STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115397	A. Building B. Wing	08/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence of Sparta Health and Rehab	60 Providence Street Sparta, GA 31087

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45813 Based on staff interview, record review, and a review of the facility policy titled Notification of Changes, the facility failed to timely notify the health agent of a significant change related to a burn for one of 18 sampled Residents (R) (R14). This deficient practice places the resident at risk for complications such as infection and further deterioration of the burn wound. Findings Include: A review of the facility's undated policy titled Notification of Changes, revealed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents a. Resulting in injury. b. Potential to require physician interventions. Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative if known. Record review of the quarterly Minimum Data Set (MDS) for R14 dated 6/12/2024 revealed a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Physical Therapy Treatment Encounter Note for R14 revealed that on 6/5/2024, upon therapist entering residents' room, R14 presented with sores around right lower leg appearing to be from e-stim machine (a device that sends electrical impulses through electrodes attached to the skin to help with physical therapy and fitness). Resident denying two sores origin being e-stim, stating sore on the right inner knee from e-stim the previous day and he has been treating it with antibiotic ointment. E-stim held this day, will follow up. Further review of therapy notes revealed there were not any follow-up notes related to the burns. Record review of the Electronic Medical Record (EMR) for R14 revealed there was no evidence that the physician or Nurse Practitioner (NP) had been notified related to R14's burn until 6/16/2024 (11 days later). Record review of a progress note for R14 dated 6/16/2024 that indicated R14's right lower leg was observed to be red and warm to touch, resident verbalized some tenderness to the area. R14 was also observed with an open area below his right knee which reported occurred with the therapy treatment. NP was called, and new orders received for Bactrim DS one tablet by mouth twice a day for ten days. During an interview on 8/9/2024 at 3:06 pm with the Physical Therapy Assistant (PTA) DD stated that she noticed the two brown areas and an open area on the resident's right lower leg and documented her observations in the progress notes. The PTA DD further stated that she did notify the Physical Therapy Manager on the day of her observations but did not communicate her observations to the nursing staff or Administrator. During an interview on 8/9/2024 at 3:49 pm with Assistant Director of Nursing (ADON) revealed no one from therapy alerted the staff about the burn that R14 received during treatment. The ADON reviewed the electronic record and verified there was no documentation in the record to include an event report or change in condition report related to the burn. The ADON further stated the nurses should have completed an SBAR and contacted the physician or NP after learning of the areas. Interview on 8/10/2024 at 9:23 am with Physical Therapy Manager stated she did not document when she was informed of the burn, nor did she or PTA DD complete an incident report. The Physical Therapy Manager further stated that she assumed the PTA DD reported the burn to nursing. She further stated it was her mistake by not asking PTA DD if she had reported the incident and for not following up on the incident. A telephone interview on 8/11/2024 at 10:25 am with the Medical Director (MD) revealed he was aware of the burn but was unsure of the timeliness of the notification. He stated he knew the NP was involved and ordered some antibiotics. The MD further stated any burns sustained in the facility should be reported to the provider immediately and the burns should be monitored frequently by staff. Cross Reference F689

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on observations, staff interviews, and a review of the facility policies titled Maintenance Inspection and Preventative Maintenance Program, the facility failed to ensure a safe, clean, comfortable home-like environment in four of 29 resident rooms (Rooms 111, 113, 102, and 302) and one common area (the Resident Dining Room). The deficient practices placed residents at risk of living in an unsanitary and unsafe living environment and the potential for diminished quality of life. Findings include: A review of the facility's undated policy titled Maintenance Inspection, revealed the Policy of The facility would be maintained to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. A review of the facility's undated policy titled Preventative Maintenance Program revealed the Policy of A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Observations on 8/9/2024 at 9:10 am and 8/10/2024 at 3:50 pm of room [ROOM NUMBER] revealed five missing tiles on the floor next to the bed next to the hallway door. Observations on 8/9/2024 at 9:10 am and 8/10/2024 at 3:50 pm of the shared restroom of room [ROOM NUMBER] and room [ROOM NUMBER] revealed the light over the sink did not have a cover, only a bare lightbulb. Observations on 8/9/2024 at 9:15 am and 8/10/2024 at 3:55 pm in room [ROOM NUMBER] revealed the baseboards on all four walls had scattered areas of chipped paint. Observations on 8/9/2024 at 9:15 am and 8/10/2024 at 3:55 pm of the restroom for room [ROOM NUMBER] revealed an area of peeling paint on the wall next to the sink, measuring approximately 3 inches wide by 8 inches long, exposing the drywall. An observation on 8/11/2024 at 8:45 am of the Resident Dining Room revealed five ceiling tiles with brown and black discolorations. 35180 Observations of room [ROOM NUMBER] on 8/10/2024 at 9:51 am and 8/11/2024 at 7:51 am and 10:54 am revealed four floor tiles were loose and not fixed in place next to bed 102-1. During an interview with the Administrator on 8/11/2024 at 10:56 am, she confirmed the floor tiles beside bed 102-1 were broken and not fixed in place. The Administrator acknowledged the loose tiles should have been repaired or replaced. 33548 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/9/2024 at 9:15 am of room [ROOM NUMBER] revealed a square tile on the left side of the window sill was missing. Observation on 8/11/2024 at 8:35 am of room [ROOM NUMBER] revealed the tile on the window sill remained missing. During observation rounds on 8/11/2024 at 9:50 am, the Administrator and Interim Maintenance Director verified the environmental findings in rooms 111, 113, 102, 302, the restrooms of 109/111 and 113, and the Resident Dining Room. He stated he was unaware of the concerns in rooms [ROOM NUMBERS]. He confirmed he was aware of the missing floor tiles in room [ROOM NUMBER] and stated the Corporate Maintenance Director was aware of the missing floor tiles and was trying to find replacement tiles. He stated he had noticed the discolored ceiling tiles in the Resident Dining Room on 8/10/2024 and would get them replaced as soon as possible. During a continued interview, he stated he conducted observational rounds throughout the facility daily to observe for needed repairs but had no documentation of the rounds or repairs. He stated the Corporate Maintenance Supervisor was in the facility a few times per month to observe for needed repairs and to provide guidance. In an interview on 8/11/2024 at 10:20 am, the Administrator stated her expectations were for maintenance concerns to be repaired and corrected as soon as possible. She stated she would like repairs to be made and for the facility to be maintained in a home-like environment. She further stated the facility was recruiting for a permanent Maintenance Director. In an interview on 8/11/2024 at 10:54 am, the Corporate Director of Procurement, Information Technology, and Maintenance stated she was in the facility at least monthly to conduct observational rounds and provide guidance to the Interim Maintenance Director. She stated she was unaware of the concerns in Rooms 102, 113, 302, or the Resident Dining Room. She confirmed she was aware of the missing floor tiles in room [ROOM NUMBER] and stated she was in the process of finding matching tiles. She stated she and/or the Interim Maintenance Director should have been aware of the observations, and repairs should be made in a timely manner. She further stated the maintenance concerns could cause the residents to feel like their home was less home-like than it should be.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46691 Based on staff interviews, record review, and review of the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to ensure pre-employment screenings, specifically reference checks, were conducted prior to employment for eight of 60 employees. This deficient practice had the potential to place residents residing in the facility at risk of abuse, neglect, and exploitation from staff. The census was 40 residents. Findings include: A review of the facility policy titled Abuse, Neglect, and Exploitation, dated 8/1/2024, revealed the Policy was It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The section titled Screening documented A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screening may be conducted by the facility staff itself, third-party agency, or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. A review of employee files on 8/10/2024 with the Business Office Manager (BOM) revealed the following: 1. The Administrator was hired on 2/5/2024 with no reference checks completed. 