STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146016	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Rehabilitation & Hlth C	129 South 1st Avenue Canton, IL 61520

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on record review and interview, the facility failed to ensure a residents Physician Orders matched their Practitioner Order for Life-Sustaining Treatment (POLST) for Cardio-Pulmonary Resuscitation (CPR) code status for one of 24 residents (R66) reviewed for Advanced Directives in the sample of 37. Findings include: The facility's DNR (Do Not Resuscitate) Policy, dated [DATE], documents, Purpose: To offer facility guidance on do not resuscitate orders. Policy: Our facility will not use cardiopulmonary resuscitation and related emergency measure to maintain life functions on a resident when there is DNR Order in effect. Interpretation and Implementation: 1. Do not resuscitate orders on the physician's order sheet maintained in the resident's medical record. 2. A DNR order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State Law). R66's Physician Orders, dated ,d+[DATE], documents Code Status: [DATE]- Full Code. R66's Illinois Department of Public Health Uniform (POLST), dated [DATE], and signed by V16/R66's Power of Attorney, V8/Medical Director, and V4/Care Plan Coordinator, documents R66 is a DNR, with selective treatment only. On [DATE] at 12:50 PM, V13/Assistant Director of Nursing verified R66's [DATE] Physician Order Sheet documents R66 is a full code, and R66's POLST form documents R66 is a DNR. V13 stated, I am responsible to ensure the Physician Orders match the POLST form. I must have missed it on (R66's) November Physician Orders. The POLST form and current Physician Orders should always match.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on observation, interview and record review, the facility failed to follow a dietician's recommendation for weight loss, provide a resident with a physician ordered calorie supplement, implement a care plan for weight loss and complete physician ordered weekly weights for two of four residents (R43, R66) reviewed for nutrition in the sample of 37. Findings include: The facility's Weight Assessment and Intervention Policy, dated 7/1/2023, documents Policy statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation: Weight Assessment- 1. The nursing staff will measure residents' weights on admission, and weekly for four weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Weights will be recorded in the resident's medical record. 5. Any weight change of five percent or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. 6. The Dietitian will review the Weight Record at least monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not he criteria for significant weight change has been met. 7. The threshold for significant unplanned and undesired weigh loss will be based on the following criteria (where percentage of body weight loss= (usual weight-actual weight)/ (usual weight) times 100): a. 1 month- five percent weight loss is significant; greater that 5 percent is severe. B. 3 months- 7. 5% weight loss is significant; greater that 7.5 percent is severe. C. 6 months 10% weight loss is significant; greater that 10% is severe. 1. R66's 2024 Weight Record documents R66's weight in May 2024 was 153 pounds and R66's weight in November 2024 was 130 pounds, which is a 15.03 percent weight loss in a 6 month period. R66's Request for Diet Change, dated 9/26/24, and signed by V21/Dietitian, documents, Summary: Regular mechanical diet, on Magic Cup two times per day, weight decrease past 30 days, Recommend Med Pass (calorie supplement) for nutrition needs. Refer PRN (as needed.) Comments: Weight Progress Note- Please change diet to: Med Pass 60cc (cubic centimeters) two times per day. This same request was documented as received by V8/R66's Physician on 10/24/24, and signed as agreed by V8/R66's Physician on 10/28/24. R66's Request for Diet Change, dated 10/16/24, and signed by V21/Dietitian, documents, Summary: Weight at 136 pounds. Magic cup is given, diet okay for needs, (R66) paces and burns calories throughout the day. Recommend Med Pass 90cc three times per day. Comments: Weight Progress Note- Please change diet to Med Pass 90 cc three times per day. This same request was documented as received by V8/R66's Physician on 10/24/24, and signed as agreed by V8/R66's Physician on 10/28/24. R66's Physician Order Sheets, dated September, October, and November 2024, do not document an order for Med Pass 60cc to be given two times per day, or an order change for Med Pass 90cc to be given three times per day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:45 AM, R66 was on the dementia