STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manderley Health Care Center	806 S Buckeye St Osgood, IN 47037

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34232 Based on observation, record review, and interview, the facility failed to treat a resident in a dignified manner during a meal service for 1 of 2 dining observations. (Resident 15) Findings include: Meal service was observed in the Main Dining Room on 01/27/25 at 12:01 P.M. At 12:10 P.M., Certified Nurse Aide (CNA) 6 stood upright next to Resident 15's wheelchair, to the resident's left side, with the resident's head at chest height to the CNA. The CNA was saying the resident's name over and over again, to get her attention, as she spooned food into the resident's mouth. Several empty chairs were observed in the dining room. Another staff member was sitting down in a chair, at the same table, assisting another resident with their meal. CNA 6 continued to stand over Resident 15 while she assisted the resident with her meal until 12:36 P.M. The clinical record for Resident 15 was reviewed on 01/28/25 at 1:29 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, hypertension, dementia, anxiety, depression, and psychotic disorder. The resident was dependent on staff for assistance with eating. During an interview on 01/30/25 at 10:05 A.M., CNA 4 indicated when assisting a resident with their meal, they would apply a clothing protector to the resident, pull up a chair, sit down next to the resident, and assist them with eating their meal. The current Resident Rights policy, with a revised date of June 2023, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, .Employees shall treat all residents with kindness, respect, and dignity . 3.1-3(a)

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 33613 Based on observation, record review, and interview, the facility failed to maintain resident records in a private manner related to information visible on a computer screen and on top of a medication cart for 2 of 6 random observations. (100 and 300 Hall Medication Carts) Findings include: 1. During a continuous observation on 01/27/25 from 2:17 P.M. to 2:39 P.M., the 100 Hall Medication Cart was left unattended. Resident 249's information was visible on the screen, - On 01/27/25 at 2:17 P.M., two Certified Nurse Aides (CNA) walked by the medication cart. - On 01/27/25 at 2:23 P.M., The computer screen on the medication cart remained unattended. - On 01/27/25 at 2:25 P.M., two CNAs walked by the medication cart. - On 01/27/25 at 2:28 P.M., a CNA walked by the medication cart. - On 01/27/25 at 2:31 P.M., RN 3 walked to the medication cart, made some notes on a piece of paper, and walked back to the nurse's station without closing the computer screen. - On 01/27/25 at 2:33 P.M., a Laundry Aide walked by the medication cart. - On 01/27/25 at 2:38 P.M., two CNAs and a Laundry Aide walked by the medication cart. During an observation and interview on 01/27/25 at 2:39 P.M., RN (3) approached the medication cart and indicated the Qualified Medication Aide was passing medications that shift. The computer screen should have been locked when left unattended. During the observation there were mobile residents in the general area three to five feet of the medication cart. 34232 2. During a continuous observation on 01/29/25 from 10:37 A.M. to 10:45 A.M., the medication cart for the 300 Hall was left unattended. A CNA Report Sheet was laying on the top of the cart and had several resident names listed with resident care information next to each name. A stack of empty medication cards were on top of the cart with one for Resident 27 lying on the top of the stack. No staff were standing in the immediate area of the cart. Several staff members and an independently mobile resident using a walker walked next to the cart during the observation time period. - On 01/29/25 at 10:39 A.M., two staff members walked past the medication cart, - On 01/29/25 at 10:39 A.M., a staff member walked past the medication cart carrying clean linens, (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 01/29/25 at 10:40 A.M., a staff member walked past the medication cart, - On 01/29/25 at 10:40 A.M., a QMA walked past the medication cart, - On 01/29/25 at 10:41 A.M., a staff member walked past the medication cart, - On 01/29/25 at 10:41 A.M., another staff member walked past the medication cart, - On 