STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135066	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street (83211-1362) American Falls, ID 83211

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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 - Few	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 that the facility failed to treat each resident with respect and dignity that promoted enhancement of his/her quality of life and dining experience. This was true for 2 of 13 residents (Resident #8 and Resident #9) who were observed eating in the dining room. The findings include: The following residents did not receive their meal trays or assistance during meal time in a timely manner: Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including hypertensive heart disease, hypothyroidism, and type 1 diabetes. On 7/8/24 at 12:04 PM, Resident #8 was observed sitting with her meal tray untouched. On 7/8/24 at 12:15 PM, it was observed that facility staff began assisting Resident #8 with eating her meal. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including hypertension and mild cognitive impairment. On 7/8/24 at 12:10 PM, Resident #9 was observed sitting at a dining room table with two other residents who had been served their meal trays. On 7/8/24 at 12:15 PM, Resident #9's food tray was discovered in the food cart and was brought to her. At 12:45 PM, LPN #1 serving meal trays in the dining room, confirmed that residents are normally fed at the same table, but the meals are placed in the cart randomly, so the staff hand them out the best they can so everyone can eat at the same time.

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure whether a resident had the ability to self-administer medications for 1 of 1 resident (Resident #14), reviewed for self-administration of medications. This failure created the potential for adverse effects if medications were self-administered inappropriately by the resident. Findings include: The facility's Self-Administration of Medication policy, dated 4/21/2014, stated, If the resident requests to self-administer their medications the following criteria and procedures will need to be met: - The charge nurse will do a basic evaluation of the resident's ability to self-administer medication, by filling out an evaluation. - The IDT will review the evaluation and determine the safety of the resident to self-administer medications. - If approved by the IDT a physician's order will be obtained. - The charge nurse will instruct the resident on what each medication is, why they are taking them, when to take them, to identify each medication by sight, and any special considerations associated with the medication. - The resident will receive from the pharmacy written instructions on each medication. - A Bedside Medication Form will be developed for the resident so that the resident can mark when each medication is taken. - Periodic checks with the resident will be conducted to discuss progress and to re-educate if there have been any problems. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including dementia and COPD (a group of lung conditions that make it difficult to breathe). On 7/10/24 at 7:35 AM, Resident #14 was observed in the dining room without the nasal cannula in place and her oxygen cylinder was not turned on. At 8:20 AM, Resident #14 applied the nasal cannula and turned the oxygen cylinder on without assistance from staff. A Self-Administration of Medication evaluation, dated 6/8/23, documented Resident #14 was not a candidate for safe self-administration of medications. Resident #14's care plan documented she was to wear oxygen at 2 Liters/minute at all times due to her COPD. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 8:33 AM, LPN #1 stated Resident #14 should have been assessed and care planned to allow the resident to turn on her own oxygen. On 7/10/24 at 8:38 AM, the DON reviewed Resident #14's record and stated Resident #14 had not been assessed to self-administer oxygen, and should have been.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on resident and staff interview, review of grievances, and record review, it was determined the facility failed to ensure: - Residents were notified individually or through postings in the facility of how to file a grievance. - A functional process for filing a grievance anonymously was in place. - Residents received written responses to grievances which included the date the grievance was received, steps taken to investigate the grievance, and corrective action taken to resolve the grievance. This was true for 1 of 20 residents (Resident #3) interviewed regarding grievances and had the potential to impact all residents in the facility who may want to file a grievance. These failures impeded the ability of residents to file a grievance and to receive a resolution. The findings include: Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia and anxiety. Resident #3's care plan documented she had a diagnosis of dementia, but was alert and oriented. On 7/8/24 at 11:25 AM, Resident #3 stated her laundry had gone missing the week before. She was not aware of anyone filling out a grievance form and stated, They looked for it, couldn't find it, and it hasn't been replaced yet. A review of the 2024 grievance log did not document that Resident #3's missing laundry had been addressed. On 7/11/24 11:42 AM, the DON and ADON stated that a grievance or complaint form is not filled out unless the issue reported cannot be resolved. Neither one were aware that there was a concern with lost laundry; however, if there were a concern, the facility would try to locate the lost laundry items. If nothing could be resolved, a grievance or complaint form would be filled out.