unit sitting in the dining room. R66 was being assisted with eating by V20/CNA (Certified Nursing Assistant). V20/CNA verified R66 requires assistance with eating. On 11/20/24 at 1:00 PM, V13/ADON (Assistant Director of Nursing) stated, (V21/Dietitian) comes in around twice a month and writes dietary recommendations for the residents who need it. When (V21) fills out the dietary recommendation forms, (V9/Dietary Manager) will send the recommendations to the resident's appropriate Physician. When the Physician sends back the dietary recommendation stating if they agree with the recommendation or not, the nurses will then process the order. I am not sure how (R66's) dietary recommendation dated 9/26/24 and 10/16/24 never got processed by the nurses. On 11/20/24 at 12:30 PM, V9/Dietary Manager verified R66's dietary recommendations, dated 9/26/24 and 10/16/24, did not get sent to V8/R66's Physician until 10/24/24. V9 stated, I was on maternity leave in September 2024, so I didn't send any dietary recommendations until I was back to work in October 2024. I don't know who was filling in for me when I was gone, but I sent both of (R66's) dietary recommendations from September and October 2024 to (V8/R66's Physician) when I got back. V9 also verified at this time R66 does not have a care plan for unplanned weight loss and R66 should have. On 11/20/24 at 1:05 PM, V2/Director of Nursing verified R66's dietary recommendations, dated 9/26/24 and 10/16/24 and signed on 10/28/24 by V8/R66's Physician, never got processed by the nurses. V2 verified R66 has not been receiving Med Pass as recommended by the Dietician for the months of September, October, and November 2024. V2 stated, Any dietary recommendation should be sent to the doctors right away and then followed up on to ensure the facility has received the recommendation back from the doctor and that the order gets processed. We (the facility) will work on a better process. I am not sure how (R66's) signed dietary recommendations got missed but it should not have. 38396 2. R43's Physician Order Sheet, dated 11/2024, documents R43 was admitted to the facility on [DATE], with a Gastric tube (supplemental internal feeding tube) and diagnoses of Dehydration, Severe Protein Calorie Malnutrition and Hypernatremia. This same Physician order sheet documents R43 is to have Weekly Weights. R43's Monthly Weight and Vitals record documents one recorded weight for October of 112.8 pounds. R43's Medication Administration Record (MAR), dated October 2024, documents weekly weight should be done between 6 AM and 2 PM one time per week. This same administration record does not document any weights recorded for R43 for the entire month of October. On 11/21/24 at 10:00 AM, V2 (Director of Nursing) and V13 (Assistant Director of Nursing) confirmed R43's weights were not recorded weekly during October, and stated they do not have documentation to reflect that any weekly weights were ever completed for R43.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review, the facility failed to date oxygen tubing, place an oxygen sign on resident doors, and ensure a nebulizer facemask and tubing was changed weekly for three of three residents (R5, R34, R56) reviewed for oxygen therapy in the sample of 37. Findings include: The Oxygen Administration Policy revised 3/17/22, documents, To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. Oxygen therapy will be administered to the resident upon the written order of a licensed physician or may be given in an emergent life-sustaining situation without an order, until an order may be obtained by a licensed physician. It will be administered by way of an oxygen mask, nasal cannula and/or a nasal catheter. Procedure: 5. Place the Oxygen in Use sign on the outside of the room entrance door. Tubing will be changed and dated weekly. 1. R5's Admission Record documents R5 was admitted on [DATE] with diagnoses which included Morbid (Severe) Obesity, Paroxysmal Atrial Fibrillation, Type 2 Diabetes Mellitus, Fibromyalgia, and Heart Failure. R5's Minimum Data Set/MDS Assessment, dated 10/11/24, documents R5 has a BIMs/Brief Interview of Mental Status of 15 (cognition intact). R5's Physician Orders for November 2024 documents Oxygen at 4 liters/minute per nasal cannula (dated 6/4/24). Change Oxygen Tubing weekly (dated 7/28/24). R5's current Care Plan documents Cardiac - diagnosis of Congestive Heart Failure. Monitor oxygen saturation every shift if with dyspnea, administer oxygen therapy per Physician Orders. On 11/18/24 at 1:43 PM, R5 was lying bed with her oxygen tubing next to the side of R5's pillow. R5 stated she does not always wear the oxygen, but keeps it close in case she needs it. The tubing was not dated. R5 stated there is no certain day the oxygen tubing is changed. R5 did not remember when the oxygen tubing was last changed. On 11/18/24 at 11:48 AM, there was no oxygen sign on R5's door. R5's Treatment Administration Record for November 2024 documents oxygen at 4 liters/minute per nasal cannula and to change oxygen tubing weekly. The last time the tubing was documented as being changed was 11/10/24. 