STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165165	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northcrest Specialty Care	2001 Heath Street Waterloo, IA 50703

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, Center for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment to accurately reflect the medication status for 1 of 1 resident reviewed on anticoagulant (blood thinner) medications (Resident #10). The facility identified a census of 87 residents. Findings include: Resident #10's MDS assessment dated [DATE] included a diagnosis of cerebrovascular accident (CVA, stroke). The MDS reflected Resident #10 took an anticoagulant medication within the lookback period. An Order Review History Report signed by the Provider on 1/5/25 documented the following physician orders dated 1/11/24: a. Aspirin (nonsteroidal anti inflammatory and antiplatelet medication) enteric (thick coating to prevent the medicine from breaking down too soon) coated delayed release 81 milligrams (MG) give 1 tablet by mouth one time a day for nonrheumatic aortic valve stenosis (a narrowing of the aortic valve that doesn't allow it to fully open, reducing the blood flow from the aorta to the rest of the body). b. Clopidogrel Bisulfate (Plavix, antiplatelet medication) oral tablet 75 MG give 1 tablet by mouth one time a day related to insufficiency of aortic valve. Interview on 1/29/25 at 10:44 AM Staff A, Assistant Director of Nursing (ADON) reviewed Resident #10 medications and verified she didn't receive an anticoagulant medication. During an interview on 1/29/25 at 10:48 AM the Director of Nursing (DON) stated the facility used traveling MDS Coordinators. She reviewed Resident #10 medications and stated she took aspirin and clopidogrel. Interview on 1/29/25 at 10:49 AM Staff B, Reimbursement Specialist, reported Resident #10 took aspirin and someone may have miscoded it as an anticoagulant on the MDS. She voiced she would look into it. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 10:59 AM Staff B reported Resident #10's MDS assessment from 1/3/25 as incorrectly coded. She thought since they did clinical documentation on bleeding risk, the nurse that completed the MDS may have confused it with that. She voiced the facility followed the RAI manual for MDS Coding. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 documented the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) required the assessment accurately reflected the resident's status. The Section N Medications section instructed to not code antiplatelet medications such as aspirin as an anticoagulant. Antiplatelet and anticoagulant medications are both used to prevent blood clots, but they work in different ways. Antiplatelet medications prevent platelets, which are blood cells responsible for clotting, from sticking together and forming clots. Anticoagulant medications interfere with the clotting cascade, a series of steps that leads to blood clot formation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review and staff interview the facility failed to provide a timely assessment and physician notification for a resident with a history of bowel obstructions and peptic ulcer disease who exhibited nausea, vomiting, and loose stools for 1 of 1 resident's reviewed (Resident #45). The facility identified a census of 87 residents. Findings include: Resident #45's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS listed Resident #45 as dependent upon staff for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after having a bowel movement). The MDS documented Resident #45 as incontinent of bowel. The MDS included diagnoses of unspecified intestinal obstruction versus complete obstruction and esophagitis (inflammation of the esophagus) with bleeding. The Patient Report dated 2/29/24 related to Resident #45's two view abdominal x ray for excessive diarrhea and a history of (bowel) obstruction. The reviewer compared the x ray to a prior abdominal x ray completed 12/14/23. The Impression indicated Resident #45 didn't have evidence of an obstruction. The Orders - Administration Note dated 10/10/24 at 3:27 PM written by Staff L, Certified Medication Assistant (CMA), documented she administered 30 milliliters (ML) Milk of Magnesia (MOM) to Resident #45 for a stomach ache. The Orders - Administration Note dated 10/10/24 at 4:53 PM documented the MOM effectiveness as unknown. The Progress Notes lacked documentation of an abdominal assessment or notification to the nurse. The Orders - Administration Note dated 10/11/24 at 8:22 AM written by Staff M, Licensed Practical Nurse (LPN), indicated they administered Miralax 17 Grams for constipation/loose stools. The Progress Notes lacked documentation of an abdominal assessment. The Orders - Administration Note dated 10/11/24 at 9:19 PM written by Staff N, Registered Nurse (RN), reflected they administered ondansetron (anti nausea medication) 4 MG to Resident #45 for nausea and vomiting. The Progress Notes lacked documentation of an abdominal assessment or notification to the Primary Physician Provider (PPP) on 10/11/24 