STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135053	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Court	2200 Ironwood Place Coeur D'Alene, ID 83814

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on observations and interviews, it was determined the facility failed to treat each resident with respect and dignity that promoted enhancement of his/her quality of life and dining experience. This deficiency created the potential for psychosocial harm if the residents felt excluded from the dining experience. This was true for 3 of 24 residents (#1, #17, and #28) who were observed eating in the dining room. The findings include: The facility posted the following meal times for the dining room: Breakfast: 7:30 AM Lunch: 12:00 PM Dinner: 5:30 PM The following residents did not receive their meal in a timely manner, or did not receive their meal at the same time as the other residents at the same table: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including GERD, multiple sclerosis, and depression. Resident #17 was admitted to the facility on [DATE] with multiple diagnoses including heart failure, hypertension, and end stage renal disease. Resident #28 was admitted to the facility on [DATE] with multiple diagnoses including anemia, hyperlipidemia, Alzheimer's disease, and dementia. On 9/22/24, the following was observed in the dining room: - At 12:40 PM, Resident #1 was observed eating her meal at a table with two other residents (#17 and #28). - At 12:45 PM, Resident #17 received his meal and the feeding aide sat next to him to assist him. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 12:49 PM, Resident #28 received her regular meal, but it was removed as she needed a mechanical chopped meal. - At 12:53 PM, Resident #28 received her mechanical chopped meal. - At 12:55 PM, with the assistance of a feeding aide, Resident #28 began eating. On 9/24/24 at 8:15 AM, the DM stated that meal orders are filled based on the meal tickets received and no one knows who is sitting where until the dining has started. Meal orders are filled, and facility staff take the completed trays out to the residents. Facility staff try to feed the residents together, but it does not always work that way.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733 Based on review of medical records, the State Survey Agency's Long-Term Care Reporting Portal, and staff interviews, it was determined the facility failed to ensure residents' rights were protected to be free from abuse and neglect. This was true for 2 of 9 residents (#69 and #72) reviewed for abuse and neglect. This failure placed all residents at risk of ongoing abuse and neglect, and potential physical and psychosocial harm. Findings include: 1. Resident #72 was admitted to the facility on [DATE], with multiple diagnoses including osteoporosis with fracture to right humerus, right pelvis, and vertebra(e), hypertension, and bilateral hearing loss. Resident #72 passed away on 5/1/24. A facility reported incident investigation, initiated 4/12/24, documented Resident #72 reported to the facility that, on 4/12/24, PT #1 came to her room to take her to a therapy session. Resident #72 declined since she was preparing to move to another room. PT #1 responded by throwing a soiled bed pan and a urinal at Resident #72 resulting in urine splashing onto her arm. The facility's investigation documented: - Resident #72 was deaf but could detect pitch and required a white board for communication. She was tearful as she recalled the incident. She stated, during the incident, PT #1 did not use the white board to communicate with her and was yelling at her. - PT #1 stated she used a whiteboard, mouthing, and gestures to communicate with Resident #72, and that Resident #72 was not listening to her explanations. - NAIT #1, who was present during the incident, stated PT #1 threw the soiled bed pan onto Resident #72 and did not use a white board to communicate with her. NAIT #1 stated, because of the incident, she had to clean feces and urine off Resident #72. The investigation documented a previous grievance, dated 3/16/23, included allegations that PT #1 had been rude to another resident who she left in a hallway without his walker. The facility investigation concluded that PT #1 did throw a bed pan and urinal at Resident #72 causing the contents to splash onto her. On 9/26/24 at 12:25 PM, the DON, Interim DON, and Administrator were interviewed together. When asked what corrective actions were taken as a result of the 4/12/24 incident involving Resident #72 and PT #1, the Interim DON stated PT #1 was suspended during the investigation, then terminated from employment at the facility on 4/17/24. On 4/26/24, the State Licensure Board was notified, by the facility, of the abuse allegations and investigative findings related to PT #1's involvement in the incident. The Interim DON stated the investigation determined that burnout may have been a factor in PT #1's behavior, therefore, all staff were educated on abuse/neglect and identifying burnout, which was completed on 4/30/24. Additionally, the staff were offered counseling services for burnout. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	48401 2. Resident #69 was admitted to the facility on [DATE], for care after a spinal surgery and had multiple diagnoses including age-related osteoporosis with current pathological fracture and history of urinary tract infections. An Admission MDS, dated [DATE], documented Resident #69 was assessed to be cognitively intact. Resident #69's care plan, dated 4/12/24, documented she required extensive assistance with personal hygiene A facility reported incident investigation, initiated on 4/15/24, documented Resident #69 used her call light to ask for assistance being changed after bowel movement incontinence. She reported NAIT #1 responded to her call light and stated she needed to get a second staff to help her, and then did not return. Resident #69 stated she used her call light to request help to be changed 3-4 times in which NAIT #1 responded to her light the same way each time and she did not receive help getting changed. RN #2's witness statement, dated 4/15/24 at 11:58 PM, documented Resident #69 asked to be helped with incontinence care at approximately 6:30 PM when she was administering her medications. RN #2 stated she asked NAIT #1 to assist Resident #69 with incontinence care and NAIT #1 agreed. An hour later, RN #2 asked NAIT #1 if Resident #69 had been helped with incontinence care. NAIT #1 responded, yes and added she had informed CNA #2 that Resident #69 had been helped with incontinence care. At 11:00 PM, CNA #2 approached RN #2 and stated Resident #69 was reporting NAIT #1 had repeatedly turned off her call light saying she was going to get help but did not return or complete incontinence care. The facility's investigation concluded NAIT #1 had neglected to help Resident #69 with incontinence care. On 9/26/24 at 11:18 AM, the Administrator stated she was not the administrator at the time of these events and, it was unfortunate because the staff were provided so much training. The Administrator stated it was appropriate for the facility to substantiate this allegation of neglect. The facility took the following actions after the allegation: - NAIT #1 was suspended immediately during the investigation. - Resident #69 was interviewed and showed no signs of psychosocial harm from the incident. - Nine other residents were interviewed about their care at the facility and none of those residents raised concerns regarding neglect or feeling unsafe. - The allegation and investigation were submitted to the State Survey Agency's Long-Term Care Reporting Portal in compliance with regulations. - Following the substantiation of the allegation, the facility terminated the employment of NAIT #1 on 4/19/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- On 4/30/24, the facility provided retraining to all nursing staff regarding abuse, neglect, and how to manage burnout. These findings represent past noncompliance with this regulatory requirement. There was sufficient evidence the facility corrected the noncompliance as of 4/30/24 and there were no other occurrences of alleged abuse or neglect. At the time of this survey, the facility was in substantial compliance for this regulatory requirement and, therefore, does not require a plan of correction.

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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** 18947 Based on review of facility policy, record review, document review, and interviews, the facility failed to ensure allegations of sexual abuse were reported to the Administrator and, within two hours, to the State Agency. This was true for 1 of 8 residents (Resident #13) reviewed for abuse and neglect. This deficient practice created the potential for psychosocial harm to Resident #13 whose sexual abuse allegation was not reported and investigated thoroughly. Findings include: The facility's Abuse Prohibition policy and procedure, dated 7/1/20, documented the center prohibits the abuse, neglect, and exploitation of residents and misappropriation of resident property by anyone, including staff, resident representative/family, and friends. The policy also stated all alleged violations would be reported immediately, but not later than two hours after all allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the Executive Director and to others. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including dementia with agitation and anxiety. A Quarterly MDS assessment dated [DATE], documented Resident #13 was severely cognitively impaired. A progress note dated 5/13/24 at 10:11 PM, documented, Notified by CNA on north hall that resident made a statement that her arm was hurting and that someone had raped her. Nurse went into room, and Resident #13 was saying that her right leg was really hurting her and pulled back the blanket stating she didn't know what was on her as she was pulling at her brief. I reminded her that she had a previous fracture to her right leg and that she is incontinent at times and that's why she has a brief on, I then asked her if she had made the statement of being raped and she said yes that she did make that statement but that she only said that because she was hurting and didn't remember why but she knows now that she was not raped and just having pain from her previous injury. A progress note dated 5/14/24 at 7:07 AM (seven hours after the resident's initial allegation of sexual abuse), documented, Patient (Pt) is seen today for acute follow-up visit. Pt complained to the nursing staff that she was raped last night. But she wasn't able to explain further. Pt is being seen today by MD to follow up on that .Plan: Accusations of rape - this is a very serious allegation. I went and interviewed patient. I asked patient if she has been harmed by anyone last night or this am, to which she answered 'no, why are you asking this.' I told her that I want to make sure that she is taken care of. She stated, I am good, and no one has hurt me. I asked her specifically if someone tried to hurt her last night, and she was annoyed that I was asking her these questions but did reply, I am doing good, and no one came in last night. But it is noted that patient is very confused during this interview and only remembers her name today. I did discuss with nursing staff and administrator as well. Since the allegations are very serious, [Staff] is to reach to pts POA to see if they would like to take action. If they would like to investigate these allegations, then patient will need to go to ED. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 5/14/24 at 11:39 AM (almost 14 hours after Resident #13's initial allegation of sexual abuse) documented, Granddaughter (POA) notified of statement made by resident last night. Discussed sending out to hospital for evaluation. Wanted to discuss with Uncle- will call back. (Physician) notified of resident statement at this time- will see resident today. A progress note dated 5/14/24 at 12:00 PM (approximately 14 hours after Resident #13's initial allegation of sexual abuse) documented, RCM and floor LN completed exam of outer genitals, buttock and breast. No abnormal discoloration, scratches, bruises, etc. noted. During exam [Resident #13] had no reports of pain nor verbalization of any further concerns regarding previous statement made leading up to this exam. Staff to continue monitor for s/s (signs and symptoms) of psychosocial harm, nursing to monitor for any latent injury. The section, Agencies/People Notified of the incident report dated 5/14/24, was left blank. The Police Department was notified of Resident #13's allegation of sexual abuse on 5/14/24 at 12:00 PM (almost 14 hours after Resident 13's initial allegation of sexual abuse). On 9/25/24 at 2:40 PM, the Administrator stated she was the facility's Abuse Coordinator and stated Resident #13's allegation of sexual abuse was not reported to administration until the morning of 5/14/24. The Administrator stated the failure of nursing staff to timely report the resident's initial allegation of sexual abuse to administration lead to the delayed reporting to Resident #13's physician, POA, SA, and law enforcement. On 9/26/24 at 8:32 AM, during a follow-up interview, the Administrator stated Resident #13's allegation of sexual abuse should have been reported immediately to administration and law enforcement, and within two hours to the SA.

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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** 18947 Based on policy review, record review, and staff interviews, it was determined the facility failed to ensure an alleged allegation of sexual abuse was thoroughly investigated. This was true for 1 of 8 residents (Resident #13) reviewed for abuse and neglect. This deficient practice created the potential for Resident #13 to continue to be sexually abused and experience physical and/or psychosocial harm. Findings include: The facility's Abuse Prohibition policy and procedure, dated 7/1/20, documented a resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation, and to have all allegations thoroughly investigated. The policy also stated all documents would be retained to show all alleged violations were thoroughly investigated. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including dementia and anxiety. A Quarterly MDS assessment, dated 7/28/24, documented Resident #13 was severely cognitively impaired. A progress note, dated 5/13/24 at 10:11 PM, documented, Notified by CNA on north hall that resident made a statement that her arm was hurting and that someone had raped her I then asked her if she had made the statement of being raped and she said yes that she did make that statement but that she only said that because she was hurting and didn't remember why but she knows now that she was not raped and just having pain from her previous injury. A facility's investigation report of Resident #13's allegation of sexual abuse on 5/13/24 was not initiated until 5/14/24. The investigation report documented one staff member was interviewed on 5/15/24, regarding the allegation of abuse. The report indicated the nursing staff who received Resident #13's initial allegation of abuse was not able to be interviewed since she was a travel nurse who was no longer working in the facility when the investigation was conducted. The report documented Resident #13 was interviewed on 5/14/24 regarding her allegation of sexual abuse on 5/13/24. The investigation report did not include documentation additional residents or staff were interviewed regarding the allegation to ensure no other residents or staff had witnessed or been subjected to potential sexual abuse. In addition, Resident #13 was not assessed for physical or psychosocial harm until 5/14/24 at 12:00 PM (almost 14 hours after the resident's initial allegation was received.) On 9/25/24 at 2:40 PM, the Administrator stated the facility's investigation into Resident #13's allegation of sexual abuse did not include statements by additional staff or residents who may have had pertinent information related to the investigation. The Administrator stated Resident #13 had not been assessed for physical or psychosocial harm related to the allegation until almost 14 hours after she initially alleged she had been sexually abused. On 9/26/24 at 8:32 AM, during a follow-up interview, the Administrator stated she was the facility's Abuse Coordinator and an investigation should include a thorough and timely assessment of Resident #13, and statements from additional staff and residents related to the allegation.