2. The Director of Nursing (DON) was hired on 6/24/2024 with no reference checks completed. 3. The Dietary Manager was hired on 2/21/2022 with no reference checks completed. 4. The Infection Preventionist was hired on 4/1/2024 with no reference checks completed. 5. The Minimum Data Set (MDS) Coordinator/Registered Nurse (RN) was hired on 7/22/2024 with no reference checks completed. 6. Licensed Practical Nurse (LPN) BB was hired on 4/15/2024 with no reference checks completed. 7. Dietary [NAME] KK was hired on 4/6/2024 with no reference checks completed. 8. RN LL was hired on 4/13/2024 with no reference checks completed. The DON had an active, unencumbered RN license. The Infection Preventionist had an active, unencumbered LPN license. The MDS Coordinator/RN had an active, unencumbered RN license. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN BB had an active, unencumbered LPN license. There were no concerns identified related to abuse or neglect within the facility. In an interview on 8/10/2024 at 1:00 pm, the BOM stated the Human Resource Director was on leave, and she was filling in for her. She stated she was unable to locate the employee pre-employment reference checks. In an interview on 8/11/2024 at 2:30 pm, the Administrator stated the Human Resource Director was responsible for ensuring the new hire packet of documents was completed and maintained in the employee file. She stated the required documents included a pre-employment reference check. She stated employee reference checks were used to obtain information about the potential employee's character. She confirmed the facility was unable to provide documentation of reference checks or physicals for eight of the employee files reviewed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on staff interviews, record review, and review of the facility policy titled Resident Assessment-Coordination with PASARR (preadmission screening and resident review) Program, the facility failed to ensure two of four residents (R) (R34 and R35) reviewed with a serious mental disorder (MD) were referred for a Level II PASARR assessment on admission or within 30 days of a new diagnosis. This deficient practice had the potential to affect the appropriate level of care and services provided for R34 and R35. Findings include: A review of the facility policy titled Resident Assessment-Coordination with PASARR Program, dated 1/9/2024, revealed the Policy was This facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. 1. A review of the electronic medical record (EMR) revealed that R34 was admitted to the facility on [DATE] with a diagnosis including, but not limited to, Post-Traumatic Stress Disorder (PTSD). A review of the Face Sheet revealed no diagnoses of dementia or Alzheimer's disease. A review of the annual Minimum Data Set (MDS) dated [DATE] revealed section A (Identification Information) documented the resident was not currently considered by the State Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I (Active Diagnoses) documented PTSD. A review of the quarterly MDS dated [DATE] revealed Section I (Active Diagnoses) documented PTSD. A review of the EMR revealed a PASARR Level I request dated 2/15/2022 without bipolar disorder marked on the form. A further review revealed no re-submission for a PASARR Level I after R34 was admitted to the facility, and there was no PASARR Level II. In an interview on 8/10/2024 at 3:00 pm, the Director of Nursing (DON) verified there was no PASARR Level II in R34's clinical record. She stated that the PASARR Level I should have documented R34's diagnosis of PTSD. She stated when a resident was admitted to the facility, the Social Service Director (SSD) reviewed the PASARR Level I and the resident's diagnoses to determine if the PASARR Level I, which was submitted before admission, was accurate and should submit an accurate PASARR Level I if the resident had a qualifying diagnosis. She stated if the PASARR submission did not contain accurate diagnoses, the resident could be at risk of not receiving needed services. The SSD was not available for interview. 33548 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the medical record revealed that R35 was admitted to the facility on [DATE] and had diagnoses including, but not limited to, dementia without behaviors, depression, anxiety disorder, and delusional disorder. A review of the annual MDS assessment dated [DATE] and the quarterly MDS assessment dated [DATE] revealed no PASARR Level II assessment completed. Continued review of the quarterly MDS assessment dated [DATE] revealed R35 had a BIMS (Brief Interview for Mental Status) score of 15 indicating cognition is intact. A review of the medical record revealed a PASARR Level I assessment was completed on 3/16/2024 and indicated that R35's primary diagnosis was not dementia. The section of the PASARR Level 1 that indicates if R35 had a primary diagnosis of serious mental illness was blank as well, as the remaining sections of the assessment sections were blank, revealing no information. An interview on 8/10/2024 at 3:45 pm with the Business Office Manager (BOM) and the DON revealed that a PASARR Level II assessment had not been completed for R35. The BOM revealed that residents admitted to the facility come with a PASARR Level I assessment completed. A continued interview with the BOM revealed that when residents are admitted to the facility from the hospital, such as R35, she assumed that a PASARR Level II assessment was initiated by the hospital and was in progress. The DON revealed that it is the responsibility of the social worker to review the resident's diagnosis and check to ensure that a PASARR Level II assessment has been completed or needs to be completed. The DON revealed that with R35's diagnosis of anxiety disorder, the resident should have been assessed for a PASARR Level II. The DON revealed that the social worker was not available for an interview.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on staff interviews, record review, and review of the facility policy titled Resident Assessment-Coordination with PASARR (preadmission screening and resident review) Program, the facility failed to ensure one of four residents (R) (R19) reviewed with a serious mental disorder (MD) was referred for a Level II PASRR assessment on admission or within 30 days of a new diagnosis. This deficient practice had the potential to affect the appropriate level of care and services provided for R19. Findings include: A review of the facility policy titled Resident Assessment-Coordination with PASARR Program, dated 1/9/2024, revealed the Policy was This facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. The Policy Explanation and Compliance Guidelines section included .6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. A review of the electronic medical record (EMR) revealed R19 was initially admitted to the facility on [DATE] with diagnoses including, but not limited to, schizophrenia. A review of the Face Sheet revealed no diagnoses of dementia or Alzheimer's disease. A review of the annual Minimum Data Set (MDS) dated [DATE] revealed section A (Identification Information) documented the resident was not currently considered by the State Level II PASARR process to have serious mental illness and/or intellectual disability or a related condition. Section I (Active Diagnoses) documented schizophrenia. A review of the quarterly MDS dated [DATE] revealed Section I (Active Diagnoses) documented schizophrenia. A review of the EMR revealed a PASARR Level I request dated 5/5/2017 revealed schizoaffective was marked as a diagnosis, and dementia was not marked as a diagnosis. A review of a facility-provided document titled PASARR (Level I) Look Up, printed 8/9/2024, revealed the Status documented Pending. A review of the EMR revealed there was no PASARR Level II. In an interview on 8/10/2024 at 3:00 pm, the Director of Nursing (DON) verified no PASARR Level II in R19's clinical record. She stated she was unsure why the PASAR Level II could not be located. She verified that R19's PASARR Level I, dated 5/15/2017, was marked with a diagnosis of schizoaffective disorder, and the status on the PASARR (Level I) Look Up was documented as Pending. She stated the Social Service Director (SSD) typically reviewed potential new admissions and referred for a PASARR Level II if the resident had a qualifying diagnosis. She stated not having a complete and accurate PASARR determination could put the resident at risk of not receiving needed services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/10/2024 at 3:05 pm, the Business Office Manager stated she received new admission information and reviewed the documentation to ensure a submission for a PASARR Level I had been submitted prior to admission. She confirmed the PASARR Level I, dated 5/15/2017, contained the diagnosis of schizoaffective disorder and the status documented as Pending. She stated that the Pending status indicated that the resident did qualify for a PASARR Level II, and she was unsure why R19 did not have a PASARR Level II. The SSD was not available for interview.