or 10/12/24. The Orders - Administration Note dated 10/13/24 at 6:39 PM written by Staff O, CMA, identified they administered ondansetron 4 MG to Resident #45 for complaints of nausea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes lacked documentation of notification to the nurse, the PPP, or an abdominal assessment on 10/13/24 or 10/14/24. The Orders - Administration Notes dated 10/15/24 at 7:00 PM written by Staff O, reflected they administered ondansetron 4 MG to Resident #45 for nausea and vomiting. The Orders - Administration Note dated 10/15/24 at 8:00 PM listed the ondansetron as ineffective for nausea and vomiting. The Nurses Note dated 10/15/24 at 10:13 PM written by Staff P, LPN, documented Resident #45 complained of abdominal pain and nausea. The assessment described Resident #45's abdomen as distended and firm. Staff P gave Resident #45 pain medication and Zofran (ondansetron) with no relief. He began vomiting a large amount of a thin light brown liquid in consistency with bits of chicken in the vomit. Resident #45 requested to go to the emergency room (ER). Staff P sent Resident #45 to the local hospital via ambulance at 10:15 PM. Resident #45's October 2024 B&B - Bowel Elimination Follow-Up Question Report from 10/9/24 - 10/15/24 list his bowel movements as: a. Formed - 10/10 b. Soft - 10/11 and 10/12 c. Loose/Diarrhea - 10/10 (2), 10/12, 10/13 (2), and 10/14 d. Watery - 10/11 and 10/13 The Weights & Vitals lacked documentation of pulses, respiration rates, blood pressures, oxygen saturations, and temperatures from 8/17/24 to 10/15/24. The eInteract Change in Condition Evaluation - V 5.1 dated 10/15/24 at 10:30 PM documented Resident #45 had uncontrolled abdominal pain, nausea and vomiting that started that afternoon with a history of GI complications. His vital signs at 9:48 PM reflected a blood pressure of 145/84 (expected normal range from 100/70 - 120/80), pulse 80/regular (expected from 60-100), respirations 19 (expected 12-20), temperature 98 degrees Fahrenheit (F) (normal body temperature range 96 to 99.9), and oxygen level 95% (expected greater than 90%). The Evaluation indicated Resident #45 had persistent nausea discomfort not associated with other acute symptoms; intermittent recurrent nausea and vomiting; mild diffuse or localized pain, unrelieved by antacids or laxatives, abdominal pain, and distention. Resident #45 had acute abdominal pain rated at an 8 out of 10 (10 being the worse pain on a 1 10 pain scale). The Evaluation documented Resident #45 went to the ER for evaluation and treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Encounter Progress Note dated 11/4/24 at 12:00 AM completed by the Family Nurse Practitioner (FMP) detailed Resident #45 had a history of severe gastritis as well as scarring that is consistent with prior peptic ulcer disease. On 10/15/24 Resident #45 began complaining of abdominal pain and nausea, with his abdomen distended and firm. The facility nurses attempted as needed (PRN) Zofran which was unsuccessful, and Resident #45 began vomiting large amounts. According to the facility charting Resident #45 requested to go the ER. Nursing obtained an order from his PPP. In addition, to Resident #45's abdomen's distension and firmness, he also had tenderness. They took a computer tomography (CT) scan of Resident #45's abdomen and pelvis with contrast which suggested a gastric perforation (puncture), thickening of the wall of the urinary bladder with infiltration which is suggestive of cystitis (inflammation of the bladder), and colonic diverticulosis with no definite evidence of diverticulitis (inflammation of the bowel). Resident #45 underwent exploratory laparotomy (surgery done with cameras) on 10/16/24. Resident #45 had a bowel perforation fixed with a [NAME] patch, he returned to the facility and nursing had no concerns at that time. Interview on 1/29/25 at 10:23 AM Staff L reported she gave Resident #45 MOM back in October 2024 because he said he needed to poop and couldn't poop. She voiced she would have reported this to a nurse but didn't recall which nurse she reported to. At that time the CMAs reported all the as needed medications they gave to the charge nurse. The nurses were to follow up to check the effectiveness of the medication. Interview on 1/29/25 at 1:56 PM Staff I, RN, explained she didn't know CMAs couldn't administer as needed MOM. If a resident hasn't had a bowel movement (BM) in three days, then the nurses would follow the physician orders for giving as needed medications according to the physician orders for constipation. If a resident didn't have a bowel movement and complained of a stomachache that would be reportable to a nurse. She would look to see when the resident had a BM last and then they would assess bowel sounds and take vital signs to assess what is going on. If the nausea and vomiting continued over more days, it would warrant more assessment and notification to the physician. During an interview on 1/29/25 at 2:07 PM Staff M recalled Resident #45 having nausea and vomiting, but couldn't recall how long it went on, but knew it