STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165275	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Haven Care Centre	1000 East Howard Creston, IA 50801

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, family interview, staff interviews and facility policy review, the facility failed to notify the family and/or physician of a medication error, a fall and a significant change for 4 of 6 residents reviewed (Resident #3, #24, #26, and #34). The facility reported a census of 30 residents. Findings include: 1. Observation of medication pass began on 7/9/24 at 7:35 am with Staff A, Registered Nurse. Staff A first administered medications to Resident #26. The administration of 18 medications were observed for Resident #26. Of the 18 medications administered, three of the medications were medication errors of the incorrect dosage. Following administering the medications to Resident #26, Staff A then administered Medications to Resident #3. One medication error was noted for Resident #26, also being an incorrect dosage. On 7/9/24 at 8:30 am, the Director of Nursing (DON) stated if a stock medication does not match the order, the nurse should notify the doctor and get an order change or get the correct dose from the pharmacy based on the doctor's preference. Review of the Progress Notes for Resident #26 and Resident #3 on 7/11/24 failed to reveal the physician had been notified of either resident having been administered medications not matching physician orders. 2. On 7/8/24 at 12:49 pm, a nurse at Resident #34's prior nursing facility stated she had come to visit Resident #34 at the current facility on 6/6/24. She stated she noticed a bruise on the resident's forehead and said Resident #34 had told her she had fallen out of her chair and also told her she was having pain in her legs. The nurse stated after the visit, she called Resident #34's family member who was not aware of Resident #34 having fallen or having any bruising or pain. On 7/8/24 at 1:50 pm, a family member of Resident #34 stated he had not been notified by the facility of Resident #34 having fallen or having any injuries. He stated he had not been aware of this until the nurse from the prior nursing facility informed him. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Profile section of Resident #34's Electronic Health Record reflected the son of Resident #34 to be: - Responsible Party - Financial Responsible Party - Power of Attorney, Financial - Power of Attorney, Care - Emergency Contact #1 The Minimum Data Set (MDS) assessment of Resident #34, dated 5/27/24 identified a Brief Interview of Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The Risk Management form dated 6/3/24 documented Resident #34 was observed on the floor beside her bed, lying on her stomach. It revealed documentation the resident stated she was self transferring to her bed and slid off the side of the bed. Page 3 of the Risk Management document revealed the Nurse on call and the Physician were both notified of the incident. The Risk Management form failed to document the Power of Attorney/Emergency Contact for Resident #34 was notified. Review of Resident #34's Progress Notes failed to reveal any documentation of the Power of Attorney/Emergency Contact for Resident #34 being notified of the fall. On 7/11/24 at 12:27 pm, the DON stated staff should notify family for falls and/or change of condition as soon as possible for injuries and within an acceptable time for family preference unless the resident competently represents themselves. 50471 3. The MDS assessment dated [DATE] for Resident #24 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident to need minimal assistance with personal care and dressing. Resident is dependent on staff for toileting hygiene and shower/bathe self. The MDS documented diagnoses that included: cerebral infarction, unspecified, Non-Alzheimer's dementia, hemiplegia, depression, and vascular dementia. The Care Plan, revised 3/5/24, revealed resident incontinent of bowel and bladder, staff to encourage resident to toilet before and after each meal, at bedtime, and at least once during the night, Check him for incontinence at that time, staff to assist as needed. Revealed resident sometimes needs some help with sit to stand, resident is able to transfer independently with his walker. Revealed resident is usually able to toilet independently, resident does need cues and assist to complete toileting hygiene and needs reminders to change soiled clothing. The Progress Note of Resident #24 dated 6/28/24 at 7:24 PM documented: Daughter was updated, resident was found in another resident's room, exposed to marijuana. Daughter voiced concern about exposure to marijuana interacting with medications and comorbidities. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note dated 6/28/24 at 10:27 PM noted blood pressure of 82/60. Resident stated to Staff P, Licensed Practical Nurse (LPN) I think someone's trying to kill me. Staff P, LPN asked who and why he thinks that, resident stated I'll tell you tomorrow, I forgot how to talk. The Progress Note dated 6/29/24 at 12:04 AM noted blood pressure 112/63. Resident stated to staff I'm ok. The Progress Note dated 6/29/24 at 2:02 AM noted blood pressure 117/66. The Progress Note dated 6/29/24 at 4:00 AM noted blood pressure 119/68. On 7/9/24 at 4:09 PM Staff Q, Certified Nurse Aide stated on 6/28/24 she worked 6:00 PM to 6:00 AM shift. She stated Resident #24 baseline is stand by assist. She took care of Resident # 24 that evening and resident required maximum assistance to total assistance of one staff to complete personal cares and toileting. Staff stated this is not his normal, he is very out of it. She stated she reported to the nurse on shift. On 7/10/24 at 6:32 AM Staff P, Registered Nurse (RN) stated on 6/28/24 at 6:30 PM, Resident #24 was found smoking marijuana, in Resident # 11 room, she removed the resident from the room and assisted the resident to his room. She monitored the resident the remainder of the shift. She noted during shift the resident was having delusions, people were trying to kill him. Staff stated she updated doctor via fax. Staff stated she did speak with the Doctor regarding resident #11, but did not update the doctor about resident #24 having delusions. Staff stated the resident does not have delusions of someone killing him at baseline. On 07/11/24 at 2:43 PM Staff P, LPN stated the resident has delusions at baseline. The residents delusions come and go. The resident is seen by a Psychiatrist. Staff P stated the resident needs assistance from staff most of the time for cares, and transferring varies depending on his status that day. The facility policy titled Notification of Resident/Patient Change in Condition, Review date 11/2019 directs: Point 7: Notify the Physician and family/resident representative at the earliest possible time, during waking hours, if there is a change in condition. Point 10: Document in the Progress Notes the times notification was made and the names of the person(s) spoken to.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to document whether or not a resident wished to appeal the decision of skilled services ending for 1 of 3 residents reviewed who discharged from skilled services(Resident #234). The facility reported a census of 30 residents. Findings include: a. A 2/1/24 Notice of Medicare Non-coverage(NOMNOC) documented the facility informed Resident #234 that her skilled services would end on 2/1/24. The facility lacked documentation they informed the resident of the reason her services would end and lacked documentation regarding whether the resident wished to appeal the decision of the services ending. b. A 3/18/24 NOMNOC documented the facility informed Resident #234 that her skilled services would end on 3/20/24. The facility lacked documentation they informed the resident of the reason her services would end and lacked documentation regarding whether the resident wished to appeal the decision of the services ending. The facility Social Services Manual, dated 2/2015, stated the facility would provide a completed copy of the Notice of Medicare Non-Coverage form to a resident no later than two days before the termination of the services. The notice enabled the resident to an immediate independent medical review of the decision to end Medicare coverage. The manual directed staff to maintain a copy in the resident's record. On 7/10/24 at 3:51 p.m., the Social Services Supervisor stated she did not keep documentation regarding whether or not residents desired to appeal the decision of skilled services ending. She stated she had the residents fill out the form but then gave it to the resident.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, staff interview, and facility policy review, the facility failed to complete a Significant Change Minimum Data Sheet (MDS) within 14 days for a resident placed on hospice care for 1 of 1 residents (Resident #27) reviewed. The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed significant change in status assessment with completion of the MDS on 6/5/24. The Progress Notes dated 5/15/24 at 3:00 PM revealed the Social Worker (SW) stated resident #27 was admitted to hospice care. The Encounter Note dated 5/22/24 revealed the Nurse Practitioner (NP) stated resident #27 had been evaluated by hospice and admitted with diagnosis of cerebral atherosclerosis. On 7/11/24 at 4:04 PM the Regional Director of Nursing stated MDS Coordinators are remote. He stated any care plan areas that trigger on the Care Area Assessments (CAA) of a comprehensive MDS is the responsibility of the remote MDS Coordinator to care plan. Daily updates should be done within the facility, and that is the responsibility of Staff P, Licensed Practical Nurse or of the DON. The facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,d+[DATE] includes the following documentation: Comprehensive or full assessments include the admission, significant change, significant correction of a prior full assessment and annual include all required MDS items along with State-designated sections, use of Care Area Assessment (CAA) including CAT's and CAA summary. Within 14 days after the facility determines that there has been a significant change in the resident's status that will not normally resolve itself, which has an impact on one or more area of the residents' health status and requires an interdisciplinary review and/or revision of the care plan.