2. R56's Admission Record documents R56 was admitted on [DATE], with diagnoses which included Type 2 Diabetes Mellitus, Fluid Overload, Morbid (Severe) Obesity, Hyperlipidemia, and Essential (Primary) Hypertension. R56's Minimum Data Set/MDS Assessment, dated 9/18/24, documents R56 has a BIMs/Brief Interview of Mental Status of 15 (cognition intact). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Physician Orders for November 2024 documents Oxygen at 5 liters/minute per nasal cannula (dated 4/30/24). R56's current Care Plan documents R56 has altered respiratory status/difficulty breathing related to Morbid Obesity and Chronic Obstructive Pulmonary Disease. On 11/18/24 at 11:26 AM, R56 was sitting in the dining room wearing oxygen. There was no date on the oxygen tubing. R56 stated she thinks the tubing was changed yesterday. They change the tubing at least every week or two. On 11/18/24 at 11:48 AM, there was no oxygen sign on R5's door. R56's Treatment Administration Record for November 2024 does not document the last time R56's oxygen tubing was changed. On 11/18/24 at 11:48 AM, V19/Licensed Practical Nurse/LPN verified that R5 and R56 are both on oxygen but neither have an oxygen sign on their door. On 11/20/24 at 12:50 PM, V13/Assistant Director of Nursing stated, The oxygen tubing should be labeled when it is changed. The tubing should be changed weekly and there should be a sign on the resident's door warning of oxygen use. 38396 3. R34's Physician Order Sheet, dated 11/2024, documents an order for Albuterol 0.083% nebulizer solution to give three milliliters per nebulizer every four hours as needed for wheezing. On 11/18/24 at 11:40 AM, R34 was in his room sitting on the edge of his bed. At this time ,V12 (Licensed Practical Nurse) administered R34's Albuterol nebulizer breathing treatment, and placed the nebulizer face mask over R34's face. This mask documented a date of 10/4/24. V12 verified the date and stated the date on the mask would be when the tubing and mask was changed. On 11/21/24 at 10:15 AM, V2 (Director of Nursing) stated resident's Oxygen and Nebulizer equipment, such as tubing, face masks and cannulas, should be changed weekly and dated to reflect the change. V2 verified the 10/4/24 date on R34's mask was over a month ago and stated, They (staff) should be changing those weekly.

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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** 38396 Based on observation, interview and record review, the facility failed to attempt a Gradual Dose Reduction (GDR) of Olanzapine (Antipsychotic medication) for one of three residents (R34) reviewed for antipsychotic medications in the sample of 37. Findings include: The facility's Psychotropic Medication Policy, dated 11/28/17, documents, It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drug is any drug used: For excessive duration. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Any resident receiving psychotropic medications will be reviewed at a minimum of every quarter by the interdisciplinary team. Reductions shall be attempted at least twice in one year, unless the physician documents the need to maintain the resident regimen according to the regulatory guidelines for such. The facility's Reduction of Psychotropic Medications Protocol policy, dated 8/22/18, documents, Residents who must receive psychotropic medications are to be maintained at the safest, lowest dosage necessary to control the resident's condition. Theses medications (psychotropic) shall be used when deemed necessary by each resident attending physician and/or psychiatric consultant. Each resident will be maintained on as low dosage of these medications as possible. Dosage reductions may be attempted whenever the resident's behavior patterns indicate to the attending physician that a dosage reduction may be appropriate. R34's Physician Order Sheet, dated 11/2024, documents R34 is to receive Olanzapine five milligrams every morning and Olanzapine five milligrams every other bedtime alternating with Olanzapine ten milligrams every other bedtime. On 11/18/24 at 11:40 AM, R34 was sitting in his room on the edge of his bed, completing a respiratory breathing treatment. R34 was cooperative with facility staff and was not displaying any behaviors. On 11/19/24 at 10:15 AM, R34 was in his room siting in bed. R34 denied having any complaints, stated he attends activities when he chooses, and was pleasant with conversation. R34 was not displaying any behaviors. R34's Behavior Tracking Sheets, dated 1/1/24-10/31/24, documents R34 is being monitored for paranoid thoughts/behaviors for the use of Olanzapine. These behavior tracking sheets over nine consecutive months document R34 has had zero episodes of paranoid thoughts/behaviors in nine months. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's (Behavioral Health service) Psychiatric Note, dated 10/25/24, documents R34 is currently [AGE] years old and was diagnosed with Bipolar Disorder in 1980. This note also documents R34's behaviors upon examination are as follows: Appearance is consistent with chronological age. Calm, cooperative, pleasant. Clear speech, adequate attention and good judgment. This Psychiatric note documents a GDR of R34's medications is Clinically contraindicated at this juncture. On 11/21/24 at 10:10 AM, V13 (Assistant Director of Nursing) confirmed R34 has not had a GDR of his Olanzapine in the past year. V13 stated, We just started with a new psychiatric service in September, 2024. I am not sure why they didn't reduce it in October. (R34) has not had an Olanzapine reduction in the last twelve months.

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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** 35509 Based on observation, interview, and record review, the facility failed to keep a clean and sanitary kitchen; dispose of outdated food; date and label opened food items; include thaw dates for supplements; correctly cool down potentially hazardous food and keep a log of the temperatures; and label and date food storage containers holding bulk food stuffs.This has the potential to affect all 75 residents living in the facility. Findings: 1. The document Kitchen Sanitation, dated 10/2020, states, It is the policy of this facility to comply with public health standards and local and state sanitation regulations. The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. The Dietary Sanitation Quality Assurance Review shall be used as a tool to monitor compliance with sanitation standards and identify which areas need corrective action. The Food Service Manager will develop a cleaning schedule for the department and ensure that dietary employees complete cleaning tasks as scheduled. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen and specify which chemical and personal protective equipment should be used for each task. The document Dietary Sanitation, Quality Assurance Review, dated 10/2020, states, Hand washing sink clean. Disposable towels, hot water available. Cooling log is accurate. Ensure food and non-food contact surfaces are easily cleanable including shelves and drawers and carts. Equipment is clean and in safe working order: Oven/Stove; Microwave; Mixer; Ice Machine. Range hoods are free of dust/grease. Refrigerator - shelves/floor/ceiling clean; no indication of spills. All food is covered; containers are labeled with contents, date opened and date to discard. Supplements have thaw and expiration date; Foods are stored in airtight containers and labeled if not in original container. Vents and pipes are clean. Ceilings and walls are clean; floors and baseboards are clean. The document, In-place Equipment, dated 4/2013, states, It is the policy of this facility that in-place equipment and surfaces that cannot be cleaned and sanitized by a mechanical dishwasher or 3-compartment sink will be cleaned and sanitized by using an appropriate wiping cloth and solution. Remove visible debris off of in-place equipment or surface with use of soap and water solution. Rinse detergent from equipment. Wipe in-place equipment or surface with sanitizing solution. Allow in-place equipment or surface to air dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/18/24 at 9:45 AM, the area under the pass-through window over the steam table wells had a large buildup of black dust, grease/grime, crumbs/food debris, and splashes of unknown origin. The microwave, sitting on a food preparation table (next to the steam table), had dried food particles and splashes of unknown origin on its inside ceiling. Under this table were four large storage bins, with dried food debris and liquid splashes of unknown origin on the lids, front, and sides. These held flour, sugar, brown sugar, and oats. There were no labels identifying the contents of the bins. Food carts used to transport resident trays had splashes on the outside and inside of the carts. The burners and on the metal wall behind the stove burners had old food splatters; the pull-out grease tray under