01/29/25 at 10:42 A.M., Resident 9, who was independently mobile with their walker, walked past the medication cart, and - On 01/29/25 at 10:45 A.M., a QMA walked up to the cart and began tearing off the portion of the medication cards containing the residents' names. During an interview on 01/29/25 at 11:18 A.M., QMA 8 indicated nothing should be left on top of the medication carts with resident names visible. The current Confidentiality of Information and Personal Privacy policy, with a revised date of 10/2017, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, .Our facility will protect and safeguard resident confidentiality and personal privacy .of all resident personal and medical records .The facility will strive to protect the resident's privacy regarding his or her .medical treatment . personal care .Access to resident personal and medical records will be limited to authorized staff and business associates . 3.1-3(o)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34232 Based on record review and interview, the facility failed to follow the physician's orders related to hold parameters for medications for 2 of 15 residents reviewed for Quality of Care. (Residents 15 and 24) Findings include: 1. The clinical record for Resident 15 was reviewed on 01/28/25 at 1:29 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes, and hypertension. A current open-ended physician's order, with a start date of 09/05/24, indicated the resident was to take Coreg (a cardiac medication) 25 milligrams (mg), two times a day related to hypertensive heart disease. The medication was to be held (not given) for a Heart Rate (HR) of less than or equal to 60 beats per minute and/or a blood pressure less than or equal to 110/50. The current October 2024, December 2024, and January 2025, Electronic Medication Administration Record (EMAR) for the resident's Coreg was provided by the Director of Nursing (DON) on 01/30/25 at 1:29 PM., and indicated the resident had received the Coreg medication when the resident's HR was less than or equal to 60 for the following dates and times: - 10/02/24 at bedtime the HR was 57, - 10/03/24 at 7:00 A.M. the HR was 60, - 10/04/24 at bedtime the HR was 60, - 10/06/24 at 7:00 A.M., the HR was 60, - 10/07/24 at 7:00 A.M., the HR was 60, - 10/09/24 at 7:00 A.M., the HR was 60, - 10/09/24 at bedtime the HR was 60, - 10/11/24 at bedtime the HR was 60, - 10/12/24 at bedtime the HR was 56, - 10/13/24 at 7:00 A.M., the HR was 60, - 10/13/24 at bedtime the HR was 54, - 10/15/24 at 7:00 A.M., the HR was 60, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/15/24 at bedtime the HR was 59, - 10/16/24 at 7:00 A.M., the HR was 60, - 10/21/24 at 7:00 A.M., the HR was 60, - 10/24/24 at 7:00 A.M., the HR was 60, - 10/24/24 at bedtime the HR was 59, - 10/25/24 at 7:00 A.M., the HR was 55, - 10/29/24 at bedtime the HR was 47, - 10/30/24 at 7:00 A.M., the HR was 60, - 12/04/24 at bedtime the HR was 59, - 12/05/24 at bedtime the HR was 59, - 12/06/24 at 7:00 A.M. the HR was 60, - 12/06/24 at bedtime the HR was 60, - 12/10/24 at 7:00 A.M., the HR was 60, - 12/11/24 at 7:00 A.M., the HR was 60, - 12/13/24 at 7:00 A.M., the HR was 60, - 12/14/24 at 7:00 A.M., the HR was 60, - 12/14/24 at bedtime the HR was 58, - 12/16/24 at bedtime the HR was 58, - 12/17/24 at bedtime the HR was 56, - 12/20/24 at bedtime the HR was 60, - 12/21/24 at bedtime the HR was 60, - 12/22/24 at 7:00 A.M., the HR was 60, - 12/24/24 at bedtime the HR was 60, - 12/25/24 at 7:00 A.M., the HR was 60, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/26/24 at 7:00 A.M., the HR was 60, - 12/27/24 at bedtime the HR was 60, - 12/28/24 at 7:00 A.M., the HR was 60, - 12/31/24 at 7:00 A.M., the HR was 60, - 01/01/25 at 7:00 A.M., the HR was 60, - 01/04/25 at 7:00 A.M., the HR was 60, - 01/06/25 at bedtime the HR was 60, - 01/07/25 at 7:00 A.M., the HR was 60, - 01/08/25 at 7:00 A.M., the HR was 60, - 01/14/25 at 7:00 A.M., the HR was 60, - 01/14/25 at bedtime the HR was 60, - 01/15/25 at 7:00 A.M., the HR was 60, - 01/15/25 at bedtime the HR was 60, - 01/17/25 at 7:00 A.M., the HR was 60, - 01/19/25 at bedtime the HR was 60, - 01/21/25 at 7:00 A.M., the HR was 60, - 01/23/25 at 7:00 A.M., the HR was 60, - 01/25/25 at bedtime the HR was 60, and - 01/27/25 at 7:00 A.M., the HR was 60. The Consultant Pharmacist's Medication Regime Review records for October and December 