STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135140	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Carriage Cove Short Stay Rehabilitation	410 West 1st North Rexburg, ID 83440

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on policy review, observation, record review, and staff interview, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medications. This was true for 1 of 1 residents (Resident #13) reviewed for self-administration of medications. This failure created the potential for adverse effects if residents self-administered medications inappropriately. Findings include: The facility's Resident Self Administration of Medication policy, dated 12/16/24, documented the interdisciplinary team would assess and determine if self-administration of medication is clinically appropriate for a resident. The results of the assessment would be recorded on the Medication Self-Administration Safety Evaluation. Resident #13 was admitted on [DATE], with multiple diagnoses including metabolic encephalopathy (when the brain does not function properly due to an imbalance in electrolytes, metabolites, or other substances in the body), pneumonia, and UTI. Resident #13's care plan intervention dated 9/24/24, documented the following: - For complaint of pain not alleviated with use of Tylenol encourage/remind resident to use pain pump bolus. May administer PRN bolus hydromorphone 0.0500M/bupivacaine 0.0500 mg every 3 hours up to 4 doses within 24 hours. Turn on communicator device, place device over pain pump, open app and tap deliver bolus button. Device will confirm dose administered. Staff may assist resident with bolus if needed. Resident #13's physician order dated 10/30/24, documented the following: - For complaint of pain not alleviated with other interventions encourage/remind resident to use pain pump bolus. May administer PRN bolus hydromorphone (a opioid pain medication) 0.0750 mg/bupivacaine (a local anesthetic) 0.0750 mg every 3 hours up to 4 doses within 24 hours. Turn on communicator device, place device over pain pump, open app and tap deliver bolus button. Device will confirm dose administered. Staff may assist resident with bolus dosing if needed. On 1/23/25 at 2:02 PM, the CCO stated Resident #13 did not have an assessment to self-administer medication and she should have.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents and their representatives received assistance to exercise their right to formulate an advanced directive. This was true for 3 of 4 residents (#7, #185, and #186) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented. Findings include: The facility Residents' Rights Regarding Treatment and Advance Directives dated 12/24/24, documented it is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Should the resident have an advance directive, copies will be requested and placed in the medical record as provided by resident/representative as well as communicated to the staff. 1. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including osteomyelitis (a bone infection) of vertebra, sacral and sacrococcygeal region, chronic post-traumatic stress disorder, and nutritional deficiency. Resident #7's medical record had various active conflicting resuscitation status documents as listed below. - POST document dated 2/6/24, documented Resident #7 was listed as a full code. - Resident #7's living will and DPOA Health Care dated 2/6/24, documented Resident #7 was listed as a full code. - facility code status document dated 1/2/25, documented Resident #7 was listed as DNR. - facility social services document dated 1/3/25, documented Resident #7 was listed as a full code. - nursing worksheet dated 1/21/25, documented Resident #7 was listed as DNR. On 1/23/25 at 10:30 AM, the facility chief clinical officer stated Resident #7's DNR status documents are confusing and need to be clarified. 2. Resident #185 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the right femur and diabetes. Resident #185's medical record did not contain documentation of the following; - an advance directives. - of the facility offering to assist the resident to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the resident declined to formulate an advanced directive. Resident #185's IDT care plan conference document dated 1/17/25, documented under code status, he was a DNR. The rest of Resident #185's advance directives questions were left blank on the IDT care plan conference. 3. Resident #186 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder and parkinsonism (general term for a group of neurological disorders that affect movement characterized by slowness, stiffness, tremors, and instability). Resident #186's medical record did not contain documentation of the following; - an advance directives. - of the facility offering to assist the resident to formulate an advance directive. - the resident declined to formulate an advanced directive. The advance directive questions section of Resident #186's IDT care plan conference document dated 1/21/25, was left blank and the document was not signed. On 1/23/25 at 10:30 AM, the CCO stated the advance directives should have been completed for Residents #185 and #186.