did result in a bowel obstruction. The facility required CMAs to notify the nurse if a resident requested an as needed medication and what they wanted it for. The charge nurse would direct the CMA if they could administer the medication or if the nurse needed to check the resident. If a resident had nausea and vomiting, she would look to see when they had their last BM, talk to the resident, listen to their bowel sounds, check vital signs, ask how long it has been going on and go from there. If it was a new condition, they should notify the physician. Interview on 1/29/25 at 2:18 PM Staff O reported if a resident requested an as needed medication such as for constipation, the CMAs have to report it to the nurse. The nurse will go talk with the resident, then the nurse will direct the CMAs what to give, for example MOM. The nurses follow up to see if the resident had a bowel movement. If a resident had nausea or vomiting, he would let the charge nurse know right away. He recalled the facility had a traveling Director of Nursing (DON) at that time and miscommunication happened as to who charted as needed medications. They had different direction given since that time on for the as needed medications. He recalled Resident #45 had nausea and he thought he reported it to the charge nurse at that time. Staff O commented the CMAs received new education on the administration of as needed medications since that time. He recalled signing the education sheet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/29/25 at 3:28 PM Staff B, Reimbursement Specialist, reported in reviewing Resident #45 he had a long history of perforations and bowel issues. During an interview on 1/29/25 at 3:41 PM Staff Q, DON Education Support Personnel, reported the facility had a Change of Condition Evaluation form they open in the Evaluations tab in the electronic health record (HER) that directed the nurses on what assessment to do. A 1/29/25 review of the EHR Evaluations revealed no Change of Condition Evaluation Form opened from 10/9/24 to 10/15/24 to monitor Resident #45 condition. The EHR Evaluations tab only contained the E Interact Change of Condition Evaluation form for 10/15/24 at 10:30 PM filled out by the nurse when they transferred Resident #45 to the ER for evaluation. On 1/30/25 at 9:02 AM Staff R, RN, reported she didn't recall any staff informing her about Resident #45 having abdominal pain. She always told the aides to report any resident issues to her. She would have assessed the resident's bowel sounds, felt his abdomen, checked his vital signs, review his medical history and report their condition to the physician. She would document the assessment and provider notification in the progress notes. Interview on 1/30/25 at 9:04 AM Staff S, LPN, reported he didn't recall any staff reporting a health change to him regarding Resident #45. If a CNA reported a resident having abdominal pain, nausea, or vomiting, he would take a full set of vitals, assess the bowel sounds, review the resident's bowel history, and contact the physician. He would document the assessment and notification of the physician in the resident's progress notes. On 1/30/25 at 9:50 AM Staff G, CMA, reported she is not allowed to give as needed medications to residents. A prior DON stated the CMAs had to stop administering as needed medications because they had just too many errors occurring. If a resident requested or complained of something, the CMAs will report it to the nurse. The nurse will go see the resident to see what is going on and go from there. The nurses do the medication follow ups on the as needed medication administration. She would alert the nurse about reports of abdominal pain, nausea, and vomiting especially with Resident #45 as he had issues in the past. Interview on 1/30/25 at 9:52 AM Staff F, RN, reported CMAs are not allowed to give as needed medications. If a resident reported symptoms or concerns, or a CNA/CMA saw a change in the resident, they are to report it to the nurse. The nurses are to go down to assess the resident by talking with them about symptoms, take vital signs, a pain assessment, abdominal assessment, review records, then give medications as needed, document the assessment either in the evaluations if a specific type of evaluation was completed or a change of in condition in the progress notes and notification of the provider in the resident's medical record. During an interview on 1/30/25 at 10:02 AM the DON reported she expected the nurses to fill out a Change of Condition Evaluation, perform a full assessment including vital signs, document the assessment and notify the physician of the change in condition. She expected a focused assessment on the area of concern to be completed every shift with vital signs until resolved. She expected the charge nurse to notify her or the Assistant DON's of the situation so they can do further monitoring as well. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 the DON provided In Service documentation to the CMAs from 11/11/24 directing that CMAs could no longer administer as needed medications. A 11/15/24 In Service Form provided nursing education that a resident's primary care physician must be notified of any changes and documented. An Acute Condition Change Clinical Protocol revised March 2018 directed the following: a. The physician will help identify individuals with a significant risk of having acute changes of condition during their stay. b. In addition, the nurse shall assess and document/report the following baseline information: vital signs, neurological status, current level of pain and recent changes in pain level, level of consciousness, cognitive and motional status, resident's age and sex, onset, duration and severity, recent labs, history of psychiatric disturbances, mental illnesses, depression, all active diagnosis and all current medications. c. Before contacting a physician about a resident with an acute change, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test resulting for comparison. f. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request prompt response (approximately one half hour or less). The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely response or appropriate response.

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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** 42133 Based on observation, clinical record review, and staff interview, the facility failed to provide food to a resident while out of the facility while they received renal dialysis for 1 of 1 resident's sampled (Resident #128). The facility identified a census of 87 residents. Findings include: Resident #128's Clinical Census reflected they admitted to the facility on [DATE]. The Handoff Report dated 1/24/24 listed Resident #128 received hemodialysis (a treatment that helps remove waste products and excess fluid from the blood when the kidneys are no longer able to do so) at a local (renal/kidney) dialysis center. The Nursing Admission/Readmission Evaluation - V 18 dated 1/24/25 documented Resident #128 as alert, oriented to person, place, time, situation and clear communication abilities. The Evaluation noted Resident #128 didn't have short term memory impairment, confusion, forgetfulness or impaired decision making ability. The Evaluation listed a Dietary Care Plan indicating the facility would provide with meals within Resident #128's diet. The Evaluation documented an arteriovenous (AV) fistula (an AV fistula is surgically created in the arm to provide easy access to a large blood flow for dialysis) present to the resident's right (arm) and a Dialysis Care Plan that lacked direction for the staff to send food or meals with Resident #128 to dialysis appointments. The Clinical - Assessment included a Brief Interview for Mental Status (BIMS) dated 1/24/25 with a score of 14, indicating intact cognition. A Communication: Nursing to Dietary V3 dated 1/24/25 directed Resident #128 admitted to the facility and required a regular, no added salt diet. The Communication lacked documentation Resident #128 received renal dialysis. The NSG: Dialysis Evaluation - V 9 dated 1/27/25 at 1:46 PM reflected the reason for evaluation as a pre-dialysis evaluation. The evaluation indicated Resident #128 left the facility at 7:00 AM for renal dialysis. The NSG: Dialysis Evaluation - V 9 dated 1/27/25 at 2:53 PM reflected the reason for evaluation as a post dialysis assessment. The evaluation indicated Resident #128 returned to the facility. During an interview on 1/28/25 at 8:24 AM Resident #128 verbalized she goes to dialysis on Monday, Wednesday and Fridays. She added the transport arrived late to pick her up around 9:45 AM. She reported she had her first dialysis appointment on 1/27/25 since admitting to the facility. When she went to her appointment, the facility didn't send any food with her. Transport picked her up around 9:45 AM and she didn't return from dialysis until late afternoon. The facility didn't send any food with her to dialysis and she got really hungry. She voiced she had to call [NAME] and pay for her own lunch to be delivered to the dialysis center. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 11:26 AM Staff C, Registered Nurse (RN), reported she usually worked on the other side of the facility so she didn't see when Resident #128 left for dialysis. She reported if she asked for a meal, then the facility would send a meal with them. It depended on what the resident wanted. She wasn't sure who had the responsibility to check with the resident, dietary staff or the certified nursing aides (CNAs). On 1/29/25 at 11:30 AM Staff D, CNA, reported the kitchen usually had sack lunches set up, but if they didn't, then the aides ask the resident if they want food to go with them to dialysis or their appointment. Interview on 1/29/25 at 11:33 AM Staff E, Assistant Dietary Services Manager, reported she didn't send any lunch with Resident #128 on 1/27/25 when they went to dialysis. None of the staff informed her Resident #128 was leaving and no one communicated that she had to go out to dialysis. Staff E communicated the aides usually let them know if a resident is going out and wanted to take