physician orders revealed an order dated 4/10/24 for O2 at 3 liters per minute (LPM) via NC. On 4/16/25 at 1:37 PM, resident #511 was observed lying in bed, using O2 via NC flowing at 3 LPM. Review of resident #511's admission MDS assessment with Assessment Reference Date (ARD) of 3/31/25 revealed Section O, Respiratory Treatments, O2 therapy was incorrectly not selected as one of the options. 2. Review of resident #511's physician orders revealed an order dated 4/10/24 for O2 at 3 liters per minute (LPM) via NC. May remove O2 for smoking. Review of resident #511's medical record revealed a Smoking Risk report dated 3/25/25 which determined he was a safe smoker. Review of resident #511's medical record revealed he signed a Smoking Policy & Procedure on 3/24/25. On 4/15/25 at 9:37 AM, resident #511 stated he was a smoker. He explained he wore an apron while smoking and the facility kept his cigarettes and lighter. On 4/15/25 at 11:38 AM, resident #511 was observed smoking on the patio, wearing an apron, accompanied by a Certified Nursing Assistant. Review of resident #511's admission MDS assessment with ARD of 3/31/25 revealed Section J, tobacco user was incorrectly answered, NO. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 11:38 AM, the MDS Lead explained the purpose of the MDS was to capture the resident's whole picture and needs. She validated Sections J and O of the admission MDS assessment for resident #511 were inaccurate. She acknowledged tobacco use and O2 use should have been answered yes. She explained the MDS assessment was used to develop the care plan, and it was important it reflected an accurate picture of the resident. The Resident Assessment Instrument (RAI) instructions for Section J1300 read, Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. The RAI instructions for Section O0100c read, Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. 40892 3. Resident #93 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction), sepsis, general anxiety disorder, and unspecified psychosis. A review of the MDS significant change assessment with an assessment reference date of 2/13/25 revealed the MDS Lead incorrectly coded under the resident's active diagnoses, psychotic disorder other than schizophrenia. Section I-Active diagnoses psychiatric/mood disorder, I5950: psychotic disorder (other than schizophrenia was checked off as an active disease). A review of the resident's medical record revealed no diagnosis of psychotic disorder. On 4/17/25 at 10:49 AM, the Director of Nursing acknowledged the resident had no psychotic disorder diagnosis. Review of the Centers for Medicare and Medicaid Services Resident Assessment Instrument Version 3.0 Manual dated 10/01/24 revealed, Active diagnoses: Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring during the last 7 days. Check off each active disease.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on interview, and record review, the facility failed to ensure individuals with a mental disorder, intellectual disability (ID), or other related disorders had accurate Level I Preadmission Screening and Resident Reviews (PASARR) completed upon admission and/or updated as needed to receive appropriate care and services in the most integrated setting appropriate for 2 of 5 residents reviewed for PASARRs, of a total sample of 44 residents, (#4 and #98). Findings: 1. Resident #4 was admitted to the facility on [DATE] with the diagnoses of hypertension, bipolar disease type II, depression, anxiety disorder, and insomnia. Resident #4's medication orders included medications for the diagnoses of bipolar disorder, and anxiety. Review of the Level I PASARR dated 6/29/22 performed pre-admission to the facility did not include the admitting diagnoses such as anxiety, depression, and bipolar disease type II. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident #4's Brief Interview for Mental Status (BIMS) score was 15/15 indicating he had no cognitive impairment. Review of the Psychiatrist Progress Note dated 1/08/25 revealed resident #4 had irritability, anger outbursts, and manipulative behaviors and was ordered six psychotropic medications. A Psychotherapy Note dated 2/13/25 indicated a treatment plan of individual psychotherapy 3 to 4 times per month, yet the consulting physician provided treatment monthly for the resident. On 2/24/25, the physician disagreed with a request for gradual dose reduction by the consulting pharmacist, describing the patient screamed, yelled, was anxious and could be agitated. The Medication Administration Report for the March and April 2025 indicated resident #4 regularly exhibited anxious behaviors. The resident's care plan indicated resident #4 had behavioral symptom's of fabrication and confabulation. On 4/17/25 at 12:28 PM, the Assistant Director of Nursing (ADON) stated the MDS staff was responsible to ensure the accuracy of Level I PASARR documentation and update the assessment when new diagnoses were realized. She acknowledged that without an accurate Level I PASARR, the resident's need for a Level II PASARR assessment was undetermined. 