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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** 47079 Based on clinical record review, staff interviews, resident interview, direction from the Resident Assessment Instrument (RAI), and policy review, the facility failed to assure each resident received an accurate Minimum Data Set (MDS) assessment, reflective of the resident's status at the time of the assessment for 1 of 14 residents (#21) reviewed for Accuracy of Assessment. The facility reported a census of 30 residents. Findings include: On 7/08/24 at 12:08 PM, the Administrator stated the facility currently had one (1) resident who received hemodialysis (HD) treatments On 7/08/24 at 3:00 PM, the resident stated he had been dependent on hemodialysis (HD) for several years and received HD treatments every Monday, Wednesday, and Friday. The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of congestive heart failure (CHF), chronic kidney disease (CKD), end-stage renal disease (ESRD), and diabetes mellitus. The MDS did not include the resident's HD treatments during the 7-day look-back period. The Electronic Health Record (EHR) dialysis communication forms indicated the resident received HD on 6/05/24, 6/07/24, and 6/10/24. A Progress Note dated 6/05/24 at 5:09 AM indicated the resident was being sent to dialysis at 5:20 AM. On 7/11/24 at 12:27 PM, the interim Director of Nursing (DON) stated the resident's HD should be included in the resident's MDS. A document titled Documentation Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated , d+[DATE] indicated the RAI/MDS assessment must include special treatments and procedures completed by nursing or designee.

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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** 50471 Based on clinical record review, staff interview, and facility policy review, the facility failed to notify Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for mental diagnosis and medications (Resident #6). The facility reported census of 30 residents. Findings include: The PASRR dated 1/4/24 for Resident #6 was prior to admission to facility, 5/21/24. The PASRR revealed no mental diagnosis or medications listed. The Minimum Data Sheet (MDS) assessment dated [DATE] revealed Resident #6 admitted to the facility with the diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance, non-Alzheimer's dementia, anxiety disorder, depression, and psychotic disorder. Resident #6 admitted to facility with drug classifications of antipsychotic, antianxiety, and antidepressant. The Care Plan initiated on 6/5/24 reveals diagnosis of dementia, depression, anxiety, and psychoactive drug use. On 7/10/24 at 10:20 AM the Social worker (SW) revealed the only PASRR for resident #6 is 1/4/24. On 7/11/24 at 3:08 PM, the SW stated she submits a new PASRR before residents admit to the facility. The SW stated when resident #6 admitted her medications were wrong. The staff clarified the resident was not taking antipsychotic medication, she was taking antidepressant and medications for dementia. An antipsychotic was started 6/27/24. The SW stated this is a trial medication. The facility policy titled Resident/Family Care & Services, Pre-Admission Screening for MR/MI revised 2/2015, includes the following documentation: -The facility verifies that all residents/patients are screened prior to admission to determine whether they have a mental illness (MI) or mental retardation/developmental disability (MR/DD) diagnosis and if the facility is able to meet the specialized needs of the resident/patient. A level II screen is done to assist the facility in determining the types of services required to care for the resident/patient. -Verify that the appropriate State-designated agency is contacted for any resident/patient requiring a MI/MR level II screen: Admission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, clinical record review, and policy review, the facility failed to implement a comprehensive care plan for 1 of 15 residents reviewed (#9). The facility reported a census of 30 residents. Findings include: On 7/09/24 at 9:06 AM, Staff I, Certified Nurse Aide (CNA) transferred Resident #9 from the bathroom to her wheelchair and from the wheelchair to her bed without a gait belt. She placed the resident's oxygen nasal cannula (NC - pronged tubing used for oxygen delivery through the nose) back on the resident. The resident's portable oxygen tank supply regulator was set on 2 Liters Per Minute (LPM) and the indicator registered in the red, refill zone. The resident's room concentrator was also set on 2 LPM. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was not conducted and indicated the resident was rarely or never understood. It included diagnoses of heart failure (HF), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), and non-Alzheimer's dementia. It also indicated the resident required maximum assistance with all transfers and was dependent with tub/shower transfers. It also revealed the resident used oxygen. The Electronic Health Record (EHR) Fall Risk assessment dated [DATE] indicated the resident was a high fall risk and required hands-on assistance to move from place to place. It also included a physician order dated 10/13/23 for oxygen at 3 liters (L) via nasal cannula (NC) every shift. The Care Plan focus dated 10/22/24 directed staff to use a mechanical aid for transfers. The Care Plan focus dated 10/20/23 indicated the resident had oxygen (O2) via nasal prongs/mask at 3 LPM continuously. On 7/09/24 at 12:19 PM, the resident was observed in her wheelchair in the dining room with her NC and oxygen tank. The oxygen tank regulator was set at 2 LPM and the indicator registered 0 in the red, refill zone. At 1:02 PM, Staff K, CNA removed the resident's nasal cannula and transferred her from her wheelchair to her bed. The resident's oxygen saturation was checked and observed at 92%. Staff A, Registered Nurse (RN) placed the resident on the oxygen concentrator at 2.5 LPM. On 7/11/24 at 12:27 PM, the interim Director of Nursing (DON) stated staff should follow the doctor's order and/or therapy expectations and use the mechanical aid if the mechanical aid was ordered. A document titled Transfer Technique dated 1/13 directed staff to review any special precautions or approaches to take when transferring a resident/patient and to obtain assistance as needed. A document titled Oxygen Administration dated 1/13 directed staff to monitor the oxygen flow rate and oxygen saturation, as ordered.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47079 Based on observations, clinical record review, resident interview, staff interviews, and policy review, the facility failed to fully review and revise the comprehensive care plan for 4 of 15 resident reviewed (#11, #12, #26, and #34). The facility reported a census of 30. Findings include: 1. An observation on 7/08/24 at 3:25 PM revealed Resident #26's legs and feet were swollen. The resident stated she was taking a water pill (diuretic) for a while for the swelling in her legs. The quarterly Minimum Data Set (MDS) assessment dated [DATE] 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 hypertension, deep vein thrombosis (DVT; deep vein blood clot), hyperlipidemia (high cholesterol in the blood), diabetes mellitus, and morbid obesity. It revealed the resident was independent with eating and oral hygiene, required maximum assistance with upper body dressing, and was dependent in all other activities of daily living (ADLs) and all mobility. It also revealed the resident received a diuretic within the 7-day look-back period. The Electronic Health Record (EHR) included a diuretic medication order dated 11/03/23. A physician's order dated 1/23/24, increased the diuretic dose. The Care Plan did not include the resident's use of diuretic medication nor interventions. On 7/11/23 at 12:27 AM, the interim Director of Nursing (DON) stated Care Plans should be continuously revised to meet the needs of the resident's care. A document titled Care Plan Development dated 8/15 indicated the Care Plan will be reviewed and revised on an as needed basis and at least every 92 days. 50471 2. The MDS assessment dated [DATE] for Resident #11 identified a BIMS score of 15 which indicates cognition intact. The MDS revealed the resident totally dependent upon staff for all cares. The MDS documented diagnoses that included: quadriplegia, anxiety disorder, depression, autonomic dysreflexia, and muscle spasms. The Comprehensive Care Plan of resident #11 initiated 10/11/22 failed to reveal resident to be a smoker. The untitled facility document provided during survey listed 4 residents as smokers which included Resident #11. Observation on 7/9/24 at 2:41 PM, revealed Resident # 11 is dependent on staff for monitoring during vaping at the designated facility times and place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Smoking: Resident/Patient Overview revised 9/19 included the following documentation: Evaluation/Assessment will include but is not limited to, the Admission/Re-Admission Documents & Initial Care Plan, Smoking Safety Screen, The RAI/MDS, and Physician orders. 