a sack lunch with them, then they make it for them. During an interview on 1/29/25 at 11:43 AM the Director of Nursing (DON) reported usually nursing informs the Dietary Manager know when a resident is going out so they can set things up. The DON voiced, Resident #128 was admitted over the weekend so it did not get communicated properly. She expects the dietary staff to send a sack lunch with the residents when the go out to dialysis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48452 Based on observation, interviews, and record review the facility failed to remove expired foods from storage, to maintain a sanitary environment, and to date opened food during 2 of 2 observations. The facility reported a census of 87 residents. Findings include: During the initial kitchen tour and observation on [DATE] at 9:36 AM the dry storage area contained an undated and nearly full clear bin of rice with a blue lid. The shelf below the rice contained two round snack bins without lids with prepackaged snacks. The bin on the left held 6 items, cheese puffs out of the wrapper, and crumbs. The bin on the right held 11 items, corn chips out of the wrapper, and chip crumbs. Another shelf contained an open, undated package of chicken and herb stuffing. The bottom shelf of the next unit contained 3 boxes of lemon bar mix. One of the boxes had two sides crumpled, and the tops of the other two had a film of dust and food particles. The boxes had expiration dates listed on the boxes as [DATE], [DATE], and [DATE]. On the top shelf of that unit contained a box of gluten free chocolate chip cookies that expired [DATE]. Further investigation of the kitchen included the walk-in refrigerator and freezer. The freezer contained an open, undated package of fajita vegetable blend. Another shelf contained a cardboard box of southern style biscuits. The front and side flaps of the box were open, and the plastic holding the biscuits was open to the freezer air (-3 degrees). The box had a delivery date, but didn't have an open date. The box looked approximately half full, and some of the biscuits had small ice crystals on them. The floor in the freezer had 3 half dollar size ice chunks stuck to the surface, tater tots, green beans, and other unidentified food particles. On [DATE] at 9:45 AM the Dietary Manager (DM) stated they had the snack bins from the day before. She didn't know why they had them in the dry storage room because they're not to be stored there. When asked when the last time they served lemon bars for a meal, the DM thought the spring and summer menu (2024) had them. During an interview on [DATE] at 4:11 PM the Administrator reported he recently audited the kitchen for expired items and didn't know how or why they still had those items there. During a second observation on [DATE] at 9:32 AM, saw a cart of clean dishes against the wall in the food preparation area. A metal surrounded floor drain approximately 5 6 inches deep with a mesh drain cup in the bottom sat approximately 9 inches from the cart. Food particles, bits of foil, and dust webs with food caught in them covered the metal-surrounded drain and the drain cup. Staff E, Assistant Dietary Services Manager (ADSM), stated they used the drain when the facility had a portable steam table, she didn't think they used it for anything at the time of survey. On [DATE] at 11:27 AM the DM reported she audited for expired food on a regular basis, and usually checked for shelf life on Mondays when she put the new food shipment away. When asked how the facility managed expired items, she stated they tossed expired food. She expected staff who opened food for meals to label items with an 'O' for opened with the date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:45 AM the DM provided a document titled Cleaning Schedule for the week of the survey. Morning staff initialed that they swept and mopped the floors, cleaned refrigerator spills, and checked for outdated food daily. Evening (PM) staff initialed they cleaned refrigerator spills daily, swept, and mopped the floors.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, Center for Disease Control and Prevention (CDC) Guidelines, policy review and staff interview, the facility failed to implement Enhanced Barrier Precautions when providing high contact care for assessing a fistula (dialysis access site), working with a gastrostomy (G) tube (feeding tube) and emptying a Urinary catheter drainage bag for 3 of 3 resident sampled (Resident #10, #128 and #132). In addition, the facility failed to provide adequate infection control prevention and practices to prevent touching medication with bare hands or dirty gloves during medication administration for 3 of 4 resident observed (Resident #34, #43 and #63). The facility identified a census of 87 residents. Findings include: 1. Resident #132's Clinical Census listed an admitted [DATE]. A Brief Interview for Mental Status (BIMS) Evaluation dated 1/14/25 listed a score of 15, indicating intact cognition. Resident #132 Minimum Data Set (MDS) assessment dated [DATE] included a diagnosis of malnutrition. The