STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145800	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home	418 Washington Street Quincy, IL 62301

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to ensure call lights were placed within reach for three of 18 residents (R30, R37, and R64) reviewed for accommodation of needs in the sample of 36. Findings include: The Call Light Policy (undated) documents All residents of (the facility) should have a working and reachable call light. Call Lights are available for residents to request assistance for a wide variety of reasons. Call lights are to be placed within reach no matter where the resident is located in their rooms. Examples of where call lights can be placed include clipped to the recliner, clipped around side rails (if the resident uses them), placed over bedside table as long as bed side table is in reach of the resident. 1. R37's MDS (Minimum Data Set) assessment dated [DATE] documents R37 is severely cognitively impaired, requires staff assistance for activities of daily living, and has a high risk for falls. On 10/22/24 from 9:45 AM through 10:40 AM R37 was lying in bed on her left side sleeping. R37's call light was on the top of her side table, out of R37's reach, during this time. On 10/22/24 at 10:40 AM V11 (CNA/Certified Nursing Assistant) verified R37 uses a call light and that her call light was not in reach. 32875 2. R30's current computerized medical record, documents R30 was admitted to the facility on [DATE] with diagnoses which included Spinal Stenosis, Lumbar Region with Neurogenic Claudication, Essential (Primary) Hypertension, Acute Respiratory Failure with Hypoxia, and Localization-Related (Focal) (Partial) Symptomatic Epilepsy and Epileptic Syndromes with Simple Partial Seizures, Not Without Status Epilepticus. R30's MDS (Minimum Data Set) dated 8/21/24 documents a BIMS (Brief Interview for Mental Status) Score of 3/15, indicating (severe cognitive impairment). R30 requires partial assistance for activities of daily living and transfers. R30 is frequently incontinent of bowel and bladder. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 10:32 AM R30's was sitting in her wheelchair in her room without a call light. The call light was clipped to the recliner and not in reach. On 10/21/24 at 10:32 AM R30 stated I use the call light, but I don't know where it is. On 10/21/24 at 11:50 AM V1, R30's Power of Attorney, stated that R30 uses her call light. 49187 3. On 10/21/24 at 9:40 AM R64 was sitting in her room in a high back wheelchair. R64's call light was hanging over R64's bedside table on her left side out of reach. R64 stated that most of the time the call light is out of reach, and she cannot always get help when needed. On 10/21/24 at 9:45 AM V6/Certified Nursing Assistant verified R64's call light was out of reach. V6 stated, The call light should be attached to (R64) or (R64's) wheelchair when she is in it, not laying on her bedside table. (R64) is dependent with cares, so she would not be able to get to her call light if it is out of reach. On 10/23/24 at 11:03 AM V2 (Director of Nursing) stated, All calls lights should be placed within reach at all times.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38396 Based on Observation, Interview and Record review the facility failed to ensure a physician ordered hand splint was in place daily and a resident's limitations in range of motion were care planned for one of two residents (R73) reviewed for limitations in range of motion in the sample of 36. Findings include: The facility's (undated) Rehabilitation/Restorative Programs policy documents Upon admission or onset of a decline in Activities of Daily Living functions, a resident will be evaluated for individual status, and as potential candidate for Rehabilitation/Restorative program developed specifically for that individual. The goal/approaches of the individual's care plan shall be re-evaluated at least quarterly for any necessary revisions or modifications. R73's Minimum Data Set assessment, dated 9/4/24, documents R73 has Range of Motion impairments on one side for both upper and lower extremities. R73's Physician Order Sheet, dated 10/22/24, documents Patient to wear left upper extremity splint during daytime hours. Splint wear schedule: Donn (apply) with AM (morning) care, can wear up to 8 hours. This order has a start date of 3/8/24. R73's current care plan does not include a plan of care addressing R73's limits in range of motion or the use of a splint for R73's left hand. On 10/21/24 at 11:15 AM, R73 was sitting in a wheelchair in his room. R73's left hand was balled into a tight fist contracture and resting on the wheelchair. V18 (R73's Power of Attorney) stated that R73 is not currently in therapy and hasn't been since about April. V18 stated (R73) is supposed to have a splint on that left hand but they (facility) never put it on him. He has not had any device, wash cloth or splint placed in his left hand