3. The MDS assessment dated [DATE] for Resident #12 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident totally dependent upon staff for all cares with exception of eating. The MDS documented diagnoses that included: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, non-Alzheimer's dementia, seizure disorder or epilepsy, anxiety disorder, schizophrenia, and dysphagia. The Care Plan of resident #12 revised 2/27/24 reveals the resident transfers with assistance of one staff member, the resident requires (supervision, cueing, encouragement, specify physical assistance) with transferring, and the resident can transfer with one assist and use of his walker. Assist as requested or as needed. The Progress Note dated 1/26/24 at 3:02 PM revealed the Social Worker (SW) states Resident #12 brother called facility, SW updated brother on the decline in condition. SW provided details of decline stated staff is assisting with meals and staff uses a Hoyer to transfer him into a wheelchair. On 7/08/24 at 1:20 PM Resident #12 observed sitting in wheelchair with a sling for a full body mechanical lift under him. On 7/09/24 at 1:15 PM Staff L, Certified Nurse Aide (CNA) assisted Resident #12 to his room. Staff K, CNA assisted Staff L. Staff gathered mechanical lift equipment, instructed resident of the task, permission granted, staff hooked up mechanical lift to sling, Staff L controlled the mechanical lift equipment, Staff K guided resident to bed, resident positioned over bed, Staff L lowered resident onto the bed. Staff unhooked the sling from the lift. Staff moved the mechanical lift away from the bed. On 7/11/24 at 12:27 PM, the Director of Nursing (DON) stated Care Plans should be continuously revised to meet the needs of the resident's care. On 7/11/24 at 3:50 PM Staff P, Licenses Practical Nurse, Nurse Manager stated she does not do care plan revisions. On 7/11/24 at 4:04 PM the Regional Director of Nursing stated MDS Coordinators are remote. He stated any care plan areas that trigger on the Care Area Assessments (CAA) of a comprehensive MDS are the responsibility of the remote MDS Coordinator to care plan. Daily updates should be done within the facility, and that is the responsibility of Staff P, LPN or of the DON. The facility policy titled Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) dated ,d+[DATE] includes the following documentation: Comprehensive or full assessments include the admission, significant change, significant correction of a prior full assessment and annual include all required MDS items along with State-designated sections, use of Care Area Assessment (CAA) including CAT's and CAA summary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Within 14 days after the facility determines that there has been a significant change in the resident's status that will not normally resolve itself, which has an impact on one or more area of the residents' health status and requires an interdisciplinary review and/or revision of the care plan. 46873 4. The Minimum Data Set assessment of Resident #34, dated 5/27/24 identified a Brief Interview of Mental Status (BIMS) score of 7 which indicates severe cognitive impairment. The Care Plan of Resident #34 revealed a focus area of Actual Fall related to poor balance and unsteady gait dated 6/4/24. The intervention put in place was to monitor for 72 hours. No intervention was put in place to prevent or reduce future falls. The Risk Management form dated 6/3/24 at 8:45 pm documented Resident #34 was observed on the floor beside her bed, lying on her stomach. It revealed documentation the resident stated she was self transferring to her bed and slid off the side of the bed. The form noted no injuries observed at the time of the incident or post incident. On 7/10/24 at 1:17 pm, the Regional Director of Clinical Services stated a Risk Management form should be started by the nurse on duty at the time of the incident. From there, there should be a full investigation of the incident and it would be discussed in the morning meeting on the next business day. He stated during the meeting, it should be assured an intervention was put in place on the resident's care plan. If the intervention initially put in place was not an appropriate intervention, it would be changed. He additionally stated follow up assessment and charting by the nurses should be completed for 72 hours after an incident. The facility policy Fall Risk Reduction & Management, revision date 12/2015 documented the following: The Interdisciplinary team will develop a care plan for all residents/patients requiring a fall management program. The interdisciplinary team will develop the care plan with input from the resident/patient and/or the family/responsible party. Point 2: Develop the goal for fall risk reduction with the resident/patient and/or family/responsible party. Point 3: Develop interventions to assist resident/patient in reaching their goal.

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Crest Haven Care Centre	1000 East Howard Creston, IA 50801

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, facility document review, observation, staff interviews, and facility policy review, the facility failed to provide an environment that is free from accidents/hazards for 2 of 5 residents reviewed for environmental hazards (Resident # 11, #9). The facility reported a census of 30 residents. Findings include: 1. The facility document titled 5 Day Investigation Summary documented information which included the following: Staff F, Registered Nurse, (RN) was walking down the east hall at 6:30 pm on 6/28/24 when she observed the door to Resident #11's room slightly ajar and saw a male in the room. Staff F, RN entered the room and observed it was hazy with an odor of marijuana present with Resident #11 and two additional residents. Staff F observed two vapes lying on Resident #11's chest as she was in her wheelchair. Staff F separated the residents and removed the vapes from the room. The Minimum Data Sheet (MDS) assessment dated [DATE] for Resident #11 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicates cognition intact. The MDS revealed the resident totally dependent upon staff for all cares. The MDS documented diagnoses that included: quadriplegia, anxiety disorder, depression, autonomic dysreflexia, and muscle spasms. The Comprehensive Care Plan of Resident #11, initiated 10/11/22, failed to reveal resident to be a smoker. The untitled facility document provided during survey listed 4 residents as smokers which including resident #11. The Progress Notes dated 6/28/24 at 8:46 PM revealed Staff F, RN walked by resident #11 room, seen a male in the room, smelled an odor at the door, and entered the room. Staff F, RN found resident #11, resident #24, and resident #30 in the room, noted a strong odor, and saw two vapes on Resident #11 right side of the chest. Staff F stated she removed the two vapes and asked resident #24 and #30 to exit the room. Resident #11 went to the front desk with sister, requested Staff F to return the two vapes. Staff F instructed resident #11 to discuss with management. Resident #11 left facility with sister. Observation on 7/9/24 at 2:41 PM, revealed Resident # 11 is dependent on staff for vaping. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 6:32 AM, Staff F recalled incident on 6/28/24 at 6:30 PM. Staff F, RN stated she walked back from vending machines at end of East hall toward Nurse Station/Center of building. She noted odor in hallway. Seen Resident #11 door was slightly opened Staff F seen male figure in room. Staff F entered room noted haze with strong odor present. Resident # 11 in w/c facing door way, Resident # 24 sitting in w/c facing window, and Resident # 30 was standing by end of bed. Staff F asked male residents to exit the room and return to their rooms. Staff F observed two vapes sitting on Resident # 11 chest. Staff F removed the two vapes and placed them in a locked area. Staff F called on call manager who updated Administrator. Staff F was instructed to call local Police Department. Resident # 11 and Resident # 11's sister went to Nurse's Station. Resident # 11 told nurse she was leaving and left the facility with sister. Local Police Officer arrived at 7:00 PM, Staff F updated Officer of incident. Officer took items and left facility. Resident # 11 arrived back to facility at 9:39 PM, noted intoxication. Staff F assessed resident #11, and updated doctor. Doctor stated to send to hospital for evaluation. Staff F updated Resident # 11, EMT's arrived evaluated, Resident # 11 refused to go to the hospital. Staff F updated doctor, ordered to monitor. Staff F monitored resident the remainder of shift. On 7/10/24 at 2:00 PM, a Police Officer with local police, stated he arrived to the facility on [DATE] at 7:00 PM, He reported Staff F, RN told him of the incident and surrendered the two vapes. The Officer was unable to complete an investigation as resident was no longer on the property at that time, no harm was committed, no chargers were filed. He stated the two vapes were not tested . but stated one vape was nicotine and the other vape was THC. On 7/11/24 at 3:23 PM, the Social Worker (SW) stated interventions put in placed, resident #24 room was changed, re-educated about facility tolerance, reviewed smoking policy, encouraged residents to meet in common area, education provided to all residents no males in females rooms and no females in males rooms. On 7/11/24 at 3:27 PM, the Administrator stated all residents had been educated about intolerance of illegal substances in facility, staff educated about situation and interventions. The facility policy titled Smoking: Resident/Patient Overview revised 9/19 included the following documentation: -Instructed staff smoking materials/electronic or vapes devices will be secured by the facility. -Designated smoking areas for residents/patients who smoke. -Evaluation/Assessment will include but is not limited to, the Admission/Re-Admission Documents & Initial Care Plan, Smoking Safety Screen, The RAI/MDS, and Physician orders. 