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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	08/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, resident interview and facility policy review, the facility failed to complete a bed hold notice with the resident or resident's responsible person when residents transferred out of the facility for 1 of 2 residents reviewed (Residents #12). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented a discharge from the facility with return anticipated. Review of Resident #12's Progress Notes revealed the following information: a. On 7/14/24 Resident #12 admitted to the hospital. b. On 7/16/24 Resident #12 returned to the facility at 3:00 PM. Review of the Resident #12's census tab revealed the following information: a. 7/14/24 hospital start date b. 7/16/24 hospital end date The MDS assessment dated [DATE] for Resident #12 documented a reentry into the facility on [DATE]. Review of Resident #12's clinical record revealed the facility lacked a bed hold notice for the hospital admission on 7/14/24. The Bed Hold policy last reviewed 12/7/24 identified at the time of discharge the state-specific form will be provided to resident and/or representative, which specifies the duration of the bed-hold policy under the state plan and the facility policy regarding bed-holds. The designated staff will review the Notice of Bed-Hold Policy and explain that future admission is based on bed availability and criteria listed in the Notice of Bed-Hold Policy. (continued on next page)

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

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/10/24 at 2:45 PM, the Administrator and Director of Nursing reported she expected staff to complete bed hold forms with the resident and/or representative for hospital transfers.

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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** 49628 Based on clinical record review, staff interview, and policy review the facility failed to complete a Pre-Admission Screening and Resident Review (PASRR) for 1 of 2 residents (Resident #20), who was diagnosed with new mental disorder diagnoses since admission to the facility. The facility reported a census of 49 residents. Findings include: Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficit. The MDS further revealed diagnoses of anxiety disorder, depression, and psychotic disorder. Review of a facility provided document titled, The Preadmission Screening and Resident Review (PASRR) Level I Screen Outcome, dated 10/28/21 revealed a summary of findings indicating that Resident #20 did not show evidence of a serious mental illness or an intellectual or developmental disability (IDD) that appears to require PASRR intervention. The document provided the resident had a diagnosis of major depressive disorder, recurrent, in remission, and medication Citalopram 20mg/day. Additional medication of Risperidone .5 mg/day for Dementia. The document further revealed that should there be a discrepancy in the reported information, a status change should be submitted for further evaluation. Review of Clinical Referral for psychiatry dated 4/7/23 revealed Resident #20 had increased hallucinations and paranoia. The Psychiatrist added a new diagnosis of unspecified paranoia. The Psychiatrist also increased the resident's Risperdal. The Psychiatrist signed the document. The electronic health record (EHR) review of medical diagnoses for Resident #20 revealed Parkinson's Disease, major depressive disorder, recurrent, moderate, generalized anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, and depression, unspecified. The medical diagnosis of unspecified psychosis was added to the diagnosis list on 11/7/23 and occurred during the stay in the facility. Clinical Physician Orders documented the following orders: Alprazolam .25 mg/day for generalized anxiety disorder, Citalopram Hydrobromide 20mg - 1.5 tablet/day for depression, unspecified, Risperidone Disintegrating .25 mg/day for other hallucinations, and Risperidone .5 mg/day for sleep related to Parkinson's Disease. On 8/10/24 at 1:22 PM Staff B, Social Services, stated a new PASRR would be completed if there were a change in behaviors noted with a resident. The staff stated the MDS Coordinator would have previously notified the staff if there were a change/addition of diagnosis. On 8/10/24 at 2:55 PM the Administrator stated she did not know a lot about PASRR regulations except to know that one is required upon admission. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Pre-Admission Screening and Resident Review (PASRR) Rehab/Skilled reviewed 12/11/23 revealed that if a resident is diagnosed with a mental disorder while in the facility contact will be made with the designated state agency for a Level II screening.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

47079

Based on observation, clinical record review, staff interviews, and policy review, the facility failed to develop a resident-centered comprehensive care plan for 3 of 3 residents reviewed (Resident #5, #18, and #39). The facility reported a census of 49 residents.