since being here. He went out of the facility and got (injectable neurotoxins) in that hand about three weeks ago. The nurse who went to give the injection had to clean his hand and remove yeast growth on his skin, from the tight contracture. On 10/22/24 at 12:15 PM, R73 was in the dining room sitting at table. R73 did not have a splint on his left hand which was resting in his lap. On 10/22/24 at 12:20 PM V13 (Licensed Practical Nurse/Restorative Nurse) confirmed R73 has an order for a left-hand splint. V13 stated He sometimes wears a splint, also he refuses a lot. The use of his splint isn't documented on an administration record. We might sometimes document refusals on the behavior tracking sheets. R73's Restorative Care logs dated September 2024 and October 2024 do not document any administration or refusals of R73's splint being worn/offered. R73's October 2024 Behavior Management Program does not document any refusals of wearing the hand splint and only documents 10/14/24- No Behaviors. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 10:30 AM, V2 (Director of Nursing) stated I wasn't aware that (R73) had a splint. (R73's) care plan does not reflect his limits in range of motion or the order for his splint. It should be on there so that staff are also aware of the need to address his deficits.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38396 Based on Observation, Interview and Record review, the facility failed to ensure a resident with a diagnosis of Dementia and a history of falling was adequately supervised to prevent a fall for one of three residents (R51) reviewed for Falls in the sample of 36. Findings include: The facility's Falls Management Program policy, dated 7/21/23, documents Fall prevention takes a combination of medical treatment, rehabilitation, and environment changes. Prevention tools may include assessments, education, medication reviews, environmental changes, and the use of fall mats and alarms. In order to maintain a successful falls prevention program, all staff members are responsible for seeking out, removing, and reporting potential fall hazards. This policy also documents Psychotropic Drugs: Know which residents take a benzodiazepine (antianxiety medication) or an antipsychotic (medication). Watch residents who are on these drugs for side effects such as confusion, drowsiness, dizziness, changes in gait (walking), loss of balance, and changes in mental status. On 10/21/24 at 11:30 AM R51 was observed in the dining room, sleeping in her wheelchair. R51's wheelchair contained a string pull alarm attached to the chair and R51's shirt. R51's current care plan, dated 10/22/24, documents R51 has diagnoses including but not limited to, Dementia, Anxiety, Parkinson's Disease, Complete Traumatic Amputation at level Between Right Hip and Knee, Phantom Limb Syndrome with Pain, and Communication Deficit. This same care plan documents R51 takes Risperidone (antipsychotic medication) and a care plan for falls that document I am high risk for falls related to impaired cognition, poor safety awareness, poor vision and a history of falls. 5/1/19 (R51) fell trying to put herself to bed. This care plan also documents R51 suffered falls on 9/29/19, 1/16/2020, 7/17/2020, 7/9/21, 7/22/21, 9/10/21,1/17/22 and 7/23/24. R51's Fall Investigation, dated 7/23/24, and signed by V2 (Director of Nursing) documents (R51) was found outside of the building lying in the front drive. (R51) appeared to have tried to go off the curb and the wheelchair tipped. On 10/23/24 at 10:00 AM, V16 (Activity Aide) confirmed she was the one who took R51 to the lobby on 7/23/24. V16 stated When we have an outdoor activity no one is allowed to go outside without staff. So, we put residents in the lobby and gather other residents. We (activity staff) put (R51) in the lobby that day and went to gather other residents. The other staff member was (V17, activity aide). No one from activities was down there when (R51) was able to go out behind another staff member without their knowledge. When (activity aides) came back down they were bringing (R51) back in from outside. This wasn't out of the normal for her to act in that way. (R51) can be strong willed and if she wants to do something she will. If I would've known she was having a bad day I wouldn't have left her unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 10:28 AM V2 (Director of Nursing) confirmed that on 7/23/24, R51 was left in the facility lobby with other residents and was not being supervised by trained staff when she got out of the building and fell . V2 stated We knew with (R51's) fall that an employee had went out the door and (R51) had gotten through before the alarm would sound. I am not positive who the employee was, I believe it was someone working in maintenance. The receptionist down there was (V20) and she saw (R51) slip out the door and called the nursing office. By the time I got down there (R51) had already gotten herself off of the curb and fallen.

