STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145844	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Montclare, The	2833 North Nordica Avenue Chicago, IL 60634

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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 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** 49486 Based on observations, interviews, and record reviews the facility failed to obtain a physician order and to determine if self-administration of medication was appropriate for one (R10) out of one resident observed with medications at bed side table in a sample of 22. Findings Include: On 3/11/25 at 11:32 AM, R10 received up in chair in bedroom alert and verbal on the phone. Surveyor observed one uncovered inhaler dispenser and nasal spray bottle on R10's bed side table. At 2:48 PM, R10 stated she has been having the inhaler and the nasal spray at her bed side for a long time since admitted to the facility. R10 stated that she uses the inhaler twice a day for wheezing and the nasal spray once a day for nasal congestion, and she uses the inhaler even when she does not have wheezing. At 2:50 PM, V4 (Licensed Practical Nurse/LPN) identified the medications as Ventolin HFA inhalation aerosol solution 108 (Albuterol Sulfate Inhaler 90 MCG/ACT) and Fluticasone propionate (nasal) bottle. V4 stated nurses should not leave medication at residents' bed side without a physician's order. V4 also stated that the medications should not have been left on R10's bed side table to prevent misuse or overuse. On 3/12/25 at 9:52 AM, R10 observed in bedroom with same medications at her bed side. V30 (Registered Nurse/RN) stated R10's medication should not be at bed side if there is no physician's order. On 3/12/25 at 10:38 AM, V2 (Director of Nursing/DON) stated that for any residents to keep medication at bed side for self-administration, there should be a medication self-administration safety assessment and a physician order. On 4/18/24 at 10:35 AM, V36 (LPN) stated V36 administered lidocaine patch to R5 around 5am and 6am on 4/16/24, V36 stated V36 did not leave the lidocaine patch at R5's bed side table and V36 could not remember leaving inhaler and the patch at R5's bed side table. V36 stated nurses should not leave any medications at bed side when there is no physician order. V36 stated another resident can take any medications left at bed side. R10's Minimum Data Set (MDS) dated [DATE] shows R10 to be cognitively intact. Medication Administration Record (MAR) as of 3/11/25 shows Lidocaine External Patch five percent, apply topically to lower back topically one time a day for mild pain of one to three, and Albuterol Sulfate Inhalation Aerosol Powder breath activated 108 (90 base MCG/ACT) inhale 2 puffs orally every six hours as needed for shortness of breath. No physician order for self-administration of medications was found. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Physician Order Sheet (POS) with active orders as of 4/16/24 shows Ventolin HFA inhalation aerosol solution 108 (Albuterol Sulfate Inhaler 90 MCG/ACT) 2 puffs inhale orally every 6 hours as needed for wheezing, and Fluticasone propionate (nasal) 1 spray in both nostrils one time a day for rhinorrhea, cough. POS do not show that resident can keep resident at bed side. R10's clinical records had no documentation showing she is safe to administer her own medication, and a review of her clinical records do not show a self-administration of medication assessment was completed. The facility policy titled, Medication Administration-General Guidelines dated 11/2021, read in part. Residents can self-administer medications when specifically authorized by the attending physician, and in accordance with procedures for self-administration of medications.

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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** 40061 Based on interviews and record reviews, the facility failed to refer a resident (R67) to the appropriate state-designated authority for a Preadmission Screening and Resident Review (PASRR) re-evaluation after new psychiatric diagnoses for one out of three residents reviewed for PASRRs. Findings include: R67's [DATE] Notice of PASRR Level I Screen Outcome documents in part that R67 did not require a Level II PASRR because R67 did not have severe mental illness, intellectual disabilities, or related conditions during the evaluation. It also documents in part that R67 did not have any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed during the evaluation. R67's Admission Record now documents in part diagnoses of anxiety disorder (onset date [DATE]), unspecified psychosis not due to a substance or known physiological condition (onset date [DATE]), and major depressive disorder, single episode, unspecified (onset date [DATE]). R67's Order Summary Report also documents in part medication orders for Escitalopram Oxalate (antidepressant) for major depressive disorder (order date [DATE]) and Risperidone (antipsychotic) for psychosis (order date [DATE]). On [DATE] at 2:01 PM, V1 (Administrator) stated V35 (Admissions Director) oversees initial/admission PASRRs but V39 (Social Service Director) is in charge of reviewing current PASRRs and re-doing expired PASRRs. V1 also stated that V40 (Regional Admissions Director) has been helping the facility catch up with residents' PASRRs. On [DATE] at 2:56 PM, V39 stated [V39] started with the facility in ,d+[DATE]. V39 has not started reviewing PASRRs; therefore, has not reviewed R67's PASRR. On [DATE] at 3:00 PM, V35 stated only handling admission/initial PASRRs. V35 stated V40 will take care of monitoring and updating expired PASRRs. V35 stated residents need PASRR re-evaluation after the current one expires or if the resident has new psychiatric issues or diagnoses. At the conclusion of the survey, facility did not provide a more recent PASRR evaluation for R67 besides the one from [DATE]. Facility's Policy: Admission Criteria (last facility review date of [DATE]) does not document in part procedures for re-evaluation/re-screening due to new diagnoses for mental disorders, intellectual disabilities, or related disorders.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observations, interviews, and record reviews the facility failed to ensure nail care was provided for three (R14, R27, and R31) residents who are dependent in grooming reviewed for Activities of Daily Living (ADL) in a total sample of 22. Findings Include: On 3/11/25 at 12:27 PM, R27 observed lying in bed alert, legally blind, and with dirty long nail that overgrown the fingers tip. R27 stated, she would like her fingernails to be cut but she cannot remember the last time the staff cut her fingernails. On 3/11/25 at 12:30 PM, V6 (Certified Nursing Assistant/CNA) stated that R27's fingernails are dirty, nasty, and too long. V6 also stated that the CNAs should be providing nail clipping care during shower twice a week and as needed. V6 stated that failure to cut the long nail, could cause R27 to scratch herself. On 3/11/25 at 12:35 PM, R14 observed up in chair in the dining room with dirty, very long fingernails overgrown the tips of his fingers. R14 could not remember when last he had a nail cut. V5 (licensed Practical Nurse/LPN) stated that the CNAs are responsible for the fingernail care, and that R14 fingernails are too long, dirty and he could get sick from eating