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy and record review, and staff interview it was determined the facility failed to ensure pertinent health information was provided to the receiving hospital for 1 of 1 resident (Resident #14) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if the residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include: The facility's Transfer and Discharge (including AMA) policy dated 12/2/24, documented for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information of the practitioner who was responsible for the care of the resident. b. Resident representative information, including contact information. c. Advance directive information. d. All other information necessary to meet the resident ' s needs, which includes, but may not be limited to: - Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs. - Diagnoses and allergies. - Medications (including when last received). - Most recent relevant labs, other diagnostic tests, and recent immunizations. - All special instructions and/or precautions for ongoing care, as appropriate such as: - Treatments and devices (oxygen, implants, IVs, tubes/catheters). - Transmission-based precautions such as contact, droplet, or airborne. - Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions. - The resident ' s comprehensive care plan goals. e. All other information necessary to meet the resident ' s needs, which includes, but may not be limited to: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs. - Diagnoses and allergies. - Medications (including when last received). - Most recent relevant labs, other diagnostic tests, and recent immunizations. - Additional information, if any, outlined in the transfer agreement with the acute care provider. Resident #14 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including respiratory failure and hypercapnia (carbon dioxide retention). A Transfer to Hospital Summary Note dated 7/26/24 at 11:25 PM, documented MD #2 gave the okay to send Resident #14 to the hospital due to her change in condition. Resident #14's medical record did not include documentation that pertinent medical information was provided to the receiving hospital. A Transfer to Hospital Summary Note dated 9/1/24 at 9:20 PM, documented Resident #14 was sent to the hospital due to weakness and lethargy. Resident #14's medical record did not include documentation that pertinent medical information was provided to the receiving hospital. On 1/22/25 at 12:02 PM, the ADON stated Resident #14's medical records did not contain documentation of what was sent with her when she was transferred to the hospital and it should have been documented.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on policy and record review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 2 of 2 residents (#14 and #24) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's Bed Hold Prior to Transfer policy dated 12/2/24, documented the facility would provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital. 1. Resident #14 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including respiratory failure and hypercapnia (carbon dioxide retention). A Transfer to Hospital Summary Note dated 7/26/24 at 11:25 PM, documented MD #2 gave the okay to send Resident #14 to the hospital due to her change in condition. Resident #14's medical record did not document a Bed Hold had been provided to her or her representative. A Transfer to Hospital Summary Note dated 9/1/24 at 9:20 PM, documented Resident #14 was sent to the hospital due to weakness and lethargy. Resident #14's medical record did not document a Bed Hold had been provided to her or her representative. 2. Resident #24 was initially admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare following surgery on the digestive system, septicemia (bacteria that enters the bloodstream and spreads throughout the body), and respiratory failure. On 10/24/24, Resident #24 was transferred to the hospital for dehiscence (separation or opening) of his abdominal incision. On 11/16/24, Resident #24 was transferred to the hospital following a fall in his room resulting in a right hip fracture and subdural hematoma. On 12/1/24, Resident #24 was transferred to the hospital following a fall in his room resulting in a brain bleed. There was no documentation in the medical record a bed hold was offered to Resident #24 for his transfers to the hospital on 10/24/24, 11/16/24, or 12/1/24. On 1/22/25 at 12:02 PM, the ADON stated they did not have documentation that Resident #14 or her representative received a bed hold, and they should have. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 12:05 PM, the ADON stated they did not have documentation Resident #24 or his representative received a bed hold for his hospital transfers on 10/24/24, 11/16/24, or 12/1/24. 50983

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on policy review, record review, and staff interview, it was determined the facility failed to develop, review with the resident, and implement a baseline care plan. This was true for 1 of 13 residents (Resident #7) 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 baseline care plans. Findings include: The facility's Care Planning-Resident Participation policy dated 12/13/24, documented the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including osteomyelitis (bone infection) of vertebra, sacral and sacrococcygeal region, chronic post-traumatic stress disorder, and nutritional deficiency. Resident #7's medical record had no documentation that the baseline care plan had been reviewed with and copy given to Resident #7 or her representative. On 1/22/25 at 2:45 PM, the CCO stated the baseline care plan should have been completed within 48 hours of admission, reviewed with, and a copy given to Resident #7 but was not.