Findings include:

1. The quarterly Minimum Data Set (MDS) assessment for Resident #5 dated 7/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Non-Alzheimer's dementia, seizure disorder, anxiety, depression, and insomnia. It also revealed the resident was independent with eating, required setup assistance with oral hygiene, and moderate to maximum assistance with all other Activities of Daily Living (ADLs). It further indicated the resident took antipsychotic and antidepressant medications within the last 7 days.

The Clinical Physician Orders dated 8/10/24 included the following prescribed medications:

a) Prozac Capsule 20 MG (FLUoxetine HCl) Give 20 mg by mouth in the morning related to major depressive disorder, recurrent, mild. Target behavior: self-isolation, refusing/non-participation in self-care. Make progress note if behaviors present.

b) Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to unspecified mental disorder due to known physiological condition. Target Behavior: verbalization of paranoia, refusal of care, talking to herself-make progress note if target behavior noted

The Care Plan included the psychotropic medications but failed to include the target behaviors for staff to monitor.

2. The quarterly MDS assessment for Resident #18 dated 7/23/24 revealed a BIMS score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of anxiety, depression, concussion with loss of consciousness, cerebral infarction (stroke caused by blocked blood vessel to the brain), schizotypal disorder (personality disorder causing eccentric behavior and anxiety with close relationships), and metabolic encephalopathy (brain dysfunction caused by chemical imbalances in the blood). It revealed the resident required setup assistance with oral hygiene, supervision with eating, and was dependent with all other Activities of Daily Living (ADLs). It further indicated the resident took antipsychotic, antidepressant, antianxiety, and hypnotic medications within the last 7 days.

The Clinical Physician Orders dated 8/10/24 included the following prescribed medications:

a) Abilify Oral Tablet 20 MG (Aripiprazole) Give 1 tablet by mouth one time a day related to concussion with loss of consciousness of 30 minutes or less, subsequent encounter.