the burners had blackened substance, crumbs. The pull-out grease tray under the grill had two to three inches of old black grease and food particles. The baffles and pipes over the stove and range had a thick visible dust covering; the pipes behind this appliance also had thick visible dust build up. The ovens under the stove and grill had layers of grease on the outside and the handle to the oven was sticky with grease. The inside of the ovens had blackened food debris. The convection oven next to this area had windows opaque from layers of dried grease and food splashes on the inside and outside of the doors. Blackened food particles and splashes were on the inside of the oven and on the wire shelves. Several food racks around the kitchen held various items, food, dishes, utensils, etc. (etcetera) or all had food debris and liquids of unknown origin on the bottom from and the side rungs. Portable coolers, stored directly on the floor, had layers of dust and debris. The windowsill and frame, wall, and floors throughout the kitchen had splashes of food and liquid items of unknown origin. The inside of the reach-in refrigerator and walk-in refrigerator had splashes on the walls, wire racks, and bottom and floor. In the stockrooms, a non-institutional container, no label to identify its contents, with a lid that was dusty with splashes of food/liquids of unknown origin held a substance used to thicken beverages and food items. Three-tiered food transport carts had old splashes of food and liquids of unknown origin. V9, Dietary Manager, confirmed observations, stating, Looks like we have a lot of cleaning to do. The document Prevention of Food Contamination, states, It is the policy of this facility that all food shall be handled and prepared to prevent contamination against dirt, odor, bacteria, etc. Store all food according to package directions or standardized guidelines. The document Hazard Analysis Critical Control Point, dated 10/2020, states, It is the policy of this facility to use a procedure to prevent the outbreak of any food borne illness. Protect foods during storage to prevent contamination. Foods are not exposed to pipes. Foods will be tightly covered or in a sealed container. Container must be labeled and dated. Rapidly cool all cooked foods to an internal temperature of 70 degrees Fahrenheit (F) or below within two hours and 41 degrees F within four hours. Label all cooling foods with appropriate log record to track cooling procedure. 2. The document Storage, dated 10/2020, states, Food shall be stored at the proper temperature and for appropriate lengths of time to protect quality of food. All items will be dated upon receipt. Store leftovers in covered, labeled, and dated containers under refrigeration or frozen. Clean up all debris dropped on the floor immediately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document Refrigerator and Freezer Storage, dated 10/2014, states, Any item placed in the refrigerator and freezer must be covered, labeled, and dated with a date-marking system that tracks when to discard perishable foods. [NAME] container with name of item. [NAME] the date that the original container is opened or date of preparation. Label refrigerated, potentially hazardous food prepared with the day/date by which the food shall be consumed or discarded (maximum of seven days from time of preparation). Clean up any spills immediately. Designated dietary employee is to check, pull and throw away any potentially hazardous foods that have been in the refrigerator for seven days. On 11/18/24 at 10:05 AM, the walk-in refrigerator held the following: a large deep pan of barbeque pork dated 11/17/24; a large deep pan of Swiss steak, dated 11/16/24; A large pan of lemon pudding dated 11/16/24; a larger pan of vanilla pudding dated 11/17/24; A pan of mixed fruit, dated 11/01/24, an opened container of a whipped topping, no open date. V9, Dietary Manager, was unable to clarify if the dates on the food items were the date to use or to discard. None of the items had a label identifying this information. This cooler also held an eight ounce container of black icing, partially used, no open date; two squeeze bottles of unknown substance, one pink, one aqua colored, covered with mold; an eight ounce package of block cheddar cheese, with the use by date of 12/07/23; a five ounce package of [NAME] Cheese with a sell by date of 9/02/23; 250 ml (milliliter) container of a supplement, expiration date of 8/01/24; two opened 36 ounce containers of thickened liquid, half used, no open date; Beverage container of apple juice, 1/4 full, dated 11/19/24; Beverage container of cranberry juice, 1/3 full, dated 11/11/24. The reach-in refrigerator held the