MDS documented Resident #132 had a feeding tube while a resident. She received 26 50 percent of her total calories and 501 cubic centimeters (CC, a unit of measurement 30 cc equals one ounce of fluids) per day or more through the feeding tube. Resident #132 January 2025 Electronic Medication Administration Record (EMAR) listed the following physician orders: a. Start Date 1/15/25: Enteral (An alternative way of eating that bypasses the mouth) feed order one time a day formula flow rate set at 60 Milliliters (ML) per Hour (HR). Discontinued 1/23/25. b. Start Date 1/15/25: Enteral feed order two times a day. Document the enteral feeding intake every shift. Discontinued 1/23/25. c. Start Date 1/14/25: Enteral feed order two times a day. Flush feeding tube with at least 15 30 ML of water before and after the administration of feedings. d. Start Date 1/14/25: Enteral feed order two times a day. Formula Osmolyte 1.2 no fiber at 60 ML/HR from 6 PM to 4 AM. Document the feeding tube intake every shift. Discontinued 1/23/25. e. Start Date 1/14/25: Enteral feed order three times a day. Check the residual every shift if less than 30 ML note in progress note. f. Start date 1/14/25: Enteral feed order three times a day. Document the amount of water every shift. Include water given before and after the medication administration. g. Start Date 1/14/25: Enteral feed order three times a day, verify the gastric (G) tube (feeding tube) placement every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25 at 10:47 AM observed Resident #132's room door. The door didn't have a CDC Enhanced Barrier Precaution (EBP) Sign on the room door. Resident #132's January 2025 Electronic Treatment Administration Record (ETAR) documented an order dated 1/27/25 to use EBP due to her having a G tube. On 1/28/25 at 7:54 AM observed Resident #132 with a CDC EBP sign posted on her room door. The CDC Enhanced Barrier Precautions Sign directed everyone must clean their hands, including before entering the room and when leaving the room. The EBP sign further directed Providers and Staff must wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assist with toileting, device care or use: feeding tube. During an interview on 1/28/25 at 8:02 AM Staff F, Registered Nurse (RN), reported Resident #132 ate a mechanical soft diet, the nursing staff only flushed and checked the placement of the feeding tube at that time. Resident #132 just started EBP on 1/27/25. Staff F voiced that up until 1/27/25 Resident #132 didn't have EBP precautions and she just started the precautions due to having a feeding tube. Interview on 1/28/25 at 1:30 PM Resident #132 reported the nurses just started using gowns and gloves when they flushed her tube the day before (1/27/25) in the afternoon. She voiced the other day the nurse pushed the syringe and the tube just blew. She reported stomach contents landed on her and went all over. On 1/28/25 at 1:24 PM watched Staff F sanitize her hands, apply an isolation gown, and gloves. Staff F then checked residual and placement of Resident #132's feeding tube. Afterwards, she removed her gown and gloves, then performed hand hygiene. During an interview on 1/29/25 at 11:46 AM the Director of Nursing (DON) reported the facility educated the certified nurses' aides (CNAs) on EBP. They just place the CDC EBP signs on the resident doors as an extra step to remind the staff of the Personal Protective Equipment (PPE) requirements. She reported she worked on the staff with the EBP and some residents, like Resident #132 and #128 just got missed. The Enhanced Barrier Precaution (EBP) Policy revised 3/28/24 directed EBP refers to an infection intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and glove use during high contact resident care activities. The Policy further directed the facility would communicate to staff to ensure staff knew of which residents required the use of EBP prior to providing high contact care activities. The Policy PPE for EBP is only necessary when performing high contact care activities which further defined included device care for central lines, feeding tubes and urinary catheters. The Policy stated EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the discontinuation of the indwelling medical device that places the resident at higher risk. 2. Resident #128's Clinical Census reflected they admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Handoff Report dated 1/24/24 listed Resident #128 received hemodialysis (a treatment that helps remove waste products and excess fluid from the blood when the kidneys are no longer able to do so) at a local (renal/kidney) dialysis center. The Nursing Admission/Readmission Evaluation - V 18 dated 1/24/25 documented Resident #128 as alert, oriented to person, place, time, situation and clear communication abilities. The Evaluation noted Resident #128 didn't have short term memory impairment, confusion, forgetfulness or impaired decision making ability. The Evaluation documented Resident #128 had an arteriovenous (AV) fistula (an AV fistula is surgically created in the arm to provide easy