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Trazodone HCl Oral Tablet 100 MG (Trazodone HCl) Give 0.5 tablet by mouth one time a day for Traumatic Brain Injury (TBI) with Shizotypal behaviors/aggression 50 mg total. c) Duloxetine HCl Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 1 capsule by mouth two times a day related to schizotypal disorder. d) Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 50 mg by mouth two times a day for Dx: MOD. e) Buspirone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth three times a day related to anxiety disorder, unspecified; major depressive disorder, single episode, unspecified. The physician orders failed to include target behaviors for each psychotropic medication order. The Care Plan initiated 6/14/23 included the psychotropic medications and hollering out as a behavior but failed to include target behaviors for his other psychotropic medications for staff to monitor. 3. The quarterly MDS assessment for Resident #39 dated 7/16/24 revealed a BIMS score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of anxiety, depression, and adjustment disorder with mixed anxiety and depressed moods. It revealed the resident required setup assistance with dressing, supervision with bathing, and was independent with all other Activities of Daily Living (ADLs). It further indicated the resident took antidepressant and antianxiety medications within the last 7 days. The Clinical Physician Orders dated 8/10/24 included the following prescribed medications: a) Bupropion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG (Bupropion HCl) Give 1 tablet by mouth in the morning related to major depressive disorder, recurrent, unspecified. b) Clonazepam Oral Tablet 1 MG (Clonazepam) Give 1 mg by mouth two times a day related to anxiety disorder, unspecified (f41.9); major depressive disorder, recurrent, unspecified. c) Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth three times a day for Anxiety and itching related to anxiety disorder, unspecified. d) Venlafaxine HCl ER Capsule Extended Release 24 Hour 150 MG Give 2 capsule by mouth at bedtime related to major depressive disorder, recurrent, unspecified. The physician orders failed to include target behaviors for each psychotropic medication order. The Care Plan initiated 3/03/22 included the psychotropic medications but failed to include target behaviors for staff to monitor. A document titled Care Plan - R/S, LTC, Therapy & Rehab revised 11/01/23 indicated each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/11/24 at 2:12 PM, the Director of Nursing (DON) stated staff should follow the Care Plan policies.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, resident interview, policy review and staff interview the facility failed to revise and update a care plan to include current transfer needs for 3 out of 4 residents reviewed (Resident #24, Resident #42, and Resident #16). The facility reported a census of 49 residents. Findings Included: 1. The Minimum Data Set (MDS) assessment dated ,d+[DATE] for Resident #24 documented diagnoses of pain in the left knee, muscle weakness and heart failure. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. The Progress Notes for Resident #24 showed the following: a. On 8/6/24 at 3:08 PM Resident #24 returned back to the facility after a procedure. Resident #24 reported having pain down her left leg. b. On 8/7/24 at 6:47 PM Resident #24 required a total lift to transfer to the wheelchair. In an interview on 8/9/24 at 1:46 PM, Resident #24 reported she received a Kyphoplasty procedure due to a compression fracture. Resident #4 reported she is still recovering and required the use of a mechanical lift for transfers. Observation 8/10/24 at 2:10 PM showed staff used a mechanical lift to transfer Resident #24 from the wheelchair to the recliner. Review of the Care Plan for Resident #24 instructed staff to use a forward wheeled walker and assist of one person for transfers during the day, and a non-mechanical stand aide with assist of one person at night. The Care Plan policy last revised 11/1/23 identified the plan of care will be modified to reflect the care currently required/provided for the resident. In an interview on 8/10/24 at 2:45 PM, the Administrator and Director of Nursing reported they expected care plans to be revised to show current transfer needs of residents. 49628 2. According to the MDS assessment dated [DATE] Resident #42 was not able to participate and score on the BIMS indicating severe cognitive impairment. The resident had diagnoses of Alzheimer's disease with late onset. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #42 required complete dependence on staff for self care, mobility and positioning. The resident required the use of a wheelchair (w/c) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed Resident #42 on 8/20/24 at 9:12 AM positioned in a tilt in space w/c with the resident tilted in a posterior position. Observed Resident #42 on 8/10/24 at 1:28 PM lying in a wide bed positioned in the lowest position with a fall mat beside the bed and a call light in place. Observed Resident #42 on 8/10/24 at 4:15 PM lying in a low wide bed with a fall mat beside the bed and a call light next to the resident. Observed Resident #42 on 8/11/4 at 10:00 AM in a low wide bed with a fall mat beside the bed and a call light next to the resident. Resident #42's Care Plan revealed a focus area for falls with interventions for staff including: scoop mattress on the bed dated 7/19/23, fall pad and wide bed in room dated 8/5/24. On 8/10/24 at 1:07 PM Staff C, Certified Nursing Assistant (CNA) stated fall interventions for Resident #42 included a bigger bed, the bed positioned in a low position, floor mat at all times and the call light directly beside the resident where she can reach it. The w/c should be reclined back when positioned in it. On 8/10/24 at 1:17 PM Staff D, CNA, stated she was not aware of all the fall interventions for the resident as she had been gone from the facility. The staff stated she would ask the nurse for the interventions and since the resident required 2 staff for transfers would learn them then. On 8/10/24 at 3:11 PM Staff E, Charge Nurse/Licensed Practical Nurse (LPN) sated the fall interventions for Resident #42 included a low and wide bed, fall mat, and the night stand was moved away from the bed as that is what the resident hit. The staff stated the w/c is also tilted back to improve the resident's posture to prevent leaning forward. 3. According to the MDS assessment dated [DATE] Resident #16's BIMS score was a 6/15 indicating severe cognitive impairment. The resident had a diagnosis of unspecified dementia and other hypertrophic osteoarthropathy at multiple sites. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #16 required substantial to dependence on staff for self care, mobility and positioning. The resident required the use of a w/c. On 8/9/24 at 1:12 PM observed Resident #16 with edema wear for bilateral lower extremities. On 8/10/24 at 9:06 AM observed Resident #16 seated in a w/c with elevating leg rests elevated approximately 45 degrees. The resident was wearing edema wear. On 8/10/24 at 10:43 AM observed Resident #16 seated in w/c with leg rests elevated with edema wear on. Resident #16's Care Plan did not reference edema or edema wear. The facility provided document, [NAME] CNA, indicated the resident wore edema wear. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/10/24 at 1:04 PM Staff C stated she knew Resident #16 wore edema wear. The staff stated she knew about the edema wear as it was on the paper at the nurses station. The staff provided a document, [NAME] CNA, that provided notes on each resident including edema wear for Resident #16. On 8/10/24 at 3:11 PM Staff E stated the CNA's and nurses have quick notes at the nurses station for easy reference on the residents. The staff stated they should be updated with the care plans. On 8/10/24 at 3:12 PM the Administrator stated care plans should match current interventions and be updated. The CNA/nurse cheat notes at the nurses stations should match the care plans. On 8/11/24 at 11:00 AM the Director of Nursing, DON, stated ideally the care plans and nurses/CNA's quick notes at the nurses station should match. The DON acknowledged that they do not currently match. The DON stated she was in the process of updating the care plans to ensure the quick notes and care plans match. The DON stated part of the process will be interviewing the staff to ensure the correct interventions are in place. The facility 's policy, Care Plan - R/S, LTC, Therapy and Rehab, reviewed/revised on 11/1/23 revealed the care plan should be reviewed, evaluated and updated when a resident has a significant change. The document also revealed the care plan will be modified to reflect the care currently required/provided for the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47079 Based on observations, clinical record review, and policy review the facility failed to ensure physician's orders were followed for 1 of 1 resident (Resident #46) reviewed. The facility identified a census of 49 residents. Findings include: On 8/09/24 at 1:22 PM, an observation revealed Resident #46's oxygen flow meter was set to 4 liters per minute (LPM). The resident stated he required oxygen continuously. The admission Minimum Data Set (MDS) assessment for Resident #46 dated 7/02/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Atrial Fibrillation (irregular heart beat), Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and deep venous thrombosis (DVT - blood clot in deep veins). It revealed the resident was independent with eating and oral hygiene but required moderate to maximum assistance with all other Activities of Daily Living (ADLs) and received oxygen therapy upon admission and in the 14-day look-back period. A physician order dated 6/30/24 revealed the resident was to receive oxygen at two (2) LPM during the day and 3 LPM at night for COPD. The Electronic Health Record (EHR) included progress notes that revealed the resident had continuous oxygen at his home and was ordered oxygen at 2 LPM during the day and 3 LPM at night for COPD. The August 2024 Medication Administration Record (MAR) revealed the resident received 4 LPM on 8/09/24. The Care Plan revised 8/09/24 directed staff to provide oxygen therapy per order. On 8/10/24 at 3:50 PM, a subsequent observation revealed the resident's oxygen flow meter was set to 3 LPM. A policy titled Oxygen Administration, Safety, Mask Types - R/S, LTC, Therapy & Rehab revised 7/08/24 directed staff to turn the oxygen concentrator's flow rate control slowly clockwise until the center of ball in flow rate indicator moves up to number of liters per minute as ordered by physician. On 8/11/24 at 2:12 PM, the Director of Nursing (DON) stated staff should follow the physician's order.