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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** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure resident comprehensive care plans were completed and reviewed with residents and update care plans when changes occur to resident's care. This was true for 3 of 13 residents (#7, #13, and #24) whose care plans were reviewed. This placed residents at risk of adverse outcomes if care and services were not provided as residents needs changed. Findings include: The facility's Care Planning-Resident Participation policy dated 12/13/24, documented the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. The State Operations Manual, Appendix PP documents a resident's care plan must be reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions. 1. Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including osteomyelitis (a bone infection) of vertebra, sacral and sacrococcygeal region, chronic post-traumatic stress disorder, and nutritional deficiency. On 1/23/25, Resident #7's medical record had no documentation the comprehensive care plan had been reviewed with her or her representative within 21 days of admission to the facility. On 1/23/25 at 10:35 AM, the CCO stated the comprehensive care plan should have been completed within 21 days of admission and reviewed with Resident #7. 2. Resident #13 was admitted on [DATE], with multiple diagnoses including metabolic encephalopathy (when the brain does not function properly due to an imbalance in electrolytes, metabolites, or other substances in the body), pneumonia, and UTI. Resident #13's care plan dated 9/24/24, documented the following: - May administer PRN bolus hydromorphone (an opioid pain medication) 0.0500M/bupivacaine (a local anesthetic) 0.0500 mg every 3 hours up to 4 doses within 24 hours. Resident #13's physician order dated 10/30/24, documented the following: - May administer PRN bolus hydromorphone 0.0750 mg/bupivacaine 0.0750 mg every 3 hours up to 4 doses within 24 hours. Resident 13's care plan was not revised to increase the hydromorphone to 0.0750 mg/bupivacaine 0.0750. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #24 was initially admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare following surgery on the digestive system and septicemia (bacteria that enters the bloodstream and spreads throughout the body). On 11/16/24, Resident #24 fell in his room and sustained a right hip fracture and subdural hematoma. Resident #24's care plan was not updated with new fall interventions realted to this fall. On 11/28/24, Resident #24 received an abrasion on his right arm after rolling out of his bed. Resident #24's care plan was not updated with new fall interventions realted to this fall. On 12/1/24, Resident #24 fell in his room and sustained a traumatic subarachnoid hemorrhage (brain bleed). On 1/23/24 at 11:28 AM, the DON stated new fall interventions were not implemented after Resident #24's falls on 11/16/24 and 11/28/24. The DON stated they should have updated Resident #24's care plan with new interventions after each fall. 51121

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on policy review, I&A review, record review, and staff interview, it was determined the facility failed to ensure adequate supervision and implement interventions to prevent falls. This was true for 1 of 1 resident, (Resident #24) whose records were reviewed for falls. This resulted in harm to Resident #24. Findings include: The State Operation Manual, Appendix PP, dated 8/8/24, defined Avoidable Accident as an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices. The facility's Accidents and Supervision policy revised 12/20/24, defines supervision/adequate supervision as an intervention and means of mitigating risk of an accident. Resident #24 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including surgical aftercare following surgery on the digestive system and septicemia (bacteria that enters the bloodstream and spreads throughout the body). On 10/29/24, Resident #24 returned from the hospital with a wound vacuum (a medical device that uses negative pressure to remove fluid, debris, and bacteria from infected or non-healing wounds) and a foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body). On 11/16/24 at 8:40 AM, RN #2 found Resident #24 lying on the floor at his bedside with his walker on the opposite side. RN #2 documented the following. - the wound vacuum was attached to the walker and the wound vacuum tubing was laying over his bed, pulling his walker into the bed. - the foley catheter was hanging from right side of bed frame. - Resident #24 appeared to have tripped on the foley catheter tubing or wound vacuum tubing. - Resident #24 stated he was trying to get out of bed when he tripped on something. Resident #24 was transferred to the hospital where he was diagnosed with a right hip fracture, subdural hematoma, and UTI. The IDT Review Note dated 11/18/24, documented Resident #24 was getting out of his bed on the left side when he fell . Therapy confirmed it is typical for Resident #24 to exit his bed from the left side. Resident #24's care plan was not updated with new fall interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/28/24, Resident #24 rolled out of bed onto the floor and sustained an abrasion to his right elbow. Resident #24's care plan was not updated with new fall interventions. On 12/1/24 at 8:20 AM, RN #3 found Resident #24 on the floor in his room. RN #3 documented the following. - Resident #24 was disoriented, confused and incontinent of urine when she approached him. - Resident #24's wheelchair was on the other side of the room and his walker was at the foot of his bed. - Resident #24 received a skin tear and scattered bruising on his right upper arm. - Resident #24 stated he stood up when getting out of bed and his hip gave out on him. Resident #24 was transferred to the hospital where he was diagnosed with a traumatic subarachnoid hemorrhage (brain bleed) and UTI. On 1/23/24 at 11:28 AM, the DON stated new fall interventions were not implemented after Resident #24's falls on 11/16/24 and 11/28/24. The DON stated they should have updated Resident #24's care plan after each fall.

