

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Newman Rehab & Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 418 South Memorial Park Drive Newman, IL 61942	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to ensure a Level II PASARR (Preadmission Screening and Resident Review) was completed for two (R11, R10) of two residents reviewed for PASARR screening in the sample list of 25 residents. Findings include: 1.) The facility provided admission sheet dated 9/15/24 documents that R11 was admitted to the facility on [DATE]. R11's (State) Department of Healthcare and Family Services Interagency Certification of Screening Results sheet dated 10/6/11 documents that R11 should have further assessment to determine the need for a Level II screening. R11's September 2024 physician order sheet documents a diagnosis of Schizoaffective Disorder and an order for Buspirone (antidepressant) 5milligrams daily. R11's Care Plan dated 3/18/24 documents diagnoses including Anxiety, Depression, and Schizoaffective Disorder with behaviors that include inappropriate sexual remarks to staff and visitors, demanding/attention seeking behaviors, false accusations and resistance of care. On 9/16/24 at 1:36PM, V7 Pharmacy Medical Records said that R11 had been taking Buspirone 5 milligrams since 12/11/23. On 9/15/24 at 9:50AM, V1 Administrator stated R11 was being seen for mental health issues; however R11 did not get the requisite Level II PASRR screen when given the new Schizophrenia diagnosis nor when the psychotropic medication was first ordered and that it should have been done. On 9/15/24 at 10:00AM, V8 Business Office Manager stated she had not gotten a Level II PASARR for R11, but was going to request one today. 40385 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R10's September 2024 Physician Order Summary documents R10 has a diagnosis of Affective Psychosis and Dementia with Behavioral Disturbances. R10's order dated 5/18/24 documents to give Olanzapine (antipsychotic) 5 milligrams (mg) by mouth twice daily for Affective Psychosis. On 9/15/24 R10's Preadmission Screening and Resident Reviews (PASARRs) were requested from V1 Administrator. R10's Interagency Certification of Screening Results dated 6/28/23, provided by V1, documents R10 admitted to the facility on [DATE] and mental illness was not suspected. There is no documentation in R10's medical record that a Level II PASARR was completed. On 9/15/24 at 11:55 AM V1 Administrator and V2 Director of Nursing stated they weren't sure if they could locate R10's admission history and physical and admission diagnosis list. V1 stated V1 will look through R10's medical record. V2 confirmed a Level II PASARR would need to be completed if R10 did not admit with a diagnosis of psychosis. At 12:07 PM V1 stated V1 looked through R10's medical records and stated R10 did not have a diagnosis of Psychosis in 2015, but it was listed in R10's 2021 records. V1 stated therefor R10 was diagnosed with psychosis some time between 2015 and 2021. V1 stated V8 Business Office Manager (BOM) recently checked all of the residents' PASARRs, especially the older ones. V1 stated V1 will follow up with V8 to see if a Level II was completed for R10. On 9/16/24 at 9:50 AM V8 BOM confirmed a Level II PASRR was not completed for R10. On 9/16/24 at 1:27 PM V7 Pharmacy Medical Records stated R10 began receiving Olanzapine on 7/13/22 at 5 mg twice daily. On 9/17/24 at 10:29 AM V1 stated facility does not have a policy for PASARR, the facility refers to the regulation.		

