STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115120	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Post Acute LLC	815 East 63 Street Savannah, GA 31405

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 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** 36377 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Self-Administration of Medications by Patients/Residents, the facility failed to ensure three of 54 sampled residents (R) (R30, R32, and R71) did not have unsecured and unauthorized medication or medicated treatment products at the bedside. This deficient practice had the potential to cause adverse effects for R30, R32, and R71 and allow unauthorized medication access to other residents and visitors. Findings include: A review of the facility's policy titled Self-Administration of Medications by Patients/Residents, effective date of 2/1/2024, documented the Policy Statement of Each resident who desires to self-administer medication is permitted to do so if the healthcare center's Licensed Nurse/Registered Nurse and physician have determined that the practice would be safe for the resident and other residents of the healthcare center. Medication self-administer also applies to family members who wish to administer medication. The Procedure section stated, 2. If the resident or family member desires to self-administer medications, an assessment is conducted by the Licensed Nurse to assess the individual's cognitive, physical, and visual ability to carry out this responsibility. Also, the resident or family member should, in conjunction with the facility Nurse, utilize the Electronic Medical Record assessment tool, Medication Self -Administration assessment, to complete the administration of the medication. 1. A review of R30's electronic medical record (EMR) revealed a Self-Administration Assessment Form was not completed to determine the resident's capability with medication self-administration. An observation on 4/8/2024 at 2:03 pm, in R30's room, revealed a bottle of fluticasone (a medication used to treat asthma, allergic rhinitis, and emphysema) stored unsecured and within visual view on the resident's bedside table. In an interview on 4/8/2024 at 2:05 pm, the Infection Control Preventionist (ICP) confirmed the medication on R30's bedside table. The ICP exited R30's room without removing the medication, stated she did not remove it because she did not have a place to secure it, and stated she planned for the Charge Nurse to return and lock the medication in the medication room or medication cart. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/08/2024 at 2:44 pm, the Director of Nursing (DON) confirmed that R30 was not assessed to self-administer medication. She reported that her expectations were for the nurses to remove the medication, place it in a secure location, and notify the DON. In an interview on 4/8/2024 at 2:49 pm, Licensed Practical Nurse (LPN) LL and LPN FFF reported being unaware of medication at R30's beside. They confirmed that R30 was not assessed to self-administer medications and reported only giving R30 their morning medication from the doorway without entering the resident's room today. 2. A review of R32's annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status Score (BIMS) of 10 (indicating moderate cognitive impairment). A review of R32's EMR revealed a Self-Administration Assessment Form was not completed to determine the resident's capability with medication self-administration. An observation on 4/8/2024 at 12:25 pm, in R30's room, revealed a container of Alka Seltzer Cold Medicine (an over-the-counter cold medication) and a 16-oz jar of Zinc Oxide Skin Protectant cream stored unsecured and within visual view on the resident's bedside table. In an interview at the time of observation on 4/8/2024 at 12:25 pm, R32 reported using the cold medication the previous night and that an unidentified certified nursing assistant (CNA) left the ointment in the room after applying it to her sacral area earlier. In an interview and during the observation of the medications, on 4/8/2024 at 1:11 pm, LPN FFF confirmed the medications at the bedside. She removed the medications and reported being unaware of the medication being in the room. She confirmed that the resident was not assessed for medication self-administration and reported not knowing the jar of zinc ointment as being included in the resident's treatment plan. She further stated the jar of zinc ointment cream should not be in the resident's room. LPN FFF checked the physician's orders and confirmed that the zinc oxide ointment was not ordered. In an interview on 4/10/2024 at 2:56 pm, Certified Medical Assistant (CMA) JJJ reported being unaware that R32 had medications in the room. 3. An observation of R71's room on 4/8/2024 at 1:00 pm revealed a bottle of rubbing alcohol and a bottle of hydrogen peroxide on a bedside nightstand within visual view. A review of R71's EMR revealed a Self-Administration Assessment Form was not completed to determine the resident's capability with medication self-administration. In an interview and observation of R71's room on 4/8/2024 at 1:16 pm, LPN FFF confirmed the unsecured medications in the resident's room. She reported the resident was not assessed to self-administer any medications, including topical anesthetic products, removed the products from the room, and confirmed the resident would be at risk of adverse effects from the medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/8/2024 at 2:18 pm, the DON stated the nurse had informed her of the medications in R30, R32, and R71's rooms. She stated that R30, R31, or R71 should not have medications or unapproved products in their rooms, and her expectation was for staff to observe for unauthorized medications and remove them from resident rooms. She further stated no residents in the facility had been assessed for safe self-administration of medications.

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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. 36377 Based on resident and staff interviews, record review, and review of the facility's policy titled Grievance Policy, the facility failed to thoroughly complete resident grievance forms to provide evidence that resident grievances were resolved in a timely manner and to ensure that residents were satisfied with the final resolutions for 42 of 101 resident grievance forms reviewed. This deficient practice had the potential to have an adverse effect on any resident who filed a grievance. Findings include: A review of the facility's policy titled Grievance Policy, revised 2/1/2024, documented the Policy Statement of It is the policy for healthcare centers to have and follow an established process whereby residents and/or other customers may have their grievances and complaints resolved in a prompt, reasonable and consistent manner. The Procedure section stated: 2. The Social Services or Administrator will be responsible for tracking all grievances: * The Social Services Director/Administrator will track the grievance on the Grievance Log Form. This will provide a central place for all grievances. * The Social Service Director or Administrator will then refer the grievance to the appropriate department if it has not already been referred. The Social Services Director Administrator will record the date of the referral and sign the form. * A copy of the grievance form will be maintained until the original form is returned. * A copy of the grievance form will also be sent to the Administrator. 5. The Grievance /Complaint should be completed within three business days. 6. If the complainant is not satisfied with the resolution or written response of the Administrator or designee, the complainant may submit an oral or written grievance to the community Ombudsman. Review and follow the state grievance procedures. A record review of the facility-provided documents titled Grievance Complaints revealed 101 handwritten or typed grievance forms. A continued review of the forms revealed 42 incomplete Grievance Complaints due to an omission of a response to provide evidence that the grievance was thoroughly investigated and a resolution was obtained to determine resident satisfaction. The form also omitted documentation to show that actual follow-up was made with the complainant to determine complainant or resident satisfaction. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council Meeting on 4/11/2024 at 1:45 pm, the residents in the meeting reported that they filed grievances, and no one got back to them with a resolution. They further stated that when they report a problem, no one offers to file a grievance for them. Six of the 11 members attending the meeting stated they did not know what a grievance was. Four of the members in attendance stated they had filed a grievance. In an interview on 4/12/2024 at 11:03 am, the Activity Director reported that she helped residents write grievances if they came up in Resident Council Meetings. She stated that if a resident complained that no one got back to them after they filed a grievance, she would then submit the complaint to the Administrator. She reported that many residents speak of grievances filed with the former Administration. She further stated that most of the residents' concerns were that they felt that staff were not getting back to them to inform them of resolutions. In an interview on 4/12/2024 at 11:58 am, the Administrator reviewed the 42 Grievance Complaints forms, which were incomplete with an omission of a response. The Administrator confirmed that this was not an effective process for resident grievances and stated that upon her hire on 2/5/2024, she identified a problem with the grievances and complaints process. She further stated residents had reported issues with the former Administrator not getting back to them and offering resolutions to their problems and concerns. She confirmed no process was in place to ensure the grievance process was completed when she began working at the facility on 2/5/2024.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations and staff interviews, the facility failed to post a complete listing of how to report abuse and the types of abuse, including a mailing address, email address, and information on how to report to the State Agency in a manner accessible to residents and visitors. The facility census was 109 residents. Findings include: During the initial tour on 4/8/2024 at 10:15 am and during daily walks throughout the building during the survey week of 4/8/2024 through 4/12/2024, observations revealed a posted white paper, measuring 8 x 10 inches, with bold black print stating Georgia Department of Community Services [PHONE NUMBER]. During the Resident Council Meeting held on 4/9/2024 at 1:45 pm, residents were educated on Resident Rights and Abuse. Eight of the 11 residents in attendance did not know what information to report to the State Agency or how to report it. None of the 11 residents could identify the location of the posting of the Georgia Department of Community Services telephone number. During a tour of the facility on 4/11/2024 at 4:34 pm with the Director of Nursing (DON), she confirmed the posting did not provide the correct agency name, address, telephone number, or detailed instructions on reporting different types of abuse. The DON reported that she was unaware of what should be on the sign and acknowledged the missing information. In an interview on 4/12/0224 at 11:58 am, the Administrator confirmed that the sign posted in the facility did not provide complete information for abuse reporting. She reported that she had identified this and that her plan before the survey was to order the correct sign.