access to a large blood flow for dialysis) present to her right (arm). Resident #128's dialysis Care Plan directed staff to use EBP. Resident #128's BIMS evaluation dated 1/24/25 listed a score of 14, indicating intact cognition. On 1/27/25 at 11:50 PM observed Resident #128's room door didn't have a CDC EBP sign on the door. Resident #128's January 2025 EMAR listed a physician order for dialysis on Monday, Wednesday and Friday, chair time at 10:45 AM. Resident #128's January 2025 ETAR listed a physician order dated 1/24/25 to assess the fistula for bruit (swish) and thrill (pulsing feeling near the fistula) every shift. The NSG: Dialysis Evaluation - V 9 dated 1/25/25 at 1:09 PM reflected the reason for evaluation as non dialysis day. The evaluation documented Resident #128 fistula as normal with bruit heard, thrill pulsation felt, and normal fistula elevation. The NSG: Dialysis Evaluation - V 9 dated 1/26/25 at 1:53 PM reflected the reason for evaluation as non dialysis day. The evaluation documented Resident #128 fistula as normal with bruit heard, thrill pulsation felt, and normal fistula elevation. The NSG: Dialysis Evaluation - V 9 dated 1/27/25 at 1:46 PM reflected the reason for evaluation as a pre-dialysis evaluation. The evaluation described Resident #128's fistula as normal with good color, bruit swish heard and thrill pulsation present with normal fistula elevation. The NSG: Dialysis Evaluation - V 9 dated 1/27/25 at 2:53 PM reflected the reason for evaluation as a post dialysis assessment. The evaluation indicated Resident #128's fistula site as normal with the bruit heard, thrill pulsation felt, and normal fistula elevation with no bleeding at the site. Interview on 1/28/25 at 8:24 AM Resident #128 reported the nurses use their stethoscope to listen to her fistula several times a day. She voiced she never saw them wear a gown and gloves when checking and touching her fistula pointing to her fistula just below the bend in her right elbow. During an interview on 1/29/25 at 11:46 AM the DON reported Resident #128 admitted on a weekend. They felt it got missed and fell through the cracks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 1/29/25 at 7:24 AM observed Staff G, Certified Medication Aide (CMA), check Resident #63's EMAR for physician orders. Staff G pulled a bottle of stock Lactaid from the medication cart drawer, shook out two tablets from the bottle into the lid, then picked up one tablet with her bare right hand and placed it back in the stock bottle and picked up the other tablet with her bare right hand and placed it in Resident #63's medication cup. Staff G removed a stock multivitamin bottle from the medication cart. She shook two multivitamins into the bottle lid. Staff G picked up 1 tablet in her bare right hand and put back in the stock bottle, then picked up the remaining multivitamin and placed it in Resident #63's medication cup. Staff G proceeded to Resident #63's room and administered the medication to them. During an interview on 1/29/25 at 7:56 AM Staff H, CMA, verbalized staff shouldn't touch resident's pills with their bare hands. She would use a clean glove or a spoon if she needed to touch a resident's oral medications. 4. On 1/29/25 at 7:58 AM watched Staff I, Registered Nurse (RN), perform hand hygiene, apply gloves to both hands, touch the computer screen to scroll through residents and opened Resident #43's EMAR. Staff I took the medication cart keys from her pocket, unlocked the medication cart, opened the drawer, and removed Resident #43's medication cards from the drawer and laid them on top of the medication cart. Staff I reviewed the physician order on the computer screen and the medication card for each medication. Without performing hand hygiene or changing her gloves, Staff I punched each medication out of the backside of the medication card to the fingertips of her gloves putting each pill into the medication cup. Staff I continued with this technique while setting up the following medications: a. Cymbalta 90 Milligram (MG) one tablet b. Baclofen 10 MG one tablet c. Lisinopril 30 MG one tablet d. Metoprolol Succinate Extended Release 50 MG one tablet At 8:00 AM without performing hand hygiene or changing her gloves, Staff I entered Resident #43's room and administered their medications. 5. On 1/29/25 at 8:08 AM observed Staff I perform hand hygiene, apply gloves to both hands, touch the computer screen to scroll through residents and opened Resident #34's EMAR. Staff I took the medication cart keys, unlocked the medication cart, opened the drawer and removed Resident #34's medication cards from the drawer and laid them on top of the medication cart. Staff I reviewed the physician order on the computer screen and the medication card for each medication. Without performing hand hygiene or changing her gloves, Staff I punched each medication out of the backside of the medication card to the fingertips of her gloves putting each pill into the medication cup. Staff I continued with this technique while setting up the following medications: a. Amlodipine 10 MG one tablet b. Carvedilol 