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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** 50603 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident care plans were revised to reflect current needs and interventions. This was true for 2 of 18 residents (#32 and #42) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's Care Planning Process policy, revised 5/19/23, documented care plans will be updated in regard to the needs, problems, strength, goals and interventions of the residents at least quarterly, annually, or with significant change. 1. Resident #42, was admitted to the facility on [DATE], with multiple diagnoses including diabetes, atrial fibrillation (irregular heartbeat), anemia, and obstructive sleep apnea. On 9/23/24 at 3:05 PM, Resident #42 stated, I'm supposed to be tested for a BiPAP. I only got a follow-up appointment today that said I need to go to the hospital to get tested . However, I have the machine already and I don't know why I can't just use it. The facility says I must go to the hospital to get evaluated. No BiPAP machine was observed in Resident #42's room. A review of Resident's #42's care plan, initiated on 5/10/24, documented that she was to use the BiPAP on settings as per order. On 9/26/24 at 11:53 AM, during an interview with the Administrator, the DON, and the Interim DON, they provided a BiPAP order which was discontinued in July 2024, and a sleep study had been ordered on 9/9/24. They verified the care plan was not updated. A copy of the discontinued medical order from July 2024 was requested. None was provided. On 9/26/24 at 12:15 PM, the RCM stated that facility protocol for any previously discontinued order, such as the non-use of BiPAP/CPAP machine for more than 30 days, requires a new sleep study to be conducted to ensure that the settings are set appropriately. She further stated the care plan should have been updated regarding the discontinuation and new order for evaluation of the BiPAP machine. 36193 2. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including anxiety. A physician's order dated 9/17/24, directed staff to weigh Resident #32 in the morning every Monday. Resident #32's care plan directed staff to notify the physician of his weight gain of greater than 5 pounds in 3 days or greater than 5 pounds in one week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 3:42 PM, the Interim DON reviewed Resident #32's care plan and stated it should have been updated with the current physician's order and it was not.

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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** 50603 Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 18 residents (Resident #42) reviewed for standards of practice. Resident #42 was not evaluated for a skin condition. This deficient practice created a potential for harm if care and services were not provided. Findings include: Resident #42, was admitted to the facility on [DATE] with multiple diagnoses including diabetes, atrial fibrillation (irregular heart beat), anemia, and obstructive sleep apnea. On 9/24/24 at 11:39 AM, Resident #42 was observed scratching at scabbed sores on her upper right arm. Resident #42 stated she is a picker/scratcher and that she suspects some of her medication may be causing a problem. A review of progress notes from 9/15/24, documented that the physician provided a follow-up visit for a skin assessment in the bilateral groin area, but nothing related to itching arms. On 9/26/24 at 10:30 AM, RN #3 stated that the CNA's rub lotion on the resident's arms to help with the itching as she is a picker. However, she does not know what kind of lotion they are using or if there was a skin assessment completed. On 9/26/24 at 12:04 PM, the RCM, DON, and Interim DON, confirmed Resident #42's medical record should have included documentation of a skin assessment or treatment plan relating to arm sores or itching. On 9/26/24 at 12:35 PM, the DON and RCM conducted a brief skin assessment with the resident. The RCM stated that due to the wounds on Resident #42's arms, a skin evaluation or dermatology review should have been completed. Both the DON and RCM stated that there should be a progress note relating to applying lotion to Resident #42's arms to relieve itching. They confirmed the care plan had not been updated, and a skin assessment had not been completed. There were no progress notes indicating that lotion had been applied to Resident #42's arms.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure podiatry (foot) services were provided as ordered for 2 of 2 residents (#13 and #61) reviewed for podiatry care. This deficient practice created the potential for residents to experience physical complications related to elongated and/or ingrown toenails and poor circulation. Findings include: 1. Resident #13 was admitted to the facility on [DATE] with a diagnosis of heart disease. A Quarterly MDS assessment, dated 7/28/24, documented Resident #13 was severely cognitively impaired. A physician's order, dated 7/12/24, documented an order for a podiatry referral. A physician's order, dated 7/31/24, documented a second order for a podiatry referral related to an ingrown right great toenail. A progress note, dated 7/18/24, documented, Received a referral for podiatry. When I talked to [POA] about upcoming appointments she specifically asked that [Resident #13] to not go out on appointments anymore as it causes to much stress. A progress note, dated 7/18/24, documented, Was informed from RCM that [Resident #13] had a care conference yesterday (7/17/24) and [POA] stated that she wants [Resident #13] to see a podiatrist. Referral sent to [podiatry clinic]. RCM notified. A progress note, dated 