following: 14 squeeze bottles, used, with splashes/sticky substance on the outside and dried substance on the top squirt spout did not have labels or dates; two small bowls containing unknown substance without labels; two Styrofoam glasses of unknown substance, no labels; 2 1/2 pounds of sliced American cheese, no open date or label; a five pound container of whipped margarine (1/8 full), a five pound package of shredded cheddar cheese (1/2 full), a five pound package of Parmesan cheese, a half-gallon container with a cup of applesauce; two gallon jars of coleslaw sauce (one 1/2 full) (one 3/4 full), a gallon of red dressing, a gallon of 1000 island dressing, a gallon of dill pickles, a gallon of mustard, none of these items had open dates or labels; a small storage bag containing 1/2 pound of lunchmeat dated 11/06/24. V9 stated, I will tell staff to put labels on the food. On the bottom shelf of a food preparation table next to the reach-in refrigerator a tray contained two bottles of red food coloring, one bottle of green food color, two bottles of vanilla extract and a five-pound container of baking powder. All had been opened, all had dust, food stains on them, none had open dates or labels. V9 stated, We don't use those very often. 3. The document Food Thawing, dated 10/2020, states, It is the policy of this facility that all food requiring thawing before serving must be thawed in a manner that avoids placing the food in the danger zone. All items placed in the refrigerator to thaw, including oral nutrition supplements, must be labeled with the thaw date. On 11/18/24 at 9:50 AM, a case (48 cartons) of a supplement thawing in the walk-in refrigerator. There was no thaw date on the case. V9, Dietary Manager, stated, I didn't know they needed to be dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document Food Cooling, dated 3/2018, states, It is the policy of this facility the Time Temperature Control for Safety (TCS) foods will be cooled properly to prevent the outbreak of food borne illness. Hot foods will be cooled to the proper temperature using a two-stage cooling process. Stage 1: Cool foods from 135 degrees Fahrenheit (F) to 70 degrees F within 2 hours. Stage 2: Cool foods from 70 degrees F to 41 degrees F or below within four hours (total of six hours). If food has not been cooled to 70 degrees F or below within the first two hours, the food needs to be thrown out or reheated one time only to 165 degrees F and held for 15 seconds. The cooling process will start overusing an alternate method to cool from what failed initially. If the food does not reach 70 degrees F or below the second time the food item must be discarded. Use the Food Cooling Log for Temperature monitoring and recording. The Dietary Manager will review and monitor the Food Cooling process and log for completion. The Dietary Manager will maintain records of the Food Cooling logs for one year. The document Food Cooling Log, dated 9/2024 through 11/2024, states, Record temperatures of potentially hazardous foods during cooling process. Food Item; start time; start temperature; time and temperature within two hours (below 70 degrees F); Time and Temperature within four more hours (below 41 degrees F); Corrective Action, if necessary. On 11/18/24 at 10:15 AM, the Food Cooling Log was reviewed. Twelve potentially hazardous foods were listed on the form: 9/05/24, Ham; 9/11/24, Chicken Dumpling; 9/24/24 Meatloaf; 9/26/24, Turkey; 9/28/24, Goulash; 9/30/24, Mixed Vegetables; 10/07/24, Hamburger; 10/22/24, Meatloaf; 11/07/24, Ham; 11/10/24, Turkey; 11/14/24, Roast Beef. Each item had the exact same start time of 12:00 PM; the exact same start temperature of 65 degrees Fahrenheit (F); the exact same temperature for the Time and Temperature within two hours (below 70 degrees F), of 65-degree F. Only one food item, ham from 9/05/24, had a temperature recorded for time and temperature within four more hours (below 41 degrees F), of 35 degrees F. Nothing else recorded on the form. V9, Dietary Manager, stated, No, the form isn't filled out as it should be. V9 agreed it was unusual that all the times, temperatures were exactly the same on the form. 4. The document Equipment, Temperatures, dated 9/2008, states, It is the policy of this facility that all refrigerator and freezers shall be monitored regularly to ensure that they are working properly and to correct any mechanical difficulties quickly. On 11/18/24 at 10:10 AM, the walk-in freezer was dripping a clear colorless substance from a hole 36 inches by 24 inches, no cover/grate over it. A large deep pan was catching the substance. An accumulation of ice was on the rack and floor under the area. The walk-in refrigerator also had a clear