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a notices of transfer was provided to the State Long Term Care Ombudsman when transferred to the hospital. This was true for 1 of 1 resident (Resident #8) whose record was reviewed for hospital transfer. This deficient practice had the potential for harm if residents were not aware of or able to exercise their rights. Findings include: The facility's Transfer and Discharge policy, dated 10/01/19, documented: - When a resident is temporarily transferred to an acute care facility, a notice of transfer must be provided to the State Ombudsman. Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including hypertensive heart disease, hypothyroidism, and diabetes. An MDS tracking record documented Resident #8 was discharged on [DATE], with an anticipated return, and readmitted to the facility on [DATE]. A hospital Admission Summary documented she was hospitalized during that time. Resident #8's record did not include documentation that a Notification of Transfer related to her hospitalization on [DATE] was provided the State Ombudsman. On 7/10/24 at 3:05 PM, the SS employee stated when a resident is transferred to the hospital, she will call the family and discuss bed holds. When asked how she notifies the Ombudsman of transfers, she stated she did not know she had to.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on staff interview, record review, and policy review, it was determined the facility failed to ensure an annual comprehensive MDS assessment was completed prior to the required completion date. This was true for 1 of 4 residents (Resident #4), whose records were reviewed for MDS accuracy. The deficient practice placed Resident #4 at risk of adverse outcomes if her preferences, goals, health status, and needs were not identified in the comprehensive MDS assessment. This failure created the potential for harm if Resident #4's care was not provided due to a delay in completion of the comprehensive MDS assessment. Findings include: The facility's Minimum Data Set policy, revised 12/15/18, documented a comprehensive assessment will be completed for Medicare recipients, at admission and annually. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including shortness of breath, gastroesophageal reflux disease, and diabetes. A review of the resident's MDS history and Final Validation Report indicated a quarterly MDS was transmitted on 6/9/24, with the following notation: Assessment Completed Late: An OBRA comprehensive assessment with the Care Area Assessment (Section V) is due every year unless the resident is no longer in the facility. A prior record with an ARD (A2300) within 366 days of the submitted record could not be found. On 7/11/24 at 10:22 AM, the DON was interviewed and Resident #4's record was reviewed in her presence. When asked if Resident #4's annual comprehensive assessment was completed and submitted prior to the completion date, she confirmed a quarterly assessment was submitted late and stated, I must have completed a quarterly MDS rather than an annual MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 5 of 13 residents (#1, #3, #6, #14, and #17) whose care plans were reviewed. These failures placed residents at risk of negative outcomes if services were not provided, or provided incorrectly, due to lack of information in their care plan. Findings include: The facility's Care Plans policy, dated 1/1/24, documented care plans will be reviewed quarterly, annually, and with change of status to ensure that they are current for the resident's care. 1. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including dementia and COPD (a group of lung conditions that make it difficult to breathe). Resident #14's care plan, dated 10/30/23, documented she was to wear oxygen at 2 Liters/minute at all times due to her COPD diagnosis. On 7/10/24 at 7:35 AM, Resident #14 was observed in the dining room without the nasal cannula in place and her oxygen cylinder had not been turned on. At 8:20 AM, Resident #14 applied the nasal cannula and turned the oxygen cylinder on. On 7/10/24 at 8:33 AM, LPN #1 stated, Resident #14 turns on her own oxygen. LPN #1 also stated Resident #14 should have had an assessment done stating she could manage her own oxygen and it should have been in her care plan. On 7/10/24 at 8:38 AM, the DON stated Resident #14 should have had an assessment to self-administer medication but, not sure if Resident #14 needed an assessment for self-administration of oxygen. She also stated that Resident #14's care plan should have had documentation that she self-administers her oxygen. 