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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 were labeled, dated, and stored appropriately; this was true for 1 of 2 medication storage rooms inspected, and 1 of 2 medication carts audited for labeling and storage of medication. This failure created the potential for residents to miss doses of medication, to receive expired medications with decreased efficacy, and created the potential for misappropriation of resident's medications. Findings include: The CDC guidelines for Preventing Unsafe Injection Practices, dated 3/26/24, documented once a multi-dose vial is opened (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial. The beyond-use-date should never exceed the manufacturer's original expiration date. The facility's Medication Storage policy dated 12/16/24, documented the following: - the facility was to ensure all medications housed on the premises are stored in medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. - During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. - Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator. 1. On 1/21/25 at 2:12 PM, the facility's south side medication cart was inspected with RN #1 present, the following were found: - 2 small white pills and 1 oval white pill lying on the bottom of the second drawer. RN #1 stated she was not sure what the pills were and they should not have been there. On 1/22/25 at 12:05 PM, the ADON stated the medication carts are cleaned on Sunday and the pills should not have been loose in the cart. 2. On 1/21/25 at 2:16 PM, the facility's south side medication room was inspected with RN #1 present, the following were found: - a Tubersol solution (a clear colorless solution used for detection of tuberculosis infection) vial with no opened date, was observed in the resident medication refrigerator. RN #1 confirmed there was no open date on the bottle of Tubersol solution or the box the solution was in. (continued on next page)

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	135140	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Carriage Cove Short Stay Rehabilitation	410 West 1st North Rexburg, ID 83440

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 12:03 PM, the ADON stated the Tubersol solution should have been dated when it was opened. 3. On 1/23/25 at 8:09 AM, observed in the south side medication storage room, the medication storage refrigerator had the emergency narcotic kit in the refrigerator sitting on a shelf, not permanently affixed. On 1/23/25 at 8:11 AM, the ADON stated the emergency narcotic kit had hospice narcotics in it. She also stated she did not know the narcotic box needed to be permanently affixed. On 1/23/25 at 11:15 AM, observed the south medication cart was unlocked with no nurse present. On 1/23/25 at 11:17 AM, RN #2 stated he was just down the hall but, the cart should have been locked. On 1/23/25 at 11:30 AM, the DON stated nursing staff must lock med carts when they are not present.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation, interview, policy review, and review of the Idaho Food Code, the facility failed to appropriately store, label, and serve foods. This deficient practice had the potential to affect all residents who received meals from the facility kitchen served in the dining room and resident rooms. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes, including food-borne illnesses. Findings include: Review of the Idaho Food Code, revised February 2021, stated ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The facility's Food Safety Requirements policy dated [DATE], documented under Policy Explanation and Compliance Guidelines 1. b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. 3. C. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded. On [DATE] at 7:00 AM, observed in kitchen area with the CFM the following. In the walk-in refrigerator observed. - containers of tomato juice and lemon aide were not labeled or dated. - meat (ham) stored in a zip lock bag, lying on top of an open bag of lettuce. - unlabeled and non-dated opened bag of shredded cheese. - an opened brick of cheese not dated. - an non-dated sandwich in a bag. - an unlabeled and non-dated bag of lunch meat. - an unlabeled and non-dated bag of spinach that was opened to room air. - an undated tray of sliced tomato, onion, pickles on plates wrapped in plastic. The CFM stated those were from a few days ago. In the walk-in freezer observed. - a large bag of cubed carrots open to the air, not sealed correctly and not dated when opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the dry food storage area observed. - expired onion powder. - expired garlic powder. On [DATE] at 7:25 AM, the CFM stated the opened non-dated food items should have been dated and correctly sealed and the bag of meat should not have been stored on top of an opened bag of lettuce. The sandwich and lunch meat bags should have been labeled and dated. On [DATE] at 2:10 PM, during a second trip into kitchen the following issues were noted. In the walk-in refrigerator observed. - a bag of lettuce opened to air and not sealed correctly. On [DATE] at 2:12 PM, the CFM stated that the bag of lettuce should have been sealed correctly. On [DATE] at 2:15 PM, observed in the grill area of the kitchen. - a liquid butter alternative container stored above the grill area, was not dated with opened date. - a squirt bottle that had contained liquid butter alternative for use on the grill was not labeled of contents and was not dated. On [DATE] at 2:20 PM, the CFM stated both liquid butter alternative containers should have been dated when opened and labeled of contents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. 