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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. 45813 Based on staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to develop or implement a comprehensive, person-centered care plan for two of 19 sampled residents (R) (R14 and R15). Specifically, the facility failed to develop a care plan for pain management for R14 and implement a care plan for oxygen therapy for R15. The deficient practice had the potential to place R14 and R15 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of the facility's undated policy titled Comprehensive Care Plans revealed the Policy stated, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [Minimum Data Set] assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. A review of R14's electronic medical record (EMR) revealed the Face Sheet documented diagnoses including, but not limited to, type 2 diabetes mellitus with diabetic neuropathy and generalized muscle weakness. A review of R14's quarterly MDS with an Assessment Reference Date (ARD) of 6/12/2024 revealed section GG (Functional Abilities and Goals) documented no functional range of motion of the upper extremities and impairment on one side of the lower extremities. Section J (Health Conditions) documented that R14 had the presence of pain. A review of the Physical Therapy Evaluation and Plan of Treatment dated 5/10/2024 revealed a plan of treatment which included modality application, electric stimulation, manual and modality application, ultrasound constant attendance. The goal included the patient will exhibit a decrease in pain at rest to 4/10 in the right knee to increase patient's ability to perform Functional transfers with supervision. A review of R14's care plan dated 11/30/2023 revealed there was no care plan area for pain management or diagnosis of type 2 diabetes with neuropathy. 2. A review of R15's EMR revealed diagnoses included but were not limited to, acute and chronic respiratory failure with hypercapnia, heart failure, shortness of breath, chronic obstructive pulmonary disease (COPD), morbid (severe) obesity due to excess calories, and obstructive sleep apnea. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R15's quarterly MDS with an ARD of 6/14/2024 revealed section O (Special Treatments, Procedures and Programs) documented that R15 received oxygen therapy. A review of R15's care plan, dated 1/5/2024, revealed R15 was at risk for a decline in respiratory function related to a history of oxygen dependence, respiratory failure, shortness of breath/wheezing, pneumonia, and diagnoses of COPD and obstructive sleep apnea. Interventions included administering respiratory treatments per current orders and referring to physician orders for details. During an interview on 8/10/2024 at 2:46 pm, the MDS/Care Plan Coordinator verified a care plans related to pain management and diabetes with neuropathy were not developed for R14. She stated there should have been a care plan area for pain management that included interventions prescribed for pain management, including e-stim treatments. She verified that R15's care plan included administering respiratory treatments per current orders and stated if the resident was not receiving the oxygen as ordered by the physician, then the care plan was not being followed. During an interview on 8/10/2024 at 4:01 pm, the Director of Nursing (DON) verified R14 did not have a care plan developed for pain management or e-stim treatments. She stated she was unaware that the care plans were not developed. The DON further stated all care areas, including medications, diagnosis, and treatments, should be care planned. The DON verified R15's care plan for oxygen and stated the care plan was not being followed. Cross-Reference F695

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence of Sparta Health and Rehab	60 Providence Street Sparta, GA 31087

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35180 Based on record review, staff interviews, and review of the facility policy titled Comprehensive Care Plans, the facility failed to revise the care plan for one resident (R) (R3) who had a change in code status. The sample size was 19. Findings include: A review of the facility's undated policy titled Comprehensive Care Plans, revealed the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. A review of R3's MDS assessments revealed the quarterly MDS assessment was completed on [DATE]. A review of the physician orders dated [DATE] revealed that R3's code status was Do Not Resuscitate (DNR). A review of the Physician Orders for Life-Sustaining Treatment (POLST) document dated [DATE] revealed that R3 had a change in code status from DNR to Allow for Natural Death. A review of R3's care plan revealed the resident was care planned for Full Code status, which indicated the staff was to honor the resident's wish and perform Cardiopulmonary Resuscitation (CPR) in the event of a medical emergency. During an interview with the MDS Coordinator on [DATE] at 3:15 pm, she acknowledged that R3 was care planned for Full Code status. She indicated the care plan should have been revised to reflect a DNR. The MDS coordinator stated the failure to revise the care plan was an oversight. During an interview with the Director of Nursing (DON) on [DATE] at 3:15 pm, she explained that the Social Service Director (SSD) was the person who handled code status changes and reported them to the MDS Coordinator. The DON stated it was her expectation for the MDS Coordinator to revise the care plan when a resident had a change in code status.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45813 Based on record review, staff and resident interviews, review of the facility policy titled, Incidents and Accidents, facility's tool titled Electrical Stimulation Prep, Precautions, and Contraindications, and Operational Manual, the facility failed to ensure three of 19 sampled residents (R) (R14, R15, R30) were free of accidents and hazards. Actual harm occurred on 6/5/2024, when physical therapy staff failed to oversee an electrical stimulation (e-stim) treatment (a device that sends electrical impulses through electrodes attached to the skin to help with physical therapy and fitness) treatment for R14, resulting in a burn to the right leg with 100% slough in the wound bed. Additionally, the facility failed to ensure resident's (R) (R14), (R15), and (R30) safety by having power strips maintained on the floor and bedside table while being utilized with medical equipment. Findings include: A review of the facility's undated policy titled Incidents and Accidents, revealed it is the policy of the facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Compliance guidelines: 6. In the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risks or harm. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. 8. The supervisor or other designee will be notified of the incident/accident. 9. The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated. 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-interventions. A review of the facility's tool titled Electrical Stimulation Prep, Precautions, and Contraindications, indicated electrical stimulation can be used in an adjunctive treatment in managing many disorders. Contraindications and Precautions: Over areas with diagnosed pathology (e.g., diabetic neuropathy). A review of the facility's tool titled _____ Operational Manual, Warning: Do not use this device under these conditions - On open wounds or rashes, or over swollen, red, infected, or inflamed areas or skin eruptions, or on top of, or in proximity to cancerous lesions; over areas of skin that lack normal sensation. Never apply the electrodes to - If the patient experiences any skin irritation or redness after a session, do not continue stimulation in that area of the skin. General Warnings - Before administering any treatment to a patient you should become acquainted with the operating procedures for each mode of treatment available, as well as the indications, contraindications, warnings, and precautions. Consult other resources for additional information regarding the application of electrotherapy and ultrasound. General precautions - If a patient is injured during treatment discontinue use immediately and contact your dealer about the injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Review of the Electronic Medical Record (EMR) for R14 revealed a diagnosis that included Type 2 diabetes mellitus with diabetic neuropathy and generalized muscle weakness. Review of the Quarterly Minimum Data Set (MDS) assessment for R14 dated 6/12/2024 revealed a Brief Interview for Mental Status Score (BIMS) of 14, indicating little or no cognitive impairment. Review of the EMR for R14 revealed a physician order dated 5/10/2024 for physical therapy to address the therex, theract, neuro re-ed and electrical