47079 2. On 7/09/24 at 9:06 AM, Staff I, Certified Nurse Aide (CNA) transferred Resident #9 from the bathroom to her wheelchair and from the wheelchair to her bed without a gait belt. Staff I stood in front of the resident, wrapped her arms around the resident's back, and lifted the resident off of the toilet and placed her in the wheelchair. She used the same technique to transfer the resident to her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not conducted and indicated the resident was rarely or never understood. It included diagnoses of heart failure (HF), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), and non-Alzheimer's dementia. It also indicated the resident required maximum assistance with all transfers and was dependent with tub/shower transfers. The Electronic Health Record (EHR) Fall Risk assessment dated [DATE] indicated the resident was a high fall risk and required hands-on assistance to move from place to place. The Care Plan focus dated 10/22/24 directed staff to use a mechanical aid for transfers. On 7/11/24 at 12:27 PM, the interim Director of Nursing (DON) stated when anyone is manually transferring a resident, a gait belt is to be used unless medically ordered otherwise. A document titled Transfer Technique dated 1/13 indicated the purpose was to safely transfer a resident/patient while minimizing the risk of injury to the resident/patient and caregiver and was resident/patient specific. It directed staff to review any special precautions or approaches to take when transferring a resident/patient and to obtain assistance as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review, observations, staff interview, and policy review the facility failed to follow infection prevention standards during incontinence cares for 2 of 2 residents review for incontinence cares (Residents #6, #12). The facility reported a census of 30 residents. Findings include: 1. The Minimum Data Set (MDS) assessment of Resident #6 dated 6/5/24 reflected the resident to have short term and long term memory problems. The MDS revealed the resident totally dependent on toileting and personal hygiene. The MDS reflected the resident always frequently incontinent of urine and not rated for bowel incontinent. The Care Plan, last reviewed 6/3/24, identified the resident to be incontinent of bladder. The Care Plan directed staff to provide incontinence care after each incontinent episode. The Care Plan did not state bowel incontinence. On 7/9/24 at 1:28 PM, Staff L, Certified Nurse Aide (CNA) entered resident #6 room. Resident #6 in wheelchair. Staff M, Certified Nurse Aide (CNA), brought the mechanical lift in room to assist resident and Staff L, CNA. Staff did not complete handwashing or hand hygiene. Staff provided privacy and stated to resident, assist with transfer and incontinent care. Staff hooked sling to equipment, transferred to bed, unhooked sling, equipment placed by door. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff remove pants, unfastened incontinent product. Staff L gathered wipe from Staff M, wiped front to back the outer labia, disposed the soiled wipe, gathered wipe from Staff M, wiped front to back the outer labia, disposed soiled wipe, with assistance from Staff M, Staff rolled resident to her right side toward the wall, Staff tucked the mechanical lift sling under resident, Staff M held onto resident, Staff L took soiled incontinent product and wipe bowel movement from anus, disposed soiled incontinent product, Staff L gathered wipe from Staff M, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff M wiped perineum, anus, sacrum, disposed wipe, gathered new incontinent product and placed under resident buttocks, Staff L tucked incontinent product fastener under right buttock, Staff rolled resident to her left onto her back, Staff rolled resident to her left side, Staff removed the mechanical lift sling, Staff L adjusted the incontinent product fastener, Staff assisted resident to her back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves, Staff L completed hand hygiene. Staff assisted resident to comfortable position, covered resident, placed call light within reach, placed floor mat at bed side, lowered bed to appropriate level. Staff L completed hand washing, Staff M took soiled bag and mechanical lift equipment to hallway, Staff M placed mechanical lift equipment against the wall, Staff M put soiled bag in soiled utility room, another staff member took the mechanical lift, mechanical lift was not disinfected. Staff M went back to resident's room, performed hand washing, Staff shut off light and exited room. During cares, staff failed to change gloves and wash/sanitize hands when going from dirty to clean. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 3:01 PM the Director of Nursing (DON) stated the staff should perform hand washing or hand hygiene before and after incontinent care, when soiled, and when gloves are removed. Stated the staff should change gloves before and after cares, during cares when soiled. Mechanical lift equipment should be cleaned per policy, routine cleaning. The facility policy titled Perineal Care revised 4/13 included the following documentation: -Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. -Remove gloves, wash hands, and apply clean gloves if original gloves were visibly soiled. -Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. -Remove gloves, wash hands, and apply clean gloves. 2. The MDS assessment dated [DATE] for Resident #12 identified a BIMS score of 4 which indicates severe cognitive impairment. The MDS revealed the resident totally dependent upon staff for all cares with exception of eating. The MDS documented diagnoses that included: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, non-Alzheimer's dementia, seizure disorder or epilepsy, anxiety disorder, schizophrenia, and dysphagia. The Care Plan revised 2/13/24 identified the resident to be incontinent of bladder and bowel. The Care Plan directed staff to provide incontinence care after each incontinent episode of bladder. The Care Plan directed staff to take resident to toilet at same time each day resident usually has bowel movement. On 7/09/24 at 1:15 PM Staff L, CNA assisted resident #12 to his room. Staff K, CNA assisted Staff L, CNA. Staff gathered mechanical lift equipment, instructed resident of the task, permission granted, staff completed hand washing, staff hooked up mechanical lift to sling, Staff L controlled the mechanical lift equipment, Staff K guided resident to bed, resident positioned over bed, Staff L lowered resident onto the bed. Staff unhooked the sling from the lift. Staff moved the mechanical lift away from the bed. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff remove pants, unfastened incontinent product. Staff L gathered wipe from Staff K, wiped right groin then left groin, disposed the soiled wipe, gathered wipe from Staff K, Staff L wiped left groin, disposed soiled wipe, with assistance from Staff K, Staff rolled resident to his right side toward the wall, Staff tucked the mechanical lift sling under resident, Staff K held onto resident, Staff L disposed soiled incontinent product, Staff L gathered wipe from Staff K, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff K wiped perineum, anus, sacrum, disposed wipe, gathered new incontinent product and placed under resident buttocks, Staff rolled resident to his left onto his back, Staff rolled resident to his left side, Staff removed the mechanical lift sling, Staff L adjusted the incontinent product, Staff assisted resident to his back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves, Staff completed hand washing. Staff assisted resident to comfortable position, covered resident, placed call light within reach, lowered bed to appropriate level. Staff removed soiled bag. During cares, staff failed to change gloves and wash/sanitize hands when going from dirty to clean and failed to disinfect the mechanical lift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 3:01 PM The Director of Nursing (DON) stated the staff should perform hand washing or hand hygiene before and after incontinent care, when soiled, and when gloves are removed. Stated the staff should change gloves before and after cares, during cares when soiled. Mechanical lift equipment should be cleaned per policy, routine cleaning. The facility policy titled Perineal Care revised 4/13 included the following documentation: -Hold the shaft of the penis with one hand and wash with the other, beginning at the tip and working in a circular motion from the center to the periphery. -Gently retract the foreskin, if uncircumcised, and clean beneath it. -Replace the foreskin to avoid constriction of the penis. -Wash the rest of the penis, using downward strokes toward the scrotum. -Clean the top and sides of the scrotum gently. -Position resident to expose, clean the bottom of the scrotum and the anal area. -Remove gloves, wash hands, and apply clean gloves.