2. Resident #98 was admitted on [DATE] with the diagnoses of epilepsy, depressive episodes, adjustment disorder with mixed anxiety and depressed moods. Review of the medical record revealed active physician orders for anti-depression medication. On 4/14/25 at 1:07 PM, resident #98's daughter stated her mom usually yelled and cried. She explained it was hard for staff to change her mother's brief as she physically fought with them, due to her condition. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Level I PASARR completed upon admission did not include any psychiatric diagnoses. Review of psychotherapy notes dated 4/02/25 and 4/09/25 indicated the resident had depressed/anxious mood. Review of the MDS dated [DATE] indicated active diagnoses of anxiety disorder and depression. Resident #98 had active care plans for anxiety and depression and noted she used psychoactive medications. On 4/17/25 at 5:32 PM, the Director of Nursing (DON), Regional Nurse, and the Administrator agreed the Level I PASARR was reviewed within 24 hours of admission by the Interdisciplinary team (IDT). The Social Services Director ensured the Level I PASARR was received and the DON ensured its accuracy. They explained PASARRs were reviewed quarterly by MDS staff. The DON, Regional Nurse and Administrator acknowledged there was a disconnect in their process when they realized discrepancies found during the survey with psychiatric diagnoses. They agreed the system didn't work in these cases. The facility's policy dated January 2024, entitled PASARR, indicated all new admissions and readmissions were screened for mental disorders, intellectual disorders, or related disorders per the PASARR to ensure only residents whose medical and nursing care needs could be met. The policy continued, the facility staff would notify the Social Worker as needed and make referrals to the appropriate state-designated authority. In addition, the policy indicated the facility would complete a Level II screening when a resident had a significant change in condition.

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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** 51234 Based on observation, interview, and record review, the facility failed to obtain physician's order for the care and treatment of catheter dressings for 1 of 5 residents sampled for skin conditions, of a total sample of 44 residents, (#412). Findings: Review of resident #412's medical record revealed an admitted [DATE]. His diagnoses included iron deficiency anemia secondary to blood loss, end stage renal disease, and need for assistance with personal care. On 4/11/25 his Brief Interview for Mental Status was assessed to be a 13/15, indicating intact cognitive function. Review of resident #412's weekly skin audit dated 4/10/25 noted in the new skin problems section that resident #412 had a surgical wound from a right chest Permacath and a chemoport on the left upper clavicle. A Permacath is a special catheter used for short term dialysis treatment that is tunneled under the skin and leads to a blood vessel going to the heart, (retrieved on 4/28/25 from www.drugs.com). A chemotherapy port is a small implantable device that attaches to a vein usually in the upper chest that can remain in place for weeks, months or even years, (retrieved on 4/28/25 from www.clevelandclinic.org). On 4/15/25 at 1:27 PM, resident #412 said that during his hospitalization prior to admission to the facility a Permacath was removed and he pulled down the right side of the neckline of his shirt to reveal a white gauze dressing in his upper chest area. He also said in the past he received hemodialysis; however, that was discontinued during his recent hospitalization because it was no longer needed. He pulled down the left side of his neckline to show a foam border dressing which he said covered a chemotherapy port. Neither dressing was marked with initials or a date they were placed. Resident #412 said the facility staff had not changed nor removed either dressing since his admission. On 4/15/25 at 5:33 PM, Registered Nurse (RN) B verified there were no physician's orders regarding the dressings covering the right upper chest area nor the left upper chest area. She said she thought resident #412 received hemodialysis. RN B said she had been his assigned nurse prior to today and she had not changed either dressing that were presently on his upper chest. On 4/15/25 at 5:50 PM, the North Unit Manager said she recalled that resident #412 was supposed to keep the right and left upper chest dressings in place until his upcoming speciality appointment. She confirmed she could not find a physician's order which stated the dressings should not be removed. The North Unit Manager verified nursing staff would not know to provide care to resident #412's chest dressing without a physician's order. On 4/16/25 at 11:36 AM, the North Unit Manager stated she was unable to find a physician's order that indicated resident #412's bilateral chest dressings should not be changed until his speciality appointment. She stated last night after being made aware there was no order, she obtained a physician's order to remove the dressings.