stimulation (e-stim) and or ultrasound (U.S.) for right knee pain 1-5 times per week for 30 days. Further review of physician orders revealed an order to wash right lower extremity with soap and water, pat dry, apply Silvadene cream/non-stick dressing daily and as needed with a start date of 6/26/2024. Review of the Physical therapy Evaluation and Plan of Treatment for R14 dated 5/10/2024 revealed a plan of treatment that included Modality application, electric stimulation, manual and modality application, ultrasound, and constant attendance. Goal -Patient will exhibit a decrease in pain at rest to 4/10 in the right knee to increase patient's ability to perform functional transfers with supervision. Record review of the Physical Therapy Treatment Encounter Note for R14 revealed that on 6/5/2024, upon therapist entering R14's room, resident presented with sores around right lower leg appearing to be from e-stim machine. Resident denying two sores origin being e-stim, stating sore on the right inner knee from e-stim the previous day and he has been treating it with antibiotic ointment. E-stim held this day, will follow up. Further review of therapy notes revealed there were not any follow -up notes related to the burns. Record review of the EMR for R14 revealed there was no evidence that the physician or nurse practitioner had been notified related to his burn until 6/16/2024 (11 days later). Review of the therapy progress notes revealed R14 received an e-stim treatment on 6/13/2024 for 20 minutes after the therapy staff were aware of the burn sustained and identified on 6/5/2024. Record review revealed a progress note dated 6/16/2024 that indicated R14's right lower leg was observed to be red and warm to touch, resident verbalized some tenderness to the area. R14 was also observed with an open area below his right knee which he reported occurred with the therapy treatment. Nurse Practitioner (NP) was called, and new orders were received for Bactrim DS, one tablet by mouth twice a day for ten days. Record review revealed a progress note dated 6/18/2024 which indicated a treatment order for the burn sustained for e-stim on 6/5/2024 was not received until 6/16/2024. An order was received for Bactroban and Santyl to the area. Further review revealed the burn was covered and an order was received for Bactroban and Santyl to site. Further review of R14's record revealed a weekly wound observation tool dated 6/18/2024, which indicated the resident had a burn; this was the first observation, and the burn had 100% slough in the wound bed. The burn measured 05 x 05 x 01 millimeters(mm). Record review revealed a progress note dated 6/18/2024 which indicated the e-stim has been discontinued at this time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/9/2024 at 8:40 am with R14, he stated that he sustained a burn on his right leg at the facility. He further revealed the therapy department had received a new machine that was supposed to stimulate his muscles and nerves in his leg. R14 further stated the girl from therapy entered his room, applied the device to three different areas on his leg, and left the room. R14 was observed to still have brown marks on his leg and a white bandage. R14 further stated that after about 15 or 20 minutes, the areas where the device was applied began to burn him like crazy, so he removed the pads from his leg. The resident stated after removing the device, he noticed, he had three burn marks on his leg. He stated two of the areas on the outer aspect of his right leg were really superficial and eventually left two brown marks, but the area on the inner aspect just below the knee was really bad, deep, and very tender. R14 further revealed that he informed the therapist when she returned to the room, but she just took the machine and left the room. Observations of the room revealed an electrical surge protector on the resident's bedside table with the red indicator light illuminated. There were three cords plugged into the surge protector with a container of clear liquid alongside the surge protector. During an interview on 8/9/2024 at 3:06 pm with the Physical Therapy Assistant (PTA) DD stated that she noticed the two brown areas and an open area on the right lower leg of R14. She further stated that R14 informed her that the e-stim had gotten too hot, and he removed the device from his leg, and the resident informed her not to worry about it. PTA DD stated she documented her observations in the progress notes and informed the Therapy Manager on the day of her observations. She revealed that she always remained with the resident during treatment, which lasted between 15 and 20 minutes. PTA DD further revealed whenever she implemented the e-stim treatment, she monitored the resident for complications, and he never voiced any concerns to her during or after the treatment. PTA DD further stated she failed to communicate her observations to the nursing staff or Administrator. During an interview on 8/9/2024 at 3:49 pm with the Assistant Director of Nursing (ADON) revealed no one from physical therapy alerted the staff about the burn that R14 received during treatment. The ADON reviewed the EMR and verified there was not any documentation in the record to include an event report or change in condition report related to the burn until 8/16/2024. The ADON further stated the nurses should have completed a Situation Background Assessment Recommendation (SBAR) and contacted the physician or NP after learning of the areas. During an interview on 8/9/2024 at 3:54 pm with Licensed Practical Nurse (LPN) BB, who stated that she learned of R14 having a burn when he informed her and notified the Registered Nurse (RN) Supervisor on 6/16/2024. LPN BB stated no one from the physical therapy department informed her of the incident with the e-stim device. During an interview on 8/9/2024 at 4:05 pm with the Administrator revealed she was aware R14 was receiving treatment for a burn, but she was not aware the burn was sustained during an e-stim treatment with physical therapy. The Administrator further stated she was under the impression that the burn was discovered shortly after his admission to the facility, and he had prior to coming to the facility. During a telephone interview on 8/9/2024 at 4:10 pm with the Regional Rehabilitation Manager revealed she was made aware of the resident sustaining a burn during e-stim treatment, a performance improvement plan (PIP) was put in place, education for e-stim training with the physical therapy staff was provided. The Regional Rehab Manager stated she couldn't change what happened, but she reinforced the education and the training after learning of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 8/10/2024 at 8:51 am revealed R14 lying in bed with his head covered. The surge protector remains on the bedside table, unsecured, with a red indicator light on and two cords plugged into the device. A follow-up interview on 8/10/2024 at 9:23 am with the Physical Therapy Manager stated she did not document when she was informed of the burn on R14, nor did PTA DD complete an incident report. The Physical Therapy Manager further stated she assumed the PTA DD reported the burn to nursing. The Physical Therapy Manager verified that R14 received e-stim treatment on 6/13/2024 after the therapy staff was aware of the burn and that the e-stim treatments were not discontinued until 6/18/2024. A telephone interview on 8/10/2024 at 9:45 am with PTA EE revealed she administered e-stim treatment for R14. PTA EE further stated the treatments were supervised; she stated someone would always be in there throughout the treatment, most likely. PTA EE stated that R14 never gave her indications that the treatment was hurting. She further stated the Physical Therapy Manager informed her of the burn, and she went and looked at it and observed a hole burned in his leg. She stated she was not sure when the e-stim treatment burn occurred. PTA EE further revealed if she had documented the treatment on the 13th, then she was not aware of the burn, and e-stim therapy is contraindicated to continue treatment on a resident who had sustained a burn. During a follow-up interview on 8/10/2024 at 10:30 am with R14 he stated that he was never informed that the machine could potentially cause a burn. R14 stated that the nurses told him that he needed to go to the doctor due to a deep hole burned in his leg, but they did not do anything for a long while. R14 revealed when he went to the wound doctor for his left amputation, he had the doctor look at the burn, and he gave him some Silvadene cream to put on it. On 8/10/2024 at 11:25 am, the Administrator and Physical Therapy Manager entered R14's room with the surveyor and stated the education with the physical therapy department began on 6/19/2024. She did not give a reason why the education was delayed. A follow-up interview on 8/10/2024 at 2:34 pm with the Infection Control Preventionist (ICP)/Wound nurse, stated R14 had already received antibiotics for treatment, and he went to the wound doctor for his stump. She revealed the wound doctor gave her an order on 6/26/2024 for the Silvadene cream. She stated that R14 reported the burn was very tender. 