2024, were provided by the DON on 01/30/25 at 1:45 P.M., and indicated the following: - On 10/16/24, the pharmacist indicated there were times when the Coreg medication should have been held due to the resident's HR. This was not documented as such on the Medication Administration Record (MAR). Please educate the staff, and - On 12/18/24, the pharmacist indicated there were times when the Coreg medication should have been held due to the resident's HR. This was not documented as such and to please educate the staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/25 at 10:40 AM., the DON indicated she received the pharmacy recommendations when they came in. Once they came in, she would give the Nurse Practitioner (NP) the recommendations designated for the NP/MD. For the ones designated for nursing, she would address them. Pharmacy recommendations usually came in around the middle of the month. She tried to have them addressed within 30 days. The Care Plan for the resident being at risk for a cardiac event related to hypertension and coronary artery disease was provided by the DON on 01/30/25 at 1:45 P.M. The interventions included, but were not limited to, monitor vital signs as ordered. 38769 2. The clinical record for Resident 24 was reviewed on 01/28/25 at 10:05 A.M. A Quarterly MDS assessment, dated 12/10/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hip and knee replacement, hypertension, anxiety, depression, and chronic pain syndrome. A physician's order, dated 09/06/24 through 01/23/25, indicated the resident was to take Midodrine 10 mg, three times a day for low blood pressure. The staff were to hold the medication when the resident's systolic blood pressure (top) number was greater than 110 or the diastolic blood pressure (bottom number) was greater than 70. A current open-ended physician's order, with a start date of 01/23/25, indicated the resident was to take Midodrine 10 mg, with meals for low blood pressure. The staff were to hold the medication when the resident's systolic blood pressure number was greater than 110 or the diastolic blood pressure was greater than 70. The current November and December 2024 and January 2025 EMAR indicated the resident had received the Midodrine when the resident's systolic blood pressure was greater than 110 or the diastolic was greater than 70 for the following dates and times: - 11/04/24 at bedtime when the blood pressure was 114/67, - 11/09/24 at bedtime when the blood pressure was 120/61, - 11/14/24 in the morning when the blood pressure was 112/64, - 11/15/24 at midday when the blood pressure was 112/65, - 11/18/24 in the morning when the blood pressure was 112/60, - 11/26/24 in the morning when the blood pressure was 114/70, - 11/27/24 in the morning when the blood pressure was 114/60, - 12/16/24 in the morning when the blood pressure was 114/68, - 12/20/24 at bedtime when the blood pressure was 115/80, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/25/24 at midday when the blood pressure was 115/78 and at bedtime when the blood pressure was 110/82, - 01/01/25 at bedtime when the blood pressure was 127/88, - 01/04/25 in the morning when the blood pressure was 112/75, - 01/05/25 at bedtime when the blood pressure was 116/75, - 01/08/25 in the morning when the blood pressure was 102/72, - 01/10/25 at bedtime when the blood pressure was 123/79, - 01/13/25 in the morning when the blood pressure was 110/72 and at bedtime when the blood pressure was 115/67, - 01/15/25 at bedtime when the blood pressure was 115/69, - 01/17/25 at bedtime when the blood pressure was 111/74, and - 01/22/25 at bedtime when the blood pressure was 119/80. During an interview on 1/30/25 at 10:12 A.M., RN 2 indicated if a medication had hold parameters, then she would obtain the resident's vital signs and if the vitals were within the acceptable parameters, then she would give the medication. If the vitals were not within the parameters, she would not administer the medications and document why the medication was not administered. The current facility policy titled, Administrating Medications, with a revised date of December 2012, was provided by the DON on 01/30/25 at 1:29 P.M. The policy indicated, .Medications shall be administered in a safe and timely manner, and as prescribed .The following information must be checked/verified for each resident prior to administering medications: .Vital signs, if necessary . 