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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. 47079 Based on observation, clinical record review, staff interviews, and policy review, the facility failed to identify target behaviors for psychotropic mediation use for 2 of 3 residents reviewed (Resident #18 & #39). The facility reported a census of 49 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) assessment for Resident #18 dated 7/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of anxiety, depression, concussion with loss of consciousness, cerebral infarction (stroke caused by blocked blood vessel to the brain), schizotypal disorder (personality disorder causing eccentric behavior and anxiety with close relationships), and metabolic encephalopathy (brain dysfunction caused by chemical imbalances in the blood). It revealed the resident required setup assistance with oral hygiene, supervision with eating, and was dependent with all other Activities of Daily Living (ADLs). It further indicated the resident took antipsychotic, antidepressant, antianxiety, and hypnotic medications within the last 7 days. The Clinical Physician Orders dated 8/10/24 included the following prescribed medications: a) Abilify Oral Tablet 20 MG (Aripiprazole) Give 1 tablet by mouth one time a day related to concussion with loss of consciousness of 30 minutes or less, subsequent encounter. b) Trazodone HCl Oral Tablet 100 MG (Trazodone HCl) Give 0.5 tablet by mouth one time a day for Traumatic Brain Injury (TBI) with Shizotypal behaviors/aggression 50 mg total. c) Duloxetine HCl Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 1 capsule by mouth two times a day related to schizotypal disorder. d) Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 50 mg by mouth two times a day for Dx: MOD. e) Buspirone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth three times a day related to anxiety disorder, unspecified; major depressive disorder, single episode, unspecified. The physician orders failed to include target behaviors for each psychotropic medication order. The Care Plan initiated 6/14/23 included the psychotropic medications and hollering out as a behavior but failed to include target behaviors for his other psychotropic medications for staff to monitor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The quarterly MDS for Resident #39 dated 7/16/24 revealed a BIMS score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of anxiety, depression, and adjustment disorder with mixed anxiety and depressed moods. It revealed the resident required setup assistance with dressing, supervision with bathing, and was independent with all other Activities of Daily Living (ADLs). It further indicated the resident took antidepressant and antianxiety medications within the last 7 days. The Clinical Physician Orders dated 8/10/24 included the following prescribed medications: a) Bupropion HCl ER (SR) Oral Tablet Extended Release 12 Hour 150 MG (Bupropion HCl) Give 1 tablet by mouth in the morning related to major depressive disorder, recurrent, unspecified. b) Clonazepam Oral Tablet 1 MG (Clonazepam) Give 1 mg by mouth two times a day related to anxiety disorder, unspecified; major depressive disorder, recurrent, unspecified. c) Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth three times a day for Anxiety and itching related to anxiety disorder, unspecified. d) Venlafaxine HCl ER Capsule Extended Release 24 Hour 150 MG Give 2 capsule by mouth at bedtime related to major depressive disorder, recurrent, unspecified. The physician orders failed to include target behaviors for each psychotropic medication order. The Care Plan initiated 3/03/22 included the psychotropic medications but failed to include target behaviors for staff to monitor. The facility did not provide a policy regarding psychotropic medications or Gradual Dose Reductions (GDRs). On 8/11/24 at 2:12 PM, the Director of Nursing (DON) stated Center for Medicare & Medicaid Services (CMS) guidelines should be followed.