with dirty fingernails. On 3/11/25 at 12:45 PM, R31 observed up in chair in the bedroom, alert, verbal with very dirty long fingernails that overgrown the tips of her fingers. She also stated that she would like her nails to be cut when the staff is ready. Surveyor contacted V4 (LPN) stated the fingernails care should be done by the CNAs with shower twice a week and as needed. V4 also stated that R31's fingernails are dirty with food debris, long, and the nail should have been cut. V4 stated that R31 tends to refuse care, but when V4 asked if she would like her nails to be cut halfway? R31 stated yes. V4 stated V4 will follow up. On 3/12/25 at 10:30 AM, V36 (Scheduler/CNA Supervisor) stated that it is V36's expectation that CNAs are providing nail care for all residents on their shower days and as needed because it is part of their grooming and personal hygiene. On 3/12/25 at 10:38 AM, V2 (Director of Nursing/DON) stated that it is V2's expectation that CNAs are cutting residents' fingernails and not toenails on shower days. V2 also stated that nail care is part of ADL grooming. On 3/13/25 at 9:10 AM, V1(Administrator) stated that the facility has no policy for nail care because it is part of the ADL grooming. R14, R27, and R31's Minimum Data Set (MDS) dated [DATE], 1/15/25, and 2/5/25 functional abilities assessment shows R14, R27, and R31 requires moderate to maximum assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for ADL dated 5/22/24, read in part: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview and record review, the facility failed to ensure low air loss mattress devices were on the correct weights setting for residents (R28, R29) with current pressure ulcer and for residents (R6, 91) who are at risk in developing pressure ulcers. This failure has the potential to affect four (R6, R28, R29, R91) out of four residents reviewed for pressure ulcer care in a final sample of 22. Findings Include: On 3/11/2025 at 11:15 AM, R91 was lying in bed and noted on a low air loss mattress with the weight dial on the machine set to 400 pounds. R91's Minimum Data Set (MDS) dated [DATE] shows R91 requires staff assistance with positioning in bed. R91's BRADEN scale dated 2/20/25 shows R91 is at risk in developing skin breakdown. R91's weight records show R91 weighs 136.6 pounds dated 3/5/25. On 3/11/2025 at 11:20 AM, R6 was sleeping in bed and noted on a low air loss mattress with the weight dial on the machine set to 350 pounds. R6's MDS dated [DATE] shows R6 requires staff assistance with positioning in bed. R6's BRADEN scale dated 12/6/24 shows R6 is high risk in developing skin breakdown. R6's weight records show R6 weighs 230 pounds dated 3/10/25. On 3/11/25 at 11:49 AM, R29 was sleeping in bed and noted on a low air loss mattress with the weight dial on the machine set to 400 lbs. R29's MDS dated [DATE] shows R29 requires staff assistance with positioning in bed. R29's skin progress notes dated 3/10/25 shows R29 has multiple pressure ulcers. R29's weight records show R29 weighs 137 pounds dated 3/5/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 10:14 AM, interviewed V9 (Wound Care Licensed Practical Nurse) and stated that residents who are at risk for developing pressure ulcers are placed on a low air loss mattress as preventative measure especially for those who needs assistance with positioning in bed. V9 stated that residents with current pressure ulcers are also placed on a low air loss mattress to help with wound healing to relieve pressure on the wound. V9 stated that the low air loss mattress should be set based on the current weight of the resident. V9 stated the low air loss mattress relieves pressure from the bony prominences, regulate pressure on specific areas of the body, and if it's not in the right setting that would deplete the purpose of the low air loss mattress. The restorative and the nurse should check the correct setting every shift. V9 stated that the facility uses a BRADEN scale to assess a resident for risk of skin breakdown. V9 stated R91 has no current wound but had history of having pressure ulcers on his sacrum. R91 is at risk for skin breakdown. R91 is on low air loss mattress for prevention of skin breakdown. R91 needs assistance with turning and repositioning. V9 stated R91's current weight is 136.6 pounds taken on 3/15/25. V9 stated 400 pounds setting for R91'sow air loss mattress is incorrect. V9 stated R29 is high risk for skin breakdown and has current pressure ulcer on her left heel. R29 is also requiring assistance with turning and repositioning. R29's current weight for is 137.0 pounds on 3/5/25. V9 stated if the dial is pointing to 400 pounds that is not the right setting for R29's low air loss mattress. V9 stated R6 is high risk for skin breakdown and is completely immobile. R6's current weight is 230.0 pounds on 3/10/25. V9 stated if the weight dial is pointing to 350 pounds that is not the right setting for the low air loss mattress. The facility's Wound Prevention and Healing policy dated 6/1/24 documents in part: Braden scale will be completed to determine the patient's level of risk and implement interventions to prevent development of pressure injuries. The facility's Skin Management: Specialty Mattress policy dated 6/24 documents in part: Settings will be observed every shift to ensure mattress is functioning properly. 49486

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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** 44103 Based on interviews and records reviews, the facility failed to follow a resident's (R95) fall care plan intervention and physician recommendation with multiple history of falls to ensure soft head helmet was applied while in bed for 1 (R95) out of 1 resident reviewed for falls. This failure resulted in R95 sustaining a left subdural hematoma after falling and hitting head on the floor on 2/4/25. Findings Include: R95's clinical records show an initial admitted [DATE] with included diagnoses but not limited to anxiety disorder, traumatic subdural hemorrhage, other lack of coordination, other abnormalities of gait and mobility, and epilepsy. R95' Minimum Data Set (MDS) dated [DATE] shows R95 has moderate cognitive impairment and is dependent with staff assistance on toileting, positioning in bed, personal hygiene, and dressing. R95's Witnessed Fall dated 2/4/25 at 7:10 PM documented by V9 (Wound Care Licensed Practical Nurse) reads in part: Writer alerted by CNA [Certified Nursing Assistant]/Staff that the resident was in her room attempting to walk without assistance and she fell hitting her left side of her head onto the floor as well as her left side of her body. Patient was in low bed with floor mat next to the bed. Resident unable to give description. R95's progress notes dated 2/5/25 at 6:10 AM documented by V38 (Licensed Practical Nurse) revealed R95 was sent to the hospital and was admitted for Acute chronic subdural hematoma. R95's hospital records HISTORY OF INJURY Event/HPI [History of Present Illness] dated 2/5/25 documents in part: [AGE] year-old female presents as a level 2 trauma transfer from outside hospital after mechanical fall at facility. She was walking, lost her balance, and struck the left side of her head. Denies loss of consciousness. She was transferred to our hospital for a left subdural hematoma. SICU (Surgical Intensive Care Unit admitted [DATE] brief HPI revealed R95 suffered from a