7/31/24, documented, Called [podiatry clinic] to F/U (follow up) on referral. Clinic stated they are not ready to schedule yet as there is no reason on the referral on why [Resident #13] needed to be seen. If it is for ankle or foot pain they can schedule, but if it is for nail or callus care they cannot schedule as they are not accepting new nail or callus care patients. Asked RCM to get more clarification on why podiatry is needed. A progress note, dated 8/28/24, documented, SW (Social Worker) received a podiatry referral dated 7/31/24. Was informed by scheduler that [podiatry clinic] is not currently accepting new nail care patients, [a second podiatry clinic] does not accept Medicare and Medicaid, and [a third podiatry clinic] did not provide nail care but did provide scheduler with two different mobile Podiatrists. Contact information was provided to this writer who gave information to administration. Was informed a foot care kit was purchased for nursing to provide needed foot care in house. Waiting to see if facility is able to contract with a mobile Podiatrist. Resident #13's EMR did not include documentation Resident #13 had seen the podiatrist related to the physician's orders and the POA's request. 2. Resident #61 was admitted to the facility on [DATE] with multiple diagnoses including diabetes and heart disease. (continued on next page)

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	135053	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Court	2200 Ironwood Place Coeur D'Alene, ID 83814

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 4:14 PM, Resident #61 stated, I need to see the podiatrist. They told me the podiatrist was not covered by insurance. Resident #61 was observed at this time to have long and thick toenails. An Admission MDS, dated [DATE], documented Resident #61 was cognitively intact. A physician's order, dated 7/31/24, documented an order for, May see . podiatrist as needed. A physician progress note, dated 8/29/24, documented, Please consider ordering referrals for podiatry .r/t (related to) DM2 (type 2 diabetes). Resident #61's EMR did not include documentation Resident #61 had seen a Podiatrist, or that a referral had been made to a Podiatrist, related to the physician's order. During an interview with the Administrator and the Interim DON on 9/26/24 at 8:38 AM, they confirmed they were not able to locate any documentation of appropriate follow-up and scheduling of Resident #13's and Resident #61's podiatry appointments. They stated podiatry services should have been arranged for both residents per physician orders and resident/POA request. The facility's policy related to podiatry care was requested on 9/25/24 at 3:00 PM, on 9/26/24 at 9:30 AM, and at 1:45 PM. The policy was not provided to the survey team prior to survey exit on 9/26/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure residents receiving PRN alprazolam (anti-anxiety medication) had clear indication for the use of the medication and clinical rationale supporting the continued use of the medication beyond 14 days. This was true for 1 of 6 (Resident #32) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents received psychotropic medications that are unwarranted and used for excessive duration. Findings include: The State Operations Manual, Appendix PP, revised 8/8/24, documented PRN orders for anti-psychotropic drugs are limited to 14 days unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's record and indicate the duration for the PRN order. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including anxiety. A physician's order, dated 9/10/24, documented Resident #32 was to receive Xanax (alprazolam) 0.25 mg (milligram) every 12 hours as needed for anxiety. There was no documentation in Resident #32's clinical record to support the continuation of Xanax beyond 14 days. On 9/24/24, the Administrator stated Resident #32's physician's order for Xanax did not have a stop date or reason for the continuation of the medication beyond 14 days.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 50603 Based on documentation and staff interview, it was determined that the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of food and nutrition services, including resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population. These deficiencies had the potential to affect all residents requiring medical nutrition therapy, nutritional assessments, and appropriate supplementation and dietary interventions. Findings include: The State Operations Manual, Appendix PP, revised 8/8/24, documented, if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. The director of food and nutrition services must at a minimum meet one of the following qualifications: - A certified dietary manager. - A certified food service manager, or - Has similar national certification for food service management and safety from a national certifying body; or - Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or - Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, forborne illness, sanitation procedures, and food purchasing/receiving. On 9/22/24, the facility provided documentation they employed a part-time dietitian. On 9/24/24 at 3:15 PM, the DM stated that she had completed food services manager training on 7/17/24, but had not yet taken the certification exam. She had been the DM for the facility for the last five years. On 9/26/24 at 12:34 PM, the Administrator stated she was a LPN, and that she had a food service certificate, not a food services degree.