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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. 49187 Based on observation, interview, and record review the facility failed to ensure an indwelling urinary catheter drainage bag was covered for one of one resident (R6) reviewed for indwelling urinary catheters in a sample of 36. Findings include: The Catheter Care Procedure (undated) documents Performed By: Licensed Staff, CNA (Certified Nursing Assistant). Procedure: 16. Be sure catheter drainage bag is inside a cloth dignity bag and catheter tubing and dignity bag is not touching the floor. R6's current care plan documents the following, (R6) has a supra pubic urinary catheter. On 10/21/24 at 10:13 AM R6 was sitting in his room in his wheelchair. R6's catheter bag was secured to the bottom of his wheelchair with no privacy bag covering R6's urinary catheter drainage bag. On 10/21/24 at 11:10 AM R6 was sitting across from the fourth unit nursing station in his wheelchair. R6's catheter drainage bag was secured to the bottom of his wheelchair with no privacy bag. On 10/21/24 at 11:13 AM V5/Agency Licensed Practical Nurse verified R6's urinary catheter drainage bag was uncovered with no privacy bag. V5 stated, (R6) should have a privacy bag covering his urinary catheter bag. I am not sure why he does not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 49187 Based on observation, interview, and record review the facility failed to ensure oxygen tubing and humidification bottles were dated and oxygen tubing was stored in a bag between uses for four of four residents (R64, R140, R147, and R290) reviewed for respiratory care in a sample of 36. Findings include: The facility's Oxygen administration Policy/Procedure by Nasal Cannula/Mask (un-dated) documents Purpose: To deliver a low to moderate concentration of oxygen when oxygen use is indicated. Action To Be Performed By: Licensed medical personnel as designated in their job description. 3- Assemble equipment: Oxygen cylinder, tank, or canister. Cannula/Mask & (and) tubing (Change tubing/mask Q (every) 7 days & PRN (as needed). 1. R64's current POS (Physician Order Sheet) documents an order to change oxygen tubing, date oxygen tubing, and place in a bag when not in use one time a day every Sunday for oxygen protocol. This same POS also documents an order for oxygen at one liter as needed for dyspnea. On 10/21/24 at 9:40 AM R64 was sitting in a high back wheelchair in her room. R64's nasal cannula oxygen tubing was laying on the floor and undated and unbagged. R64's oxygen humidification bottle was also undated. 2. R290's current POS documents an order for three liters of oxygen per nasal cannula continuous. On 10/21/24 at 10:02 AM R290 was sitting in her recliner with oxygen flowing at three liters via nasal cannula. R290's oxygen tubing and humidification bottle was undated. On 10/21/24 at 10:04 AM V5/Agency Licensed Practical Nurse verified R64 and R290's oxygen tubing and humidification bottles were undated and R64's oxygen tubing were not placed in a bag while not in use. 31682 3. On 10/22/24 at 12:13 PM R140's oxygen nasal cannula tubing was lying on top of R140's oxygen concentrator. R140's oxygen nasal cannula tubing was not labeled with the date or stored within a bag and R140's humidifier bottle was not labeled with the date. 4. On 10/21/24 at 10:36 AM R147's oxygen nasal cannula tubing was hanging on R147's right side rail. R147's oxygen tubing was not labeled with the date and was placed within a bag while not in use. On 10/23/24 at 11:03 AM V2 (Director of Nursing) stated, All oxygen tubing and humidifier bottles should be dated and stored in plastic bags when not in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to follow a physician order for a daily weight for one of one resident (R45) reviewed for dialysis in the sample of 36. Findings include: The policy for Residents Receiving Hemodialysis (undated) documents Residents receiving dialysis will be weighed daily. Increases in weight will be monitored and reported as appropriate. R45's current computerized medical record, documents R45 was admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease, Hypertensive Chronic Kidney Disease with Stage 5 Chronic Kidney Disease or End Stage Renal Disease, Heart Failure, and Hypertensive Heart Disease with Heart Failure. R45's MDS (Minimum Data Set) dated 8/14/24 documents a BIMS (Brief Interview for Mental Status) Score of 15/15, indicating (cognitively intact). R45's Care Plan documents that R45 receives hemodialysis related to End Stage Renal Disease. Obtain weight daily. R45's Physician Order documents to weigh daily and call physician if more than five-pound increase in three days one time a day for post-surgery, start date 8/3/24. R45's Weight and Vitals Summary documents R45 was not weighed on 9/1, 9/5, 9/8, 9/11, 9/15, 9/16, 9/19, 9/22, 9/23, 9/28, 9/29, 10/5, 10/6, 10/8, 10/14, and 10/19/24. On 10/21/24 at 2:34 PM, R45 stated that she is supposed to be weighed every day, but it does not get done daily. On 10/23/24 at 9:03 AM, V2/Director of Nursing stated that R45 goes to dialysis three times a week and is to be weighed daily. V2 verified R45's weights were not getting done daily as ordered.