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NAME OF PROVIDER OR SUPPLIER Salem Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2027 College Avenue Elk Horn, IA 51531	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47079 Based on observations, menu review, and staff interviews, the facility failed to properly prepare and serve the appropriate portions of pureed diets for 3 of 3 residents and minced and moist diets for 7 of 7 residents. The facility reported a census of 49. Findings include: The facility's lunch menu for 8/10/24 identified the following items to be served as part of the following planned textured diets. A) Pureed diet: 5 fluid ounces (fl oz) of ground/minced baked pork chop 4 fl oz of mashed potatoes 4 fl oz of pureed carrots (substitution for buttered summer squash) 1 each pureed bread slice 3 fl oz pureed peaches 8 fluid oz 2% milk 6 fl oz black coffee or tea B) Minced & Moist diet: 4 fluid ounces (fl oz) of pureed baked pork chop 4 fl oz of mashed potatoes 4 fl oz of pureed carrots (substitution for buttered summer squash) 1 each pureed bread slice 4 fl oz pureed peaches 8 fluid oz 2% milk 6 fl oz black coffee or tea (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuous observation of lunch preparation and service began on 8/10/24 at 10:20 AM. Staff I, Cook, stated she was preparing minced & moist diets for 9 servings. She minced 9 pork chops and 2 cups of chicken broth in the blender and poured the unmeasured contents into a steam pan and placed it back in the oven. At 10:30 AM, Staff I blended three (3) pork chops, an unmeasured amount of chicken broth, and two (2) tablespoons (tbs) of thickener in a blender. She poured the contents into a measuring pitcher and stated it was two (2) cups. At 10:45 AM, Staff I blended 12 ounces of carrots in the blender and poured the unmeasured contents into a steam pan. She indicated it was for minced & moist diets. She blended 12 ounces of carrots with a hand blender and measured 1 1/2 cups. She indicated it was for pureed diets. At 11:00 AM, Staff J, Dietary Assistant (DA) prepared 11/2 cups of minced peaches and poured the unmeasured contents into 3 separate bowls. At 11:30 AM, Staff I identified the following serving size dishers used to provide diet portions: 1) 3-oz disher for pureed pork chop 2) 4-oz disher for minced & moist pork chops 3) 4-oz disher for both pureed and minced & moist carrots The volume method (total volume/# of servings) used for alternate texture diets indicated the following dishers to be used based on the volume method: 1) #6 disher (5 1/3 oz) for pureed pork chop 2) #8 disher (4 oz) for pureed carrots The total volume of minced & moist pork chops and carrots was not measured; therefore, the appropriate serving size was not determined. On 8/10/24 at 1:15 PM, the Dietary Manger (DM) stated staff used the volume method and not the alternate texture conversion chart. On 8/10/24 at 2:44 PM, Staff I stated she did not measure the minced & moist meat. A policy titled Portion Control - Food and Nutrition revised 2/19/24 indicated the portion control chart is posted in the kitchen for reference by employees unless another such chart is preferred. It revealed a #6 disher was needed for 5 1/3-ounce portion size. On 8/11/24 at 2:08 PM, the Administrator stated staff should measure the volume correctly and follow the appropriate chart.