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on resident and staff interviews, record review, and review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property, the facility failed to develop and implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Specifically, the facility failed to report the misappropriation of property to the State Survey Agency (SSA) for two of four residents (R) (R41 and R45) who were investigated for abuse. This failure had the potential to have a negative impact on the quality of life for R65 and R41. The sample size was 54 residents. A review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property, revised 9/15/2023, revealed the Policy Statement stated: It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal {sic}or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the Stated Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident residing in the facility. The Definitions section stated: Misappropriation of resident property is defined as the deliberated misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's personal belongings or money without the resident's consent. The Policy Components section, subsection G. Reporting/Response Reporting Guidelines stated: Any allegation of neglect, exploitation, mistreatment, or misappropriation of resident property must be reported to the State Regulatory Agency within 24 hours. 1. A review of the R41's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. A review of the facility's Grievance Log revealed a grievance dated 3/22/2024 by R41 indicating he was missing six hundred dollars. The resident stated that he gave the receptionist the money upon admission to the facility. The Social Service Assistant (SSA) documented the grievance. Further review of the grievance form revealed that the SSA and the resident signed the form on 3/22/2024. The form was not signed or dated by the Administrator. During an interview on 4/11/2024 at 10:07 am, R41 revealed he had six one-hundred-dollar bills in his wallet when he was admitted to the facility. He stated that upon entering the facility, he handed the money and his wallet to the receptionist to lock them into the lockbox. He stated he never saw the money again and was unsure of the staff member's name. During an interview on 4/11/2024 at 10:18 am, the SSA revealed that R41 had informed her he was missing money, which he gave to the receptionist upon his admission to the facility in 2022. The SSA stated she reported the missing money to the Administrator but did not report it to the Social Services Director (SSD) or the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of R45's quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. A review of the facility-provided Grievance Log revealed a grievance dated 3/27/2024 by R45 stating she was missing $7.80. The grievance documented that the resident did not know when she had the money, but she had put it in her bra, and it was no longer there. The SSA documented the grievance. Further review of the grievance form revealed that the SSA signed the form on 3/27/2024. The section for the Administrator's signature was blank. During an interview on 4/11/2024 at 10:23 am, the SSA revealed that R45 informed her she was not sure when she had the money, but it was missing. She stated she reported R45's missing money to the Administrator but did not report the allegation to the State Agency. During an interview on 4/11/2024 at 10:59 am, the Director of Nursing (DON) revealed she was unaware of R41 or R45 missing money. She stated the concerns should have been discussed and reported to the State Agency, and the Social Service Department did not follow the facility's policy with the investigations. During a telephone interview on 4/11/2024 at 11:08 am, the Administrator revealed she did not remember being informed that any resident in the facility was missing money. She stated the initial report should have been filed with the State Agency, the police notified, and a five-day follow-up report should have been sent to the State office after the investigation. The Administrator stated the facility did not follow the process related to reporting grievances and abuse allegations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on resident and staff interviews, record review, and a review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property, the facility failed to ensure that abuse allegations, specifically an allegation of physical abuse and allegations of misappropriation of resident property, were thoroughly investigated for four residents (R) (R65, R41, R45, an R64) reviewed for abuse. These failures had the potential to negatively impact R65, R41, R45, and R64's quality of life. The sample size was 54 residents. Findings include: A review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property, revised 9/15/2023, revealed the Policy Statement of It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal {sic}or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the Stated Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident residing in the facility. The Investigation Guidelines stated: 1. The facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse, injuries of unknown source, exploitation, or suspicions of crime, as defined in this document. The facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation and to draw conclusions regarding the nature of the incident. 2. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 3. To the extent possible and applicable, provide complete and thorough documentation of the investigation. 4. The investigation should be documented, and any specific forms required by the State or as otherwise instructed by legal counsel (if applicable). These forms are not part of a resident's medical record. The documentation will be kept in the Facility Administrator of Directo of Nursing office in a secure administrative file marked CONFIDENTIAL or as otherwise instructed by legal (if applicable). 6. The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Any affected resident's physician and family/responsible party will be informed of the result of the investigation. 1. A review of a complaint filed with the State Agency revealed an allegation of staff to resident physical abuse involving R65. A review of R65's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. In an interview on 4/9/2024 at 12:35 pm, the Social Services Director (SSD) stated he had spoken to R65 about the allegation and that a nurse had assessed the resident. The SSD also stated that local law enforcement came out to see R65 and could not determine if there was abuse toward the resident. When asked if the investigation, the assessment, and the police visit were documented, the SSD revealed that they were not. A review of R65's Electronic Medical Record (EMR) Progress Notes revealed no documentation of the investigation of the alleged abuse. In an interview on 4/9/2024 at 6:00 pm, the Director of Nursing (DON) revealed she was not aware of the alleged abuse. She stated that the process when abuse was alleged was to notify the DON and the Administrator, file a report with the State Agency, and notify the Ombudsman, the local law enforcement, the physician, and the family. She further stated that the SSD should have investigated and documented everything that occurred. In an interview on 4/10/2024 at 12:58 pm, the SSD confirmed that he did not notify the Administrator or the DON of the abuse allegation and did not interview other residents or staff. In a telephone interview on 4/10/2024 at 1:10 pm, the Administrator revealed she was not aware of the alleged abuse incident, that it was not reported to her, and she could not answer if an investigation was conducted. She stated that the facility process is to report the abuse to the Administrator, who then reports it to the State and conducts an internal investigation. She stated if a staff member is involved, the staff member will be suspended pending investigation. She further stated that she would interview residents, staff, and anybody involved with the incident, and the investigation should be documented and kept in a file. 45813 2. A review of R41's quarterly MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. The assessment documented that R41 had not exhibited behaviors. A review of a Grievance/Concern Form documented that R41 filed a grievance on 3/22/2024 stating that he was missing six hundred dollars. This grievance was documented by the Social Service Assistant (SSA). Findings from the grievance investigation indicated that the facility's safe was checked, and the money or wallet was not found. Further review of the grievance form revealed that the SSA and resident signed the form on 3/22/2024. The form was not signed or dated by the Administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/2024 at 10:07 am, R41 revealed that he had recently reported that 600 dollars had been taken from him. R41 further stated that a report was taken and that he had filed a grievance in the past related to the issue, but no one had followed up with him about his money. A further interview revealed he signed the form but was not told the investigation was over. In an interview on 4/11/2024 at 10:18 am, the SSA revealed that R41 informed her he was missing money, which he gave to the receptionist upon his admission to the facility. The SSA stated she checked the facility's safe and had informed R41 that the money was not there, and that was all that had been done. The SSA stated she did not investigate the allegation further after she could not locate the money. The SSA did not give a reason for the allegation not being investigated. However, she acknowledged that allegations of misappropriation of resident property should be investigated. 3. A review of R45's quarterly MDS dated [DATE] revealed a BIMS score of 8, indicating moderate cognitive impairment. A review of the facility's Grievance/Concern Form revealed R45 filed a grievance on 3/27/2024 stating she had $7.80 missing. Findings from the grievance investigation documented that social services checked the residents' room for the money, but it was not found. Further review of the grievance form revealed that the SSA signed the form on 3/27/2024, and R45 signed the form with no date. The section for the Administrator's signature was blank. In an interview on 4/11/2024 at 10:23 am, the SSA revealed that R45 informed her she was unsure of the last time she had the money was, but it was missing. The SSA stated that the money was not found after checking the resident's room, and she reported the missing money to the Administrator but did not report the allegation to the State Agency. The SSA stated she spoke to other residents who regularly attended activities in the dining room because R45 frequents the dining room, but there was no documentation about the residents she spoke with. She further stated that she did not interview the resident's roommate or staff members who may have entered the resident's room. On 4/12/2024 at 10:05 am, R45 was observed sitting in the dining room getting ready for an activity. The resident was alert and oriented. In an interview, R45 stated that no one had searched her room for money. She further stated that she looked for the money and could not find it, and that she had not heard anything from the facility's staff about her money. 