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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** 31682 Based on observation, interview, and record review the facility failed to document behaviors and diagnoses to justify the use of antipsychotic medications, perform psychotropic assessments quarterly, and perform gradual dose reductions of scheduled antipsychotic medications for two of three residents (R37 and R51) reviewed for the use of anti-psychotic medications with the diagnosis of Dementia in the sample of 36. Findings include: The Psychotropic Drug Use policy (undated) documents A psychotropic drug is any that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: a) Anti-psychotic Psychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Policy Interpretation and Implementation 1. Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The Attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 7. Psychotropic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorder (e.g. (example) bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. 8. Diagnosis alone do not warrant the use of psychotropic medication. In addition to the above criteria, psychotropic medications will generally only be considered if the following conditions are also met: a The behavioral symptoms present a danger to the resident or others; AND: (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) Behavioral interventions have been attempted and included in the plan of care, except in emergency. 11. Psychotropic medications will not be used if the only symptoms are one or more of the following: a. wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness. R37's Physician's Orders dated 10-22-24 document, Order date 5-23-24: Risperidone 0.25 mg (milligrams) two times daily for the diagnosis of Dementia with Behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's MDS (Minimum Data Set) Assessments dated 1-31-24, 5-1-24, and 7-24-24 document R37 is severely cognitively impaired and has no behaviors except for wandering. These same MDS Assessments document R37 takes anti-psychotic medication on a routine basis, has not had a GDR (Gradual Dose Reduction) attempt within the last year, and does not have a physician documented clinical rationale as to why a GDR has not been attempted. R37's Psychotropic assessment dated [DATE] documents R37 only has one behavior of restless. R37's Medical Record does not include evidence of completion of a psychotropic drug assessment since 9-23-23. R37's Behavior Management Program Logs dated 7-1-24 through 10-23-24 document R37 has had no behaviors within this timeframe. On 10-22-24 from 9:45 AM through 10:40 AM R37 was lying in bed on her left side sleeping. R37 had no behaviors during this time. On 10-22-24 from 11:50 AM through 12:45 PM R37 was sitting in a wheelchair in the dining room. R37 has no behaviors during this time. On 10-22-24 at 9:55 AM V11 (CNA/Certified Nursing Assistant) stated, (R37) does not have any behaviors. On 10-22-24 at 10:20 AM V12 (CNA) stated, (R37) does not have any behaviors that I am aware of. On 10-22-24 at 11:15 AM V5 (Agency LPN/Licensed Practical Nurse) stated, (R37) only has a behavior of wandering around in her wheelchair. (R37) does not have any other behaviors. On 10-22-24 at 1:26 PM V2 (Director of Nursing) stated, (R37) has not had a psychotropic drug assessment performed since 9-13-23. Psychotropic drug assessments are supposed to be completed quarterly. (R37) should have had an annual GDR. (R37) does not have behaviors to justify the use of Risperidone. The diagnosis of Dementia does not justify the use of Risperidone. (R37's) only behavior is wandering. 38396 2. On 10/21/24 at 11:30 AM, R51 was sitting in the dining room in a wheelchair, sleeping. R51 was not displaying any behaviors. On 10/22/24 at 12:15 PM and 12:30 PM, R51 was sitting in the dining room in a wheelchair and then was assisted back to her bedroom by facility staff. R51's eyes opened and shut slowly and frequently giving the appearance of being drowsy. R51 was not displaying any behaviors. R51's Physician Order Sheet, dated 10/23/24, documents R51 has an order for Risperidone (antipsychotic medication) tablet 0.25 milligrams (MG). Give one tablet by mouth two times a day for dementia with behaviors related to Dementia with Lewy Bodies. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's current Care Plan, dated 10/22/24, documents R51 has diagnoses including but not limited to Parkinson's disease, Anxiety and Dementia without behaviors. This care plan documents Repetitive verbalizations. (R51) has impaired recall and decision-making skills secondary to Lewy Body dementia. At times, (R51) has chanted, Oh God or other verbalizations repeatedly. Receives Risperdal (Risperidone) for behaviors related to Lewy Body dementia. Hallucinations (R51) has diagnosis of Lewy Body Dementia. She seen a baby while in unit dining room, there was no baby. Hallucinations occur 1 time in 3 months. Receives Risperdal for dementia. R51's Behavior Management Program tracking sheets dated June 2024- October 2024, documents R51 is being