mechanical fall and sustained an acute on chronic left frontal subdural hematoma. R95's fall risk assessment dated [DATE] shows R95 is moderate risk for falling. This fall risk assessment also shows R95 has inadequate vision, exhibits loss of balance while standing, requires hands on assistance to move from place to place, had history of falls in the past six months, and on psychotropic and sedative/hypnotic medications. R95's fall care plan initiated on 3/11/24 documents in part: [R95] had an actual fall with [NAME] balance, unsteady gait, and poor safety awareness with one fall intervention initiated on 3/14/24 that reads: Soft head helmet while resident is bed or during therapy session. R95's fall care plan also revealed R95 had multiples falls (more than 5) in the last six months. R95's progress notes dated 1/18/25 at 1:11 PM documented by V43 (R95's Physician) revealed R95 had history of skull surgery, wear helmet every shift, fall precautions, and aspiration precautions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/11/25 at 12:33 PM, R95 was sitting on her wheelchair in the dining room with soft helmet on, alert and verbally responsive with forgetfulness. When Surveyor asked about the fall incident that happened on 2/4/25, R95 stated, I don't remember how I fell . They sent me to the hospital. I just woke up and I was in the hospital. R95 stated she has to wear her helmet all the time according to the doctor, but she does not know the reason why. On 3/11/25 at 3:08 PM, interviewed V2 (Director of Nursing/Falls Nurse) and stated that fall interventions in the resident's care plan are initiated and implemented based on the root cause of the resident's previous falls, the fall assessments, and based on the needs of the resident. V2 stated that care plans are individualized and updated accordingly. V2 stated that the purpose of the fall care plan interventions is for the resident to avoid more falls in the future and for the staff to know what to do for the resident. V2 stated that frontline staff is aware of the residents' care plan interventions and all interventions in the care plan should be implemented and followed by the staff on the floor working with the resident. On 3/12/25 at 10:14 AM, interviewed V9 about R95's fall incident on 2/4/25. V9 stated, it happened between 7:10 PM to 7:15 PM. V9 was sitting at the nurse's station doing documentation. V22 (Former Certified Nursing Assistant) alerted V9 that [R95] was on the floor. V9 stated she went inside R95's room and saw R95 lying on the floor beside the floor mattress without her soft helmet on and call light was off. V9 stated R95 hit her head but denied pain and no visible injuries upon V9 assessment on R95. V9 stated that when R95 is in bed, her helmet can come off and only being applied back on when R95 is up on her wheelchair. V9 stated the last time she saw R95 was around 6:30 PM when V22 was wheeling R95 on a wheelchair back in her room to put R95 in bed. V9 stated R95 was sent to the hospital because she hit her head and needed to be evaluated. V9 stated R95 is high risk for falling, has unsteady gait, will get up without asking for help, and needs constant monitoring and re-education. On 3/12/25 at 11:29, a phone interview was conducted with V21 (Medical Director/R95's Physician) and stated that R95 is very impulsive and had multiple falls that happened by falling off from the bed. V21 stated R95 should be wearing the soft helmet while in bed to minimize injury. V21 stated R95 had brain surgery, her skull was taken out and was put back eight months ago. V21 stated R95's skull is not intact and wearing soft helmet could minimize injury. V21 stated if R95 falls and hit her head without the soft helmet, she is high risk for severe injury on the head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/12/25 at 11:52 AM, a phone interview was conducted with V22 about R95's fall incident on 2/4/25. V22 stated she remembers R95 to be alert but with forgetfulness and confusion at times. V22 stated, Sometimes [R95] knows how to use the call light sometimes she forgets. [R95] has the tendency to get up by herself all the time without calling for help. [R95] is high risk for falls. [R95] had multiple history of falls before. [R95] needs one staff assistance to get up from bed and she's incontinent, but sometimes she goes to the toilet with staff assistance if she's up in the chair. When I put [R95] to bed I don't put her helmet on. I only put it on when she's [R95] up in the wheelchair. On 2/4/25 after dinner at around 6:30 PM I put [R95] to bed she told me she was tired. [R95] did not tell me she was ready to sleep, she just told me she's tired. The last time I saw her [R95] was about 6:40 PM she was lying in bed awake watching TV [television]. [R95] was not wearing her helmet because we don't put the helmet on while she's in bed. I changed her [R95] diaper around 6:30 PM and I made sure her call light was within reach. So around 7:00 PM I was rounding because I always look at the fall risk rooms. I saw [R95] walking in circles in her room texting on her cellphone. As soon I saw that I went inside the room to put her [R95] back in bed but then she [R95] fell right in front of me. [R95] lost her balance. [R95] was not wearing her helmet and stood up by herself without asking for help. [R95] fell directly on the floor and hit her head. I think it was her [R95] left side of her head. I went to get the nurse [V9] right away. [V9] assessed [R95] and 911 sent her to the hospital. On 3/13/25 at 9:40 AM, a phone interview was conducted with V38 (Licensed Practical Nurse) and stated that she called the hospital in the morning of 2/5/25 and was informed that R95 was admitted for subdural hematoma. The facility's Fall Prevention and Management policy dated 4/8/24 documents in part: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. A comprehensive falls care plan is developed. Development of the fall interventions plan is based on results of the Falls Assessment as well as investigation of all circumstances and related resident outcomes. Facility will initiate monitoring of interventions for residents who fall in the facility and with history of fall, who trigger the Falls CAA, and when a resident falls. Frequency and duration of monitoring of interventions will be based on current risks.