25 MG one tablet (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 1:07 PM witnessed Staff J, CNA, enter Resident #10's room. Staff J applied a pair of gloves, placed two paper towels on the floor, placed a graduate container on top of the paper towels, cleansed the urinary drainage bag drain tube with alcohol, opened the drain tube and emptied the urine out of the bag into the graduate. Staff J emptied the graduate container of urine into the toilet, then placed the graduate under Resident #10's bathroom faucet and ran water into the graduate to rinse and dumped the urine water into the bathroom sink. Staff J filled the graduate a second time with water and dumped it into the sink before storing the graduate. Staff J failed to apply an isolation gown prior to emptying the urinary drainage bag. Interview on 1/29/25 at 1:18 PM, Staff G reported when resident is on EBP, a gown and gloves are to be worn when working with the catheter or high resident care activity. On 1/29/25 at 1:35 PM Staff K, CNA, voiced residents on EBP require the use of a gown, gloves, and a mask when working with the resident for PPE. During an interview on 1/29/25 at approximately 2:30 PM the DON reported she expected the staff to use a gown and gloves for EBP when emptying a catheter bag. She voiced it wasn't appropriate for the CNA to rinse the graduate and empty into the resident's sink. She ensured someone fully cleaned Resident #10's sink.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on resident interview, record review, staff interview, and policy review the facility failed to administer the flu vaccine for 1 of 6 residents reviewed (Resident #9). The resident requested the vaccine during her admission assessment. The facility reported a census of 87 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] documented an admitted [DATE]. The MDS included diagnoses of stroke and asthma. During an interview on 1/27/25 at 12:47 PM Resident #9 reported she didn't receive any vaccines at the facility, and she wanted the flu and COVID vaccines. When asked if she spoke to the staff about it, she replied she asked for the vaccines when she first arrived. On 1/30/25 at 10:19 AM the Director of Nursing (DON) provided documentation from Resident #10's clinical record dated 9/4/24 at 11:44 AM titled Admission/Readmission Evaluation. It documented Resident #10 consented to the flu vaccine, directed staff to complete the consent form, and noted the consent entered into Resident #10's immunization tab. The DON confirmed her record didn't have documentation about why Resident #10 didn't receive the vaccine, and acknowledged the facility had a flu clinic for residents at the facility in October after Resident #9's admission. The facility didn't have an original consent or declination form. During an interview at 11:28 AM on 1/30/25 the Administrator stated they usually have a progress note that said why the resident refused or why they didn't receive the vaccine during a clinic. A policy titled Influenza Vaccine revised October 2019 documented all residents who had no medical contraindications to the vaccine would be offered the influenza vaccine annually. It further indicated that if a resident refused the vaccine it would be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on resident interview, record review, staff interview, and policy review the facility failed to administer the flu vaccine for 1 of 6 residents reviewed (Resident #9). The resident requested the vaccine during her admission assessment. The facility reported a census of 87 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] documented an admitted [DATE]. The MDS included diagnoses of stroke and asthma. During an interview on 1/27/25 at 12:47 PM Resident #9 reported she didn't receive any vaccines at the facility, and she wanted the flu and COVID vaccines. When asked if she spoke to the staff about it, she replied she asked for the vaccines when she first arrived. On 1/30/25 at 10:19 AM the Director of Nursing (DON) provided documentation from Resident #10's clinical record dated 9/4/24 at 11:44 AM titled Admission/Readmission Evaluation. It documented Resident #10 consented to the flu vaccine, directed staff to complete the consent form, and noted the consent entered into Resident #10's immunization tab. The DON confirmed her record didn't have documentation about why Resident #10 didn't receive the vaccine, and acknowledged the facility had a flu clinic for residents at the facility in October after Resident #9's admission. The facility didn't have an original consent or declination form. During an interview at 11:28 AM on 1/30/25 the Administrator stated they usually have a progress note that said why the resident refused or why they didn't receive the vaccine during a clinic. A policy titled Influenza Vaccine revised October 2019 documented all residents who had no medical contraindications to the vaccine would be offered the influenza vaccine annually. It further indicated that if a resident refused the vaccine it would be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.