tracked for behaviors of Hallucinations of cats, people, and Repetitive verbalizations. These same sheets document R51 displayed no behaviors from June through September 2024 and displayed behaviors of Repeating the same thing over and over again two times on 10/14 and 10/15/24. R51's Psychotropic assessment, dated 6/27/24, documents R51 displays behaviors of restless and agitation two to six days a week in the afternoon. R51's Pharmacy recommendation for dose reduction of R51's Risperidone, dated 5/30/24, documents the Gradual Dose Reduction (GDR) was denied by V15 (R51's Nurse Practitioner) but does not list clinical rational and evidence to support the denial. On 10/22/24 at 12:20 PM, V13 (Licensed Practical Nurse) stated (R51) does have some behaviors at times. She will yell out sometimes, curse and refuse medications. (R51) is not harmful to herself or other residents. (R51) can sometimes forget her limitations with her amputated leg and try to get up so she wears an alarm for that. On 10/22/24 at 12:30 PM, V14 (Certified Nursing Assistant) stated (R51) has mostly behaviors of sundowners (confusion in the evening). Around evening she will yell out and sometimes rocks back and forth. (R51) isn't harmful to other residents or herself. On 10/23/24 at 10:28 AM, V2 (Director of Nursing) confirmed R51 does not have a diagnosis or Behaviors that warrant the use of an antipsychotic medication. V2 stated (R51) has behaviors but they're more verbal and not physical to my knowledge. (R51) has been on Risperidone for a long time. The GDR was denied by the nurse practitioner (V15) for (R51's) Risperidone. I am aware it wasn't at all decreased in the past year and that she is on it for a diagnosis of Dementia.

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	145800	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home	418 Washington Street Quincy, IL 62301

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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. 38396 Based on observation, interview and record review, the facility failed to ensure a chemical dishwasher was monitored for safe sanitizer concentration, failed to ensure opened bags of freezer kept food items were labeled with dates of opening, and failed to record cool down temperatures for soups that were prepared ahead and stored in the freezer for future use. This failure has the potential to affect all 87 residents living in the facility. Findings include: The facility Dishwashing Machine Use policy, dated 3/2010, documents Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. Dishwashing machine chemical sanitizer concentrations and contact times will be as follows: Quaternary Ammonium- minimum concentration 150-200 parts per million (PPM). Concentrations will be recorded in a facility approved log. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperature or PPM are adjusted. On 10/21/24 at 10:30 AM, V7 (Dietary Manager) performed a test to check concentration of the dishwasher's chemical level during a cycle. V7 stated the facility uses a chemical dishwasher and the sanitation checks should be completed twice daily. Once in the morning and once in the evening. V7 stated the concentration should fall between 100-200 PPM with a testing strip for measurement and the facility staff should document the checks on the Dish Machine Sanitizer log. The facility's Dish Machine-PPM Sanitizer Record log dated September 2024 documents the dish machine sanitation checks were not completed on three mornings and not completed on 17 evenings throughout the month of September. This same record also documents October 1-21st 2024 checks were not completed on two mornings and 18 evening sanitation checks were not completed. The facility's Refrigerators and Freezers policy, dated 12/2014, documents This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked in cases and on individual items removed from cases for storage. Use by dates will be competed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Food Preparation and Service policy, dated 10/2017, documents Food and nutrition's services shall prepare and serve food in a manner that complies with safe food handling practices. The danger zone for food temperatures is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. This policy also documents Rapid Cooling. Potentially hazardous foods should be cooled rapidly. This is defined as cooling from 135 degrees Fahrenheit to 70 degrees within two hours and then to a temperature of below 41 degrees Fahrenheit within the next four hours. The total cooling time between 135 degrees and 41 degrees is not to exceed six hours. Large or dense foods may need special interventions in order to meet the time and temperature requirements for cooling. On 10/21/24 at 10:20 AM, the facility's walk-in freezer contained several opened plastic bags on shelves. These bags contained frozen french fries, onion rings, pork fritters and chicken strips. All four bags were without label indicating a date opened or a use by date. V7 (Dietary Manger) stated the kitchen staff should be putting those bags back in the