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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** 51234 Based on observation, interview, and record review, the facility failed to ensure timely assessment and follow-up for removal of an indwelling urinary catheter including a urology referral, for 1 of 2 residents reviewed for urinary catheters, of a total sample of 44 residents, (#95). Findings: Resident #95 was admitted to the facility on [DATE] with a diagnosis of acute urinary tract infection. In the hospital discharge paperwork it noted resident #95 had a urinary catheter placed on 3/16/25 related to urinary retention. The discharge paperwork noted the catheter needed to be changed every 30 days and the resident needed a follow-up appointment with a urology specialist. There was no documentation in resident #95's medical record that a urology follow-up had been scheduled by the facility. On 4/16/25 at 5:50 PM, the Director of Nursing (DON) stated Advanced Practice Registered Nurse (APRN) H, had told her he did not want resident #95 to have the indwelling urinary catheter removed until he had a urology consultation. Attempts to contact APRN H were unsuccessful. On 4/17/25 at 10:10 AM, the DON and the Regional Nurse Consultant reviewed resident #95's medical record and verified that no interventions for the removal of the urinary catheter, such as intermittent catheterization, had been attempted since his admission on 4/02/25, including a urology consult. On 4/17/25 at 10:17 AM, the facility's Scheduler, with the DON present, verified that no urology consults had been scheduled for resident #95. She did not know why there had been a delay in scheduling the consult. Review of the facility's undated, Urinary Incontinence-Clinical Protocol it noted that if a resident was admitted from the hospital with a newly placed indwelling catheter, the attending physician and the staff would evaluate the potential for removing it.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to follow up on a triggered excessive weight loss for 1 of 13 residents reviewed for food and nutrition, of a total sample of 44 residents, (#26). Findings: Review of the medical record revealed resident #26 was admitted to the facility on [DATE] with diagnoses including aphasia (language disorder) following cerebral infarction, dysphagia (difficulty swallowing), dementia, and need for assistance with personal care. Review of the Minimum Data Set Quarterly assessment with Assessment Reference Date of 3/30/25 revealed resident #26 had a Brief Interview for Mental Status score of 3/15 which indicated he had severe cognitive impairment. The MDS assessment showed the resident exhibited weight loss although he was not on a physician-prescribed weight loss prevention regimen. Review of resident #26's weights revealed on 1/10/25, the resident weighed 111.2 lbs. On 3/07/25 resident #26 weighed 109.8 lbs. and on 3/14/25 he weighed 100.4 lbs., an 8% loss in one week. On 4/11/25, the resident weighed 98.4 pounds which is -11.51% in 90 days. There was no evidence in resident #26's medical record the significant weight loss on 3/14/25 was addressed for over three weeks. Review of a progress note entered by the Registered Dietician (RD) on 1/31/25 confirmed the weights and weight loss noted in the medical record by nursing staff. Review of a progress note entered by the RD dated 4/09/25 read, Resident triggered for significant weight loss of 11.5% x 30 days. Weight loss was addressed last week with further weight loss of 2.2# (lbs.). Review of resident #26's care plan for nutritional status revised on 3/31/25 revealed he had potential for alteration in nutrition. A long-term goal read, Resident will consume 50-75% of meals as evidence by no significant weight loss through next review date. On 4/16/25 at 11:47 AM, the RD indicated she had been in the facility for a couple of weeks and was not familiar with resident #26. She stated the former RD last saw resident #26 on 3/31/25. She indicated the initial evaluation mentioned he had variable intakes and the RD recommended med pass (nutritional supplement). She indicated on 3/14/25, resident #26 showed a significant weight loss of 8% from the previous week. She stated since the RD did not attend the weekly meetings, the facility should have alerted the RD when the significant weight loss was noted. The RD indicated they did annual, admission, significant change assessments but resident #26 did not trigger for a 30-day review until she saw the weight last week. She indicated they needed to pay more attention to weekly weights. She stated they did not look at actual pounds, just percentages and mainly the 30 and 90 day data. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 4:57 PM, the Regional Nurse Consultant (RNC), and former Director of Nursing (DON) explained Standards of Care (SOC) meetings were held weekly and included discussion of residents who had significant weight loss. The stated the Certified Dietary Manager (CDM) would pull a weight variance report to identify anyone who had lost or gain five or more percent of weight in 30 days, 7.5% in 90 days or 10% in 180 days. She stated they would discuss the interventions that were in place during the meeting and inform the RD and physician of any changes. The DON indicated she did not recall the CDM bringing resident #26 to the SOC meetings. She mentioned if she had known of a significant weight loss they would have discussed it and ensured the interventions were appropriate. They validated there was no progress notes from the CDM and explained they were not previously aware of resident #26's significant change in weight. They acknowledged the current interventions were not working, and resident #26 continued to lose weight. Review of the facility's policy and procedure for Food and Nutrition Services revised on October 2017 read, The multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident's nutritional needs, food likes, dislikes, and eating habits, as well as physical, functional, and psychological factors that affect eating and nutritional intake and utilization.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety by failing to label, date, and discard food after an acceptable time period and by failing to air-dry glasses, cups, and trays prior to their use in meal service, in one of one walk-in refrigerator/freezer, one of one dry storage room and one of one kitchen. Findings: On [DATE] at 9:45 AM, during the initial kitchen tour with the Consultant Certified Dietary Manager (CDM) S, there were multiple leftover/previously opened food items found unlabeled and undated in the walk-in refrigerator as listed: four packages of wrapped American Cheese slices, two packages of shredded cheese, a half-pan of what appeared to be chicken breasts floating in water, a ,d+[DATE] steamtable pan of rice, a , d+[DATE] pan of what appeared to be egg salad, a ,d+[DATE] pan of what appeared to be au gratin potatoes, a ,d+[DATE] pan of jello and a deep pan of some kind of ground, cooked meat. In addition, there was a number of leftover food items, undated as to when they were prepared and stored including a , d+[DATE] steamtable pan labeled as 'chicken for soup', a ,d+[DATE] pan of leftover lemon pepper chicken, and previously opened sliced ham in the original packaging. There was multiple steamtable pans of leftover food items that contained labels but were expired, including a ,d+[DATE] pan of corned beef dated [DATE] (15 days prior), a ,d+[DATE] pan of what appeared to be sausage patties, unlabeled as to the contents but dated [DATE] (9 days prior), a ,d+[DATE] pan of gravy dated [DATE] (17 days prior), a ,d+[DATE] pan of leftover hot dogs dated [DATE] (6 days prior), a ,d+[DATE] pan of glazed cauliflower dated [DATE] (13 days prior), a ,d+[DATE] pan of baked beans dated [DATE] (6 days prior), a ,d+[DATE] pan of potato salad, dated [DATE] (6 days prior), and a ,d+[DATE] pan of ham slices dated [DATE] (2 days in the future). There were also four packages of raw meat in their original box/packaging that were held and unused longer than recommended: one case of ground turkey, received [DATE] (13 days prior), 2 cases with pork legs and one case of chicken breast, received [DATE] (6 days prior). In addition, an unopened case of hard-boiled eggs was found to be sitting on the ground. The consultant CDM S stated it appeared the cooks just wrapped and kept most food items from tray line instead of throwing away the leftovers. He stated if food items were retained, they needed to be labeled and dated so the other staff could identify the food items and know when they should be discarded. He stated these procedures were necessary to make sure foods that were going bad would not be served to residents. There was no signage to reference acceptable storage periods for perishable foods posted in the kitchen. A short time later, n the walk-in freezer, two boxes of chicken breasts were sitting on the floor of the freezer with two additional boxes of food stacked on top of them. The consultant CDM added that no food should be stored on the ground for sanitary reasons. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the dish machine area, four trays of plastic drinking glasses and four trays of coffee cups sat inverted on wet trays, upside down. Dietary staff D stated they would use a towel to dry the cups before using them for service to residents. The Consultant CDM informed the dietary staff the glasses and cups needed to be air-dried and not dried with a towel for sanitary reasons. In the dry storage room, a large bin labeled sugar, dated [DATE] was noted to have a round plastic container sitting inside the container of sugar. The round container did not have a handle but was being used as a scoop. In addition, there was a large plastic container of cereal, along with a box of cake mix and a box of artificial sweetener, sitting on the floor. On [DATE] at 12:22 PM, 42 residents in the main dining room were observed waiting for lunch to be served. While they waited, the residents were offered and served beverages. It was noted the drinking glasses and coffee cups were brought from the kitchen on, and served from, wet trays with the lip of the cup sitting in the water of the trays. On [DATE] at 2:43 PM, CDM T stated everyone in the kitchen was responsible to label and date foods put into the refrigerator. She explained it was important that food items were labeled and dated so staff knew when food items would expire so they could be discarded. The CDM stated the facility didn't want any cases of food poisoning at the facility, wanted residents to be safe. She clarified food items should not be stored on the ground to ensure they were not contaminated. The CDM unlabeled and undated food was not acceptable standards of food service safety. On [DATE] at 2:50 PM, the tour of the nourishment room with the CDM T revealed a previously opened, undated carton of liquid nutrition supplement and thickened juice. The South Wing Unit Manager acknowledged all food items should be dated when opened and he was unsure how long they could be used after opening. He acknowledged if the products were bad, it could make residents sick. The Unit Manager said he should ensure nursing staff dated items after they were opened. The facility's undated policy entitled Perishable Food Storage revealed leftovers could typically be safely stored for three to four days, raw poultry and ground meat for one to two days, cooked ham for seven days, and prepared lunchmeats for a week after being opened. The facility's policy entitled Food Receiving and Storage dated 2001, indicated stored food should be kept at least six inches off the floor; beverages in the nursing unit refrigerators should be dated when opened and discarded after 24 hours. In addition, the policy entitled Refrigerators and Freezers, dated 2001 indicated all food should be properly dated with received dates and with use by dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105839	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace of Kissimmee, The	221 Park Place Blvd Kissimmee, FL 34741

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43192 Based on interview, and review of facility documentation, the facility failed to ensure implementation of policies to the extent of including thorough monitoring of previously identified areas of concern and adequately tracking performance to ensure prior improvement measures were realized and sustained for two of ten concerns identified during the survey, (F554, and F880). Findings: Review of the facility's undated policy, Quality Assurance and Performance Improvement (QAPI) Program, revealed the purpose of the QAPI Program was to establish data driven, facility wide processes to improve the quality of care, quality of life and clinical outcomes of their residents. The policy included Action Steps to support and enhance the QAPI Program. The document included, Gathering and using QAPI data in an organized and meaningful way. Areas that may be appropriate to monitor and evaluate include: . State surveys and deficiencies . The facility had concerns related to infection control and self-administration/improper administration of medications which led to deficiencies at F880 in the last recertification survey of 9/14/23 and F554 for the recertification survey of 1/13/22. During this survey, the following deficiencies were again identified, F554 and F880. As a result of these repeat citations, it was identified there was insufficient auditing and oversight of the mentioned citations. On 4/17/25 at 4:57 PM, the Administrator stated during their monthly QAPI meetings they discussed areas in need of improvement. He explained Performance Improvement Projects (PIPs) may be developed and implemented accordingly. He mentioned the length of PIP's depended on how long it took to correct the problem. He stated they performed