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, staff interviews clinical record review, and policy review, the facility failed to provide oxygen per physician orders for 1 of 14 residents reviewed (#9). The facility reported a census of 30 residents. Findings include: On 7/09/24 at 9:06 AM, Staff I, Certified Nurse Aide (CNA) placed the resident's oxygen nasal cannula (NC - pronged tubing used for oxygen delivery through the nose) back on the resident. The resident's portable oxygen tank supply regulator was set on 2 Liters Per Minute (LPM) and the indicator registered in the red, refill zone. The resident's room concentrator was also set on 2 LPM. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not conducted and indicated the resident was rarely or never understood. It included diagnoses of heart failure (HF), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), and non-Alzheimer's dementia. It also indicated the resident used oxygen. The Electronic Health Record (EHR) included a physician order dated 10/13/23 for oxygen at 3 LPM via nasal cannula (NC) every shift. The Care Plan dated 10/20/23 indicated the resident had oxygen (O2) via nasal prongs/mask at 3 LPM continuously. On 7/09/24 at 12:19 PM, the resident was observed in her wheelchair in the dining room with her NC and oxygen tank. The oxygen tank regulator was set at 2 LPM and the indicator registered 0 in the red, refill zone. At 1:02 PM, Staff K, CNA removed the resident's nasal cannula and transferred her from her wheelchair to her bed. The resident's oxygen saturation was checked and observed at 92%. Staff A, Registered Nurse (RN) placed the resident on the oxygen concentrator at 2.5 LPM. On 7/11/24 at 12:27 PM, the interim Director of Nursing (DON) stated staff should follow the doctor's order and/or therapy expectations. On 7/11/24 at 4:00 PM, the Regional Director of Clinical Services stated the facility did not have a policy for following physician's orders. A document titled Oxygen Administration dated 1/13 directed staff to verify physician's order to include the flow rate and duration of use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46873 Based on observations, clinical record review, staff interview and facility policy review the facility failed to administer medications at an error rate of under 5%. The facility reported a census of 30 residents. Findings include: The continuous observation of medication pass on 7/9/24, beginning at 7:35 am observed the following: Staff A, Registered Nurse (RN) passed medications to Resident #26. A total of 19 medications were observed being administered to Resident #26. The State Surveyor recorded each medication given to Resident #26 during the observation which included: - Furosemide, 10 mg, 2 tablets - Magnesium Oxide, 400 mg, 1 tablet - Fiber Lax, 625 mg, 1 capsule Staff A, RN next passed medications to Resident #3. A total of 8 medications were observed being administered to Resident #3. The State Surveyor again recorded each medication given to Resident #3 during observation which included: - Calcium, 500 mg, 1 tablet Following the observation of the medication pass, the list of administered medications were reconciled against the July 2024 Medication Administration Record (MAR) of both of the residents. The MAR of Resident #26 revealed the following: - The AM order of Furosemide was for 40 mg, not 20 mg which was administered. - The order for Magnesium Oxide was for 250 mg, not 400 mg which was administered - The order for the Fiber supplement was for 500 mg, not the 625 mg which was administered. The MAR of Resident #3 revealed the following: - The order for Calcium was for 600 mg, not 500 mg which was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Four errors for 27 medication administrations calculated a medication error rate of 14.8%. On 7/9/24 at 8:30 am, the Director of Nursing stated all orders should be checked against the medication for accuracy. The facility policy Medication Administration, dated 01/2013 included the following documentation: Point 10 - Read the Medication Administration Record (MAR) for the ordered medication, dose, route and time. Point 11 - Verify the pharmacy prescription label on the drug and the manufacturer's identification system matches the MAR. Point 13- Verify the following, again, by comparing medication to MAR prior to administering: - Correct resident/patient - Correct medication - Expiration date - Dose and dosage form - Route - Time

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46873 Based on observations and staff interview, the facility failed to maintain proper food temperature during lunch service. The facility reported a census of 30 residents. Findings include: Continuous observation of lunch service on 7/9/24 at 12:00 pm. Temperatures were obtained prior to meal service beginning which reflected the following: Creamy cheddar macaroni salad - 40 degrees Fruit - 38 degrees Ham salad - 40 degrees Tomatoes slices - 38 degrees Bacon (previously fully cooked) - 150 degrees Deviled eggs - 40 degrees. All of the cold items had been removed from the refrigerator just prior to checking temperatures. The bacon was placed on the steam table turned to heat. The macaroni salad, the fruit and the tomatoes were placed on the opposite end of the steam table which was turned off. The wells of the the cold end of the steam table were packed with ice. A full sized sheet pan of deviled eggs was placed on the counter with a cake pan underneath of it full of ice. It was noted during meal service the sheet pan was moved off of the cake pan of ice with approximately the half of the deviled eggs over the ice. Meal service was completed on 7/9/24 at 12:43 pm. When end of service temperatures were checked, the following was noted: Creamy cheddar macaroni salad - 50 degrees Tomato slices - 58 degrees Deviled egg - 60 degrees. On 7/11/24, Staff C, the current Activity Director and former Dietary Manager stated cold foods should be maintained at 41 degrees or colder. She stated the procedure is for the wells of the steam table to be filled with ice for cold foods and that this will be monitored. She additionally stated kitchen staff will continue to receive education regarding dangerous food temperatures and food borne illnesses. The facility document Sanitation and Food Production, dated 6/2015 documented: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Point 7 - Maintain hot foods above 140 degrees F (Fahrenheit) and cold foods at or below 41 degrees F

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46873 Based on observations, clinical record review, staff interviews, and facility education record review, the facility failed to prepare and serve the recommended therapeutic meals in a form designed to safely meet their needs and according to physician orders for 3 of 3 residents reviewed (Resident #9, Res #16, Res #25). This had the potential of causing harm to the residents due to the risk of choking or aspiration related to eating food which was prepared at the improper consistency or being served the incorrect textured diet. The facility reported a census of 30 residents. On July 9, 2024 at 4:35 pm, the State Agency informed the facility the staff's failure to properly prepare and serve the therapeutic meals per orders creating an Immediate Jeopardy situation, which began on July 9, 2024. The facility staff removed the immediacy on July 10, 2024 when facility staff implemented the following Corrective Actions: a. Meal service for Res #9 and Res #16, puree diets, were audited by the Director of Nursing (DON)/Designee to validate they were served the meal at the correct therapeutic menu and pureed consistency on 7/9/24. b. An audit was completed by the DON/Designee on 7/9/24 to ensure required therapeutic diet consistency was provided as ordered by the physician. c. Dietary staff were re-educated beginning 7/9/24 by the DON/Designee regarding the requirements of serving therapeutic diets including pureed consistency per physician's orders. Any dietary staff not trained on 7/9/24 would be trained prior to the beginning of his/her next scheduled shift. d. An audit set up for completion by the Administrator/Designee weekly for 12 weeks to ensure dietary staff continue to provide therapeutic diet consistencies per physician's orders including puree consistency. The scope lowered from J to D at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: 1. The Diet Type Report, reviewed 7/9/24 at 11:34 am revealed Resident #9 has an order for puree texture diets. The Care Plan of Resident #9 revealed a Nutritional Problem which documented a diagnosis of dysphagia (difficulty swallowing foods or liquids). The Care Plan directed staff as follows: -Monitor/document/report to doctor as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts to swallow, refusing to eat and/or appears concerned at meals. -Provide/serve diet as ordered. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Notes of Resident #9 included the following: On 6/26/24 at 8:58 am resident is receiving a pureed diet with honey thick liquids. No complaints of chewing/swallowing at this time but does put food in mouth and then spit it out in a napkin at times. 2. The Diet Type Report, reviewed 7/9/24 at 11:34 am revealed Resident #16 has an order for puree texture diets. The Care Plan of Resident #16 revealed a Potential Nutritional Problem which documented a diagnosis of dysphagia. The Care Plan additionally documented the resident to also receive tube feedings. The Care Plan directed staff as follows: -Monitor/document/report to doctor as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts to swallow, refusing to eat and/or appears concerned at meals. The Progress Notes of Resident #16 included the following: On 10/18/23: Nursing states that the resident has been coughing more at meals. On 4/9/24: Resident at birthday party and choked while eating ice cream. Heimlich performed and was able to get up thick phlegm in small amount. Continued to cough. Taken to room. Ambulance called and here. Resident able to drink small amount of thickened water. Ambulance did not feel transport was necessary. On 4/17/24 at 10:07 am dietary progress note: oral intake down since choking episode (4/9), averaging 0-25 percent at meals. 3. The Diet Type Report, reviewed 7/9/24 at 11:34 am revealed Resident #25 to have an order for mechanical soft texture diet. The Active Orders of Resident #25 revealed Resident #25 had a diet order of mechanical soft placed on 6/12/24. The Dietary Progress Notes documented the following for Resident #25: On 12/13/23 at 1:36 pm resident is receiving a dysphagia advanced with added moisture. No complaints of chewing/swallowing at this time with TUMS as needed. Observed no coughing at meals. On 3/6/24 at 3:11 pm resident is receiving a regular diet with added moisture to solid foods. No complaints of chewing/swallowing at this time with TUMS as needed. On 6/5/24 at 9:54 am resident is receiving a mechanical soft diet with added moisture to solids. No complaints of chewing/swallowing at this time with TUMS as needed. Continuous observation of preparation of pureed foods began on 7/9/24 at 10:40 am. Staff B, [NAME] was preparing foods for lunch service. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The menu for the pureed residents included: Pureed ham salad sandwich Pureed deviled egg halves Pureed creamy cheddar macaroni salad Pureed fruit. Staff B first placed one #8 scoop of ham into the food processor and placed a second scoop into a separate food processor bowel. She pureed each serving separately and asked the State Surveyor if it looked ok. The State Surveyor informed Staff B the surveyor was making observations only and could not advise. She placed each serving in parchment paper and into a steam pan and then placed it in the refrigerator. Staff B next placed one #8 scoop of macaroni salad into one food processor and a second #8 scoop of macaroni salad into a separate food processor bowl. She added a minimal amount of Ranch salad dressing to the salad and ran the food processor. Staff B, [NAME] stated she thought that looked like pudding consistency. When complete, the individual ingredients were still identifiable and the puree was not smooth. Staff B, [NAME] repeated this for the second serving. She placed the individual servings in parchment paper and then into a steam pan and also placed these in the refrigerator. Staff B next pureed four deviled eggs. She placed 4 deviled eggs into the food processor and pureed the eggs. Using a spatula, she transferred the pureed eggs into a #10 scoop. Some of the puree was left in the food processor. She looked at the eggs in the scoop, placed the spatula approximately in the middle, dividing it into two, and placed half in one bowl and half in another. Staff B stated I guess I should have measured that but oh well, that's how it's getting done. She also asked the State Surveyor if the remaining eggs needed to be scraped from the bowl. The State Surveyor again stated the surveyor was making observations only and could not advise. At the end of observation, Staff B stated the fruit was not yet ready for puree and that it could be watched closer to lunch service. On 7/9/24 at 11:40 am, Staff B was observed pureeing the fruit for lunch. She used a 4 oz scoop and placed two scoops of mandarin oranges into the food processor. Staff B stated it appeared too thin. She then stated I don't know what to do. I need to do something. Maybe I should add some cookies, but I don't think I have any cookies. Staff B left the area and returned a short moment later with food thickener. She added food thickener to the pureed mandarin oranges and the oranges were thickened to an appropriate texture. She poured the oranges into a measuring cup and then into 2 bowls. She did not reference the Puree Conversion Chart for serving sizes. The Dietary Manager was not in the facility during the survey week as she was on vacation. Staff C, Activities Director (AD), a former Dietary Manager and Staff D, Certified Nurse Aide (CNA), also a former Dietary Manager were assisting to oversee the kitchen during the week in her absence. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/9/24 at 11:50 am, Staff C, AD, stated when she was the Dietary Manager, she would not have macaroni salad be pureed. She stated it would not puree smooth and a substitute such as cottage cheese should be used instead. She told Staff D, CNA, to inform the kitchen staff to make pureed cottage cheese instead of serving the macaroni salad. On 7/9/24 at 12:05 pm, Staff B, [NAME] began lunch service. At 12:10 pm Staff B began to prepare the plate of pureed food for Resident #9. The plate included the previously pureed macaroni salad. After plate being fully prepared, Staff B carried the plate to the serving area to be served to the resident. At this time, the State Surveyor intervened and asked the staff to stop service and not serve the plate to Resident #9. Staff D, CNA, former Dietary Manager was outside of the serving window and the State Surveyor asked him to step inside of the kitchen. After donning a hair net and washing his hands, Staff D came to the serving area. The State Surveyor asked him to look at the pureed food and verify if he felt the food was a safe texture for Resident #9 to eat. Staff D stated no, and informed Staff B to dispose of the macaroni salad and to puree cottage cheese as a substitute. Staff B opened the refrigerator and removed cottage cheese. She appropriately pureed two servings of cottage cheese and returned to the serving area to resume lunch service. On 7/9/24 at 12:20 pm, Staff B began preparing a tray for Resident #25. She made a BLT sandwich, and using her gloved hands, ripped it into several pieces and stuffed it into a two handled cup. Staff B, cook stated I know I didn't do that right. The State Surveyor asked Staff E, Dietary Aide what Resident #25's diet order is. He looked at the resident's tray card and replied that Resident #25's diet order was a regular diet with thin liquids. He further stated the resident eats all of his meals out of two handled cups. On 7/9/24 at 1:15 pm, the Registered Dietitian stated that Resident #16 has been seen by Speech Therapy. She stated he gets enteral tube feedings and eats orally a puree diet for pleasure feedings. The State Surveyor described to the RD what the macaroni salad looked like and she responded it did not sound like it was properly pureed. She stated milk or mayonnaise should have been added to make it a smooth, pudding-like consistency. She additionally stated that cottage cheese was not an appropriate substitution as the macaroni salad was a starch. She said mashed potatoes would have been a proper choice or another starch item. On 7/9/24 at 2:00 pm, the Speech Therapist stated Resident #16 had been picked up for Speech Therapy due to having a choking incident or having increased coughing spells. She stated he had a swallow study with a camera being placed through his nose recording oral intake. The recommendation was a puree diet with thickened fluids. She stated Resident #16 has significant oral deficits. On 7/9/24 at 2:35 pm, Staff C, AD, stated the RD has noted improperly pureed food in the kitchen in the past. She stated there was a recent meeting held for all kitchen staff which included multiple topics. She stated every kitchen staff member was educated on food storage, sanitizing the kitchen, food contamination, mechanical soft, puree textures. Everything was covered. Staff C provided copies of the paperwork from the in-service. She stated the instance of improper puree was not an isolated incident. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon reviewing the diet order of Resident #25 on 7/10/24, the State Surveyor requested to see the menu tray card of Resident #25. Staff C, AD stated she had removed all of the tray cards. She stated during an audit she realized not all of them were correct. She verified that on 7/9/24, Resident #25's tray card was labeled as Regular diet and that it should have said Mechanical Soft. She additionally verified Resident #25 was served the incorrect diet during lunch observation on 7/9/24. On 7/10/24 at 11:44 am, the RD stated she completes a kitchen audit monthly. She stated towards the end of June she had a meeting with the Administrator and the Dietary Manager and informed them she had witnessed at least a couple of instances of food not being pureed correctly. She stated she had witnessed no concerns with Mechanical soft diets but the entire puree process was not being followed. She said in-services were to be done with the kitchen staff. Staff C provided copies of the paperwork from the in-service. Multiple topics were covered including food temperatures, proper sanitizing, food storage and the proper procedure for preparing mechanical soft and puree foods. An untitled document included in the paperwork provided was notes from the in-service. A portion of this note read I have a practice test I want all the cooks to do. It is on the puree and mechanical process. We had our audit and we did not pass the puree and/or the mechanical process. Additional documents included step by step process of mechanically grinding meat, step by step process of the puree process, and sign in sheets which reflected Staff B had attended the training on 6/27/24.

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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. 46873 Based on observation, interview and facility policy review, the facility failed to properly label, date, store and serve resident foods. The facility reported a census of 30 residents. Findings include: During initial walk through of the facility kitchen on 7/8/24 at 12:05 pm, the following items were found in the kitchen refrigerator: - A gallon of chocolate milk, approximately half empty, with no open date noted. - Three 20 oz bottles of cola. One of the bottles was greater than 3/4 empty. None of the bottles were labeled with a resident name or dated. - The bottom shelf of the refrigerator had a large plastic bowl of ice. On top of this bowl was a second plastic bowl filled with hard boiled eggs. The eggs were not covered with any protective wrap and had no date on them. Continuous lunch service observation began on 7/9/24 at 12:00 pm with Staff B, Cook, serving the lunch meal and observed the following: The meal for residents with a regular diet consisted of: - Bacon, lettuce and tomato (BLT) sandwich - 2 deviled egg halves - Creamy cheddar macaroni salad - Fruit The meal for residents with a mechanical soft diet was the same with the exception of a ham salad sandwich in place of the BLT sandwich The meal for residents on a puree diet was the same as the mechanical soft, but all items were pureed. On 7/9/24 at 12:05 pm, Staff B, Cook, began lunch service. She washed her hands and placed gloves on her hands. After placing gloves on her hands, she picked up the steam table lid covering the bacon. She then removed a large pan of bread from the refrigerator and removed the plastic wrap from the bread pan and disposed of it in the trash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She then began, without changing gloves, to prepare lunch trays. She picked up a slice of bread with her gloved hand, placed bacon, lettuce and tomato on the bread using tongs, and then picked up a second slice of bread with her gloved hand to complete the process of making the sandwich. She then proceeded to use serving utensils to place the remaining food items on the plate, then walked to the counter and picked up 2 deviled eggs with her gloved hands to add to the plate and placed the plate on the tray to be served to residents. This process was observed for each resident of the facility that a regular diet order tray plated during observation. On 7/9/24 at 12:10 pm Staff B, Cook, began to prepare the plate of pureed food for Resident #9. The plate included pureed macaroni salad which was not at a proper or safe puree texture. Staff B was instructed by Staff D, Certified Nurse Aide (CNA) and also a former Dietary Manager, to discard the macaroni salad and puree a substitute item. Staff B opened the refrigerator and removed cottage cheese. She appropriately pureed two servings of cottage cheese and returned to the serving area. No glove change or hand hygiene was witnessed. Staff B then placed a clean plate on the serving area. She covered the macaroni salad with one gloved hand and dumped the plate upside down for the pureed ham salad sandwich to land on the clean plate. She went to the sink and obtained a paper towel, and wiped her soiled glove off with a paper towel. She then resumed lunch service. On 7/9/24 at 12:20 pm, Staff B was observed, with her gloved hands, having prolonged contact with contaminated portions of the steam table. She then began preparing a tray for Resident #25. She made a BLT sandwich, and using her gloved hands, ripped it into several pieces and stuffed it into a two handled cup. Staff B, [NAME] stated I know I didn't do that right. The State Surveyor asked Staff E, Dietary Aide what Resident #25's diet order was. He looked at the resident's tray card and stated he is on a regular diet with thin liquids. He further stated the resident eats all of his meals out of two handled cups. On 7/9/24 at 12:23 pm, Staff B removed her gloves, threw them in the trash can and placed clean gloves on. No hand hygiene was performed. She resumed meal services. At 12:32 pm she prepared the pureed meal for Resident #16. She went to the refrigerator, obtained a single serving of pureed ham salad sandwich which was wrapped in parchment paper and stored in a steam pan. She opened the parchment paper and held it over the plate, and scraped the parchment paper with her gloved hand to get as much of the salad off the parchment as she could. She took the contaminated pan and the parchment paper, disposed of the parchment and took the pan to the dishwasher and returned to the serving area. With no hand hygiene or glove change, she continued service. At 12:40 pm, service was ending, as Staff B was preparing the final plate. As she reached for the deviled eggs with her gloves hands, she stated I should probably be using tongs on those, oops. That might be a problem. Staff B stated she also should have used separate tongs for the tomato and lettuce which had been in the same steam pan. On 7/9/24 at 1:15 pm, the Registered Dietitian (RD) stated she has always encouraged tongs because gloves give a sense of false security and staff don't think about what they are doing. She stated she prefers staff to use tongs, a spatula, even a fork is a better choice instead of gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietary Manager was out of the facility during the survey week. Staff C, the current Activities Director, and also the former Dietary Manager was assisting to oversee the kitchen in her absence. On 7/9/24 at 2:35 pm, Staff C stated there was a recent meeting held for all kitchen staff which included multiple topics. She stated every kitchen staff member was educated on food storage, sanitizing the kitchen, food contamination, mechanical soft, puree textures. Everything was covered. Staff C provided copies of the paperwork from the in-service. Included in this paperwork was an undated policy titled Bare Hand Contact with Food and Use of Gloves. Point 3 - Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Point 6 - Remember, gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed: - After handling garbage or garbage cans - After handling soiled trays or dishes - After handling anything soiled - Anytime you touch any contaminated surface Additionally found in the in-service packet was an undated document titled How To Store Food Properly. This document included direction to staff to label and date all stored food. The paperwork also included a sign in sheet for the meeting dated 6/27/24. Staff B's signature indicated she had attended the meeting. On 7/11/24 at 8:40 am, Staff C stated staff education will be continued to include food borne illnesses as well as other topics.