boxes they came in and conformed they should all be labeled with dates for expiration purposes. This same freezer also contained multiple quart sized bags of frozen soup with various October dates on them. V7 confirmed the variety of soups were made in the kitchen this month and then frozen and will be used for the facility's Fall menu options. On 10/21/24 at 10:45 AM V7 provided the facility's October 2024 cool down logs for food prepared in the kitchen that needed cooling. This log did not document any cool down temperatures for the soups in the facility's freezer. On 10/21/24 at 10:50 AM, V9 (Cook) confirmed she made the soups that are in the freezer and stated, I didn't even think about doing cool down logs for those. On 10/21/24 at 10:52 AM, V7 confirmed V9 made the following soups that are stored in the freezer: Vegetable on 10/15/24, Potato on 10/17/24, Chili on 10/15/24, Broccoli Cheese on 10/16/24, and Taco Soup on 10/15/24. V7 also confirmed that V8 (Assistant Dietary Manager) made Oriental Soup on 10/18/24 and stored in the freezer. V7 verified she has no documentation to show temperatures of the soups during their cool down process and stated Cool down temperatures should have been done and documented. I will discard the bags of soup today. The facility's Long Term Care Application for Medicare and Medicaid dated 10/21/24 and signed by V1 (Administrator) documents 87 residents reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for residents with open wounds and indwelling urinary catheters for 10 of 10 residents (R1, R6, R20, R29, R49, R50, R54, R73, R81, and R143) reviewed for EBP in the sample of 36. Findings include: The facility's EBP (Enhanced Barrier Precaution) policy, undated, documents Policy Statement: EBPs are utilized to prevent the spread of MDROs (multi-drug resistant organisms) to residents. Policy Interpretation and Implementation: 1. EBPs are used as an infection prevention and control intervention to reduce the spread of (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. A. gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. PPE (Personal Protective Equipment) is changed before caring for another resident. C. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etcetera); and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. 10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside of the resident rooms. On 10/21/24 from 9:25 AM to 9:40 AM a tour was done of the facility. During this tour, no EBP signs were on any resident's door indicating they were in EBP. On 10/21/24 at 10:13 AM R6 was in his room sitting in his wheelchair with a urinary catheter bag attached underneath R6's wheelchair. No EBP sign was observed on R6's door or inside of R6's room, nor any PPE was noted inside or outside of R6's room. R6 stated, The staff do not wear gowns when provided catheter care to me or at any time. On 10/21/24 at 9:57 AM R49 was in her wheelchair in her room with a catheter bag secured underneath R49's wheelchair. No EBP sign was observed on R49's door or inside of R49's room, nor any PPE was observed inside or outside of R49's room. 32875 R54's current computerized medical record, documents R54 was admitted to the facility on [DATE] with a diagnosis of Urinary Tract Infection and Neuromuscular Dysfunction of Bladder. R54's MDS (Minimum Data Set) dated 7/31/24 documents a BIMS (Brief Interview for Mental Status) Score of 15/15, indicating (cognitively intact). R54 has an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 1:00 PM, V10/Licensed Practical Nurse/LPN stated that there is no-one on the second floor that requires Personal Protective Equipment/PPE to be worn when entering a resident's room or providing care. On 10/21/24 at 1:07 PM, there was no Enhanced Barrier Precaution/EBP sign on R54's door or inside of R54's room. There was no PPE available inside or outside of R54's room. On 10/21/24 at 1:07 PM, R54 stated that the staff do not wear any gowns when they do catheter care. 31682 On 10/21/24 at 10:54 AM R1 was in his room and had an indwelling urinary catheter draining yellow urine into a bag attached to the bottom of his wheelchair. R1 did not have EBP signs on his door, nor any PPE was noted inside or outside of R1's room. R1 stated, The staff do not ever wear a mask or gown when they are cleaning my catheter. On 10/23/24 at 10:18 AM V4/ADON/Infection Preventionist provided a list of residents who should have been placed in EBPs but were not. The list included the following residents: R1, R6, R20, R29, R49, R50, R54, R73, R81, and R143. V4 stated, None of these residents were placed on EBP on 10/21/24. On 10/23/24 at 10:25 AM V3/Assistant Director of Nursing (ADON)/Infection Preventionist stated she has been attempting to implement EBP for the past couple of months but has not been ensuring the EBPs are being implemented to residents who require EBP. V3 stated, I should be monitoring at least weekly residents who require EBP to ensure the signs are being put up, PPE is available inside or outside of the resident's rooms, and that staff are following the EBPs. I have not been doing this.