2. A review of the EMR for R30 revealed a diagnosis that included but not limited to chronic pulmonary disease, generalized anxiety disorder, and major depressive disorder. Review of the quarterly MDS for R30 dated 6/4/2024 revealed a BIMS of 14, indicating little or no cognitive impairment. Observation on 8/09/2024 at 8:33 am and 3:12 pm revealed an unsecured surge protector on the floor with the red light on, indicating it was in use. The surge protector was on the floor at the foot of R30's bed and had the oxygen concentrator, nebulizer, and electrical bed plugged in at the time of this observation. Observation on 8/10/2024 at 8:46 am revealed R30 sitting up in bed eating breakfast. The surge protector continues to be on the floor, unsecured, with medical equipment plugged into the device. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/10/2024 at 10:12 am with R30 revealed the surge protector has been on the floor for over a week. He further stated the Maintenance Director (MD) placed it there when he was repairing their bathroom and never placed it back on the wall. 3. Record review of EMR for R15 revealed a diagnosis that included but not limited to chronic pulmonary disease, heart failure, shortness of breath, and obstructive sleep apnea. Record review of the quarterly MDS for R15 dated 6/14/2024 revealed a BIMS of 5, indicating severe cognitive impairment. Observation on 8/9/2024 at 8:24 am and 3:19 pm in R15's room revealed an unsecured surge protector on the floor at the head of the bed with the oxygen concentrator and electrical bed plugged into the surge protector. Observation on 8/10/2024 at 8:48 am in R15's room revealed the surge protector remained on the floor unsecured with the oxygen concentrator plugged in and the bed. During an interview on 8/10/2024 at 10:18 am with Certified Nursing Assistant (CNA) AA, revealed she was aware that surge protectors were supposed to be mounted on the wall and off the floor for safety reasons. She further stated all staff were responsible for notifying the maintenance supervisor when they were not properly mounted. During an interview on 8/10/2024 at 10:24 am with LPN AA revealed she was never informed that surge protectors should not be on the floor and were required to be mounted if being utilized by medical equipment. LPN AA further stated she could see that unmounted electrical devices could potentially be a hazard. During an interview on 8/10/2024 at 10:31 am with Housekeeping Aide CC revealed she had visualized surge protectors in resident's rooms on the floor and tables but was not aware that was an issue and it needed to be reported. Interview and walking rounds on 8/10/2024 at 10:41 am with the Director of Nursing (DON) and Maintenance Director (MD) verified the unsecured surge protectors on the floor and resident bedside table being utilized with medical equipment plugged into them. The DON stated the MD was responsible for mounting surge protectors on the wall and that surge protectors should never be on the floor. The MD stated he thought surge protectors should be mounted on the wall because it was a trip hazard. The MD further stated he walks around and checks surge protectors weekly, and they were last checked last Friday. The MD revealed further staff informed him yesterday morning (8/9/2024) that there were some surge protectors on the floor, but he didn't have time to mount the surge protectors.

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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 a review of the facility policies titled, Oxygen Administration and Nebulizer Therapy, the facility failed to provide respiratory care consistent with professional standards of practice for two of five residents (R) reviewed for respiratory services (R15 and R30). Specifically, the facility failed to ensure oxygen (O2) was administered as ordered for R15 and failed to properly store the nebulizer mouthpiece, when not in use, for R30. The deficient practices had the potential to cause respiratory distress for R15 and respiratory infection for R30. Findings include: A review of the facility's undated policy titled Oxygen Administration revealed the Policy Explanation and Compliance Guidelines section included: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 5. Other infection control measures include: e. Keep delivery devices covered in a plastic bag when not in use. A review of the facility's undated policy titled Nebulizer Therapy revealed the Policy Explanation and Compliance Guidelines section included: Care of the Resident: . 15. When medication delivery is complete, turn the machine off. 16. Disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry. Care of Equipment: 7. Once completely dry, store the nebulizer cup and mouthpiece in a [sealed] bag. 1. A review of the electronic medical record (EMR) revealed R15's diagnoses included, but were not limited to, acute and chronic respiratory failure with hypercapnia, heart failure, shortness of breath, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. A review of the active physician orders for R15 included an order dated 8/23/2023 for O2 at 2 liters per minute (LPM) continuous. A review of R15's electronic medication record (eMAR) dated July 2024, August 2024, and July 2024, revealed the O2 was not documented as administered. Further review of the EMR revealed there was no documentation of R15 refusing or removing the O2. Observations on 8/9/2024 at 8:24 am and 3:19 pm revealed R15 lying in bed with the O2 tubing and nasal cannula (NC) lying across the bed rail of the bed exposed to the environment, and R15 was not receiving the O2. Observation on 8/10/2024 at 8:48 am, in R15's room, revealed the O2 tubing and NC lying across the bed rail exposed to the environment, and R15 was not receiving the O2. The O2 concentrator (a machine that dispenses O2) was turned on. 2. A review of the EMR revealed R30's diagnoses included, but not limited to, dyspnea and COPD with acute exacerbation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status Score (BIMS) of 14 (indicating little or no cognitive impairment). A review of R30's care plan, dated 2/9/2022, revealed that R30 was at risk for a decline in respiratory function and/or respiratory distress due to his smoking and disease process (COPD). He uses oxygen per physician's order, as well as jet neb treatment/other respiratory medications. A review of the active physician orders for R30 included ipratropium-albuterol solution (a medication used to control the symptoms of lung disease) 0.5-2.5 (3) milligrams (mg)/3 milliliter (ml) 1 applicator inhale orally via nebulizer four times a day for shortness of breath and wheezing. Observations on 8/9/2024 at 8:33 am and 3:12 pm in R30's room revealed the nebulizer cup and mouthpiece were lying on the resident's bed, unbagged and exposed to the environment. Observation on 8/10/2024 at 8:46 am in R30's room revealed the nebulizer cup and mouthpiece were lying on the bed, unbagged and exposed to the environment. In an interview on 8/10/204 at 10:12 am, R30 revealed he used the nebulizer frequently and had been told to keep it in a plastic bag. He stated the bag had been thrown away and had been missing for a few days. In an interview on 8/10/2024 at 10:18 am, Certified Nursing Assistant (CNA) AA stated she was aware that respiratory tubing should be stored in a clear plastic bag if the resident was not using it. She further stated storing respiratory supplies cuts down on infections and germs and all staff were responsible for ensuring the tubing and mouthpieces were stored while not in use. In an interview on 8/10/2024 at 10:24 am, Licensed Practical Nurse (LPN) BB stated R30's nebulizer should be stored in a plastic bag when not in use. LPN BB confirmed R15's physician's order was for continuous O2 and stated the resident does not like to wear it. LPN BB stated the Nurse Practitioner was aware that R15 did not like to wear the O2, but she had not changed the order because of R15's respiratory history. During walking rounds on 8/10/2024 at 10:41 am, the Director of Nursing (DON) verified that R30's nebulizer mouthpiece was unbagged and exposed to the environment. The DON also verified that R15's nasal cannula was across the bedrail and exposed to the environment. She stated the nursing staff was responsible for ensuring all respiratory circuits were clean and placed in a plastic bag when they were not being used to reduce respiratory infections due to environmental exposure. In an interview on 8/10/2024 at 11:21 am, the DON verified