colorless substance dripping out of its ceiling grate onto the containers of food items below it, pooling on their tin foil coverings. A container of whipped topping had the liquid pooled on its lid and a paper case containing whipped topping was saturated with the liquid. The automatic paper towel machine by the hand washing sink did not work and no paper towels were by the sink. The water faucet was difficult to turn on and could not be totally turned off, water continuing to run out of the faucet. A floor drain, opposite of the hand washing sink, protruded to the edge of the above counter and did not have a grate over the 12 by 10-inch hole. V9, Dietary Manager, stated, We keep the large containers in both the walk-ins to catch the water. There's been some problems, but they fixed it. There's a grate for the floor drain. I'm not sure where it is now. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. The document Ice Machine, dated 10/2017, states, It is the policy of this facility to assure that ice is handled in a clean, sanitary manner. The ice machine should be kept clean at all times. The ice machine is cleaned and sanitized on a regular basis. Refer to the manufacturer's cleaning procedure and recommendation. The document Ice Machine Operator Use and Care Manual, dated 6/1999, states, Clean and sanitize the ice machine. If required, an extremely dirty ice machine may be taken apart for cleaning and sanitizing. Refer to Sanitizing Procedure. Use sanitizer to remove algae or slime. Periodic cleaning must be performed on adjacent surface areas not contacted by the water distribution system. If the bin requires sanitizing, remove all the ice and sanitize it. On 11/18/24 at 9:35 AM the following observations were made: a three-drawer plastic storage unit, non-institutional, holding utensils and various kitchen items, sat by the kitchen door. The unit had splashes of unknown liquids and food debris on the top, sides and front. Wheels were attached to only one side of the unit, making it sit on a slant; the bottom right side bottom drawer was smashed/cracked, gapping open, sitting directly on the floor with items inside the drawer exposed to contamination. Water coming from the floor by the ice machine was seeping toward the storage unit. The ice machine had mineral deposits on the exterior and interior. The interior area where ice passes from where it is made into the well for ice storage has a lip across the width of the machine. This contained a black/brown/pink unknown slime appearing substance. V9, Dietary Manager, confirmed the observations. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671, dated 11/18/24, signed by V11, Business Office Manager, documents 75 residents currently reside within the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review, the facility failed to change gloves and perform hand hygiene while providing incontinent care and implement Enhanced Barrier Precautions (EBP) for a resident with an open wound, for two of 18 residents (R5, R56) reviewed for infection control in the sample of 37. Findings include: The Incontinence Care Policy, dated 7/1/23, documents, To provide guidelines to all nursing staff for providing proper incontinence care in order to clean skin clean, dry, free of irritation and odor. All incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/or odor. Incontinence care will be provided as required. 8. Wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and performing hand hygiene as required to prevent cross-contamination. The Enhanced Barrier Precautions, dated 7/13/23, documents, Purpose: To reduce transmission of multi-drug-resistant organisms/MDRO (Multi-Drug Resistant Organisms). Enhanced Barrier Precautions should be used when contact precautions do not apply, for residents with any of the following: Open wounds that require a dressing change, Indwelling Medical Devices, Infection or colonized with a MDRO. Enhance Barrier Precautions require use of a gown and gloves during high contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. EBP is primarily intended to use for care that occurs within a residence room when high contact resident care activities are bundled together. Outside of a resident's room, EBP should be followed when performing transfers in the shower/assisting with shower and when assisting a resident with toileting and common restrooms. High-contact care activities include Dressing, Bathing/Showering, Transfers (when bundled with other high- contact resident care activities), Hygiene, Changing linens, Changing briefs or Toileting, Caring for medical devices (central lines, urinary catheters, feeding tubes, tracheotomies, drainage tubes, end ports), Wound care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds), and Skilled Therapies. Procedure 1. Educate staff on EBP. 2. Identify residents with an infection or colonized with a MDRO, residents with medical devices or chronic wounds that do not require contact precautions. 