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 Meal Supervision and Assistance policy dated 12/20/24, documented staff will offer to assist residents with hand hygiene prior to meal service. The facility's Standard Precautions Infection Control policy revision date 1/30/23, documented hand hygiene was to be completed after touching blood, body fluids, secretions, excretions, contaminated items, before and after removing PPE, between resident contacts, before and after meals, and after using the restroom. The facility's Handling Soiled Linen policy revision date 12/12/24, documented linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons. The facility's Enhanced Barrier Precautions policy dated 12/12/24, documented an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices. The following was observed for infection control: a) On 1/21/25 at 7:40 AM, observed the DA #2 serve breakfast to rooms [ROOM NUMBERS]. She did not assist residents with cleaning hands or encourage the residents to clean their hands. On 1/21/25 at 7:43 AM, the DA #2 stated she did not offer hand hygiene or encourage them to wash their hands and she should have. On 1/21/25 at 8:06 AM, observed the DA #2 serve breakfast to room [ROOM NUMBER], 223, and 234. She did not assist residents with cleaning hands or encourage the residents to clean their hands. On 1/21/25 at 8:10 AM, the DA #2 stated she did not offer hand hygiene or encourage them to wash their hands and she should have. b) Resident #29 was admit to the facility on [DATE], with multiple diagnoses including hemiplegia (partial paralysis on one side of the body) and kidney failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 8:31 AM, CNA #1 and CNA #2 were observed providing catheter care to Resident #29. CNA #1 cleaned Resident #29's peri area and cleaned her catheter. After CNA #1 finished providing catheter care she changed her gloves. CNA #1 did not perform hand hygiene before applying a new pair of gloves. CNA #2 assisted with placement of new brief and then removed her gloves and applied new gloves. CNA #2 did not perform hand hygiene before applying new gloves. CNA #1 removed the bed pad out from underneath Resident #29 and placed it on the floor. Observed in Resident #29's bed a large amount of black substance on the bed linens, underneath her. The CNAs did not remove the black substance or change the bed linens. The clean bed pad was placed over the black substance. CNA #1 applied barrier cream to Resident #29's peri area and inner thighs and then applied the barrier cream to abdominal pannus without changing her gloves. On 1/23/25 at 8:43 AM, CNA #1 stated she should have performed hand hygiene between each glove change, she should have put the linens in a bag and not on the floor, and she should have changed Resident #29's bed linens. She also stated she should have changed her gloves after applying the barrier cream to Resident #29's peri area and before touching her abdominal pannus. c) Resident #29's care plan dated 12/17/24, directed staff to use of EBP when inside of her room for high-contact resident care activities. High contact resident care activities include dressing, bathing, transferring, changing linens, changing briefs, assisting with toileting, and device care. On 1/23/25 at 11:26 AM, observed CNA #1, CNA #2, and the OT use a Hoyer lift to transfer resident #29 without PPE gowns on. On 1/23/25 at 11:30 AM, CNA #1 stated they only wear a PPE gown when providing incontinent care and they should have worn a PPE gown for transferring. On 1/23/25 at 11:34 AM, the ADON stated the staff should have had PPE gowns on when transferring Resident #29. 51121

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on interview, document review, review of the Centers for Disease Control and Prevention (CDC) guidance, and review of facility policy, the facility failed to maintain an infection prevention and control program (IPCP) that included a functional Antibiotic Stewardship Program that followed the McGeer Criteria for antibiotics for 1 of 13 residents (Resident #185) whose medical records were reviewed. This had the potential to affect residents being prescribed antibiotics that were potentially unnecessary. Findings include: The Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes guidelines dated 3/18/24, documented facility perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. The facility's Antibiotic Stewardship Program policy dated 12/19/23, documented under Policy Explanation and Compliance Guidelines. - 4.a.iv. The McGeer Criteria may be used to determine whether to treat an infection with antibiotics. - 4.a.v. All prescriptions for antibiotics shall specify the dose, duration, and indications for use. Resident #185 was admitted to the facility on [DATE], with multiple diagnoses including fracture of the right femur and diabetes. Resident #185's medical record documented erythromycin eye ointment was ordered on 1/3/25, however there was no duration or end date for use. On 1/23/25 at 10:09 AM, the IP stated she was normally notified via PCC (electronic medical records) dashboard when an antibiotic is started and she checks the orders at that time. The IP stated she had not seen the erythromycin antibiotic ordered for Resident #185 so the lack of duration date was not caught and it should have been.