4. A review of a Facility-Reported Incident (FRI) revealed that the SSD submitted the report to the State Agency on 2/9/2024. The report documented that R64 alleged he placed his wallet on his nightstand with 36 dollars in it before he went to bed. He stated that the money was missing the next morning, and he reported the missing money to the nursing staff. A review of R64's quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. A review of R64's clinical record did not reveal any documentation of the resident's allegation to the social worker about the missing money. A review of the Investigative Files provided by the DON revealed no documentation that the facility investigated the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/2024 at 9:13 am, R64 revealed his money and wallet were missing. He further stated that he had told staff about it, but no one had done anything or told him any information about it. In an interview on 4/11/2024 at 10:02 am, the SSD revealed that R64 reported his missing money and wallet to him. He stated he searched the resident's room, and after the items were not located, he reported it to the State Agency and informed the current Administrator. The SSD stated he investigated the allegation when he searched for the wallet and money in the resident's room, but he did not interview staff who had access to R64's room because the resident said the money was missing and not that it was stolen. He further stated that he did not document any part of the investigation other than the grievance form or complete the 5-day follow-up for the State office because he did not receive the letter from the State Agency acknowledging that the report was filed. The SSD stated that he informed R64 three or four days after the allegation that he had not found his money. In an interview on 4/11/2024 at 10:59 am, the DON revealed she was unaware of R41, R45, or R64 missing any money. She stated the issues should have been reported to the State, a thorough investigation should have been conducted to include written witness statements, and the Social Service Department did not follow the facility's policy with these investigations. In a telephone interview on 4/11/2024 at 11:08 am, the Administrator revealed she did not remember being informed that any resident in the facility had missing money. She stated that after the initial report was filed with the State office and the police were called, a thorough investigation, including written witness statements, should have been started. The Administrator stated that the facility did not follow the process related to investigating grievances and abuse.

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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** 45813 Based on record review, staff interviews, and review of the facility's policy titled Minimum Data Set (MDS)/Care Plan, the facility failed to develop or implement a comprehensive, person-centered care plan for three of 54 sampled residents (R) (R11, R60, and R49). Specifically, the facility failed to develop a care plan for contracture management for R11, implement a care plan for oxygen therapy for R11, dialysis care and treatment for R60, and oxygen therapy for R49. The deficient practice had the potential to place R49, R11, and R60 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of the facility's policy titled Minimum Data Set (MDS)/Care Plan, dated 2/1/2024, revealed the Policy Statement of Each resident will have an individualized interdisciplinary plan of care in place. The Comprehensive Care Plan will be resident-centered, having the individual resident as the focus of control. The Procedure section stated: 2. The Interdisciplinary Team will develop and implement the Comprehensive Care Plan within 21 days of admission. This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths, and individual preferences of the resident. 3. Each discipline will be responsible for the initiation and ongoing follow-up for care plans as related to their area of expertise. 1. A review of R11's electronic medical record (EMR) revealed the Face Sheet documented diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, generalized weakness, functional quadriplegia, lack of coordination, and acute and chronic respiratory failure with hypoxia. A review of R11's quarterly MDS with an Assessment Reference Date (ARD) of 2/9/2024 revealed Section GG (Functional Abilities and Goals) documented impaired functional range of motion on one side of the upper extremities and both sides of the lower extremities. Section O (Special Treatments and Programs) documented that R11 received oxygen therapy. A review of R11's care plan dated 11/30/2023 revealed there was no care plan area for contracture management. A further view of the care plan revealed a care plan area indicating the resident had an impaired respiratory status due to a diagnosis of respiratory failure with hypoxia and a history of pneumonia. Interventions included administering oxygen as ordered and monitoring oxygen saturations as needed. A review of the Medication Administration Record (MAR) dated April 2024 revealed oxygen was not documented as administered, and oxygen saturation checks were not documented as performed. During an interview on 4/10/2024 at 11:50 am with the Director of Nursing (DON), she verified that R11 did not have a care plan for contracture management. She stated she attended care plan meetings and was unsure why a care plan for contracture management was not developed for R11. The DON also verified that if the facility was not documenting oxygen saturations, then R11's respiratory care plan was not being followed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS/Care Plan Coordinators were not available for interviews during the survey. 36377 2. A review of R60's quarterly Minimum Data Set (MDS) dated [DATE] revealed section I (Active Diagnoses) included, but was not limited to, renal insufficiency, renal failure, or ESRD. Section O (Special Treatments and Programs) documented that R60 received hemodialysis while a resident. A review of the EMR revealed a physician's order dated 1/21/2021 for dialysis services on Monday, Wednesday, and Friday and vital signs prior to dialysis once a day on Monday, Wednesday, and Friday. A review of R60's care plan, initiated 1/21/2021 and last reviewed 2/8/2024, listed a care area for dialysis. Interventions included communicating with the dialysis center regarding medication, diet, and lab results and coordinating the resident's care with the dialysis center. In an interview with the DON on 4/11/2024 at 10:13 am, she confirmed there were no current dialysis communication forms in R60's EMR, and the last one filed was dated 10/2023. She verified the care plan interventions and confirmed that R60's care plan was not being followed if the nursing staff was not communicating with the dialysis center and coordinating the services. 49394 3. A review of the clinical record revealed that R49 had diagnoses that included, but not limited to, acute respiratory failure with hypoxia and pneumonia. A review of R49's quarterly MDS dated [DATE] revealed Section O (Special Treatments and Programs) documented that R49 received oxygen therapy. A review of the physician's orders revealed an order dated 4/11/2024 for oxygen at 2 liters per minute via nasal cannula. A review of R49's Care Plan revealed there was no care plan area for oxygen therapy. In an interview on 4/10/2024 at 9:35 am, Licensed Practical Nurse (LPN) LL verified that R49's care plan did not include an area for oxygen therapy. In an interview on 4/10/2024 at 11:50 am, the DON verified that R49 did not have a care plan related to oxygen therapy. She stated she attended care plan meetings but was unsure why a care plan was not developed. In an interview on 4/12/2024 at 12:01 pm, the Administrator reported being unaware that R49 did not have a care plan for oxygen therapy. She reported that her expectation for staff was to make sure all care plans were completed and updated accordingly. Cross Reference F695 and F698

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on resident and staff interviews, record review, and review of the facility's policy titled Bathing-Shower, the facility failed to provide assistance with activities of daily living (ADL), specifically baths or showers, for one resident (R) (R5) of 54 sampled residents. This failure placed R5 at risk for unmet needs and a diminished quality of life. Findings include: A review of the facility's policy titled Bathing-Shower, effective 2/1/2024, revealed the Purpose section stated: To clean the skin and shampoo hair (as needed). To increase circulation. To exercise body parts. To reduce tension. To promote comfort while maintaining safety and dignity. The Procedure section stated: 29. Provide the resident with the opportunity to bathe according to preference and facility procedure. 31. Review and revise resident/patient bathing plan, as indicated. A review of the clinical record revealed R5 had diagnoses including, but not limited to, muscle weakness, type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy, acquired absence of right leg below the knee, acquired absence of left leg below the knee, and need for assistance with personal care. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] and the most recent quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that R5 required supervision with bathing and showering. A review of R5's care plan revised on 3/7/2024, documented that Resident's ability to transfer, walk in room, walk in corridor, dress, eat, toilet, maintain personal hygiene has deteriorated related to below the knee leg amputation, physical limitations, peripheral vascular disease (PVD), difficulty walking. Approaches to care included providing supervision with minimal assistance with ADL care and monitoring for the presence of pain/intolerance during self-care. A review of the facility-provided documents titled CNA (Certified Nursing Assistant) Skin Care Alert (a form that tracks when showers or baths are given) revealed R5 had received two showers, dated March 11, 2024, and March 21, 2024, in the past 25 days. There was no documentation that R5 had received any type of bath from April 1, 2024, to April 6, 2024. In interviews on 4/8/2024 at 11:31 am, 4/9/2024 at 10:04 am, and 4/10/2024 at 1:20 pm, R5 stated he had not received a shower in two weeks and was supposed to receive one twice a week on Wednesday and Saturday. R5 was observed to be in the same clothes for three days in a row. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/9/2024 at 3:50 pm, the Director of Nursing (DON) revealed bath sheets were completed on all residents, whether they received a shower or a bed bath. She further revealed that if a resident refused a shower or bed bath, the sheet would reflect the refusal, and staff would let her know so that the care plan could be revised within 24 hours. The DON confirmed that two bath sheets were completed on R5 during the last 25 days, indicating R5 only received two baths in the last 25 days. She revealed her expectation was for nursing staff to provide care by giving residents baths or showers according to the bath schedule. In an interview on 4/12/2024 at 10:11 am, Certified Nursing Assistant (CNA) PP revealed that staff followed the bath schedule most of the time. CNA PP revealed that if a bath sheet was not completed, then the shower/bath was not provided. In an interview on 4/12/2024 at 10:21 am, CNA TT revealed that staff followed a shower schedule and completed bath sheets for all residents when a bath or shower was provided.