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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. 42702 Based on observation, interview and record the facility failed to initiate care plans to include resident centered problems, goals, and interventions for one (R11) of 16 residents for care plans from a sample list of 25 residents. Findings include: The facility Comprehensive Care Planning Policy dated 7/20/22 documents that the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The comprehensive care plan shall be revised as necessary to reflect the resident's current medical, nursing, mental and psychosocial needs. On 9/15/24 at 9:19AM, R11's right hand was contracted. R11 said that she has hand splints to prevent contracting and that she wants to wear them but the girls forget to put them on. No splints were in R11's hands at this time. On 9/16/24 at 10:45AM, V21 Licensed Practical Nurse found a right hand splint and hand roll in R11's bedside drawer. On 9/16/24 at 10:47AM, V5 Certified Nursing Assistant stated R11 had her hand roll in her right hand this morning before she assisted R11 with a shower. R11's undated care plan does not document anything about a splint or hand roll or any type of positioning aid. On 9/15/24 at 9:15AM, R11 was laying in bed wearing oxygen at two liters per nasal cannula, via a concentrator. On 9/15/24 at 9:16AM, R11 stated she usually only wears oxygen at night. R11's physician order sheet dated September 2024, documents an order for oxygen to be administered at two liters per nasal cannula as needed to keep oxygen saturation levels greater than 92 percent. R11's treatment administration record dated September 2024, documents oxygen administered daily to R11. R11's undated care plan does not include oxygen administration or maintaining oxygenation levels for R11. On 9/17/24 at 8:00AM, V2 Director of Nursing stated R11's care plan should reflect both positioning aids and oxygen.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide hygienic incontinence and urinary catheter care to prevent cross contamination for two (R12, R18) of four residents reviewed for urinary care in the sample list of 25. Findings include: 1.) R12's Minimum Data Set, dated dated dated [DATE] documents R12 has severe cognitive impairment, is always incontinent of bowel and bladder, and is dependent on staff assistance for toileting hygiene. On 9/16/24 at 2:33 PM V11 and V12 Certified Nursing Assistants transferred R12 into bed with a full mechanical lift and R12 was incontinent of urine. V12 provided R12's incontinence cares starting with R12's buttocks. V12 wiped R12's buttocks three times with wash cloths and bowel movement was visible on the cloths. V12 turned R12 onto R12's back, and used wash cloths to cleanse R12's frontal perineal area using the same gloves worn to cleanse R12's buttocks. V12 did not change gloves until after V12 applied R12's clean incontinence brief. On 9/16/24 at 2:49 PM V12 stated the facility has given education on incontinence cares and V12 should have performed perineal care moving from front to back. V12 stated V12 was unsure when gloves should be changed while providing incontinence cares. V12 confirmed V12 did not change gloves during R12's incontinence care. On 9/17/24 at 10:12 AM V2 Director of Nursing/Infection Preventionist confirmed staff should first cleanse the frontal perineal area and then the buttocks when providing incontinence cares. V2 confirmed V12 should have changed gloves during R12's incontinence care after cleansing R12's buttocks and prior to cleansing R12's frontal perineal area. The facility's Perineal Cleansing policy dated December 2017 documents for female incontinence care wash the pubic area first followed by the peri-anal area. This policy documents to remove gloves after washing the peri-anal area and perform hand hygiene prior to applying a clean incontinence brief. 32853 2.) R18's Physician's Orders dated 9/1/24 to 9/30/24 documents diagnoses including Obstructive Uropathy and Urethral Erosion by Catheter. These Physician's Orders document orders for a Suprapubic catheter for the diagnosis Obstructive Uropathy. These Physician's Orders document an order for a Urinalysis with a culture and sensitivity dated 9/4/24 and an order dated 9/12/24 for Amoxicillin 500 mg (milligrams)/Clavulanic Acid 125 mg (antibiotic) via gastrostomy tube every 12 hours for seven days. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Nurse's Notes dated 9/12/24 documents a new order received for the Amoxicillin/Clavulanic Acid for diagnosis of UTI (Urinary Tract Infection) and ESBL (Extended Spectrum Beta-Lactamase). R18's laboratory result sheet dated 9/12/24 documents culture results of 50,000 to 100,000 CFU(Colony Forming Unit)/ml (milliliter) of ESBL producing Proteus Mirabilis, Multiple Drug Resistant Organism isolated. R18's Care Plan dated 3/18/24 documents R18 has a suprapubic catheter with an intervention to position the catheter bag and tubing below the level of the bladder. On 9/15/24 at 9:30 AM, 12:46 PM and on 9/16/24 at 11:07 AM, 2:14 PM and 2:56 PM, R18's urinary catheter drainage bag was hooked on the side of the bed and laying on the floor. On 9/16/24 at 2:56 PM during incontinence care V11 and V16 Certified Nursing Assistants passed the urinary catheter drainage bag over R18 from one side of the bed to the other, lifting the drainage bag and least 1 1/2 feet over the top of R18 allowing urine to flow back down the tubing to the bladder. On 9/17/24 at 11:26 AM, V2 Director of Nursing stated that the urinary catheter drainage bag should not be laying on the floor and should not be lifted about the level of the bladder.