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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. 47079 Based on observation, staff interview, and policy review, the facility failed to maintain sanitary practices by failing to prevent cross-contamination while serving food. The facility reported a census of 49 residents. Findings include: On 8/10/24 at 11:45 AM a continuous observation revealed, Staff I used tongs to move plastic wrap from pan with rolls then grabbed a roll with the same tongs and placed it on a resident's plate. She also used the same tongs to remove aluminum foil from a casserole pan. Staff I placed butter packets on residents' plates which directly touched the residents' food throughout meal service. At 12:04 PM, Staff I placed her right hand on the steam table counter and waited for a staff member to take the prepared plate from her left hand. She grabbed dedicated food scissors and cut a resident's meat into bite sized portions, placed the scissors on the steam table counter where her hand had been, picked up the scissors and cut two (2) more residents' meat into bite sized portions. At 12:10 PM, Staff I moved 2 pans from the left side of the steam table area and continued serving food without performing hand hygiene. A policy titled Food Handling - Food and Nutrition revised 6/25/24 indicated proper utensils such as tissue, spatula, tongs, and single-use gloves are used for food handling. On 8/11/24 at 2:08 PM, the Administrator stated staff should follow the policy regarding safe food handling.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47079 Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access. The facility reported a census of 49 residents. Findings include: On 8/09/24 at 3:45 PM, an observation revealed an open laptop screen with visible resident Electronic Health Record (EHR) information. A sheet was face-up on the cart with resident names, room numbers, blood glucose results, and insulin. At 3:47 PM, Staff D, Certified Nurse Aide, (CNA) stated staff usually did not leave the information visible and the screen is usually locked. At 3:50 PM, Staff F, Registered Nurse (RN) stated she used the sheet as her cheat sheet so she would not forget the information. A policy titled Confidentiality revised 5/06/24 indicated individuals who have access to confidential information must ensure that such info4matinon, in whatever form it exists, is handled strictly in accordance with the policy and applicable legal, accreditation and regulatory requirements regarding safeguarding confidential information. On 8/11/24 at 2:08 PM, the Administrator stated staff should follow Health Insurance Portability and Accountability Act (HIPAA) policies.