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview and record review, the facility failed to ensure (a) oxygen and nebulization tubing were dated / changed; (b) BiPAP (Bilevel Positive Airway Pressure) and CPAP (Continuous Positive Airway Pressure) masks, oxygen and nebulization tubing were properly stored when not in used; and (c) obtain physician orders for use of BiPAP and CPAP. These failures affected four (R48, R61, R66, R86) out of four residents reviewed for respiratory care in a sample of 22. The findings include: R61's admission record showed admitted on 2/14/23 with diagnoses not limited to Unspecified atrial fibrillation, Acute on chronic systolic (congestive) heart failure, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease. On 3/11/25 at 11:28 AM R61's room door signage indicated oxygen in use. Observed R61 lying in bed on moderate high back rest, alert and verbally responsive. Stated she has been residing in the facility for 2 years. Stated she was using oxygen and nebulization before, not able to recall when the last time she used it. Observed oxygen cannula and nebulization tubing at bedside not dated, tubings were hanging freely, touching the floor and not stored properly. On 3/11/25 at 11:32 AM Surveyor requested V4 (Licensed Practical Nurse / LPN) to R61's room and stated R61 is using oxygen as needed, unable to recall when the last time she used it. V4 said oxygen tubing should be changed at least weekly every Sunday at night shift and should be dated once changed. She said oxygen tubing and nebulization tubing should be stored in plastic bag when not in use to prevent contamination. On 3/11/25 At 3:00 PM V2 (DIRECTOR OF NURSING / DON) stated she has been working in the facility for over a year. She said oxygen and nebulization tubing should be changed weekly and as needed and should be dated once changed to know when it was changed last. V2 said oxygen tubing, neb tubing, CPAP / BIPAP tubing and mask should be stored properly in a clear bag when not in use to keep it clean. V2 said use of CPAP and BIPAP should have a physician order in resident's record. R61's order summary report dated 3/11/25 showed active order not limited to: Administer PRN (as needed) oxygen at 2/L if o2 sat is below 94% at room air, as needed for SOB/oxygen saturation below 94. Place 2 Liters of oxygen if saturation if goes below 93%. Care plan dated 4/19/24 showed in part: R61 has oxygen therapy at 2/L if O2 (oxygen) saturation is below 94% at room air PRN related to CHF (Congestive Heart Failure). MDS (Minimum Data Set) dated 2/10/2025 showed R61's cognition was intact. Facility's care and cleaning of respiratory equipment policy dated 11/11/24 showed in part: Disposable respiratory equipment will be replaced on a scheduled basis in order to minimize the risk of nosocomial infection. Nasal cannulas are changed weekly and as needed. Respiratory tubings, masks will be secured or placed in a container, original package or bag. (continued on next page)

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	145844	A. Building B. Wing	03/14/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44103 On 3/11/25 at 9:36 AM, R48's resting in bed alert and able to verbalize needs. Surveyor noted R48's BiPAP mask on the floor connected to the machine not stored inside a bag. R48 stated she uses the BiPAP at night for sleep apnea. R48's face sheet has included diagnoses but not limited to obstructive sleep apnea and morbid obesity. R48's Minimum Data Set (MDS) dated [DATE] shows R48 is cognitively intact and requires staff assistance with her activities of daily living (ADL). R48's order summary report printed on 3/11/25 does not show any order for her BiPAP. On 3/11/25 at 11:37 AM, R66's lying in bed noted on oxygen at 4 liters per minute via nasal cannula. R66's oxygen tubing had no date when it was last changed. R66's nebulizer treatment was not in used sitting on R66's nightstand with the mask had no date when it was last changed and not inside a clear bag. Surveyor also noted R66's CPAP mask not in use and not stored inside a bag. R66 stated she uses her CPAP at night. R66's face sheet has included diagnoses but not limited to chronic obstructive pulmonary disease and Parkinson's disease. R66's MDS dated [DATE] shows R66 is cognitively intact and requires staff assistance with her ADLs. R66's order summary report printed on 3/11/25 documents in part: oxygen, continuous, at 4-5 liters/minute via nasal cannula, but no order for her CPAP. 49486 Resident #86 Respiratory Care 03/14/25 02:30 PM Findings Include: R86's Electronic Medical Record (EMR) revealed R86 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: encounter for palliative care, rhabdomyolysis, anemia, malignant neoplasm of large intestine, and malignant neoplasm of colon. On 03/11/25 at 10:34 AM, surveyor and V4 (License Practical Nurse/LPN) entered R86's room, observed her Oxygen Nasal Cannula on oxygen concentration tank, not dated and not in a plastic bag when not in use. V4 stated R86's oxygen nasal cannula tubing should have been contained in a plastic bag when not in use to prevent her from breathing in germs like bacteria, and the oxygen nasal cannula tubing should have been dated so that staff will know when next it should be changed. On 03/12/25 at 10:38 AM, V2 (Director of Nursing/DON) stated, it is V2's expectation that nurses will change oxygen tubing weekly, date and keep oxygen nasal cannula tubing in a plastic bag when not in use to prevent exposure to germs, maintain good hygiene, and prevent infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R86's Minimum Data Set, dated dated dated [DATE] shows she is cognitively impaired. Physician Order Sheet (POS) with active orders as of 3/11/25 shows an order for Oxygen at 2 liters/minute for shortness of breath/SOB via nasal cannula. Change oxygen tubing every weeknight shift, every Sunday.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Resident #37 Accidents PLEASE SEE F700 CITATION FOR DETAILS. Resident #41 Accidents F700 Based on observation, interview and record review, the facility failed to ensure the appropriate side rails were used, evaluate the use of side rails quarterly and develop plan of care for use of side rails for four (R37, R41, R61 and R63) out of four residents reviewed for accident / hazard in a sample of 22. The findings include: 1. On 3/11/25 at 11:11 AM Observed R63 Lying in bed, alert and verbally responsive, both upper bed / side rails were up. R63's admission record showed admitted on 2/21/2023 with diagnoses not limited to Alzheimer's disease, Essential (primary) hypertension, Heart failure, Obstructive sleep apnea (adult), Nonrheumatic aortic (valve) stenosis. No care plan found for bed / side rail use in R63's EHR (electronic health record). R63's last side rail assessment was dated 10/25/24 showed in part: 1/4 rails due to weakness. MDS dated [DATE] showed R63's cognition was severely impaired. She needed supervision or touching assistance with oral hygiene; Dependent with toileting hygiene, shower / bathe self, lower body dressing, chair / bed transfer; Partial / moderate assistance with upper body dressing, Substantial / maximal assistance with personal hygiene. 2. On 3/11/25 at 11:28 AM Observed R61 lying in bed on moderate high back rest, alert and verbally responsive, both upper bed / side rails were up. R61 appears comfortable and well groomed, alert and verbally responsive. R61's admission record showed admitted on 2/14/23 with diagnoses not limited to Unspecified atrial fibrillation, Acute on chronic systolic (congestive) heart failure, Hypertensive heart and chronic kidney disease with heart failure. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No care plan found for bed / side rail use in R61's EHR. R61's last side rail assessment was completed on 11/12/24 showed in part: 1/4 rails due to generalized weakness. MDS dated [DATE] showed R61's cognition was intact. She needed Partial or moderate assistance with oral and personal hygiene; Dependent with toileting hygiene, shower / bathe self, lower body dressing, Substantial / maximal assistance with upper body dressing, chair / bed transfer. 