50603 2. Resident #1 was admitted to the facility on [DATE], with a diagnosis of dementia. A review of records showed Resident #1 was admitted with a diagnosis of dementia. However, a review of her care plan did not identify dementia as a one of her diagnoses, nor did it address the care of dementia. The care plan identified the following diagnoses: hyperlipidemia, major depression disorder, anxiety disorder, and type 2 diabetes. On 7/11/24 at 11:32 AM, the DON stated she was supposed to update the care plans at least quarterly, and Resident #1's care plan was not updated. Additionally, she stated she was unaware Resident #1 had a diagnosis of dementia. 3. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including dementia and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/8/24 at 3:45 PM, it was observed side rails were up on Resident #3's bed. A review of Resident #3's medical record documented on 11/23/23, an initial side rail usage assessment was completed and noted the resident would like to have side rails. Resident #3's care plan did not document interventions for the use of side rails. On 7/11/24 at 11:28 AM, the DON stated she was supposed to update the care plans at least quarterly, and Resident #3's care plan was not updated. 4. Resident #6 was admitted to the facility on [DATE], with a diagnosis of Huntington's disease (a condition that causes nerve cells in the brain to decay over time.) On 7/8/24 through 7/11/24, Resident #6 was observed multiple times during the day to be seated in a large recliner in the TV living/dining room area. No call light was observed next to Resident #6. Resident #6's care plan instructed staff to have her call light attached to chair or clothing while in her room. Her care plan did not address the call light while Resident #6 was in the TV room. I & As dated 1/9/23, 10/15/23, 10/22/23, 2/1/24, & 3/15/24, documented Resident #6 had fallen from the TV living/dining room chair. Resident #6's care plan did not include updated interventions in reference to Resident #6 falling from the TV living/dining room chair, or what she was do if she needed help while sitting in this chair. On 7/11/24 at 11:28 AM, the DON stated she was supposed to update the care plans at least quarterly, and Resident #6's care plan was not updated. She stated a new chair had been ordered that would reduce her falls as it is designed for individuals who have Huntington's disease. The DON stated if Resident #6 requires help she will yell for help. 5. Resident #17 was admitted to the facility on [DATE], with a diagnosis of Alzheimer's disease. A hospice physician's order, dated 5/20/24, for oxygen 2 Liters/minute via nasal cannula at night and when in-bed to maintain O2 saturations above 90%. An order for oxygen use was not found on Resident #17's care plan. Resident #17's MAR documented CPAP machine care was discontinued on 6/1/24. His care plan did not document CPAP machine use had been discontinued. On 7/9/24 at 11:40 AM, the DON stated she could not find an order to discontinue Resident #17's CPAP use. She stated discontinuing his CPAP was discussed in the IDT meeting. On 7/11/24 at 11:28 AM, the DON stated she was supposed to update the care plans at least quarterly, and Resident #17's care plan had not been updated for his oxygen use and discontinued CPAP use.

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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 3 of 13 residents (Resident #6, #15, and #17) 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 Plans policy, dated 1/1/24, documented care plans will be reviewed quarterly, annually, and with change of status to ensure that they are current for residents' care. 1. Resident #6, was admitted to the facility on [DATE], with a diagnosis of Huntington's disease (a condition that causes nerve cells in the brain to decay over time). On 6/11/24 at 8:30 AM, Resident #6's care plan, initiated on 1/8/21, documented her care plan should have been reviewed on 1/15/24. On 7/11/24 at 11:28 AM, the DON stated that she should have updated Resident #6's care plan at least quarterly. 2. Resident #17, was admitted to the facility on [DATE], with a diagnosis of Alzheimer's disease. Resident #17's care plan documented his care plan should have been reviewed on 2/23/24. On 7/11/24 11:28 AM, the DON stated that Resident #17's care plan had not been updated on 2/23/24. 49552 3. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including dementia and COPD (a group of lung conditions that make it difficult to breathe). On 7/10/24 at 11:24 AM, Resident #15's care plan documented her care plan should have been reviewed 1/18/24. On 7/10/24 at 11:47 AM, the DON stated she updates the care plans for nursing, and the kitchen and activities departments update their section of the resident's care plan. The DON stated she was aware that the resident's care plan reviews were overdue.