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50603 Based on observation, policy review, and staff interview the facility failed to ensure staff provided meal service according to the facility's posted mealtime schedule. This failure created the potential for 69 residents to experience poor quality of life, potential nutritional issues, and complications with medications required to be taken with meals if waiting more than 45 minutes to receive their meals. Findings include: A posted dining schedule at the front entrance of the facility documented: - Breakfast at 7:30 AM - Lunch at 12:00 PM - Dinner at 5:30 PM On 9/22/24 at 12:30 PM, during the lunch dining room observation, residents were seated for the lunch meal at 12:00 PM. At 12:35 PM it was observed that the first tray of food was delivered to residents in the dining room. The last meal was delivered to dining room residents was at 12:53 PM. On 9/24/24 at 8:00 AM, the following was observed during the second kitchen inspection: - 7:30 PM - Residents are seated in the dining room for their breakfast meal. - 8:00 AM - Dining room service begins. - 8:07 AM - Meal service begins for North Hall residents. - 8:25 AM - Meal service begins for the East Hall residents. - 8:46 AM - Meal service begins for the South Hall residents. On 9/24/24 at 3:15 PM, the DM and RD (Registered Dietitian) reviewed the posted dining mealtimes at the front of the facility. Both stated they were not familiar with the posted mealtimes. The DM and RD stated the actual facility mealtimes were different from the posted mealtimes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50603 Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, clean, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 69 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: The FDA (Food Drug Administration) Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, states cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. 1. The initial kitchen inspection was conducted on 9/22/24 at 12:03 PM, the following was observed: - Bowled noodle soup placed on counter, no heat or time stamp. - Bowled salad on counter, no ice or time stamp. - Ice buildup in freezer on ceiling. - Three inches of ice growing up from a cardboard food box, under one inch of ice growing down from shelf. - Open and undated, Stir-fry veggies and carrot coins. - Open and undated, ice cream sandwiches. - Two large ice cream container lids were not sealed and open directly under freezer ceiling. - In the refrigerator, the following were undated and unlabeled: noodle soup, shredded carrots, and a container of noodle/macaroni spiral salad. - A fully cooked ham was placed on top of the liquid eggs. - A brown layer of dirt was around the AC unit and across the ceiling. Directly below were open and undated bags of shredded lettuce, and an open container of dry, grated parmesan cheese. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A second kitchen inspection was conducted on 9/24/24 at 2:55 PM with the NSD (Nutritional Services Director). The following was observed: - Ice buildup in freezer on ceiling in the form of droplets. - Three inches of ice growing up from a cardboard food box, under one inch of ice growing down from shelf. - Two large ice cream containers lids were not sealed and open directly under freezer ceiling. - In the refrigerator, a brown layer of dirt was around the AC unit, and across the ceiling. A review of the September 2024 [NAME] AM/PM Cleaning Duty schedule documented that the freezer floor was cleaned on all but the following dates: 9/1/24 and 9/13/24 during the AM shift, and from 9/1/24 - 9/6/24 during the PM shift. On 9/24/24 at 3:13 PM, the DM stated that maintenance completes the cleaning of the refrigerator and freezer units if there are issues with the air conditioner or freezer units. Kitchen cleaning is done daily, but deep cleaning is done monthly, if not quarterly. The ice buildup happens because the freezer door doesn't close well. The ice is usually cleaned up daily. On 9/24/24 a work history report from maintenance was provided that documented the refrigerator and freezer condenser coils were inspected and cleaned on 9/20/24 by the maintenance director. On 9/25/24 at 11:45 AM, the maintenance director was shown the ceiling in the refrigerator and the ice buildup in the freezer, he stated that he only checked the equipment. The cleaning of the refrigerators and freezers are supposed to be completed by the kitchen staff.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 36193 Based on observation and staff interview, it was determined the facility failed ensure Activity Room has adequate and comfortable lighting for the residents to enjoy their activity. This failure had the potential for residents to experienced psychosocial harm if they were unable to perform their independent functioning and task performance. Findings include: On 9/23/24 at 2:50 PM, Resident #40 asked the surveyor to visit the Activity Room. On 9/23/24 at 2:59 PM, the facility's Bistro which was being use by the facility as their Activity Room was observed to have dim lighting. There were missing light bulbs and multiple lights were out on the track lighting. On 9/24/24 at 2:26 PM, the Maintenance Director stated he was unable to replace the light tracks because it was no longer available in the area. The Maintenance Director stated he reported it to the previous administrator, and he was told it would be replaced during the remodeling of the facility. On 9/24/24 at 2:41 PM, the Activity Director (AD) stated residents expressed concerns about the lighting in the Activity Room especially when they are doing their activities such as working on their jigsaw puzzles. The AD also stated it was not easy for her to apply nail polish to the residents. On 9/24/24 at 3:08 PM, the Interim DON stated the track lightings were not replaced because they were waiting for the remodeling of the facility.