3. On 3/11/25 at 11:49 AM Observed R41 lying in bed, alert and verbally responsive both upper bed / side rails were up. R41's admission record showed admitted on 11/1/2014 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Type 2 diabetes mellitus, Atrial fibrillation, Vascular dementia, Contracture left hand, Essential (primary) hypertension. R41's last side rails assessment was dated 10/11/24 showed in part: 1/4 rails due to weakness. No care plan found for side / bed rail use in R41's EHR (electronic health record). MDS dated [DATE] showed R41's cognition was intact. She needed supervision or touching assistance with oral hygiene, Dependent with toileting hygiene, shower / bathe self, lower body dressing, chair / bed transfer; Substantial / maximal assistance with upper body dressing; Partial / moderate assistance with personal hygiene. 4. On 03/11/25 at 11:58 AM Observed R37 lying in bed, alert and verbally responsive, both upper side / bed rails were up. R37's admission record showed admitted on 6/10/2024 with diagnoses not limited to Benign neoplasm of meninges, Encounter for palliative care, Cerebral infarction, Hemiplegia, Hypertensive heart disease without heart failure, Atherosclerosis of aorta, Other seizures, Rheumatoid arthritis, Scoliosis, Acquired absence of lung. No care plan found for side / bed rails use in R37's EHR. R37's last side rails assessment was dated 9/16/24 and showed in part: 1/4 rails due to generalized weakness and assist in positioning. MDS dated [DATE] showed R37's cognition was severely impaired. She needed partial / moderate assistance with eating, oral and personal hygiene, upper body dressing, Dependent with toileting hygiene, shower / bathe self, lower body dressing, chair / bed transfer. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 At 3:00PM V2 (DIRECTOR OF NURSING / RESTORATIVE NURSE) stated she has been working in the facility for over a year and overseeing restorative. She said use of side rails for resident should be assessed upon admission / readmission, quarterly, or significant change to determine if side / bed rails is use for repositioning or assisting self to get up in bed or to promote more independence in bed mobility. V2 stated the purpose of side rail assessment is to determine if the resident need side rails and resident utilizes it. She said side rail assessment should be reviewed quarterly and as needed to know if resident still need it. V2 said there should be a care plan for side rail use. Stated care plan directs staff on how to care for the resident. Surveyor reviewed R37, R41, R61 and R63' EHR with V2 and stated their side rail assessments were not reviewed quarterly and there were no care plan found for use of side / bed rails. Facility's bed or side rails policy dated 10/22/21 showed in part: provide adequate management of bedrails to ensure resident attain or maintain the highest practicable physical, mental and psychosocial well-being. Use of bed / side rails will be discussed with IDT (Interdisciplinary team) to initiate and implement plan of care. Plan of care will be reviewed, revised, and or updated. Resident #61 Accidents PLEASE SEE F700 CITATION FOR DETAILS. Resident #63 Accidents PLEASE SEE F700 CITATION FOR DETAILS.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44103 FACILITY Medication Administration F759 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate of less than 5% for 1 (R51) of 3 residents reviewed for medication administration. There was a total of 32 opportunities with 2 errors observed, which resulted in a medication error rate of 6.25%. Findings Include: On 3/11/25 at 9:45 AM, after V8 (Registered Nurse) checked R51's blood pressure and heart rate, V8 started to prepare R51's morning medications. V8 started R51's nebulizer treatment Ipratropium-Albuterol and then prepared the oral pills Amlodipine 10 mg, Ferrous Sulfate 325 mg, Finasteride 5 mg, Fluoxetine 20 mg, Folic Acid 1 mg, Nebivolol 10 mg, Oxybutynin 5 mg, Senna 1 tablet, Sodium Bicarb 650 mg, and Vitamin B12 1000 mcg. At 9:56 AM, R51's nebulizer treatment was completed and took all his oral pills. At 9:57 AM, V8 stated she completed R51's medication pass and signed the Electronic Medication Administration Record (EMAR) indicating R51's medications were administered. R51's 3/11/25 Medication Administration Record (MAR) shows Advair Diskus Aerosol Powder 1 puff inhaler and Lisinopril 20 mg 1 tablet by mouth to be given to R51 scheduled on DAY1 (between 7:00 AM to 11:00 AM). R51's Medication Administration Audit Report documents in part a 7:00 AM dose of Advair Diskus Aerosol Powder 1 puff inhaler and Lisinopril 20 mg 1 tablet by mouth that were documented administered at 9:57 AM by V8. Surveyor did not see V8 administer these medications during the medication administration observation with R51 on 3/11/25 completed at 9:57 AM. On 3/11/25 at 3:08 PM, interviewed V2 (Director of Nursing) and stated that for medication administration, the nurses should be following the right resident, right route, right medication, right time, and right dose. V2 stated nurses are supposed to be following physician orders when administering medications to the residents. V2 stated that after a resident takes their medications, the Nurses are documenting the time they administered the medications in the EMAR. V2 stated that they have to document what are given, what's missed or refused. The facility's Medication Administration policy dated 8/1/24 documents in part: An order is required for administration of all medication. Check medication administration record prior to administering medication for the right mediation, dose, route, patient and time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40061 Based on observations, interviews, and record reviews, the facility failed to follow their menu and failed to follow cooking instructions. This affected all 108 residents receiving nutrition from the kitchen. Findings include: Surveyor conducted an initial kitchen tour with V11 (Dietary Manager) on 3/11/2025 at 9:03 AM. At 9:29 AM, there were multiple boxes of pies sitting on the kitchen counter. V11 stated the pies were frozen and are defrosting for lunch. Facility's Week at a glance menu documents in part that the facility was to serve lemon meringue pies for lunch on 3/11/2025. At 11:40 AM, V14 (Cook) began plating the lunch meal for the residents. Did not observe V14 slice or plate any pies. V11 stated the dessert for lunch was now a 4-ounce serving of pears. Later that day, V11 stated that the pies did not defrost in time for the lunch meal and the facility could not serve them. During a Resident Council meeting on 3/12/2025 at 1:24 PM, R67 and R88 stated that the facility does not follow the menus. R88 stated the menu will say one thing but the facility will serve a different food item instead. Facility's undated Accuracy of Quality of Tray Line Service policy documents in part: The director of food and nutrition services or designee will be responsible for assuring that all foods needed for meal assembly are present at the appropriate time. Tray line and/or meal service positions for breakfast, lunch and dinner will be planned and determined: according to the menu. The meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu. -- On 3/12/2025 at 10:01 AM, V14 (Cook) started the pureed mashed potatoes. Surveyor asked how many portions V14 was going to make. V14 asked V11 (Dietary Manager) how many residents were on pureed diet. V11 answered about 15 residents. V14 grabbed a deep pan and filled it halfway with regular water. Surveyor asked how much water was in the pan. V14 did not know. Surveyor asked the capacity of the pan and V14 did not know. V11 stated it was a 6-inch pan. V11 stated the facility uses powdered mashed potatoes and V14 only needs to reconstitute it. V14 opened the lid of the mashed potato granules and started pouring unmeasured amounts of it into the water. V14 stirred it with a whisk and then added more granules until V14 got a pureed consistency. V14 did not add salt. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the label on the mashed potato container. It documents in part that for 35 servings, the preparer should use a fourth of the can or 3 cups of the granules with three quarts water and two teaspoon salt. Instructions read to use boiling water and mix on low and slowly add all potato granules over one minute.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40061 Based on observations, interviews, and record reviews, the facility failed to follow physician orders for nectar-thick liquids for one resident (R40) out of a total sample of 22 residents. Findings include: R40's Order Summary Report documents in part an active diet order for nectar-thick consistency for liquids (order date 2/26/2024). R40's Care Plan Report documents in part that R40 has swallowing/chewing difficulties and requires mechanically altered diet with thickened liquids (last revised 1/09/2025). Intervention initiated on 1/09/2025 documents in part to Provide and serve diet as ordered. On 3/11/2025 at 12:15 PM, V15 (Certified Nurse Aide) assisted R40 with lunch meal. R40 had a 114-milliliter carton of apple juice with lunch meal. V15 fed the apple juice thin and not nectar thick to R40. Facility's undated Accuracy of Quality of Tray Line Service policy documents in part: All meals will be checked for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal to the individual. The meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu. Staff will refer to the meal identification (ID) card/ticket for food dislikes, allergies and other details and substitute appropriately for those items. Each meal will be check for correct name, room number, and diet order.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 46342 Based on observations, interviews, and record reviews, the facility failed to provide oral supplements on meal trays as part of the therapeutic diet prescribed by the physician for five (R15, R32, R40, R92, R106) residents reviewed for dining services in a total sample of 22. Finding include: R15, R32, R40, R92, R106's Order Summary Reports document in part dietary supplement order for High Calorie Frozen Dessert to be given at lunch. R15, R32, R40, R92, R106's lunch meal tickets document in part for Frozen Nutritional Treat to be served as a daily item. R15, R32, R40, R92, R106's nutrition care plan documents in part, provide and serve supplement as ordered and/or as needed. On 03/11/25 at 11:45 AM, observed R106 eating lunch in main dining room. R106 did not receive a High Calorie Frozen Dessert (Frozen Nutritional Treat) on her tray. R106 said, I didn't get it today and I don't get it every day, only sometimes. On 03/11/25 at 12:35 PM, V19 (R32's Guardian) stated she had fed R32 lunch and there was no Frozen Nutritional Treat on R32's lunch tray. V19 showed surveyor R32's lunch tray. There was no Frozen Nutritional Treat on it. V19 stated she feeds R32 on a regular basis and cannot remember if she has seen the Frozen Nutritional Treat on R32's lunch tray or not. On 03/11/25 at 12:40 PM, V13 (Dietary Aide) stated she was serving lunch in the main dining room and did not give out any Frozen Nutritional Treats. V13 said, I have not seen those in a couple of days. I think we are waiting for a delivery. If the kitchen had the Frozen Nutritional Treats, I would have given them out. On 03/11/25 at 12:50 PM, V11 (Dietary Manager) stated the kitchen receives orders for Frozen Nutritional Treats based on the doctor's orders. V11 stated once she receives the order the item gets added to the residents' meal ticket so the staff knows who to give the supplement to. V11 stated the kitchen has Frozen Nutritional Treats in stock. V11 showed surveyor inside freezer and observed 12 cases of Gelato High Calorie which V11 stated is what they serve as the Frozen Nutritional Treat. Cases were dated 1/21. V11 stated that is the date the cases were delivered. V11 stated she does not know why the supplements were not given out. V11 stated they have enough in stock so they should have been given out. V11 stated the Frozen Nutritional Treats are used for residents who need extra calories so the potential problem of the residents not receiving the supplements is that they could lose weight. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/25 at 11:52 AM, V33 (Registered Dietitian) stated oral supplements are ordered by the doctor and are considered to be part of the resident's therapeutic diet. V33 stated that some of the reasons she might put someone on an oral supplement could be to increase calorie intake because weight loss has occurred, or if they are not eating well to prevent weight loss, or for wound healing if they require more calories and protein. V33 stated the Frozen Nutritional Treats should be given as ordered by the doctor and the potential problem of the supplement not being given is that weight loss can continue or occur and/or the resident's wound may not heal because wounds require energy and protein for healing. V33 stated R32 is underweight and has a poor appetite. V33 stated R106 has a pressure ulcer and needs extra calories and protein for wound healing. Facility provided list of residents with physician orders for Frozen Nutritional Treat dated 03/11/25 including R15, R32, R40, R92, R106. Facility provided policy titled, Fortified Foods/Supplements undated which documents in part, Fortified foods and supplements are used to promote adequacy of the diet as a nutrition intervention for at risk patients/residents and patient/residents who are at nutritional risk are considered for fortified foods/supplements to increase their overall calorie and nutrient intake. Facility provided policy titled, Accuracy of Quality of Tray Line Service undated which documents in part, the director of food and nutrition services or designee will be responsible for assuring that all foods needed for meal assembly are present at the appropriate time and each tray will be checked for food and beverage preferences, allergies, intolerances and special food requests. 40061 Findings include: On 3/11/2025 at 12:15 PM, V15 (Certified Nurse Aide) assisted R40 with lunch meal. V15 stated R40 did not get a high calorie frozen dessert with the meal. V15 stated [V15] hasn't seen any high calorie desserts in a while. V15 stated usually assisting R40 with meals. V15 stated during the times V15 fed lunch to R40, R40 has not received the high calorie frozen dessert. On 3/11/2025 at 12:18 PM, R92 sat at a lunch table on own. R92's lunch meal did not include a high calorie frozen dessert. On 3/11/2025 at 12:33 PM, V11 (Dietary Manager) stated R40 and R92 are supposed to get a high calorie frozen dessert based on the residents' meal tickets. V11 does not know why kitchen staff failed to provide them to R40 or R92. On 3/11/2025 at 12:50 PM, R40 had a high calorie gelato sitting on the table in front of R40. Staff was not present to assist R40 eat it. At 1:00 PM, V16 (Certified Nurse Aide) stated [V16] wasn't aware that R40 needed the high calorie frozen dessert or that it was physician ordered due to R40's nutritional risk and weight loss.