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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. 50603 Based on observation, record review, and staff interview, it was determined the facility failed to ensure CPAP use was discontinued with a physician's order. This was true for 1 of 1 resident (Resident #17) who used a CPAP machine. This failure created the potential for Resident #17 to experience increased respiratory problems if he did not receive treatment necessary to meet his respiratory needs. Findings include: A physician's order dated 2/2/24, documented to administer CPAP to Resident #17 nightly. The MAR indicated CPAP equipment care was initiated on 5/12/24 and discontinued on 6/1/24. On 7/8/24 at 2:45 PM, a CPAP machine was not observed in Resident #17's room. On 7/9/24 at 11:40 AM, the DON stated Resident #17 no longer used a CPAP and there was no order to discontinue CPAP use. She stated that stopping the CPAP was discussed in the IDT meeting, but there is no order on file for stopping CPAP use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents had not expired; this was true for 1 of 1 medication storage room inspected and 1 of 1 medication cart inspected. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: The facility's Disposition of Medication policy, dated 6/1/2019, documented all medications no longer in use, expired, or otherwise marked for disposition will be identified and disposed of in a timely manner and consistent with current standards of practice in a long-term care setting. 1. On 7/9/24 at 2:06 PM, during a medication storage room audit, the following was observed: - Tetanus Toxoid reduced Diphtheria Toxoid and Acellular Pertussis vaccine, 4 syringes, with expiration date 3/2024. - Influenza vaccine 3 doses, with expiration date 6/30/24. On 7/9/24 at 2:10 PM, LPN #1 stated the vaccines were expired and should have been removed from the refrigerator. She also stated she was not sure what to do with the expired medications. On 7/9/24 at 2:14 PM, the DON stated expired liquid medications go upstairs to be destroyed by the pharmacy, and the rest of the expired medications should have been removed from the medication room to be destroyed. 2. On 7/10/24 at 8:24 AM, during a medication cart audit a bottle of Antacid liquid was observed with expiration date 6/2024. On 7/10/24 at 8:26 AM, LPN #1 stated she had just opened the Antacid liquid bottle the day before and did not notice that it was expired. She also stated that expired medications should have been removed from the medication cart.

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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 staff interview, it was determined that the facility failed to employ sufficient staff with the appropriate competencies and skills 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 the 20 residents requiring medical nutrition therapy, initial nutritional assessments, and appropriate supplementation and dietary interventions. Findings include: On 7/10/24 at 11:30 AM, the documentation of the DM certification was requested. No certification was provided. On 7/10/24 at 2:50 PM, both the RD and DM stated, for about 18-months, they have shared the responsibilities of resident nutritional assessments, interventions, progress notes, and care plan development and updates. They stated the Food Services Manager has an engineering degree and does not have a food and nutrition degree. On 7/11/24 at 12:20 PM, the DM stated she worked as a kitchen aide for one year before she was hired as a DM. She confirmed she does not have a DM certification in food services or an associate degree or higher in food or nutrition services. The DM stated that she plans to sit for the DM certification exam sometime this year.