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38239 Based on record review and interview, the facility failed to treat a Urinary Tract Infection (UTI) in a timely manner for 1 of 2 residents reviewed for UTIs. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 01/28/25 at 2:10 P.M. An Admission Minimum Data Set assessment, dated 11/07/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, aortic valve disorder, urinary retention, and hypertension. A Nursing Note, dated 11/02/24 (Saturday) at 11:51 P.M., indicated new physician's orders were received to obtain a Urinalysis and Culture and Sensitivity (UA/CS). A Nursing Note, dated 11/03/24 (Sunday) at 8:38 A.M., indicated the resident denied pain or discomfort but experienced frequent incontinent episodes and frequent feelings of needing to void. The resident's urine had a strong odor. The laboratory (lab) report for the urinalysis indicated the resident's urine was collected on 11/06/24 (Wednesday) and the results were reported on 11/08/24 (Friday). The report indicated the following bacteria were detected in the sample: - Klebsiella pneumoniae, with an estimated high microbial load, - Citrobacter freundii/braak/koseri, with an estimated moderate microbial load, - Proteus mirabilis, with an estimated moderate microbial load, - Pseudomonas aeruginosa, with an estimated moderate microbial load, - Actinobaculum schaalii, with an estimated low microbial load, - Enterobacteriaceae, with an estimated low microbial load, and - Enterococcus faecalis, with an estimated low microbial load. The report recommended potential antibiotics to treat the bacteria. A Nursing Note, dated 11/11/24 (Monday) at 3:31 P.M., indicated a new physician's order was received to administer Fosfomycin (an antibiotic), 3 milligrams every 72 hours for three doses. A Nursing Note, dated 11/11/24 at 4:10 P.M., indicated the facility requested the pharmacy to STAT (immediate) send the Fosfomycin packet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Shift Level Administration Note, dated 11/11/24 at 7:04 P.M., indicated the resident received first dose of the antibiotic to treat her UTI. During an interview on 01/31/25 at 11:12 A.M., the Director of Nursing (DON) indicated If UA/CS results were available on a Friday, the facility could contact the physician and the pharmacy and get an antibiotic started on the weekend. The current Physician Orders policy, with a revised date of 03/17/22, was provided by the DON on 01/30/25 at 10:25 A.M. The policy indicated, .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines . 3.1-41(a)(2) 3.1-49(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33613 Based on observation and interview, the facility failed to store medications appropriately for 1 of 2 medication carts reviewed. (100-Hall Medication Cart) Findings include: During a continuous observation on 01/27/25 from 2:17 P.M. to 2:39 P.M., the 100-Hall Medication Cart was unlocked and left unattended, - On 01/27/25 at 2:17 P.M., two Certified Nurse Aides (CNA) walked by the medication cart, - On 01/27/25 at 2:23 P.M., The medication cart remained unlocked and unattended, - On 01/27/25 at 2:25 P.M., two CNAs walked by the medication cart, - On 01/27/25 at 2:28 P.M., a CNA walked by the medication cart, - On 01/27/25 at 2:31 P.M., RN 3 walked to the medication cart, made some notes on a piece of paper, and walked back to the nurse's station without locking the medication cart, - On 01/27/25 at 2:33 P.M., a Laundry Aide walked by the medication cart, and - On 01/27/25 at 2:38 P.M., two CNAs and a Laundry Aide walked by the medication cart. During an observation and interview on 01/27/25 at 2:39 P.M., RN 3 approached the medication cart and indicated the Qualified Medication Aide (QMA) had been passing medications this shift. The medication cart should be locked when left unattended. During the observation there were mobile residents in the general area three to five feet of the medication cart. The current facility policy, titled Storage of Medications, with a revision date of April 2007, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . 3.1-25(o)