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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** 40061 Based on observations, interviews, and record reviews, the facility failed to follow their policies and dispose of food items past their expiration/best buy/use by dates, label opened food item, store food and food related items away from cleaning solutions, perform hand hygiene during dishwashing, and cover prepared food to prevent contamination. This has the potential to affect all 108 residents that receive nutrition from the kitchen. Findings include: On [DATE] at 9:03 AM, surveyor conducted an initial tour of the kitchen and food storage areas with V11 (Dietary Manager). During the tour of the facility's dry goods stock room on [DATE] at 9:05 AM, there was a gallon of maraschino cherries that expired on [DATE] in the bottom shelf. In the same bottom shelf, there was an opened jug of soy sauce with the 'best by' date of [DATE]. The label reads to refrigerate after opening. V11 did not know it had to be refrigerated. In the same bottom shelf, there was an additional jug of unopened soy sauce with a 'best by' date of [DATE]. There was also an unopened gallon of Caesar dressing with a 'use by' date of [DATE]. V11 stated that the facility's policy is to move all the old stock to the front of the shelves and the incoming stock to the back of the shelves. V11 stated V42 (Dietary Aide) and the other kitchen staff are supposed to check all the labels and toss the expired items. V11 stated when there is no written expiration date, the facility follows the 'use by' or 'best by' date to discard them. In a separate shelf there was an opened clear bag with brown powder inside it. The bag was tied manually and did not have a label. V11 stated it was brownie mix. V11 stated staff were supposed to label the bag when they opened it. In the back of the dry storage room, there was a shelf against the wall perpendicular to the large can racks against the window (contained cans of fruits). In the bottom shelf, there were opened bags of food lids next to two 1-gallon bottles of bleach cleaning solution. V11 stated the lids were for cups and bowls used during residents' meals. Additionally, underneath the shelf (resting on the floor), there was a case of six 1-gallon bottles of bleach cleaning solution. On [DATE] at 9:21 AM, V12 (Dietary Aide) and V13 (Dietary Aide) were cleaning up the breakfast trays. V12 was tossing the food waste and handing over the trays, dishes, and utensils to V13. V13 loaded the dirty dishes through the hot-temperature dishwasher. V13 then pulled out the washed trays, dishes, and utensils out the other end of the dishwasher without performing hand hygiene or changing gloves. V13 touched the clean dishes with the same dirty gloves throughout the washing process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:29 AM, there was coffee grounds in a coffee liner lying on top of the metal table next to the coffee machine. The coffee grounds were open to air and located next to two buckets with solution. V11 stated the kitchen staff uses the buckets to sanitize and clean the kitchen. V11 stated staff opened the coffee grounds that morning and shouldn't have left them out next to the sanitation station. V11 verbally acknowledged that there could be cross contamination from the cleaning solutions splashing on the coffee grounds. The open coffee grounds remained on top of the metal table during return observations later that day at 11:40 AM. During the initial tour, there were also trays of uncovered, pre-portioned pears on the top counters. V11 stated they were 4-ounce servings of pears that one of the dietary aides prepared earlier that morning. Facility will serve them for lunch. The facility's heating and air conditioning unit was blowing over the uncovered pears. The pre-portioned pears were on the counter uncovered during return observations later that day at 11:40 AM. On [DATE] at 9:36 AM, V11 took the surveyor to the basement where the facility's walk-in refrigerator and freezer were located. In the refrigerator, there was a box of cucumbers in one of the top shelves. Multiple cucumbers were mushy, soft to touch, and had multiple black spots. V11 took the box out and stated staff should have tossed them out. In the freezer, there was a large, opened bag of ice in the bottom, left shelf. There was ice recrystallization (freezer burn) throughout the ice block. V11 stated the large bag of ice was there when V11 started working for the facility, which was seven months ago. V11 does not know what the facility used it for or why the facility purchased it. On [DATE] at 11:40 AM, V14 (Cook) started serving food from the kitchen tray line. Did not observe V14 check the temperatures of the food prior to plating. V11 showed the surveyor the kitchen's daily food temperature logs. The form for the current meal was empty. Surveyor asked V11 if V14 took the food temperatures. V11 did not know and asked V14. At 11:47 AM, V14 stated taking the temperatures prior to surveyor's arrival (before 11:30 AM) but forgot to write them down. Facility's undated General Infection Control in Dining Services policy documents in part: The Dining Department follows all local, state and federal regulations in order to assure a safe and sanitary department. Facility's undated Food Storage policy documents in part: All food stock and food products are stored in a safe and sanitary manner. All food stock is dated and used on a first in, first out basis. Facility's Labeling and Dating policy (last reviewed [DATE]) documents in part: Leftovers and opened foods shall be clearly labeled with date food item is to be discarded. Food items to be labeled and dated include items prepared in house and food items that are opened and stored for later use. Facility's undated Chemical Storage Guidelines documents in part: Poisonous and toxic materials are to be stored only in areas designated for such use and for no other purpose, or in a storage area outside the food, equipment and utensil storage area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility's undated Dish Room - Safe Handling policy documents in part: Potential cross-contamination is prevented in the Dish Room. The task of loading the dirty dishes and utensils into the dishwashing machine is handled by one person. The task of removing the clean dishes and utensils from the dishwashing machine is handled by a different person. If there is only one person working in the dish room, the person will remove their gloves, wash their hands and put on fresh gloves whenever they cross over to the clean side of the dishwashing machine to unload the sanitized dishes and utensils. Facility's undated Food Temperatures policy documents in part: Temperatures of TCS (temperature controlled for safety) foods shall be recorded before being served from the steam table. Food temperatures shall be checked at the end of cooking and recorded before meal service on the Food Temperature log or production sheet.