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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. 50603 Based on observation and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, appropriate hand hygiene was performed, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 20 residents residing in the facility 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: 1. The FDA Food Code Section 2-301.14 When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified under paragraph 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; . E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; . (H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. On 7/10/24 from 12:30 PM through 1:00 PM, during the tray-line inspection, it was observed the DM, KA #1, and KA #2 did not wash their hands between glove use, when changing tasks, when donning new gloves, and when entering the kitchen. On 7/10/24 at 1:15 PM, KA #1 stated that hands are to be washed between glove use, when changing tasks, and when entering the kitchen for any reason. She stated that employees receive handwashing training during the year. On 7/11/24 at 3:15 PM, the facility could not produce a policy on handwashing practices within the kitchen environment. On 7/11/24 at 12:10 PM, the DM stated that the facility completes an annual handwashing safety training, that was not specific to food services. 2. The FDA Food Code Section 3-305.11(A) documented food should be protected from contamination and stored in a clean, dry location where it was not exposed to splash, dust, or other contamination; and at least 6 inches above the floor. On 7/10/24 at 10:00 AM, during the follow-up kitchen inspection, it was observed that in the larger dry pantry area, two white shelves were directly on the floor without any clearance. The following items were stored on the lower shelves: cherry pie filling, plastic cups, and tray liners. On 7/10/24 at 10:00 AM, the DM confirmed that shelves should be 6 inches off the floor and were not. (continued on next page)

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	135066	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Power County Skilled Nursing Facility	510 Roosevelt Street (83211-1362) American Falls, ID 83211

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. FDA Food Code Section 6-403.11 documented areas designated for employees to eat, drink, and use tobacco products shall be located so that food, equipment, and linens single-service and single use articles are protected from contamination. On 7/10/24 at 12:20 PM, it was observed that multiple food items for a staff potluck had been stored in the resident's nourishment refrigerator. There was also a personal container of food belonging to a facility employee. On 7/10/24 at 12:22 PM, the DM stated employees have use of a facility employee refrigerator located in the employee and facility dining room area, and personal food should be stored in that location. 4. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions. 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. On 7/8/24 and 7/10/24, more than 4 inches of ice buildup under the fan was observed in the deep freezer, covering various items of food, which accumulated between the vertical shelving units. The cooling fan, in the larger refrigerator, had a layer of dust coating the outer area. Unboxed containers of single-serve yogurt containers were stored directly underneath, and touching the surface of the cooling fan. On 7/10/24 at 11:10 AM, the DM stated the deep freezer fan had broken a couple of weeks ago, and maintenance had fixed the fan, but the build-up of ice was not removed. She also stated she was not aware of the accumulation of dust on the fan and she would have the yogurt removed and disposed of. On 7/10/24 at 11:15 AM, a review of the cleaning schedule documented cleaning was conducted daily, and the refrigerator fan was not included. 5. The FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, documented (A) (1) The day the original container is opened in the food establishment shall be counted as Day 1, and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety . (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: . (3) 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 as specified under (B) of this section. On 7/8/24 at 11:00 AM, during the initial kitchen inspection, it was observed that multiple items stored within the kitchen refrigerators and freezers were open and undated, including ice cream, bread, vegetables, frosting, and pies. In the pantry area and above the chef's cooking area, the spice containers were open and not dated. On 7/10/24 at 10:00 AM, during the follow-up kitchen inspection, it was observed the same items noted at the initial inspection remained open and undated: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Six containers of spices were open and not dated. Two containers of spices were opened and dated, 1/23/23 and 2/6/23. - Undated loaves of bread, frosting, peas and carrots, pie crust, and various pies. - Open and undated containers of blueberries and strawberries. - One half of a watermelon was covered and undated. On 7/10/24 at 10:15 AM, the DM stated they had purchased labels, and the staff would be instructed to be more consistent in dating the foods that were open. She also stated that one of her cooks preferred to refill the smaller spice containers from the larger spice containers. The DM stated she would review the need to sanitize the containers between use, as well as to date the spice containers when opened or when refilled.