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38239 Based on interview and record review, the facility failed to obtain a blood test and a urinalysis for 1 of 5 residents reviewed for laboratory services. (Resident 1) Findings include: 1a. The clinical record for Resident 1 was reviewed on [DATE] at 2:10 P.M. An Admission Minimum Data Set assessment, dated [DATE], indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and aortic valve disorder. The resident's [DATE] physician's orders included, but were not limited to, the following: - An order, with a start date of [DATE], to administer warfarin (an anticoagulant) medication. The resident was to receive 3.5 milligrams (mg), every Monday, Wednesday, Thursday, Saturday, and Sunday and 4 mg every Tuesday and Friday, and - An order, with a start date of [DATE], to obtain a weekly PT/INR (a blood test that measured how long it took for a blood sample to clot). A Nursing Note, dated [DATE] at 4:51P.M., indicated the laboratory (lab) technician had an expired sample collection tube and would have to obtain the blood sample on [DATE]. A Nursing Note, dated [DATE] at 2:56 P.M., indicated the lab was unable to collect the PT/INR sample on [DATE], [DATE], or [DATE]. The facility spoke with the lab, and they were going to come and collect a STAT (immediate) PT/INR. The lab report for the PT/INR blood test indicated the sample was collected on [DATE] and resulted on [DATE]. The results were within the recommended therapeutic range for the resident. A Nursing Note, dated [DATE] at 11:22 A.M., indicated the Nurse Practitioner was updated on the PT/INR results. The resident was to continue the current dose of warfarin. During an interview on [DATE] at 11:12 A.M., the Director of Nursing (DON) indicated the lab said they couldn't obtain a sample from the resident so there was an order for a STAT PT/INR on [DATE]. The sample was collected by the lab on [DATE] and resulted on [DATE]. She would have liked to have had the lab drawn before [DATE]. 1b. A Nursing Note, dated [DATE] (Saturday) at 11:51 P.M., indicated new physician's orders were received to obtain a Urinalysis and Culture and Sensitivity (UA/CS) for Resident 1. A Nursing Note, dated [DATE] (Sunday) at 8:38 A.M., indicated the resident denied pain or discomfort but experienced frequent incontinent episodes and frequent feelings of needing to void. The resident's urine had a strong odor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manderley Health Care Center	806 S Buckeye St Osgood, IN 47037

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Shift Level Administration Note, dated [DATE] (Monday) at 1:08 A.M., indicated the resident's urine sample was obtained and placed in the refrigerator. The laboratory (lab) report for the urinalysis indicated the resident's urine was collected on [DATE] (Wednesday) and the results were reported on [DATE] (Friday). The report indicated the following bacteria were detected in the sample: - Klebsiella pneumoniae, with an estimated high microbial load, - Citrobacter freundii/braak/koseri, with an estimated moderate microbial load, - Proteus mirabilis, with an estimated moderate microbial load, - Pseudomonas aeruginosa, with an estimated moderate microbial load, - Actinobaculum schaalii, with an estimated low microbial load, - Enterobacteriaceae, with an estimated low microbial load, and - Enterococcus faecalis, with an estimated low microbial load. The report recommended potential antibiotics to treat the bacteria. A Nursing Note, dated [DATE] (Monday) at 3:31 P.M., indicated a new physician's order was received to administer Fosfomycin (an antibiotic), 3 milligrams every 72 hours for three doses. During an interview on [DATE] at 9:25 A.M., RN 2 indicated the lab would pick up specimens on Thursdays, Fridays, and Saturdays. If the facility had a urine specimen that needed to be sent out at any other time the facility would have to ship it. During an interview on [DATE] at 11:12 A.M., the DON indicated nursing staff were to collect the urine sample and contact the lab to pick up the sample. If the sample was collected on a day the lab didn't come to the facility, they would have to ship the sample out. She was unsure where the lab company was located. The current Lab and Diagnostic Test Results - Clinical Protocol with a revision date of [DATE], was provided by the DON on [DATE] at 2:54 P.M. The policy indicated, .The physician will identify, and order diagnostic and lab testing based on diagnostic and monitoring needs .The staff will process test requisitions and arrange for tests . 