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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. 49486 Based on observations, interviews and record reviews, the facility: 1. Failed to follow Contact Precautions guidelines by not wearing appropriate Personal Protective Equipment (PPE) for one (R4) resident. 2. Failed to ensure that there was an Enhanced Barrier Precautions (EBP) sign and PPE outside of R16's room and failed to don PPE prior to incontinence care. 3. Failed to don PPE prior to incontinence and wound care to 2 (R15, and R28) residents. These failures could potentially affect 4 (R4, R15, R16, and R28) of 8 residents reviewed for Transmission-Based Precautions in a sample of 22. Findings Include: On 03/11/25 at 10:21 AM, R15 observed lying in bed with V3 (Certified Nursing Assistant/CNA) providing incontinence care to R15 without donning a gown as Personal Protective Equipment/PPE. V3 stated that V3 should be wearing a gown before providing incontinence care to R15 because she has sacral wound and an enhanced Barrier Precautions (EBP) signage by her door. V3 stated that providing care to R15 without donning a gown exposes her to germs and transmission of infection. On 03/12/25 at 9:41 AM, R28 observed lying in bed, with V9 (Wound Care Licensed Practical Nurse) assisted by V29 (CNA) providing wound care to R28 without donning gown as PPE. V9 and V29 both stated that failure to don the gown as the appropriate PPE while providing high contact care can cause cross contamination. V9 stated that R28 has EBP signage by the door, so V9 should always wear a gown before providing wound care. On 03/12/25 at 10:38 AM, V2 (Director of Nursing/Infection Preventionist) stated that staff and visitors should not enter contact isolation room without donning the appropriate PPE (gown, gloves, and mask). V2 also stated that it is V2's expectation that staff will don gown when providing high contact care like, wound and incontinence care to residents with EBP and contact precaution signage to prevent cross contamination. R15 and R28's Physician Order Sheet (POS) with active orders as of 3/11/25 shows Enhance Barrier Precaution due to wounds every shift. The facility policy on EBP dated 10/23 documents read in part: EBP is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and multidrug Resistant Organisms (MDRO). Transmission Based Precautions (TBPs) include airborne, droplet, contact, and EBP. TBP are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. 40061 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Order Summary Report documents in part an active order for Enhance Barrier Precaution due to: wound every shift (order date 1/29/2025). R16's Care Plan Report documents in part that R16 is on Enhanced Barrier Precautions related to wound (initiated 1/29/2025). Intervention initiated 1/29/2025 documents in part for staff to clean/wash hands, including before entering and when leaving the room. Staff are to wear gloves and a gown for high contact resident care activities such as changing briefs or assisting with toileting. On 3/11/2025 at 10:40 AM, there was no Enhanced Barrier Precaution (EBP) sign outside of R16's room or on the door. There was no Personal Protective Equipment bin readily accessible near R16's room. After the surveyor interviewed R16, V37 (Certified Nurse Aide) provided incontinence care and dressing assistance to R16. V37 did not don a gown during the high touch care activities. R16's room remained without EBP signage and PPE bin during additional observations on 3/11/2025 at 2:58 PM and on 3/12/2025 at 9:34 AM. On 3/12/2025 at 9:36 AM, V23 (Nurse) stated [V23] is assigned to care for R16. V23 stated [V23] works on an as needed schedule and does not work often with R16. During interview, V23 did not know which residents would qualify for EBP or why residents would be on EBP. V23 stated the facility would usually have signs on the doors to alert staff which residents were on EBP. V23 guessed that V2 (Director of Nursing) was the one responsible to put the signs up. V23 stated [V23] was not aware that R16 had orders for EBP because R16 didn't have signs on the door or outside the room. 46342 Findings include: On 03/11/25 at 11:34 AM, observed signage posted for Contact Isolation outside of R4's room with adequate supply of Personal Protective Equipment (PPE) located outside R4's room including gowns, masks, gloves. On 03/11/25 at 11:48 AM, observed V17 (Nursing Supervisor/Licensed Practical Nurse) enter R4's room without gown or gloves. V17 only wore a mask. On 03/11/25 at 11:50 AM, V18 (Licensed Practical Nurse) stated R4 is on Contact Isolation for c. diff (Clostridium Difficile) and anyone going into R4's room whether they are providing care or not needs to wear a gown, mask, and gloves. On 03/11/25 at 11:54 AM, V17 said, I didn't do any touching. V17 stated she did not wear a gown or gloves but should have and the reason for wearing gown, gloves and mask is prevent the transfer of c.diff to other residents. V17 stated c.diff is contagious and the problem with her not wearing the correct PPE is she could transfer c.diff to other residents. R4's diagnosis included but not limited to Enterocolitis Due to Clostridium Difficile, Sepsis, Urinary Tract Infection, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3, Malignant Neoplasm of Prostate, Malignant Neoplasm of Lung, Hypertensive Heart Disease without Heart Failure, Iron Deficiency Anemia, Obstructive Sleep Apnea. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Order Summary Report dated 03/12/25 documents in part, active order for Contact Isolation for C. Diff every shift ordered 03/07/25 and Vancomycin HCl Oral Capsule 125 mg give 4 capsule by mouth every 6 hours for c.diff ordered 03/06/25.