that R15's order for O2 was continuous and that she was aware that the resident does not always have O2 on. The DON further stated the O2 order had been addressed with the Nurse Practitioner, but no changes were made. The DON verified there was no documentation of R15 being noncompliant with the respiratory treatment. The DON further stated the nurse should document noncompliance with physician orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35180 Based on record review, staff interview, and review of the facility policy titled Use of Psychotropic Medication, the facility failed to ensure a stop date was implemented, not to exceed 14 days for psychotropic medications for one of six residents (R) reviewed for unnecessary medications (R3). Findings include: A review of the facility's undated policy titled Use of Psychotropic Medication revealed as needed (PRN) psychotropic drugs should be used only when necessary and for a limited duration. If the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, they would document the rationale in the resident's medical record and indicate the duration of the PRN order. A review of R3's physician orders dated 5/30/2024 revealed an order for 0.5 milligrams (mg) of Ativan (a psychotropic medication used to treat anxiety) by mouth every four hours as needed for anxiety. The order had an indefinite end date. A review of the Medication Administration Record (MAR) revealed R3 was administered Ativan 0.5 mg by mouth on 7/4/2024 at 4:30 pm, 7/10/2024 at 9:00 am, 7/13/2024 at 8:15 am and 9:09 pm, 7/21/2024 at 4:00 am, 8/6/2024 at 9:00 am, and 8/9/2024 at 7:45 am. During an interview with the Director of Nursing (DON) on 8/10/2024 at 12:27 pm, she stated that she and the Assistant Director of Nursing (ADON) had audited resident charts to ensure psychotropic medications had a 14-day stop date. The DON stated that R3's Ativan order should have had a 14-day stop date, but it was overlooked.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 33548 Based on observation, staff interviews, review of facility menus, and review of the facility policy titled Therapeutic Diet Orders, the facility failed to follow established menus posted to ensure the appropriate nutrition was provided to residents. In addition, the facility also failed to notify the Registered Dietitian (RD) of meal/menu substitutions. This deficient practice affected three residents receiving a mechanical soft ground diet and six residents receiving a puree diet, from 40 residents consuming an oral diet. Findings include: A review of the facility policy titled Therapeutic Diet Orders revealed that the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. A review of the main resident menu and the Diet Spread Sheet revealed the posted lunch meal for all diet consistencies was fried chicken, black eye peas, collard greens, cornbread, and cake. Observation on 8/10/2024 at 12:30 pm of Dietary [NAME] JJ, while plating the lunch meal for residents receiving a mechanical soft ground meat diet, revealed the cook placed ground plain chicken topped with brown gravy, boiled cabbage, blackeye peas, and a slice of cornbread on the plate. Continued observation of Dietary [NAME] JJ plating the lunch meal revealed for residents receiving a puree diet, the cook placed plain puree chicken topped with brown gravy, puree blackeye peas, and mashed potatoes. In an interview on 8/10/2024 at 12:30 pm, Dietary [NAME] JJ revealed that gravy in a pan on the stovetop was brown gravy to use for the ground and pureed chicken. Dietary [NAME] JJ stated they use the brown gravy because that is how they have always served that meal. In an interview on 8/10/2024 at 12:30 pm, the Dietary Manager (DM) confirmed that the posted menu to be served was fried chicken, blackeye peas, collard greens, and cornbread. The DM stated that she did notify the RD they were going to substitute cabbage for collard greens. The DM stated that brown gravy was added to the ground pureed chicken because she thought the residents would like it that way. The DM stated that she does not have the option, when ordering, to purchase chicken gravy which is why they use brown gravy on chicken. Continued interview with the DM revealed that the residents receiving puree consistency were served mashed potatoes for a substitute for puree cabbage and stated they did not have time to puree the cabbage for that meal. The DM also confirmed that the residents receiving puree consistency meals were not served pureed cornbread as listed on the menu and stated that it just was not prepared. The DM revealed that the RD was not notified of the brown gravy being added to the ground and pureed chicken, the substitution of mashed potatoes for pureed cabbage, and not serving pureed cornbread. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 8/11/2024 at 10:05 am, the facility's RD revealed that she was notified and approved the substitution of cabbage for collard greens for the lunch meal. The RD revealed that she was not notified that dietary staff were adding gravy to ground and pureed chicken. The RD revealed that she was not notified that dietary staff substituted mashed potatoes for pureed cabbage, and she was not notified that dietary staff eliminated serving puree cornbread. The RD stated that dietary staff should serve the menu as posted and should notify her of any modifications to the menu. The RD stated the DM should either call her or send a text message with the food substitution as well as complete the food substitute log sheet which she reviews and signs after review when in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33548 Based on observation, staff interviews, review of the posted menu, review of the recipe for puree fried chicken, and review of the facility policy titled Food Preparation Guidelines, the dietary staff failed to follow the recipe for fried chicken as printed, compromising the nutrient value. This deficient practice affected six residents who received puree consistency and three residents who received mechanical soft ground consistency from 40 residents receiving an oral diet. Findings include: A review of the resident menu revealed lunch meal to be served included fried chicken, blackeye peas, collard greens, cornbread, and cake. A review of the recipe for Chicken Fried Pureed Thick revealed the ingredients listed were fried chicken, low sodium chicken base, hot water, and food thickener. A review of the facility policy titled Food Preparation Guidelines revealed the cook or designee shall prepare menu items following the facility's written menus and standardized recipes. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance. This includes but is not limited to preparing foods as directed. Observation on 8/10/2024 at 10:40 am of Dietary [NAME] II puree fried chicken revealed he placed three eight-ounce spoons of steamed diced chicken from a stock that was on the stovetop into the food processor bowl and pureed. Dietary [NAME] II stopped the food processor twice to scrape the sides of the bowl and added an unmeasured amount of water. Once the chicken achieved the desired pureed consistency, Dietary [NAME] II placed it in a steam table pan for service. Continued observation revealed Dietary [NAME] II had ground some of the steamed plain chicken in a pan and placed it in the steam table. During an interview on 8/10/2024 at 10:45 am, Dietary [NAME] II confirmed the posted menu and stated the residents were to receive fried chicken for lunch. Dietary [NAME] II revealed he had always used plain diced chicken for fried chicken and stated he steams it in a stock pot with chicken broth. Dietary [NAME] II was unsure if there was a recipe to follow for fried chicken. During an interview on 8/10/2024 at 10:45 am, the Dietary Manager (DM) confirmed that plain steamed chicken was used for preparing the fried chicken indicated on the menu. The DM revealed that they have always used plain diced chicken and not actual fried chicken. The DM revealed that the facility's Registered Dietitian (RD) had not been made aware that dietary staff were using plain steamed chicken instead of fried chicken for puree. The DM stated that she thought as long as it was chicken, it would be fine to use. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 8/11/2024 at 10:05 am, the facility's RD revealed she had not been made aware that dietary staff was using steamed plain diced chicken instead of actual fried chicken for puree and mechanical soft ground. The RD revealed that she expects dietary staff to follow recipes, and when fried chicken is indicated, it is to be served to all diet consistencies, including puree and ground. The RD stated that actual fried chicken should have been prepared to provide the proper nutrient value as well as for taste/flavor. The RD revealed that the DM should notify her when making any adjustments to recipes.