3. Review Contact precautions to ensure that Enhanced Barrier Precautions are appropriate. Post approved EBP signage that indicates high-contact activities. 4. Ensure that disposable or washable isolation gowns and gloves are available to HCP (Health Care Providers), where high- contact resident care activities may be required. 5. Keep a container or hamper inside resident's room for HCP to dispose of PPE (Personal Protective Equipment). 1. R5's Admission Record documents R5 was admitted on [DATE], with diagnoses which included Morbid (Severe) Obesity, Paroxysmal Atrial Fibrillation, Type 2 Diabetes Mellitus, Fibromyalgia, and Heart Failure. R5's Minimum Data Set/MDS Assessment, dated 10/11/24, documents R5 has a BIMs/Brief Interview of Mental Status of 15 (cognition intact). R5 is dependent on staff for toileting and occasionally incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's current Care Plan documents Continence - Alteration in Bladder Elimination as related to incontinence. Give proper hygiene for incontinence. On 11/18/24 at 1:09 PM, V17/Certified Nursing Assistant/CNA and V18/CNA provided incontinent care for R5. R5 was incontinent of bowel and bladder. V17 removed the soiled disposable brief, then cleaned R5's vaginal area and buttocks. R5 had runny liquid stool. V17 then applied the clean disposable brief. V17 did not change her gloves or do any hand hygiene during the incontinent care. On 11/20/24 at 12:46 PM, V13/Assistant Director of Nursing stated during incontinent care, staff should be washing/sanitizing their hands and changing their gloves when going from the dirty disposable brief to the clean disposable brief. 2. R56's Admission Record documents R56 was admitted on [DATE], with diagnoses which included Type 2 Diabetes Mellitus, Fluid Overload, Morbid (Severe) Obesity, Hyperlipidemia, and Essential (Primary) Hypertension. R56's Minimum Data Set/MDS Assessment, dated 9/18/24, documents R56 has a BIMs/Brief Interview of Mental Status of 15 (cognition intact). R56's Physician Orders for November 2024 documents Right Abdominal Area - Cleanse, pat dry and apply Hydrogel with Collagen and cover daily (dated 11/15/24). Left Lateral Outer Ankle - Cleanse, pat dry, apply collagen matrix dressing and cover with dry dressing on Tuesday, Thursday, and Saturday. Right Lateral Outer Ankle - Cleanse, pat dry, apply collagen matrix dressing, and cover with dry dressing on Tuesday, Thursday, and Saturday. R56's Wound Assessment and Plan written by V15/Wound Physician, dated 11/19/24, documents R56 has an abdominal wound which started on 11/13/24. Description of Wound- Full Thickness: with Fat Layer Exposed. Measuring 0.5 cm/centimeters by 0.8 cm by 0.1 cm. Left Ankle Lateral Malleolus which started on 8/13/24. Description of Wound Full Thickness: with Fat Layer Exposed. Measuring 0.7 cm by 0.7 cm by 0.1 cm. Right Ankle Lateral Malleolus which started on 8/13/24. Description of Wound 0.7 cm by 1 cm X 0.1 cm. On 11/19/24 at 12:51 AM, R56 was sitting on her bed waiting for V3/Wound Nurse and V15/Wound Physician to check her wounds. R56 stated she has a wound on her abdomen and a wound on the outside of each ankle. R56 also stated none of the staff wear gowns when providing care, or when doing a dressing change. There was not any Personal Protective Equipment outside of R56's door, and no sign on R56's room that R56 was in Enhanced Barrier Precautions. On 11/19/24 at 12:51 PM, V15/Wound Physician went into R56's room to assess R56's wounds. V15 did not wear a gown while assessing R56's wounds. V15 removed the dressing from R56's abdomen that had a small amount of drainage on the dressing. V15 measured the wound. V15 then removed the stocking from R56's left ankle. The wound did not have a dressing on it. V15 measured the wound to the left ankle. V15 then removed the dressing from R56's right ankle and measured it. On 11/19/24 at 12:56 PM, V3/Infection Preventionist/Wound Nurse came in to put dressings on R56's wounds. V3 was wearing gloves but no gown. V3 applied dressings to all three wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 12:54 PM, V13/Assistant Director of Nursing verified R56 was not in Enhanced Barrier Precautions. V13 stated that R56's wounds were not pressure ulcers. V13 also stated she did not know all wounds required a resident to be in EBP. On 11/20/24 at 2:56 PM, V3/Wound Nurse stated V2/Director of Nursing explained to V3 that R56 should have been in EBP due to her wounds.