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 32853 Based on observation, interview and record review the facility failed to follow facility policy and document/record the daily amount of enteral feeding administered to a resident for one of one resident (R18) reviewed for Gastrostomy tube feedings in the sample list of 25. Findings include: The facility's Enteral Feeding policy with a revised date of February/2008 documents, Purpose: To ensure a safe, nutritionally appropriate product which provides a source of complete nutrition in a form that will pass through a tube into the digestive system and which will maintain nutritional status as designated. 1. The Dietician/Consultant will monitor all diet orders for tube feedings and will recommend as appropriate changes in product according to resident need. 4. The fluid intake for the resident receiving a tube feeding should be equivalent to the fluid needs as assessed by the Dietician. Fluid need not be met by product alone in which case water flush ordered may be recommended to meet the needs of the tube fed resident. A record of daily intake of the tube feeding and the flushes for the resident will be kept by the nursing department. R18's Physician's Orders dated 9/1/24 to 9/30/24 documents diagnoses including Alzheimer's, Failure to Thrive, Dysphagia, Metabolic Encephalopathy and Gastroesophageal Reflux Disease. These Physician's Orders document an order for Fibersource HN (High Nitrogen) via G-Tube (Gastrostomy tube) at 70 ml (milliliters)/hr (hour) continuous on at 6:00 AM and off at 2:00 AM (20 hours). These orders also document an order to flush G-Tube with 200 ml of water every 6 hours at 4:00 AM, 10:00 AM, 4:00 PM and 10:00 PM. R18's Treatment Administration Record (TAR) dated 8/1/24 to 8/31/24 documents output every shift but does not document any intake. R18's TAR dated 9/1/24 to 9/30/24 documents output every shift but does not document any intake. R18's Report of Monthly Weight and Vitals documents R18's weight in August as 196.7 and R18's weight in September as 189.4 which is a 3.71% weight loss in one month. This report documents a weight loss from April to May, June to July, July to August and August to September. V15 Dietician's progress note dated 5/29/24 documents R18 should have a total of 2231 cc (cubic centimeters) total free water daily. There is no documentation in R18's medical record to show how much feeding R18 is receiving per day. On 9/15/24 at 9:13 AM, R18 was in bed in his room with the G-tube feeding running at 70 ml/hr (milliliters/hour). The feeding that is hanging is Fibersource HN and was hung at 11:00 PM on 9/14/24 according to the writing on the bag. On 9/16/24 at 1:20 PM, V2 Director of Nursing confirmed that they do not document the amount of intake for R18's G-tube feedings. V2 confirmed that R18 has had weight loss and she has not informed the Dietician yet since the Dietician comes at the end of the month. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 1:26 PM, V15 (Dietician) stated when asked if the facility is expected to document R18's daily intake that she expects them to document when they start and stop the feeding. V15 stated that she assumes they are following R18's orders for the feeding and assumes that he is getting what is ordered. V15 stated that she has not been notified of R18's weight loss. She stated that she gets the weight report when she comes at the end of the month and that is how she gets notified of weight loss.		

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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** 40385 Based on interview and record review the facility failed to obtain consents, complete assessments, document nonpharmacological interventions, develop a care plan and document stop dates for psychotropic medications for two (R10, R12) of six residents reviewed for unnecessary medications in the sample list of 25. Findings include: The facility's Psychotropic Medication Policy dated 12/30/13 documents to attempt to rule out social and environmental factors as causes for behaviors, initiate a Pre-Psychotropic Medication Assessment, attempt nonpharmacological interventions prior to prescribing psychotropic medications, and obtain consent for psychotropic medication use from the resident or resident representative. This policy documents psychotropic medication assessments will be completed at least quarterly, and psychotropic medication use, potential side effects and targeted behaviors will be included in the resident's plan of care. This policy does not address stop dates for psychotropic medications ordered to be given as needed. 