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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** 49394 Based on staff interviews and record review, the facility failed to transcribe an antibiotic medication order and administer it as ordered by the physician, resulting in a delay in treatment for one resident (R) (R49) of seven residents receiving antibiotics. This failure had the potential for R49 to not receive medical treatment according to their needs and placed R49 at risk for adverse consequences. Findings Include: A review of the electronic medical record (EMR) Face Sheet revealed that R49 was readmitted to the facility from an acute care hospital on 4/5/2024. A review of the facility-provided document titled Internal Medicine Discharge Summary, dated 4/6/2024, revealed that R49 had a current diagnosis of multifocal pneumonia. The discharge medication list included, but was not limited to, Levaquin (a medication used to treat bacterial infections) 750 milligrams (mg) by mouth daily for five days, starting 4/5/2024. R49 was discharged back to the facility on [DATE]. A review of theProgress Notes revealed an entry dated 4/7/2024 of Resident returned to the facility on [DATE] from the hospital. The entry was signed by a nurse. Further observation revealed an entry dated 4/9/2024 of . Patient readmitted stats [sic] post pneumonia. Continue Levaquin for one week. The entry was signed by a physician. A review of the Physician's Order revealed a telephone physician's order dated 4/9/2024 for Levaquin 750 mg, 1 tablet by mouth one time a day. A review of the medication administration record (MARS) dated 4/2024 revealed that Levaquin 750 mg, 1 tablet by mouth one time a day, was first administered on 4/10/2024. In an interview on 4/9/2024 at 10:32 am, Licensed Practical Nurse (LPN) LL stated she was the receiving nurse when R49 returned from the hospital. When asked about R49's medication order for Levaquin not being transcribed and ordered at the time the resident returned to the facility, she stated it must have been an oversight. She verified there was no order in R49's EMR for Levaquin at the time of the interview and confirmed that R49 returned to the facility on [DATE] with a physician's order for Levaquin. In an interview on 4/11/2024 at 12:54 pm, LPN LL stated that floor nurses were responsible for transcribing physician orders when a resident returned to the facility from a hospital stay. She acknowledged that there was not a physician's order for Levaquin until 4/9/2024 and that the order had not been transcribed until 4/10/2024, resulting in R49 not receiving the medication until 4/10/2024. She further confirmed that oral Levaquin was kept in stock at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/12/24 at 12:34 pm, the Director of Nursing (DON) stated the floor nurses were responsible for transcribing physician orders. She acknowledged there was a lapse in care for R49 due to the medication order not being transcribed in a timely manner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 45813 Based on observations, staff and resident interviews, record review, and a review of the facility's policy titled Contracture Management, the facility failed to ensure one of 54 sampled residents (R) (R11) reviewed for limited range of motion (ROM) received passive range of motion (PROM) exercises and splint application as needed to address limited ROM in her right upper extremity. This failure created a potential for worsening contracture (fixed resistance to passive stretch), pain, or skin breakdown for R11. Findings include: A review of the facility's policy titled Contracture Management, dated 02/01/2024, revealed the Policy Statement of Assisting a resident to attain and/or maintain joint mobility promotes independence, prevents, or reduces contractures, preserves range of motion for use of prothesis, stimulates circulation and enhances muscle strengthening. A resident requiring passive range of motion, active range of motion and/or splint/brace application and removal are considered for the restorative program. Restorative programs including range of motion and splint/brace assistance are provided by trained nursing assistants or licensed nurses. The Procedures section stated: 1. Review resident status with the interdisciplinary team. A resident may benefit from a restorative contracture prevention and management program if one of the following exists: * Currently receiving PT and/or OT which includes range of motion or splint/brace application and removal. Interdisciplinary team recommends restorative nursing to begin after completion of therapy goals. * Demonstrates change in condition that indicates a need for range of motion or a splint or brace. 2. Verify resident meets criteria to participate in this restorative program. Criteria includes, but is not limited to: * Requires application and/or removal of a splint or brace. 4. Review any recommendations from therapy on providing range of motion or splint/brace assistance. 10. Re-evaluate range of motion at least quarterly and with change in condition. A review of R11's electronic medical record (EMR) Face Sheet revealed diagnoses that included, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, generalized weakness, functional quadriplegia, and lack of coordination. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R11's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/9/2024, revealed Section GG (Functional Abilities and Goals) documented impaired functional range of motion on one side of the upper extremities and both sides of the lower extremities. Section O (Special Treatments and Programs) documented that the resident did not receive therapies or restorative nursing. A review of R11's Orders tab of the EMR revealed no orders for using a hand splint or brace on the right or left hand, PROM, or restorative nursing services. A review of R11's record revealed an Occupational Therapy Treatment Encounter Progress Note dated 4/6/2022 documented Manual Tx (treatment): joint mobilization techniques and manipulation techniques. Donning orthotic to R (right) hand. Demo (demonstrate) and educate cart nurse on proper application. Verbalized understanding. Patient tolerated for 6 hours. Further record review revealed an Occupational Therapy Treatment Encounter Progress Note dated 1/18/2023 documented Discharge Recommendations and Status D/C (discharge) (Recs Discharge Recommendations: RNP (Restorative Nursing Program) for R WHFO (wrist, hand, finger orthodic). Tolerating 6-8 hours. Restorative Programs Restorative Program Established/Trained = Restorative Splint and Brace Program Splint and Brace Program Established / Trained: Yes Functional Maintenance Functional Maintenance Program Established/Trained = Not Indicated at This Time Prognosis to Maintain CLOF (current level of functioning) = Excellent with participation in RN (Restorative Nursing). Observations on 4/8/2024 at 10:45 am and 12:45 pm and on 4/9/2024 at 10:16 am and 4:47 pm revealed R11 lying in bed without anything in her hand. Both hands were closed, and nothing was in her hands to reduce the progression of contracture. During an interview on 4/10/2024 at 10:16 am, Restorative Aide (RA) AA revealed that R11 is not currently on the restorative caseload. RA AA also stated she attends the weekly restorative meetings to determine which residents will remain on restorative services and she did not recall R11's name mentioned in the meetings. RA AA further stated that she had not seen R11 wearing a splint to her right hand or having anything in her left hand to prevent contracture. During an interview on 4/10/2024 at 10:24 am, RA BB revealed that R11 was not assigned to her for restorative caseload, and she had not witnessed R11 wearing a splint on her right hand. RA BB further stated that decisions are made in the weekly meetings and that once R11 was discharged from the Restorative Nursing Program, she was placed on maintenance services for the Certified Nursing Assistant (CNA) on the floor to perform the ROM exercises and splinting. During an interview on 4/10/2024 at 10:51 am, Licensed Practical Nurse (LPN) Restorative Nurse CC revealed that she oversees the Restorative Nursing Program. She stated that R11 was on the restorative caseload from 5/3/2023 through 7/12/2023. She further stated once a resident was discharged from the Restorative Nursing caseload, the CNAs on the floor were responsible for providing the services. She stated that the CNAs assigned to the resident don't document the ROM exercises and the application and removal of the splints in the EMR. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/2024 at 11:17 am, the Rehabilitation Manager revealed he was unaware that R11's left hand had begun to contract. After viewing R11's record, he stated that the resident is dependent on all movement, meaning R11 does not display any voluntary movement of joints or follow directions for any physical action. The Rehabilitation Manager further stated that R11 was discontinued from therapy services on 4/6/2022 with PROM and a right wrist, hand, and finger contracture orthotic device. He stated there had not been anything to indicate discontinuation of the device, and it should still be in use. The Rehabilitation Manager further stated there had not been any referrals for screening from the nursing department related to contracture management. During an observation in the room with R11, the Rehabilitation Manager moved the resident's left hand and was able to get the resident to open her hand with a gentle stretch and massage. He stated that R11 would benefit from therapy services and needed ROM for the left hand and the orthotic device for the right hand. During an interview on 4/10/2024 at 11:24 am, CNA EE stated she was assigned to R11 on this date, but she did not perform PROM exercises, nor did she apply the splint to the resident's right hand. She stated she was unaware that R11 was required to have PROM or a splint on her hands and further stated she opened R11's hand and applied a rolled cloth sometimes because her hands were so stiff. During an interview on 4/10/2024 at 11:29 am, Registered Nurse (RN) FF revealed she had not observed R11 with a hand splint but had observed R11 with a blue spongy item in her right hand before, but not consistently. She stated she was unaware if R11 was supposed to receive PROM for her hands and a splint for the right hand. During an interview on 4/10/2024 at 11:50 am, the Director of Nursing (DON) revealed that if a resident requires a splint, that resident should remain on the Restorative Nursing Program. She stated that nursing staff should have informed her of any changes in the resident's condition. She further stated that she was unaware that R11 no longer received PROM and splinting to the right hand or that the left hand had limited ROM and that a new referral should be sent to therapy for an assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, staff interviews, record review, and review of the facility's policies titled Oxygen Administration and Tracheostomy Care-Adults, the facility failed to provide respiratory care consistent with professional standards of practice for four of seven residents (R) (R11, R39, R22, and R49) receiving respiratory services. Specifically, the facility failed to ensure there was a current physician's order for oxygen therapy and oxygen saturation checks before administering oxygen, to ensure the oxygen concentrator and concentrator filters were clean, and to provide humidification for oxygen therapy for R11. In addition, the facility failed to document daily tracheostomy inner cannula change for R39. Additionally, the facility failed to ensure the oxygen concentrator filter was clean and to clarify a physician's order for oxygen for R22, failed to follow the physician's orders for oxygen, to ensure the oxygen concentrator had a filter, and to label and store respiratory equipment in a sanitary manner when not in use for R49. These deficient practices had the potential to cause respiratory distress or respiratory-associated infections for R11, R39, R22, and R49. Findings include: A review of the facility's policy titled Oxygen Administration, dated 02/01/2024, documented: Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Equipment and Supplies: 2. Nasal cannula, nasal catheter, mask (as ordered). 3. Humidifier bottle. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 4. Vital signs. Steps in the Procedure: 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that water bubbles as oxygen flows through. 14. Periodically re-check water level in humidifying jar. A review of the facility's policy titled Tracheostomy Care-Adults, dated 2/1/2024, documented: Purpose 1. To keep stoma area clean and free from excessive amounts of secretions. 2. To maintain the patency of the airway, prevent breakdown of the skin surrounding the site, and prevent infection. Definitions 1. Tracheostomy care includes changing the inner cannula. The facility did not provide a policy related to the maintenance of oxygen equipment. 1. A review of the clinical record revealed R11 had diagnoses that include, but not limited to, acute and chronic respiratory failure with hypoxia. A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Section O (Special Treatments and Programs) documented that R11 received oxygen therapy. Observations on 4/4/2023 at 10:45 am and 12:45 pm revealed R11 lying in bed receiving oxygen via nasal cannula at 4 liters per minute (LPM). The oxygen concentrator's filter had a light gray fuzzy substance over the entire filter. The oxygen concentrator had an accumulation of a light gray fuzzy substance and a white substance along both sides and the front. The humidification container was empty, and the nasal cannula tubing was connected to the concentrator instead of the humidification container. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 4/9/2024 at 10:16 am and 4:47 pm revealed R11 lying in bed receiving oxygen via nasal cannula at 4 LPM. Further observation revealed the humidification container was not on the concentrator. The oxygen concentrator continued to be dirty, and the concentrator's oxygen filter continued to have a light gray fuzzy substance on both filters. A review of the electronic medical record (EMR) Physician Orders dated March 2024 revealed orders for oxygen at 4 liters per minute via nasal cannula every shift and oxygen saturations every shift with a start date of 5/10/2023. A review of the active Physician Orders dated 4/9/2024 revealed no order for oxygen therapy or to check oxygen saturation every shift. Further review of the EMR revealed no documentation that the oxygen or oxygen saturation orders had been discontinued or changed. A review of the Medication Administration Record (MAR) dated March 2024 revealed documentation of oxygen being administered continuously at 4 liters per minute and oxygen saturations as checked every shift. A review of the Medication Administration Record (MAR) dated April 2024 revealed oxygen was not documented as administered, and oxygen saturation checks were not documented as performed. In an interview and walking rounds on 4/9/2024 at 4:57 pm, the Director of Nursing (DON) verified the oxygen concentrator and filters were not clean. She stated that oxygen being administered at 4 LPM should be humidified, and the nurses should check the concentrators and filters for cleanliness and verify that there was a physician's order for the oxygen. She further stated the Central Supply Clerk and the nurse were ultimately responsible for ensuring that humidification bottles were in place for residents requiring humidified oxygen and that oxygen concentrators and filters were cleaned weekly and as needed. In a continued interview, she stated all residents on continuous oxygen should have orders for the oxygen and for oxygen saturations to be checked and documented every shift on the MARS. She verified oxygen saturations were not documented as being checked every shift, and there was no current order for oxygen therapy in the EMR. In an interview on 4/9/2024 at 5:06 pm, Licensed Practical Nurse (LPN) GG verified that R11's concentrator was set at 4 LPM and stated a humidification bottle should be on the concentrator. LPN GG also verified the dirty filters and the unclean concentrator and stated that the concentrator's condition places R11 at risk for potential respiratory infections. She further stated that it was all of the nurse's responsibility to check the oxygen concentrators. In an interview on 4/9/2024 at 5:11 pm, Registered Nurse (RN) HH revealed she was not aware that R 11's oxygen order did not carry over to the April 2024 EMR. RN HH further stated that R11 had been receiving oxygen and should have a current order in the EMR. In an interview on 4/9/2024 at 5:16 pm, the Central Supply Clerk revealed she was responsible for cleaning the filters on the oxygen concentrators, wiping the concentrators down, and replacing the humidification bottles. The Central Supply Clerk verified the condition of R11s concentrator and the missing humidification bottle and stated that she had not had the opportunity to check on the concentrators recently. In a follow-up interview on 4/10/2024 at 8:14 am, the DON revealed the facility changed EMRs on April 1, 2024, and only the medication orders were transferred to the new EMR. The DON stated she was aware of the lack of transfer of other orders but had not had the opportunity to check on residents' orders to see what was there and what was not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44959 2. A review of the clinical record revealed that R39 had diagnoses that included, but not limited to, tracheostomy and shortness of breath. A review of R39's quarterly MDS dated [DATE] revealed that section GG (Functional Abilities and Goals) documented that R39 was dependent on staff for all Activities of Daily Living (ADLs), and Section O (Special Treatments and Programs) documented that R39 received oxygen therapy, suctioning, and tracheostomy care. A review of the EMR revealed a physician's order dated 4/6/2024 to change the inner cannula, cleanse the tracheostomy site with normal saline, pat dry, and cover with a drain sponge daily and as needed (PRN) every day shift for a preventative measure. A review of the Treatment Administration Record (TAR) dated 4/2024 revealed there was no documentation that the inner tracheostomy cannula was changed from 4/7/2024 through 4/10/2024. In an interview on 4/10/2024 at 10:47 am, LPN GG verified a physician order dated 4/6/2024 to change R39's inner tracheostomy cannula every day. She further verified there was no documentation on the TAR of R39's inner tracheostomy cannula being changed from 4/7/2024 to 4/10/2024. LPN GG stated she could not say why it was not documented on the TAR or if the cannula had been changed from 4/7/2024 through 4/10/2024. In