consistent audits of medication related concerns but had not identified any recent trends of medication variances. He acknowledged the QAPI committee did not adequately implement, monitor, and review the identified areas to prevent repeat non-compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on observation, interview, and record review, the facility failed to provide a system for preventing and controlling infections and communicable diseases for residents by not offering hand hygiene to residents prior to meals and not maintaining a catheter bag dragging on the floor. This had the potential to affect 43 residents eating meals in the dining room, and one of one resident reviewed for urinary tract infections, (#95) of a total sample of 44 residents. Findings: 1. On 4/14/25 at 12:22 PM, during dining observation, 43 residents in the main dining room and the small room off the main dining room, were observed waiting for lunch to be served. At 12:38 PM, the first of three carts with meal trays were delivered from the kitchen and were served to residents. None of the residents were offered hand hygiene before the meal. On 4/15/25 at 12:35 PM, 39 residents were observed waiting for their lunch meal in the main dining room. Five visitors and three residents confirmed they had not been offered hand hygiene before the meal nor had they previously been offered hand hygiene before meals that they could recall. On 4/15/25 at 1:08 PM, Certified Nursing Assistant (CNA) F assisted a resident with their meal and acknowledged she had not offered hand hygiene to the resident before they ate. The CNA stated hand sanitizer was available if they found a resident needed it, but was unsure if the residents were provided any hand hygiene before coming to the dining room to eat. On 4/16/25 at 12:50 PM, 36 residents were in the main dining room either eating or awaiting their meal to be served. A few minutes later at 1:15 PM, CNA G assisted a resident with his meal and explained they used to offer hand hygiene to residents in the dining room, but not as a hard rule. She said over time, the staff forgot to ask residents if they wanted to clean their hands. She stated it was important for the residents to have clean hands because many of them touched their food with their hands which could have a lot of germs on them. She added they had disinfectant in the cabinets in the dining room if a resident needed it, but did not say why it wasn't offered to the residents. On 4/17/25 at 3:08 PM, the Infection Control nurse, stated she realized this week, on Monday, 4/14/25, the facility did not provide hand hygiene to residents prior to meals. She added, she was surprised about that and explained her goal was to provide individualized packets of hand wipes to residents prior to meals so they could clean their hands when they wanted to. The facility's policy entitled Standard Precautions, dated 2024, contained procedures to limit or stop the spread of transmissible infectious agents. It indicated facility personnel assisted residents with hand hygiene before meals, after toileting, and when indicated. 51234 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #95 was admitted on [DATE] with diagnoses that included lower urinary tract symptoms after prostate removal surgery, unspecified dementia with unspecified severity, and need for assistance with personal care. He had a physician's order dated 4/02/25 for a urinary catheter due to prostate diagnoses. On 4/14/25 at 10:26 AM, resident #95 was seated in his wheelchair, the bottom of his urinary catheter drainage bag was dragging along the facility's floor as he was pushed in his wheelchair by a staff member. On 4/14/25 at 12:55 PM, resident #95 was seated in his wheelchair in the facility's dining room. The bottom portion of the urine drainage bag of his catheter was lying on the ground under his wheelchair. Multiple staff were present in the dining room including the facility's Infection Preventionist. No one noticed or picked up the bag from the floor at that time. On 4/14/25 at 4:00 PM, resident #95's urine collection bag and the tubing scraped the right wheel of his wheelchair as he self propelled himself down the hallway from the nursing station to his room. On 4/17/25 at 10:10 AM, the Director of Nursing and the Regional Nurse Consultant confirmed that urinary catheter tubing and collection bags should not touch the floor nor the wheels of wheelchairs to prevent potential infection. Review of the facility's undated policy entitled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, noted the urinary catheter drainage bag should not be placed on the floor.