1.) R10's Minimum Data Set (MDS) dated [DATE] documents R10 has severe cognitive impairment. R10's September 2024 Physician's Order Summary documents R10 receives hospice care and R10's diagnoses include depression, dementia with behavioral disturbances, and psychosis. R10's physician orders includes an order dated 8/26/24 for Lorazepam (antianxiety) 2 milligrams per milliliter (mg/ml) give 0.25 ml every four hours as needed (PRN) for anxiety/restlessness, an order dated 9/5/24 for scheduled Lorazepam give 0.25 ml twice daily, and an order dated 5/18/24 for Olanzapine (antipsychotic) 5 mg twice daily. There is no stop date for the Lorazepam PRN order. R10's Care Plan dated 6/7/24 documents R10 uses psychotropic medications, but Olanzapine and Sertraline are the only listed psychotropic medications. R10's nursing note dated 4/1/24-4/4/24 document no changes in behaviors related to decrease in Olanzapine. R10's nursing notes dated 4/6/24-4/7/24 document R10 yelling at staff and residents, swatting at staff during cares, and R10 putting her fingers down her throat to cause vomiting. These notes do not document specific nonpharmacological interventions that were used to respond to R10's behaviors. R10's nursing note dated 4/11/24 at 1:30 AM documents Zyprexa was increased back to prior dose. R10's nursing notes dated 9/4/24 document R10 yelled leave me alone during cares and yelled help during meals and there is no documentation what nonpharmacological interventions were implemented to address these behaviors. R10's nursing note dated 9/5/24 documents hospice gave orders to increase Lorazepam to scheduled twice daily. R10's medical record does not include consents or psychotropic medication assessments for the use of Lorazepam. R10's Psychotropic Medication Quarterly Evaluations document assessments were completed on 3/5/24, 6/5/24, and 9/3/24 for Olanzapine. There is no documentation that a psychotropic medication assessment was completed prior to increasing Olanzapine on 5/18/24. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pharmacy Consultation Report dated 8/28/24 documents R10 has a PRN Lorazepam order with no stop date and to either discontinue the medication or document the indication for use, duration of therapy, and rational for the extended time period. This form is signed by a hospice provider and documents to continue use related to hospice care, but does not include a duration or stop date. On 9/16/24 at 12:17 PM V2 Director of Nursing provided a pharmacy recommendation for R10 PRN Lorazepam order, and confirmed there is no stop date or duration for this order. V2 confirmed R10 should have a consent and assessments for Lorazepam. V2 reviewed R10's medical record and confirmed there was no Lorazepam assessments or consents documented. V2 stated psychotropic medication assessments are completed quarterly with the MDS schedule and not with new orders or changes in dosages. V2 stated an assessment was not completed for R10's Lorazepam since it was a fairly new order, but that is something we should probably be doing. V2 stated V2 was unsure why R10's Lorazepam was increased to scheduled twice daily and V2 was not aware of the medication order. V2 reviewed R10's nursing notes and stated R10 had increased anxiety at meal times and hospice ordered scheduled Lorazepam. V2 confirmed there is no documentation of nonpharmacological interventions used to address R10's behaviors prior to scheduling Lorazepam. V2 stated an agency nurse worked that day and that is why V2 was not notified of the order. V2 stated V10 MDS Coordinator is responsible for completing the psychotropic medication assessments and updating the care plans with psychotropic medications, and V2 is responsible for ensuring these things are completed. At 12:39 PM V2 stated V2 was unable to locate R10's Lorazepam consent and the nurses are responsible for obtaining the consent. V2 stated the consent likely wasn't done since an agency nurse worked that day. V2 confirmed there is no documentation that an assessment was completed when R10's Zyprexa was increased in May 2024. 2.) R12's MDS dated [DATE] documents R12 has severe cognitive impairment. R12's September 2024 Physician's Order Summary documents R12's diagnoses include dementia with behavioral disturbances and anxiety disorder. R12's physician order dated 7/12/24 documents Lorazepam 2 mg/ml give 0.5 ml every four hours PRN for anxiety/restlessness, and there is no stop date for this order. R12's September 2024 Medication Administration Record documents Lorazepam was administered on 9/7, 9/8, and 9/9 for nerves, anxiety, and crawling out of bed. The pharmacy Consultation Report dated 2/13/24 documents R12 has a PRN Lorazepam order with no stop date and includes a recommendation to continue the PRN order through August 2024 when the medication will be re-evaluated, and this form is signed by V22 Nurse Practitioner. The pharmacy Consultation Report dated 8/28/24 documents R12 has a PRN Lorazepam order with no stop date and to either discontinue the medication or document the indication for use, duration of therapy, and rational for the extended time period. This form is signed by a hospice provider and documents to continue use related to hospice care, but does not include a duration or stop date. R12's Care Plan dated 3/19/24 documents R12 receives hospice care and uses antidepressant medication. R12's care plan does not document use of Lorazepam. There are no documented assessments for Lorazepam in R12's medical record. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 9:39 AM V2 stated we try to keep a stop date for PRN Lorazepam when the resident is on hospice. V2 stated the pharmacy is good about giving V2 the forms to remind V2 of stop dates needed, but hospice isn't always timely in returning the forms back to V2. On 9/16/24 at 12:17 PM V2 provided a pharmacy recommendation for R12's PRN Lorazepam order, and confirmed there is no stop date or duration recorded for this order. At 1:40 PM V2 confirmed there are no documented psychotropic medication assessments for R12's Lorazepam. V2 stated V2 believes the Lorazepam orders for R10 and R12 were overlooked since they are both on hospice care.		