an interview on 4/10/2024 at 4:40 pm, the DON verified the physician order dated 4/6/2024 to change R39's inner tracheostomy cannula daily. She acknowledged that there was no documentation on the TAR that the cannula had been changed from 4/7/2024 to 4/10/2024. She stated that she expected staff to follow physician orders and document care. 49675 3. A review of R22's quarterly MDS dated [DATE] revealed that Section I (Active Diagnoses) documented that R22 had chronic obstructive pulmonary disease, and Section O (Special Treatments and Programs) documented that R22 received oxygen therapy. Observations on 4/8/2024 at 3:59 pm and on 4/9/2024 at 10:12 am and 5:00 pm revealed that R22's oxygen concentrator filter was covered in dirt and dust. R22 was receiving oxygen via the concentrator and nasal cannula at a rate of 4 LPM. A review of the EMR revealed a physician order dated 2/2/2024 for oxygen via nasal cannula at 4 to 5 LPM. During an observation on 4/9/2024 at 5:05 pm with the DON, she verified the oxygen filter was covered in dirt and dust and stated it was not clean. The DON stated the filter should be changed every Sunday on the night shift. She further stated a supply nurse followed up on Mondays to ensure the oxygen concentrator filters were changed. She verified the physician's order for oxygen at a flow rate of 4 to 5 LPM and stated that a nurse should have verified the order, and the order should have indicated a flow rate of either 4 or 5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49394 4. A review of the clinical record revealed that R49 had diagnoses that included, but not limited to, acute respiratory failure with hypoxia and pneumonia. A review of R49's quarterly MDS dated [DATE] revealed Section O (Special Treatments and Programs) documented that R49 received oxygen therapy. A review of the EMR revealed a physician's order dated 4/11/2024 for oxygen at 2 LPM via nasal cannula. An observation on 4/8/2024 at 11:49 am revealed that R49 had a nasal cannula and oxygen tubing in her hand. The oxygen tubing was not labeled with a date, and the oxygen concentrator did not have a filter. An observation on 4/9/2024 at 12:12 pm revealed that R49's nasal cannula was lying on the floor, the tubing was not labeled with a date, and R49 was not receiving oxygen. An observation on 4/10/2024 at 9:33 am revealed that R49 was not receiving oxygen. The nasal cannula was lying on top of the oxygen concentrator, undated and not in a protective bag. Observation of the oxygen concentrator revealed there was no filter. In an interview on 4/9/2024 at 5:07 pm, LPN MM verified that R49's nasal cannula was lying on the floor, not in a protective bag. LPN MM further verified that R49's oxygen concentrator did not have a filter. During an observation on 4/9/2024 at 5:03 pm with the DON, she acknowledged that R49's nasal cannula was lying on the floor, not in a protective bag, the tubing was unlabeled, and the oxygen concentrator did not have a filter. The DON verified that R49 was not receiving oxygen during the observation. In an interview on 4/10/2024 at 9:35 am, LPN LL verified that R49's physician's orders were for oxygen at 2 LPM via nasal cannula. She verified the resident was not receiving oxygen. Cross-Reference F656

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record review, and review of the facility's policy titled Dialysis Care, the facility failed to ensure ongoing communication and collaboration with the dialysis center for one of one resident (R) (R60) reviewed for dialysis services. This deficient practice had the potential to place R60 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of the facility's policy titled Dialysis Care, effective 2/1/2024, documented the Policy Statement of Pre and Post care will be provided for dialysis residents. Communication to the dialysis will be completed and return documentation from the dialysis center will ensure the dialysis resident receives necessary interventions and shunt /end-stage renal disease (ESRD) management holistically. The Documentation section stated: 3. Complete the Pre and Post Dialysis assessment and send with the resident to dialysis. When a resident returns, upload document into the electronic health record and note any recommendations/orders from the dialysis clinic. A review of R60's quarterly Minimum Data Set (MDS) dated [DATE] revealed section I (Active Diagnoses) included, but was not limited to, renal insufficiency, renal failure, or ESRD. Section O (Special Treatments and Programs) documented that R60 received hemodialysis while a resident. A review of the electronic medical record (EMR) revealed a physician's order dated 1/21/2021 for dialysis services on Monday, Wednesday, and Friday and vital signs prior to dialysis once a day on Monday, Wednesday, and Friday. In an interview on 4/11/2024 at 9:44 am, Registered Nurse (RN) SS confirmed that R60's dialysis black book, which contained the dialysis communication forms, was missing. In an interview on 4/11/2024 at 10:13 am, the Director of Nursing (DON) confirmed the only dialysis communication form documented in R60's EMR was dated 10/2023. She reported being unaware of the missing forms and that the forms were not being sent to the dialysis clinic at each dialysis appointment. She stated her expectation was for the nurse who received the form from the dialysis center to verify the information, obtain vital signs, monitor for symptoms, and sign and file the form. In an interview on 4/11/2024 at 10:48 am, Central Supply/Medical Record Licensed Practical Nurse (LPN) II verified that there were no hard copies of R60's dialysis forms in her office. She stated the process was for the nursing staff to submit the forms for her to load in the resident's EMR and confirmed the last dialysis communication form in the EMR was dated 10/2023. She reported that she could not recall the last time she received a dialysis form from staff to load in the EMR. She stated that each dialysis resident should have a black binder with their dialysis communication forms and reported that R60's binder was missing. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/2024 at 11:01 am, the Dialysis Register Nurse (RN) confirmed that the facility was not submitting R60's dialysis communication forms to the dialysis clinic at the time of the resident's dialysis appointments. She reported that the dialysis clinic had contacted the facility to request the forms once the problem was identified and stated that after a while, the dialysis clinic stopped following up after the facility continued to fail to submit the forms. She stated she could not recall the last time the facility submitted the communication form. In an interview on 4/12/2024 at 12:01 pm, the Administrator reported being unaware of R60's dialysis communication forms not being sent with him to dialysis appointments. She reported that her expectations were for the nursing staff to send the dialysis communication form to each dialysis appointment. Cross Reference F656

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47946 Based on staff interviews, a review of the Payroll-Based Journal (PBJ) Staffing Data Report, and a review of the facility document titled Facility Assessment Tool 2024, the facility failed to ensure adequate nursing staff for the first quarter of 2024. The deficient practice had the potential to adversely affect the care and services provided to the residents residing in the facility. The census was 109 residents. Findings include: A review of the PBJ Staffing Data Report Quarter 1 2024 (October 1, 2023, through December 31, 2023) revealed that based on the data submitted, the facility triggered for a One-Star Staffing Rating (Failure to submit PBJ data by the deadline, more than 4 days in the quarter without Registered Nurse (RN) Staffing hours, failure to respond to, submit documentation for, or failure to pass a Center for Medicare and Medicaid Services (CMS) audit designed to discover discrepancies in PBJ data). A review of The Facility Assessment Tool 2024 revealed the average daily census in the facility was 106 to 109 residents. Further review revealed the facility personnel included, but not limited to, 20 licensed nurses {Registered Nurses (RNs) and Licensed Practical Nurses (LPNs)}, 38 certified nursing assistants (CNAs), and seven certified medication technicians (CMT). The section titled Staffing Plan Table documented the number of staff available to meet residents' needs, included, but not limited to, eight licensed nurses for days and four for evenings, 12 CNAs for days and eight for evenings, four to six CNAs for nights, and one to two CMTs available for care during those shifts. In an interview on 4/10/2024 at 9:45 am, the Director of Nursing (DON) and the Nursing Scheduler (NS) III revealed they were both aware of the facility's PBJ's one-star staffing rating for the first quarter of 2024. The DON stated that it was due to the facility's high turnover rate and that it utilizes staffing agencies. In an interview on 4/12/2024 at 12:10 pm, the Administrator acknowledged she was aware of the facility's PBJ's one-star staffing rating for the first quarter of 2024.