3XXX,d+[DATE](a)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38239 Based on observation and interview, the facility failed to store foods in a sanitary manner related to unlabeled and outdated foods for 1 of 3 kitchen observations. This deficient practice had the potential to affect 45 of 47 resident that receive food from the kitchen. Findings include: During the initial tour of the facility kitchen on [DATE] at 10:35 A.M., the following items were observed: - A ,d+[DATE] full half gallon of lactose free 2% milk that expired on [DATE], - An unopened half gallon of lactose free 2% milk that expired on [DATE], and - A metal pan ,d+[DATE] full of brown gravy. The pan was covered with plastic wrap and dated [DATE]. During an interview on [DATE] at 10:40 A.M., [NAME] 5 indicated the milk and brown gravy were expired and should have been thrown out. The current facility policy, titled Policy: Storage Areas, dated ,d+[DATE], was provided by the Director of Nursing on [DATE] at 10:25 A.M. The policy indicated, .Leftover food is used within 3 days or discarded .All foods should be covered, labeled, and dated . 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(3)

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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. 38769 Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to urinary catheter care for 1 of 2 residents reviewed for infection control. (Resident 19) Findings include: 1a. During an observation on 01/27/25 at 1:50 P.M., Resident 19 was lying in bed. His entire urinary catheter bag was lying on the floor. The urine in the tubing appeared to be cloudy. During an observation 01/30/25 at 10:17 A.M., half of the resident's urinary catheter bag was lying on the floor. During an interview and observation on 01/30/25 at 10:18 A.M., Qualified Medication Aide (QMA) 7 indicated the resident's urinary catheter bags should be below bladder level and should not touch the floor. She went to Resident 19's room, donned gloves and removed the urinary catheter bag off the floor and secured it to the side of the bed. The clinical record for the resident was reviewed on 01/29/25 at 10:15 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, neurogenic bladder and obstructive uropathy. The resident had a urinary catheter and was dependent on staff for all care. The clinical record indicated the resident was on enhanced barrier precautions due to having a urinary catheter. The current facility policy titled Catheter Care, Urinary, with a revised date of September 2014, was provided by the Director of Nursing (DON) on 01/30/25 at 11:12 A.M. The policy indicated, .Infection Control .Be sure the catheter tubing and drainage bag are kept off the floor . 1b. During an observation on 01/31/25 at 1:01 P.M., Certified Nurse Aide (CNA) 9 entered Resident 19's room and donned a gown and gloves. She was performing urinary catheter care on the resident when CNA 10 walked into the room and donned gloves. CNA 10 went to the right side of the resident's bed, held the dirty washcloths for CNA 9 and placed them in a bag. After the urinary catheter care was completed CNA 10 rolled the resident to his left side to check his backside and laid him on his back. She retrieved a pillow and as she was getting ready to place it behind the resident, the pillow touched her clothing. As the care was completed CNA 9 indicated she was aware that CNA 10 did not don a gown when she entered the room to help care for the resident. During an interview on 01/31/25 at 1:07 P.M., CNA 9 indicated when CNA 10 entered the room to help with urinary catheter care she should have donned a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled, Enhanced Barrier Precautions updated April 2024 was provided by the Administrator on 01/31/25 at 1:23 P.M. The policy indicated, .Enhanced barrier precautions [EBPs] are utilized to prevent the spread of multi-drug resistant organisms [MDROs] to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply .Gloves and gown are applied prior to performing the high contact resident care activities .Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include .providing hygiene .changing briefs or assisting with toileting .device care or use .urinary catheter .EBPs are indicated [when contact precautions for not otherwise apply] for residents with wounds and/or indwelling medical devices regardless of MDRO colonization . 3.1-18(b) 3.1-41(a)(2)