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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. 42702 Based on observation, interview and record review the facility failed to store and secure controlled medications behind a separately locked compartment for three (R10, R12 and R23) of three residents reviewed for medication storage from a total sample list of 25 residents. Findings include: The facility provided Procurement and Storage of Medications Policy date reviewed October 2006, documents that Schedule II drugs are to be stored under a double-lock subject to a different key. On 9/16/24 at 3:03PM, an unlocked refrigerator contained five bottles of Lorazepam (schedule IV controlled substance) 30 milliliters, with a concentration of 2 milligrams per milliliter. One bottle was documented for R23, three bottles were documented for R12 and one bottle was documented for R10. On 9/16/24 at 3:04PM, V3 Registered Nurse stated the refrigerator should have been locked because it had Lorazepam in it. On 9/16/24 at 3:06PM, V2 Director of Nursing observed that the refrigerator housing five bottles of Lorazepam was unlocked and confirmed that the refrigerator should have been locked.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to employ a clinically qualified Director of Food and Nutrition. This failure has the potential to affect all 35 residents residing in the facility. Findings include: On 9/15/24 at 8:16 AM, there were opened food items in the refrigerator that were not labeled with open dates and there were open food items in the dry storage room that were not labeled with open dates. At this same time there was dust and debris hanging directly above the cook top and the toaster was dirty with crumbs inside and around the outside. On 9/16/24 at 9:00 AM, V19 Dietary Manager stated that she is not a certified Dietary Manager. V19 stated that she has taken some courses but has not had time to complete all of the courses. The facility assessment dated [DATE] documents that a dietician or other clinically qualified nutrition professional will serve as the director of food and nutrition services. The Long-Term Care Facility Application for Medicare and Medicaid dated 9/15/24 documents 35 residents reside in the facility.		

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NAME OF PROVIDER OR SUPPLIER Newman Rehab & Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 418 South Memorial Park Drive Newman, IL 61942	
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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. 32853 Based on observation, interview, and record review the facility failed to properly label the open date on open food items, failed to have an internal thermometer in a refrigerator and failed to maintain the range hood and the toaster in sanitary conditions to protect food that was being prepared on the range and in the toaster. This failure has the potential to affect all 35 residents residing in the facility. Findings include: The facility's storage policy with a revised date of October 2020 documents, It is the policy of (the facility) that food shall be stored on shelves in areas that provide the best preservation. Food shall be stored at the proper temperature and for appropriate lengths of time to protect quality of food and food costs. Procedure: 1. All items will be dated upon receipt. Individual cans or bags shall each be dated to ensure that stock is rotated properly. 5. Store leftovers in covered, labeled and dated containers under refrigeration or frozen. 6. When using only part of a product, the remaining product should be in the original package or air tight container(s) and labeled and dated. The facility's Kitchen Sanitation policy with a revised date of October 2020 documents, 1. The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. 3. The Food Services Manager will develop a cleaning schedule for the department and ensure that dietary employees complete cleaning tasks as scheduled. 4. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen, and specify which chemical and personal protective equipment should be used for each task. On 9/15/24 at 8:16 AM during the initial tour of the kitchen with V17 Dietary Aide and V18 Cook, the first refrigerator inside the kitchen did not have an internal thermometer and this refrigerator contained cold drinks including milk. This refrigerator contained a pitcher of tomato juice which had no lid or cover and was not labeled with identification or dates of preparation. V18 confirmed there was no lid or any labels on the pitcher of tomato juice. Another refrigerator contained cartons of liquid eggs. There was one opened carton that was not labeled with a date in which it had been opened. This refrigerator contained a metal bowl with ripped aluminum foil over the top of it. The contents of this bowl were unidentifiable and was not labeled with it's contents or a date in which it was prepared. The range hood had dust and debris hanging from it and from the pipes located above the cook top. There was a toaster on a cart in the dry storage room that had crumbs inside on the bottom of it and on the cart around the outside of the toaster. There was an open and used gallon jug of pancake and waffle syrup on the top shelf with no open date and a small bottle of butter flavored syrup that was opened and used that did not have an open date on it. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/16/24 at 9:00 AM, V19 Dietary Manager confirmed the thermometer was not in the first refrigerator, it was laying on the preparation table and she stated that it fell out the other day and did not get put back inside the refrigerator. V19 stated that she cleaned out the refrigerator yesterday and threw away unlabeled items. V19 confirmed everything should have been labeled with the preparation date and identification. The stove top still has dirt and debris hanging down from above and V19 confirmed the dust and debris was there. V19 stated that she cleaned it not too long ago but could not confirm that there was a plan or a cleaning schedule for the range hood or pipes above the stove top. V19 confirmed the tomato juice should have been labeled. The toaster still had crumbs all around the inside bottom and the tray around it. V19 stated that it should be cleaned after each use. The unlabeled syrup was still unlabeled and on the shelf in the dry storage area and V19 confirmed it should be labeled. On 9/16/24 at 9:48 AM, V19 confirmed the liquid eggs should be labeled when opened. The Long-Term Care Facility Application for Medicare and Medicaid dated 9/15/24 documents 35 residents reside in the facility.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Failures at this level require more than one deficient practice statement. A. Based on interview and record review the facility failed to identify high risk areas for Legionella and implement control measures. This failure has the potential to affect all 35 residents that reside in the facility. B. Based on observation, interview, and record review the facility failed to ensure staff wore personal protective equipment (PPE) properly during a COVID-19 (human coronavirus infection) outbreak. This failure affects eight of sixteen residents reviewed for infection control in the sample list of 25. Findings include: a.) The facility's undated Legionella Policy and Procedure, provided by V1 Administrator, documents Legionella is a bacterium that is common in the natural water system (ponds, [NAME], lochs, etc (etcetera)) and Legionella are widespread in the environment they may contaminate and grow in artificial water systems (cooling towers, hot and cold water systems, storage tanks, pipe work, taps and showers). Legionella survive at relatively low temperatures of between 20 degrees C (Celsius) and 45 degrees C especially if the conditions are right (if a supply of nutrients are available such as rust, sludge, scale, algae and other bacteria). High temperatures of 60 degrees C and above will kill the Legionella bacteria, Legionnaires Disease is a potentially fatal form of Pneumonia caused by inhaling the Legionella bacteria. The infection is caused by breathing in droplets of water contaminated by the bacteria, but this cannot be passed from one person to another. Legionella Bacteria thrive and multiply in hot or cold water systems and storage tanks and then spread through spray from showers and taps. Should concerns are identified the following measures may be initiated to minimize and control the risks: Have the water system inspected, maintained and cleaned. (Annually) Ensure water cannot stagnate anywhere in the system remove redundant pipe work. (As needed) Run through taps and showers no longer in use or used infrequently for a minimum of 1 minute X once a week. (Weekly) Check hot and cold water temperature after water has been running for 1 minute. (random weekly) Take shower heads apart every 3 months clean and disinfect. (Quarterly) Keep water tanks and cisterns covered, clean and free from debris. Insulate tanks and pipe work. Ensure water stored in the hot water tank or cylinder is above 60 degrees C. Annual servicing of boiler and thermostatic mixing valves. (Annual) The facility's Legionella Risk assessment dated [DATE] documents answering yes to any of the questions listed suggests a potential risk for Legionella exposure. This assessment documents V9 Maintenance Director completed the assessment, and yes was answered to having multiple housing units with a centralized hot water system and conditions are right for bacterial growth for water temperatures between 20 and 45 degrees C. There is no documentation that the facility identified specific high risk areas for Legionella growth and implemented routine control measures to address high risk areas. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/16/24 between 3:10 PM and 3:25 PM V9 stated V1 Administrator and V9 collectively completed a Legionella risk assessment and they did not identify any high risk areas for Legionella in the facility. V9 stated V9 was not aware if the facility has any dead ends in the plumbing and V9 did not use a map of the facility's plumbing to evaluate this. V9 stated V9 was not aware of any control measures implemented to address the risk for Legionella since there were no high risk areas identified from the assessment form. On 9/16/24 at 3:15 PM V1 stated a fish tank was the only standing water and high risk area that the facility identified, and the fish tank was removed. At 3:45 PM V1 stated V1 does not have a plumbing layout/floor plan and has never seen one for this facility. On 9/17/24 at 2:00 PM V1 confirmed the facility's maintenance director is responsible for implementing Legionella control measures and confirmed there was no documentation of routine control measures to address high risk areas. V1 stated we thought our policy was enough documentation. The Long-Term Care Facility Application For Medicare and Medicaid dated 9/15/24 documents 35 residents reside in the facility. b.) The facility's COVID-19 Control Measures policy dated 5/19/23 documents that employees should wear an N95 mask while the facility is in outbreak status. On 9/15/24 at 7:53 AM there was a sign posted on the facility's entrance door that documented the facility has active COVID-19 cases and to wear an N95 mask. On 9/15/24 between 12:35 PM and 12:53 PM V17 Dietary Aide wore an N95 mask with V17's nose and mouth exposed while V17 served meals to R1, R26, R15, R13, R4, R36, R11, and R12. On 9/15/24 at 1:30 PM V17 confirmed V17 wore her mask pulled down with her nose and mouth exposed while V17 served resident meals. V17 stated V17 has difficulty breathing at times, which is why she pulls her mask down. On 9/17/24 at 10:12 AM V2 Director of Nursing/Infection Preventionist stated the facility has been in COVID-19 outbreak since 8/22/24 and a lot of staff and residents have been asymptomatic when testing positive. V2 confirmed during a COVID-19 outbreak, staff should wear an N95 mask covering both nose and mouth when they are near residents. The facility's August and September 2024 Infection Control logs document nine residents and ten employees have tested positive for COVID-19 since the outbreak began on 8/22/24.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to maintain documentation of COVID-19 vaccination for three (R9, R19, R36) of five residents reviewed for immunizations in the sample list of 25. Findings include: The facility's Immunization of Residents policy dated 5/19/23 documents the facility will offer immunizations to aid in preventing infectious diseases. This policy documents to offer the current recommended COVID-19 vaccine upon admission for residents who are not considered up to date with the vaccine, review consent forms to verify timing of previous vaccinations and document immunizations on the resident's Immunization Record. 1.) R9's Face Sheet documents R9 admitted to the facility on [DATE] and R9 is over age 65. R9's Cumulative Diagnosis Log documents R9's diagnoses include Congestive Heart Failure, Coronary Artery Disease, and Type 2 Diabetes Mellitus. R9's COVID-19 Vaccination Record Card documents vaccine administrations on 2/4/21, 3/4/21, 11/4/21, and 6/29/22. There is no documentation that R9 was offered a COVID-19 booster vaccine after 6/29/22. 2.) R19's Face Sheet documents R19 admitted to the facility on [DATE] and R19 is over age 65. R19's September 2024 Physician's Order Summary documents R19's diagnoses include Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. R19's COVID-19 Vaccination Record Card documents vaccine administrations on 12/28/20, 1/18/21, 11/15/21, and 6/29/22. There is no documentation that R19 was offered a COVID-19 booster vaccine after 6/29/22. The facility's September 2024 Resident Infection Control and Antimicrobial Log documents R19 tested positive for COVID-19 on 9/4/24. On 9/16/24 at 9:42 AM V2 Director of Nursing/Infection Preventionist stated residents are offered COVID-19 vaccination upon admission and any time there is a new booster. V2 stated all residents were offered the booster vaccine in 2023, but we don't have documentation of declination for this vaccine as it was done through an outside company. At 12:55 PM V2 stated R9 and R19 refused the last COVID-19 booster vaccine, but V2 does not have documentation of this. 3.) The facility's binder containing resident COVID-19 vaccination information was reviewed and did not contain R36's information. R36's Face Sheet dated 4/29/24 documents R36 admitted to the facility on [DATE] and R36 is over age 65. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 1:35 PM V20 Social Services Director stated V20 contacted R36's family today to request COVID-19 vaccination information and the facility should have this information by tomorrow. On 9/17/24 at 9:35 AM V1 Administrator provided R36's COVID-19 vaccine documentation dated 9/17/24. V1 confirmed R36 is not up to date with COVID-19 boosters and confirmed there is no documentation that a booster was offered to R36 after admission. R36's Immunization Summary dated 9/17/24 documents COVID-19 vaccine administrations on 12/8/21, 2/28/21, and 1/31/21. There is no documentation that R36 was offered a COVID-19 booster vaccine.		