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45813 Based on staff interviews and a review of the facility document titled Certified Medication Aide Bi-Annual Checklist, the facility failed to ensure that services provided by Certified Medication Aides (CMA) met professional standards of quality. Specifically, the facility failed to provide evidence that three of four CMAs completed a Medication Administration Competency Skills Checklist for CMAs before being allowed to administer medications to residents. This deficient practice had the potential to result in adverse outcomes for residents related to medication administration. The census was 109 residents. Findings: A review of the facility's document titled Certified Medication Aide Bi-Annual Checklist, dated 2/1/2024, documented that RN (Registered Nurse)/Pharmacist will conduct an Annual Competency for Medication Administration for a Certified Medication Aide in the state of Georgia. The CMA must either conduct the medication administration skill with proficiency or verbalize how to complete the medication administration based on various routes. The checklist will remain in the Education Folder for CMA. A review of the facility-provided documents for the four CMAs revealed that the Medication Administration Clinical Skills checklist was not documented for three of the four CMAs currently employed in the facility. In an interview on 4/12/2024 at 9:28 am, CMA PP revealed she began working full-time in the facility as a CMA in 2022. She stated she received orientation on the medication cart with a nurse but did not remember completing a skills competency checklist upon hire. She further stated she only recalled her medication administration skills being observed by a consultant pharmacist once since being hired and stated her primary job was to administer medication. In an interview on 4/12/2024 at 9:34 am, CMA JJJ revealed she began working at the facility full-time in 2022 on the night shift. She stated she had not completed a medication administration skills checkoff and had not been observed by a consultant pharmacist or the nursing administration staff during medication administration. In an interview on 4/12/2024 at 9:40 am, the Director of Nursing (DON) revealed she was aware that CMAs were required to complete a medication skills checklist prior to being released from orientation. She further stated there was no additional information in the CMA files, and she was unsure if the medication skills checklists were completed for the CMAs. In an interview on 4/12/2024 at 9:48 am, the Administrator revealed she was unaware the CMAs had not completed the required checkoffs. She stated the facility should have ensured that the CMAs completed a medication skills checkoff prior to being allowed to administer medications to residents.

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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** 49673 Based on observations, staff interviews, and review of the facility's policies titled Equipment and Environment, the facility failed to ensure that the kitchen walls, floors, and equipment were clean and free of rust, debris, and grease buildup and failed to use un-expired quaternary test strips in the three-compartment sink. The deficient practices had the potential to place all residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. The census was 109 residents. Findings include: A review of the facility's policy titled Equipment, revised ,d+[DATE], revealed the Policy Statementof All foodservice equipment will be clean, sanitary, and in proper working order. The Procedures section stated: 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. 4. All non-food contact equipment will be cleaned and sanitized after every use. 5. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed. A review of the facility's policy titled Environment, revised ,d+[DATE], revealed the Policy Statement of All food preparation areas, food services areas, and dining areas will be maintained in a clean and sanitary condition. The Procedures section stated: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. Observations on [DATE] at 10:10 am during the initial kitchen walk-through with the Food Service Manager (FSM) revealed sticky, brown, greasy substance and debris behind the oven and surrounding area, a dusty ventilation unit on the juice machine, and a build-up of rust and dust on the fire extinguisher located next to the handwashing sink. Further observation revealed water puddles on the floor near the three-compartment sink, and the water from the handwashing sink would not turn off completely. The FSM confirmed the observations. An observation of the three-compartment sink on [DATE] at 11:11 am revealed that Dietary Aide CCC tested the sanitizing sink using quaternary test strips. The observation revealed that the strips' expiration date was [DATE]. The FSM confirmed that the strips were expired. In an interview on [DATE] at 11:00 am, Dietary Aide CCC revealed she did not have a cleaning list or schedule. She further stated that water was usually on the floor around the sinks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the FSM on [DATE] at 11:25 am, she stated that the staff does a lot of scrubbing and cleaning, but it is an old building, and the grease and grime build up. In an interview on [DATE] at 11:05 am, Dietary Aide DDD confirmed that everyone was responsible for cleaning, but she had never seen anyone clean the ventilation units or filters. She also stated she had never seen the maintenance department deep clean or repair anything in the kitchen. In an interview on [DATE] at 11:06 am, Dietary Aide EEE stated that she had not observed deep cleaning in the kitchen this month. During a walk-through of the kitchen on [DATE] at 2:30 pm, the [NAME] President (VP) of Clinical Operations observed and confirmed that the kitchen was not clean and needed to be deep cleaned. She also confirmed that the fire extinguisher near the hand-washing sink needed cleaning. The VP revealed her expectations were that dietary staff should maintain cleanliness in the kitchen and all equipment should be in good working condition.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 49673 Based on observations, staff interviews, and a review of the facility's policies titled Dispose of Garbage and Refuse and Environment, the facility failed to ensure the outdoor garbage and refuse area was free of litter and maintained in a sanitary manner for two of two dumpsters. The deficient practice had the potential to promote the harboring of pests, insects, and other organisms and create the potential for disease transmission by pests and rodents. The census was 109 residents. Findings include: A review of the facility policy titled Dispose of Garbage and Refuse, dated 8/2017, revealed the Policy Statement of All garbage and refuse will be collected and disposed of in a safe and effective manner. The Procedures section stated: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. A review of the facility's policy titled Environment, dated 9/2017, revealed the Procedures section stated: 7. All trash will be properly disposed of in external receptacles (dumpsters), and the surrounding area will be free of debris. During the initial observation of the dumpsters on 4/9/2024 at 12:26 pm, the Food Service Manager (FSM) and the District Manager verified that two of the two dumpsters were open and filled with visible black trash bags and boxes. Continued observation also revealed uncompressed empty boxes surrounding the two dumpsters. The District Manager and FSM confirmed the dumpsters were open and stated they should be closed without trash or boxes on the ground around them. In an interview on 4/9/2024 at 12:30 pm, the District Manager confirmed that he noticed yesterday's dumpster pick-up had not been made upon his arrival. He stated the Maintenance Director was responsible for maintaining the dumpster pick-up scheduling and had called for an alternative pick-up. The District Manager confirmed the dumpsters were the kitchen staff's responsibility and verified the dumpsters were open to the environment and should be closed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on observations, staff interviews, and review of the facility's policies titled Infection Control and Prevention Policy and COVID-19 Employee and Resident Prevention and Control Practices, the facility failed to ensure infection control practices were followed to prevent transmission and spread of COVID-19. Specifically, the facility failed to ensure staff changed their masks when entering and exiting COVID-19 Transmission-Based Precaution (TBP) rooms and failed to ensure staff closed the doors of two COVID-19 TBP rooms during care. The facility was in an outbreak, with 31 residents and 11 staff tested positive for COVID-19. This deficient practice had the potential to spread COVID-19 to other residents, staff, and visitors. The census was 109 residents. Findings include: A review of the facility's policy titled Infection Prevention and Control Policy, dated 2/1/2024, revealed the Policy Statement included: The facility strives to prevent transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community-acquired infection. A review of the facility policy titled COVID-19 Employee and Resident Prevention and Control Practices, dated 2/1/2024, revealed the section titled Masking Requirements documented: 2. If the center is in an outbreak status, . Personal Protective Equipment (PPE) for Transmission-based precautions will be utilized at individual Transmission-based precautions rooms and includes eye protection/face shield and N95 mask. The mask and eye protection must be changed when entering the room and a clean mask/eye protection applied after exiting the room and doffing soiled/dirty mask/eye protection. Observations on 4/8/2024 at 10:58 am revealed that Resident rooms [ROOM NUMBERS] had signage on the doors indicating they were TBP/COVID-19 isolation rooms. Further observation revealed both resident room doors to the hallway were open. Staff was observed walking up and down the hallway, passing the open TBP room doors, without closing the doors. An observation on 4/8/2024 at 11:06 am revealed Restorative Aide BB positioned a resident in a wheelchair in front of room [ROOM NUMBER]. The door to room [ROOM NUMBER] was open, and Restorative Aide BB did not close the door. An observation on 4/8/2024 at 11:08 am revealed a Certified Nursing Assistant (CNA) entering room [ROOM NUMBER] to answer the call light. Upon exiting the room, she failed to close the door. An observation on 4/8/2024 at 11:10 am revealed a housekeeper disinfecting resident room door handles. After cleaning the door handles of rooms [ROOM NUMBERS], he failed to close the doors. An observation on 4/9/2024 at 5:21 pm revealed that CNA UU approached room [ROOM NUMBER] with a mask on. Observation revealed her to don (put on) a gown and gloves. She was observed entering and exiting room [ROOM NUMBER] without discarding or changing her mask. room [ROOM NUMBER] had TBP signage on the door. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 4/9/2024 at 5:23 pm revealed that CNA VV approached room [ROOM NUMBER] with a mask on. She was observed to don a gown and gloves. She was further observed entering and exiting room [ROOM NUMBER] without discarding or changing her mask. room [ROOM NUMBER] had TBP signage on the door. In an interview with CNA VV, after she exited room [ROOM NUMBER], she stated she had received COVID and Infection Control education in the past but had not received COVID-19 or Infection Control education since the current outbreak began on April 1, 2024. An observation on 4/9/2024 at 5:25 pm revealed that a CNA was observed exiting a room with TBP signage on the door. The CNA was observed in the hallway after exiting the room and was not observed to change her mask. In an interview on 4/8/2024 at 12:32 pm, Restorative Aide AA revealed she did not realize the TBP room doors were open, and she stated further she was aware that the TBP room doors should remain closed at all times. In an interview on 4/12/2024 at 11:49 am, the Director of Nursing (DON) revealed she was just made aware there was an issue with the TBP room doors being left open. She stated that the TBP room doors should be closed when staff enter and exit the room. She further stated that she re-educated the staff on this date about the importance of containing the spread of infections and illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115120	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45813 Based on record review, staff interviews, and review of the facility's policy titled Antibiotic Stewardship, the facility failed to provide evidence of a process for periodic review of antibiotic prescribing practices and failed to document follow-up measures in response to the data for 12 of 12 months of infection control data reviewed. This deficient practice had the potential to adversely affect any resident who was prescribed an antibiotic. The facility census was 109 residents. Findings include: A review of the facility's policy titled Antibiotic Stewardship, dated 2/1/2024, revealed a Policy Statement of Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The Procedure section stated, 1. The purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics to the residents. A review of the facility's Antibiotic Stewardship Log revealed no documentation in the log book for July 2023 and January 2024 through March 2024. Further review revealed only a facility map labeled with infections for December 2023, a color-coded mapping, and an antibiotic report from the pharmacy for March 2023 through June 2023 and August 2023 through November 2023. There was no documented testing data to determine if infections were true infections (meeting the McGeers criteria) or were facility or community-acquired in the log. In addition, only the facility's calculated infection rate was documented for April 2023 through March 2024. A review of the Antibiotic Medications Reports provided by the facility's pharmacy revealed a listing with the resident's name, start date, drug label name, order duration, and provider. Further review of this report revealed that it did not document the organism, if a culture was performed, or the organism's susceptibility to the prescribed antibiotic. In addition, this report did not indicate if the McGeers criteria was met or if the infection was a true infection. During an interview on 4/9/2024 at 8:32 am, the Director of Nursing (DON) revealed she was responsible for tracking the antibiotics from March 2023 through December 2023. The DON stated that the new orders for antibiotics are reviewed during the daily clinical meeting. She confirmed that the program's trending, surveillance, and monthly calculation rates were not being monitored and that monthly infection control meetings were not conducted in the facility. She stated that typically, with antibiotic stewardship, all that was performed was verifying that the orders and the antibiotic therapy duration were correct. During an interview on 4/9/2024 at 8:53 am, the [NAME] President of Clinical Services revealed that around the end of February, she realized the Infection Control Program, particularly the Antibiotic Stewardship Program, did not utilize the floor plan mapping effectively or track organisms and perform surveillance. She revealed they were not tracking and trending infections or monitoring infection rates. She further stated she had educated the DON on the process but had not followed up to see if the process was implemented. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 4/11/2024 at 9:13 am, the DON stated that she had not had the opportunity to review the facility's Infection Control Policies or the Antibiotic Stewardship Program. The DON stated that there had not been a specific person in place monitoring the Antibiotic Stewardship Program since December 2023.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44959 Based on record review, staff interviews, and review of the facility document titled Healthcare Center Infection Preventionist, the facility failed to designate a qualified staff member to the role of Infection Control Preventionist (ICP) for two of the last 12 months and failed to ensure staff assigned to the role of ICP had enough time to perform the ICP responsibilities for six of the last 12 months. These deficient practices had the potential to create an ineffective Infection Prevention program that may contribute to the spread of infectious diseases among all residents in the facility. The census was 109 residents. Findings include: A review of the facility document titled Healthcare Center Infection Preventionist, with an effective date of 2/1/2024, revealed the Job Purpose of: The Healthcare Center Infection Preventionist is responsible for the development, direction, implementation, management and operation of the infection prevention in the healthcare center. The Key Responsibilities section and the subtitle Infection Prevention documented: j. Develops, implements and evaluates infection prevention and control goals, measurable objectives and action plans for the healthcare center infection prevention and control program. A review of the Infection Control book revealed no documentation of infection surveillance from November 2023 to April 2024. The facility was unable to provide line listings for any infectious illnesses for January 2024, February 2024, and March 2024. In an interview on 4/9/2024 at 2:13 pm, the ICP and the Director of Nursing (DON) confirmed they were not tracking and trending infections and further stated it had not been completed since November 2023. They confirmed there was no color coding tracking or line listing that included the residents' names and types of infection for January 2024, February 2024, and March 2024. The DON stated she did not have time to manage the program effectively and confirmed that the program's trending, surveillance, and monthly calculation rates were not being monitored and that monthly infection control meetings were not conducted in the facility. She further confirmed that infection surveillance had not been correctly documented for the last six months. During the interview, the ICP stated that she had been employed as the ICP since 4/8/2024. She stated she could not provide any information on infection control tracking. In an interview on 4/11/2024 at 9:30 am, the DON stated she was responsible for infection control from March 2023 through December 2023. She stated that a staff member no longer employed by the facility was responsible for infection control in January 2024. She verified that no one was responsible for infection control from February 2024 through March 2024 and stated the new ICP began the position in April 2024. The DON further stated that she had asked for help from the Corporation's [NAME] President, that she was not adequately trained in the Infection Control program, and confirmed that she did not have enough time to track and trend infections in the facility while performing the job responsibilities of the DON and the ICP.