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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. 44420 Based on observation, facility policy and staff interview, the facility failed to provide proper hand hygiene during toileting and urinary catheter care for 2 of 2 residents (Resident #1, Resident #35) observed. The facility also failed to perform hand hygiene between feeding two (2) residents. The facility reported a total census of 49 residents. Findings include: 1. Observation on 08/10/24 at 2:08 PM, Staff A, Certified Nursing Assistant (CNA) donned personal protective equipment (PPE) then assisted Resident #10 to the bathroom. Staff A lowered the resident's pants and incontinence brief then assisted the resident to sit on the toilet. Staff A removed and discarded soiled gloves, reached beneath her PPE gown, and retrieved hand sanitizer. Staff A performed hand hygiene then donned new gloves. After Resident #10 attempted to have a bowel movement, Staff A cleansed Resident # 10's buttock, pulled up his incontinence brief and pants, then sat the resident back on the toilet. Staff A removed and discarded soiled gloves. Staff A failed to perform hand hygiene, then donned new gloves. Staff A placed a graduated measuring container directly on the floor then emptied the urine into the colander. Staff A cleansed the urine catheter drainage spout, placed the spout back into the holder, removed and discarded soiled gloves. Staff A failed to perform hand hygiene, then donned new gloves. The Catheter policy last revised 7/30/24 instructed staff to perform hand hygiene after removing gloves. The policy also showed the procedure for catheter drainage required staff to avoid placing the graduated measuring container directly on the floor by placing a barrier between the graduated measuring container and the floor. The Personal Protect Equipment policy last revised 12/4/23 instructed staff to wear PPE gowns appropriate to the tasks being performed, to protect skin and prevent soiling or combination of clothing during procedures and resident care activities when contact with blood, body fluids, secretions or excretions is anticipated. In an interview on 8/10/24 at 2:45 PM, the Administrator and Director of Nursing reported that staff are expected to perform hand hygiene after removing gloves, use PPE per policy and place a barrier between the graduated measuring container and the floor. 47079 2. On 8/09/24 at 12:20 PM, Staff H, Certified Nurse Aide (CNA) assisted two (2) residents (Resident #14 & #42) with eating lunch. Staff H wiped Resident #42's mouth with her right hand then grabbed Resident #14's knife with the same hand, and cut the resident's meat. She used her left hand and attempted to feed Resident #14 as Resident #14 grabbed the same knife. Staff H used her right hand, took the knife from Resident #14, and held the resident's left arm down as she fed her. Staff H turned toward Resident #42 and grabbed the resident's cloth napkin, and wiped Resident #42's mouth. No hand hygiene was performed throughout the observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled Hand Hygiene revised 3/29/22 indicated all employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. On 8/11/24 at 2:08 PM, the Administrator stated staff should follow the facility policy. 3. On 8/09/24 at 3:07 PM, observed the indwelling catheter drainage bag hanging on the side of the resident's trash can. The resident stated that is where staff normally hung it. The admission Minimum Data Set (MDS) assessment for Resident #35 dated 7/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of urine retention, Chronic Obstructive Pulmonary Disease (COPD), Transient Ischemic Attack (TIA - brief blockage of blood flow to the brain), and multiple left rib fractures. It indicated the resident was independent with eating, required set-up assistance with oral hygiene, moderate assistance with toileting hygiene, maximal assistance with bathing, dressing, and personal hygiene and moderate to maximal assistance with all forms of mobility. The MDS also revealed the resident had an indwelling catheter and a urinary tract infection within the previous 30 days. The Progress Note dated 7/28/24 indicated the resident had hematuria (blood in the urine) in the catheter drainage bag. A subsequent progress note dated 8/01/24 revealed the resident received an antibiotic for a urinary tract infection. The Care Plan dated 8/08/24 revealed the resident required staff to manage the indwelling catheter and directed staff to assist with peri-care if needed. On 8/11/24 at 10:45 AM, Staff A, Certified Nurse Aide (CNA) and Staff G, CNA were observed providing Resident #35's catheter and peri-care. Staff A and Staff F, Registered Nurse (RN) transferred the resident from her recliner to her bed. Staff A held the gait belt with her gloved right hand. Staff F hung the drainage bag on bed frame. Staff A and Staff B assisted the resident to a lying position and pulled her pants down. Staff F refastened the drainage tubing to the resident's left leg, washed her hands and exited. Staff A changed her gloves, got a urine collection container and placed it on paper towel on the floor. She grabbed the package of hygiene wipes, removed one and wiped the resident's right groin area then the left groin area. She grabbed a new hygiene wipe and cleaned the indwelling catheter tubing insertion site. She moved the drainage bag to a lower spot on the bed frame and repositioned the resident toward the wall. She applied barrier cream to the resident's buttocks, changed gloves, and put briefs on the resident. She grabbed the drainage bag with her left hand, opened the drainage bag spigot with her right hand, drained the urine, closed the spigot, grabbed an alcohol swab with her right hand and cleaned the spigot. She emptied the urine in the toilet and changed her gloves. No hand hygiene was performed throughout the procedure. At 2:02 PM, Staff A stated she should have performed hand hygiene after moving the resident's walker but did not due to resident safety related to other resident equipment such as oxygen tubing. A policy titled Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen- AL, R/S, & LTC revised 7/30/24 directed staff to perform hand hygiene between resident contact and catheter care. It also directed staff to use a fluid-impermeable pad under the urine collection container. On 8/11/24 at 2:08 PM, the Director of Nursing (DON) stated staff should follow the procedure for donning & doffing gloves for catheter care and emptying the catheter drainage bag.