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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. 33548 Based on observations, staff interviews, and review of the facility policies titled Manual Warewashing-3 Compartment Sink and Food Receiving and Storage, the dietary staff failed to prevent wet nesting with stacks of steam table pans to prevent bacteria growth, failed to store food items off the floor in the dry storage area, and failed to demonstrate the proper usage of the three compartment sink to prevent cross-contamination. The deficient practices had the potential to place 40 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. Findings include: 1. A review of the facility's undated policy titled Manual Warewashing-3 Compartment Sink revealed the sanitizing procedures for three-compartment sink included to allow pots/utensils to air dry and store pots upside down or covered. Observation on 8/9/2024 at 8:50 am revealed four stacks of steam table pan on a shelf under the steam team. A stack with four square pans were pulled apart which revealed the inside of the top pan was wet with water. Continued observation revealed a stack with five large rectangle pans, and when the top pan was pulled from the stack, the inside was wet with water. In an interview on 8/9/2024 at 8:50 am, the Dietary Manager (DM) confirmed that the inside of the top stacked square steam table pan and the top of the large rectangle steam table pan were wet with water. The DM revealed that dietary staff were to completely air-dry pans before stacking. 2. A review of the facility's undated policy titled Food Receiving and Storage revealed food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes, and vents. Observation on 8/9/2024 at 8:55 am of the dry storage area revealed two stacks of cases of food on the floor in the dry storage area. One stack had four cases of food items stacked on top of each other. The second stack had six cases of food items stacked on top of each other. During an interview on 8/9/2024 at 8:55 am, the DM confirmed that the two stacks of food items were directly on the floor. The DM stated that they had a grocery delivery yesterday (8/8/2024), and no one had an opportunity to put the groceries away. The DM stated that when her shift ended, she had to punch out and was not able to continue to work, which left the food items in the dry storage area on the floor. 3. A review of the facility policy titled Manual Warewashing-3 Compartment Sink included A 3-step process used to manually wash, rinse, and sanitize dishware correctly. Chemical sanitizing solution used according to manufacturer's instruction. Immerse rinsed pots/utensils in sanitizer per manufacturer instructions. A review of the Multi-Quat Sanitizer Product Specification Document revealed: Expose all surfaces to the sanitizing solution for a period of not less than 1 minute. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 8/10/2024 at 10:35 am of the three-compartment sink revealed the facility was utilizing a quaternary chemical solution to sanitize dishware. Continued observation revealed Dietary [NAME] II washed the food processor bowl and blade by washing in soapy water, rinsing with clean water, and then swished the dish items in the sanitizing solution for a second. Dietary [NAME] II did not place the dishware items in an area to air dry, he placed the food processor bowl and blade on the main unit to continue food preparation. In an interview on 8/10/2024 at 10:35 am, Dietary [NAME] II confirmed that he only had the food processor bowl and blade in the chemical sanitizing solution for a second. The dietary cook revealed that dishware should be submerged in the solution for at least 60 seconds. He further revealed that he was nervous, which was why he did not keep the dish items in the sanitizing solution for the recommended period of time. In an interview on 8/10/24 at 10:35 am, the DM revealed that she expected dietary staff to submerge dishware in the sanitizing solution for at least 60 seconds.

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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. 33548 Based on observations and staff interviews, the facility failed to properly maintain one of two dumpsters to prevent leakage onto the ground. The facility census was 40 residents. Findings include: Observation on 8/9/2024 at 9:00 am of the dumpster area revealed that the facility had two medium-sized dumpsters located on asphalt behind the building. The dumpster closest to the building was missing the plug located towards the bottom of the dumpster. Continued observation of this dumpster revealed a liquid substance actively dripping from the unplugged hole. During an interview on 8/9/2024 at 9:00 am, the Dietary Manager (DM) confirmed that no plug was in place at the bottom of the dumpster. The DM also confirmed that the unplugged hole was actively dripping a liquid substance onto the asphalt ground. Observation on 8/10/2024 at 9:00 am of the dumpster closest to the building revealed that the plug at the bottom was still not in place. In an interview on 8/10/ 2024 at 9:00 am, the DM confirmed that the dumpster continued to have no bottom plug in place. Observation on 8/11/2024 at 9:30 am of the dumpster closest to the building revealed that it continued to have no plug in place at the bottom side. Continued observation revealed that it was actively dripping a liquid substance onto the asphalt ground. In an interview on 8/11/2024 at 9:30 am, the DM confirmed that there still was no plug in place on the dumpster and that the unplugged hole was actively leaking liquid a substance The DM stated that she notified the maintenance director and was told that he contacted the waste management company to have them bring a plug for the dumpster. In an interview on 8/11/2024 at 12:05 pm, the Administrator revealed that the dumpsters were city-owned and the city maintains them. The Administrator revealed that she had just been made aware that there was no plug in place in one of two dumpsters. The Administrator revealed that the facility does not have a policy regarding dumpsters or waste disposal. In an interview on 8/11/2024 at 1:45 pm, the Interim Maintenance Director (IMD) confirmed that the dumpster closest to the building had no bottom plug in place and was actively leaking a liquid substance. The IMD stated that the dumpsters were owned by the city, and he had contacted the company indicated on the dumpsters and asked if someone was available to bring a plug for the dumpster. The IMD confirmed he was notified on 8/9/2024 by the DM that the plug on the one dumpster was missing. He further stated that the plug likely dislodged during the last garbage pick-up. The IMD revealed that he did contact the waste management company and asked if someone could come this weekend and replace the missing plug. He revealed that he had gone to the hardware store and purchased a plug for the dumpster due to not knowing when the waste management company would come and replace it.