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49552 Based on policy review and staff interview, it was determined the facility failed to meet the minimum member requirement of a quality assurance and performance improvement (QAPI) committee. This failure placed all residents at risk of not receiving quality care. Findings include: On 7/11/24 at 3:42 PM, the QAPI monthly meeting minutes for the prior six months were reviewed and noted the Medical Director had not attended the QAPI meetings. On 7/11/24 at 3:45 PM, the DON stated the Medical Director had not attended the QAPI committee meetings and she was not aware he needed to be at the meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not clean resident equipment properly, store oxygen supplies in a sanitary manner, perform proper hand hygiene, or use appropriate detergent for residents' personal laundry items. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The facility's Hand Hygiene policy, dated 8/21/23, documented the facility will follow the Center for Disease Control guidelines. The facility's Glucose Point of Care Testing policy, dated 6/4/18, documented The Center for Disease Control and Prevention is concerned about the risks for transmitting Hepatitis B and other infectious diseases during assisted blood glucose monitoring. If it is not possible to assign the blood glucose meter to an individual, the device should be cleaned and disinfected after each use to prevent carry over of blood and infectious agents. The following was observed: 1. Resident #12 was admitted [DATE], with multiple diagnoses including Parkinson's (a disorder of the central nervous system that affects movement) and diabetes. On 7/8/24 at 2:49 PM, the Hoyer lift (an assistive device that allows resident to be transferred by the use of electrical power), at the end of the hall was observed with a brown, dry substance on the left leg base and dust accumulation on the base. On 7/9/24 at 9:24 AM, in Resident #12's room, the surveyor observed a Sit to Stand (a lifting device used to assist residents who have difficulty rising from a seated position to standing) with crumb like substance, on the base of the device. On 7/9/24 at 11:34 AM, the DON stated each lift is designated to a resident and the lifts are cleaned weekly. She also stated the cleaning log for the lifts was in the laundry room. On 7/9/24 at 11:40 AM, the July 2024 lifts cleaning log was reviewed and did not include documentation the lifts had been cleaned. On 7/10/24 at 8:08 AM, LPN #1 used the glucometer (a device used to measure the amount of glucose in your blood) to check a resident's blood sugar. LPN #1 brought the glucometer to the medication cart and was observed wiping the glucometer off with a Sani wipe (disinfecting wipe) and then placed the glucometer in the top drawer of the medication cart. LPN #1 did not follow recommended dry time of 2 minutes as listed on the Sani wipe container. On 7/10/24 at 10:26 AM, LPN #1 stated the glucometer is used for only one resident at this time but can be used for other residents if needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 10:34 AM, LPN #1 stated she had wiped off the glucometer and put it back in the medication cart. She also stated she did not know what the dry time was or what dry time meant. 2. On 7/8/24 at 2:51 PM, an oxygen concentrator was observed in the common room at the end of the hall. The oxygen concentrator had an undated water bottle attached to it. A nasal cannula dated 12/2023, was observed lying on the floor next to the oxygen concentrator. On 7/9/24 at 9:38 AM, CNA #1 stated the oxygen concentrator was a community use oxygen concentrator, anyone using the room that needed oxygen could use it. Resident #15 was admitted [DATE], with multiple diagnoses including diabetes and COPD (a group of lung conditions that make it difficult to breathe). On 7/9/24 at 9:56 AM, Resident #15's nebulizer and tubing were observed hanging on the wall undated and uncovered. On 7/9/24 at 11:32 AM, the DON stated she did not know whose oxygen concentrator was in the common room, it was not a multi-user concentrator, and it should not be used. She also stated the resident's oxygen tubing is changed weekly, and she did not know whose nasal cannula, dated 12/2023, was on the floor and why it was on the floor. On 7/10/24 at 3:29 PM, the DON stated Resident #15's nebulizer and tubing should have been dated and covered with a bag. She also stated there was no policy and procedure regarding storage of respiratory supplies. 3. On 7/10/24 at 7:40 AM, LPN #1 was observed blowing her nose and began dispensing medication without performing hand hygiene. On 7/10/24 at 8:12 AM, LPN #1 stated she should have cleaned her hands after blowing her nose and before doing anything else. 50983 4. During an observation of the laundry room on 7/11/24 at 3:34 PM, the facility's two commercial washing machines used to launder residents' personal laundry items, were connected to a container of detergent which was labeled SparClean HIGH TEMPERATURE RINSE AID, designed for the use in dishwasher machines. On 7/11/24 at 3:49 PM, the maintenance director confirmed the rinse aide was not the appropriate detergent for laundering residents' personal laundry items. He immediately replaced the detergent with the appropriate laundry detergent.