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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. 45813 Based on observations, staff interviews, and review of the facility's policies titled Infection Prevention and Control Program and Laundry Services, the facility failed to maintain an effective infection control program by failing to ensure infection control policies were followed during the handling, storage, and processing of linens. In addition, the laundry staff failed to ensure the washing machine was clean and free from chemical deposits, dust, and lint. These failures had the potential to spread infection due to cross-contamination to 40 residents residing in the facility. Findings include: A review of the facility's policy titled Infection Prevention and Control Program, reviewed and revised 1/9/2024, revealed the facility had established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The Policy Explanation and Compliance Guidelines section included: 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. b. Clean linen shall be separated from soiled linen at all times. c. Clean linen shall be delivered to resident care units on covered linen carts with covers down. A review of the facility's undated policy titled Laundry Services revealed the Purpose was To assure a clean supply of linens and to protect employees who handle and process the laundry. The policy included: II. Transportation of Linen - A. Clean linen is not to come in contact with dirty linen. IV. Protecting Personnel Who Sort Laundry - A. In the laundry, hand hygiene facilities, and protective barriers (e.g., fluid-resident gowns or aprons, gloves, and masks/face protection) shall be made available to personnel who sort laundry. During a tour of the laundry on 8/9/2024 at 9:05 am, the Laundry Supervisor revealed the facility had one operable industrial washer. The washer was fed washing chemicals by Echo-Lab and observed to have accumulations of chemical residue and dust on the surfaces. Laundry Aide/Floor Tech GG was observed handling dirty and clean laundry without wearing personal protective equipment (PPE). Further observations on the clean side of the laundry revealed an uncovered clothing rack with resident clothing hanging for distribution. In an interview on 8/9/2024 at 9:12 am, Laundry Aide GG stated he was not aware he needed to wear PPE when handling linen in the laundry. He further stated he had observed all the chemical spills and dust on the washer, but he was not sure who was responsible for keeping it clean. Laundry Aide GG also verified the clothing on the rack was clean and ready to be distributed to residents. He further stated he was not aware that the rack needed to be covered and stated he had never witnessed the rack being covered in the laundry or when taken on the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 8/9/2024 at 9:19 am, the Laundry Manager revealed he had only been in the position for a short while and did not receive any training. He verified the chemical spillage and further stated that the laundry aides were responsible for wiping the washer down and keeping it clean. The Laundry Manager also stated he was unaware the clean clothing rack should be covered or that the laundry staff was required to wear PPE when handling soiled linen and clothes. Observations on 8/9/2024 at 10:34 am revealed Laundry Aide GG leaving the laundry with an uncovered metal laundry basket containing clean linen. Laundry Aide GG went to the 100 Hall, parked the uncovered linen basket directly in front of the dirty linen cart, and began to place linen on the clean linen cart. In an interview, Laundry Aide GG stated he had never been told or witnessed laundry coming from the laundry room to the floor to be covered. He verified the clean linen cart was next to the dirty linen cart and stated it should not be. Laundry Aide GG proceeded to place the linen on the clean linen cart, transported the remaining linen uncovered to the 200 Hall, and loaded the remainder of the linen on that clean linen cart. In an interview on 8/9/2024 at 10:39 am, the Director of Nursing (DON) stated she would ensure the linen on the 100 and 200 Halls was rewashed before being used. The DON confirmed all linen and processed resident clothing should always be covered prior to leaving the laundry. She further stated laundry staff should wear gloves and gowns when handling soiled linen and dirty clothes in the laundry. In an interview on 8/9/2034 at 10:41 am, the Laundry Manager stated he had not witnessed the laundry basket being covered when linen was transported, and he was unsure if it should be covered or not. He further stated no one had informed him, but he was aware that the clean and dirty linen carts should never be together. In an interview on 8/9/2024 at 10:47 am, the Infection Prevention Nurse revealed clean linen should always be covered during transport and clean and dirty linen should never be together. She further stated the laundry aides were required to wear PPE when handling soiled items in the laundry. In an interview on 8/9/2024 at 10:54 am, the Administrator revealed clean and dirty linen should be separated at all times and not stored together. In an interview on 8/10/2024 at 8:57 am, Laundry Aide HH revealed she transported laundry to the floor in the laundry baskets and had never covered it during transport. Laundry Aide HH also stated she had never covered the clothes rack of personal clothing when transporting it to the halls to distribute to residents and had never worn PPE when handling contaminated or clean linen. She stated she had cleaned the chemicals on the washer, but she was not aware of a schedule or who was responsible for cleaning the washer.

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F 0940 Level of Harm - Actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observation, staff and resident interviews, record review, and a review of the facility's Facility Assessment, the facility failed to ensure the physical therapy staff were informed or educated prior to applying an electronic medical device for electrical stimulation treatment (also known as e-stim, which is a treatment method often used in physical therapy and pain management to deliver mild electrical currents through the patient's skin to either target the muscles to stimulate quicker recovery or the nerves to reduce pain) for one of one resident (R) (R 14). Actual harm occurred on 6/5/2024, when physical therapy staff failed to oversee an e-stim treatment for R14, resulting in a burn to the right leg with 100% slough in the wound bed. Findings include: A review of the Facility Assessment, dated 8/8/2024, revealed Purpose Statement: The purpose of this assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Information About Our Staff Training/Education and Competencies: Our facility's training program includes an orientation process and ongoing training for all new and existing staff, including managers, nursing, and other direct care staff, and other individuals consistent with their expected roles. The training content at a minimum includes Effective communication, special needs of residents, and identification of resident changes in condition. Record review of the quarterly Minimum Data Set (MDS) for R14 dated 6/12/2024 revealed a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. During an observation and interview on 8/09/2024 at 8:40 am with R14, he stated that he sustained a burn on his right leg at the facility after a girl from physical therapy applied the device in three different areas and left the room. R14 stated the device started burning him like crazy and he removed the device. Once he removed the device R14 stated he saw three burn marks on his leg. R14 revealed that staff should not be allowed to use them as [NAME] pigs to try out new equipment without the proper training. R14 stated the staff did not have any training on the machine and that the Physical Therapy Assistant (PTA) DD informed him she had to go home and look up the operation of the device online. During an interview on 8/9/2024 at 3:01 pm with the Physical Therapy Manager, she revealed that R14 was the only resident with a treatment plan to include e-stim treatment in the last couple of years. The Therapy Manager stated she was not credentialed to administer the treatment, but it was her understanding that once the e-stim treatment started, the staff member applying the device was required to remain with the resident throughout the entire treatment. The Therapy Manager further stated that the therapy staff were not trained nor received education in the facility to ensure they were competent before initiating the e-stim treatment because it is a part of their schooling. During an interview on 8/9/2024 at 3:06 pm with the Physical Therapy Assistant (PTA) DD stated the facility did not provide her with any training on the e-stim device before initiating treatments for R14. PTA DD stated she received modality training while in school, and she can apply the e-stim, but we don't get a certification for it. (continued on next page)

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F 0940 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/9/2024 at 4:05 pm with the Administrator revealed she believes the therapy staff should have some type of skill checkoff to ensure that they are competent. The Administrator revealed that she was aware R14 was receiving treatment for a burn, but she was not aware the burn was sustained during an e-stim treatment with physical therapy. During a telephone interview on 8/9/2024 at 4:10 pm with the Regional Rehabilitation Manager revealed that there was no training provided to the therapy staff related to the e-stim device before the burn occurred. She stated the therapy staff are trained through their certification on e-stim. She further stated the therapy department has made it a practice from that point forward that the staff will be trained to ensure they are appropriately applying the treatment. During a follow-up interview on 8/10/2024 at 9:23 am with the Physical Therapy Manager, she stated she assumed the Physical Therapy Assistants (PTA)s had more experience as clinicians. During a telephone interview on 8/10/2024 at 9:45 am with the Physical Therapy Assistant (PTA) EE revealed the facility did not provide any formal training on e-stim. PTA EE stated she applied the device on herself to figure it out before she used it on the R14. On 8/10/2024 at 11:25 am the Administrator and Physical Therapy Manager entered R14's room with the surveyor and stated the education with the physical therapy department began on 6/19/2024. She did not give a reason why the education was delayed. Cross Reference F689