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 35434 Based on the facility assessment and staff interview, the facility failed to review and update the facility assessment annually. The facility reported a census of 30 residents. Findings include: The Facility Assessment listed the latest date of review as 4/26/23. The assessment lacked documentation of a review of the assessment conducted from 4/26/23-7/10/24. On 7/09/24 at 4:45 PM, the Regional Director of Clinical Services stated the current facility assessment could not be located and the new one was not completed. The facility policy Facility Assessment-Rules of Participation reviewed 12/19/24, stated the facility would review the assessment at a minimum annually.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 35434 Based on facility document review and staff interview, the facility failed to hold a written transfer agreement with a hospital in order to assure that residents would be transferred from the facility to the hospital. The facility reported a census of 30 residents. Findings include: The facility lacked documentation of a transfer agreement with a local hospital. On 7/11/24 at 8:50 a.m., via phone, the Regional Director of Clinical Services stated the facility did not have a transfer agreement with a local hospital but the Administrator was in contact with the hospital last night to get this completed. Via email correspondence on 7/11/24 at 12:00 p.m., the Regional Director of Clinical Services stated the facility did not have a policy regarding a hospital Transfer Agreement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, record review, staff interview, and policy review, the facility failed to implement infection control practices to prevent cross contamination by staff failing to perform appropriate hand hygiene during resident cares, medication administration, and meal service for 5 of 5 residents (Resident #3, #6, #12, #16, and #26) reviewed for infection control. The facility also failed to ensure resident equipment was sanitized after use for 2 of 2 residents (Resident #6 and #12). The facility reported a census of 30 residents. Findings include: 1. An observation on 7/08/24 at 1:18 PM revealed Resident #3's indwelling catheter tubing had a dependent loop with clear, yellow urine and sediment in it. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated severely impaired cognition. It included diagnoses of neurogenic bladder (nerves that control the bladder do not function), epilepsy, cognitive communication deficit, mild intellectual disability, normal pressure hydrocephalus (fluid buildup in the brain), and benign prostatic hyperplasia (prostate enlargement). It also revealed he was independent with eating but dependent with all other activities of daily living (ADLs) and all mobility. It indicated the resident had an indwelling catheter. The Care Plan revised 10/20/23 indicated the resident's catheter goal was to show no signs or symptoms of a urinary tract infection (UTI) and directed staff to position the catheter bag and tubing below the level of the bladder an away from the entrance room door. The Electronic Health Record (EHR) progress notes indicated the resident Suprapubic (indwelling) catheter was changed on 6/22/24. On 7/10/24 at 2:33 PM, Staff N, Certified Nurse Aide (CNA) performed Resident #3's catheter care. Staff N donned a protective gown and gloves and entered Resident #3's room. She obtained a graduated cylinder (container used to measure urine) from the resident bathroom cabinet then opened the resident's chest-of-drawers and night stand to get alcohol wipes. She opened the urine collection bag drain spout with her right hand, emptied the urine into the cylinder, opened the alcohol wipe package, grabbed the alcohol wipe with her right hand, and wiped the drain spout. She closed the spout and secured it to the drain bag. She emptied the urine into the toilet, removed her gown and gloves, performed hand hygiene with soap and water, and left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:42 PM, Staff N and Staff O, Nurse Aide (NA) returned to the resident's room. Staff N donned a protective gown, entered the resident's room and donned gloves. Staff O did not don a protective gown nor gloves. Staff O connected the resident's transfer sling to the mechanical lift, picked up the indwelling catheter drainage bag, and held it while Staff N raised the resident from the wheelchair. Staff O handed the drainage bag to Staff N. Staff N held the drainage bag in her right hand, grabbed the upper handle on the mechanical lift above the resident's bladder, and lowered the resident onto his mattress. Staff N laid the drainage bag on the resident's mattress, removed her gloves and donned new gloves without performing hand hygiene. Staff O moved the mechanical lift, and both Staff N and Staff O adjusted the resident's pants. Staff N handed Staff O the periwipe package. Staff O removed a periwipe and gave it to Staff N. Staff N wiped Resident #3's waistline at the level of the suprapubic catheter (SPC) insertion site. They repeated this process three (3) times. They pulled the resident's pants back up, connected the sling to the mechanical lift, raised the resident off the bed, and positioned him over the wheelchair. Staff N held the drain bag above the resident's bladder while she leaned around the left side of the mechanical lift, adjusted the wheelchair seat antiskid pad, and lowered the resident down onto the wheelchair seat. At 4:20 PM, Staff O stated the facility requires hand hygiene after bathroom use, removing gloves, changing resident briefs, risk of body fluid exposure, and working with indwelling catheters. He stated the policy does not require staff to wear gloves while touching residents. At 4:35 PM, Staff N stated hand hygiene and gloves are required before and after resident care and when contacting visibly soiled items or residents. She stated she should've washed her hands prior to beginning the procedures. On 7/11/24 at 12:27 PM, the interim Director of Nursing stated staff should follow the orders of the care plan and the drainage bag is to remain below the resident's bladder. She also stated hand hygiene should be done before, after, and as needed during a procedure. A document titled Catheter Care dated 1/13 directed staff to not allow the end of the drainage spout to touch other surfaces and position the catheter and drainage bag below the level of the resident's bladder. 2. On 7/09/24 at 9:01 AM, Resident #16 pointed to his abdomen and indicated he had a gastric tube (G-tube; tube directly into the stomach). The Electronic Health Record (EHR) included a Speech Therapy note dated 11/21/23 which directed staff to continue an alternate means of hydration and nutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have a Brief Interview for Mental Status (BIMS) score. It included diagnoses of cerebrovascular accident (stroke), aphasia (inability to speak), left sided hemiplegia (one-sided paralysis), and dysphagia (difficulty swallowing). It also revealed he was independent with eating, required moderate assistance with bathing and rolling in bed, and was dependent with all other activities of daily living (ADLs) and all mobility. It indicated the resident had a feeding tube. The Care Plan revised 8/14/23 directed staff to provide local care to the G-tube site as ordered and monitor for signs and symptoms of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 8/09/23 directed staff to clean the peg tube site with normal saline and cover with a split 4 x 4 gauze one time per day. On 7/10/24 at 2:56 PM, Staff A, Registered Nurse (RN) performed G-tube site care. Staff A entered the resident's room, performed hand hygiene with soap and water, closed the door with her foot, and donned a protective gown and gloves. She opened the bottle of normal saline (NS) and the package of 2 x 2 s, saturated the 2 x 2 s with the NS, pulled up the resident's shirt, wiped the top of the insertion site, folded the 2 x 2 s, and wiped the bottom of the insertion site. She removed her gloves, sanitized her hands, donned new gloves, and put slit dressing on his site. She taped the slit together for secure and dated it. She removed her gown and gloves and performed hand hygiene. At 3:03 PM, Staff A stated the opportunities to perform hand hygiene are when gloves are soiled, when moving from dirty to clean cares, and between patient-to-patient care. She stated packaged supplies should be opened after gloves are donned. On 7/11/24 at 12:27 PM, the interim Director of Nursing stated hand hygiene should be done before, after, and as needed during a procedure. 50471 3. On 7/9/24 at 1:28 PM, Staff L, Certified Nurse Aide (CNA) entered resident #6 room. Observed Resident #6 in her wheelchair. Staff M brought the mechanical lift in the room to assist resident and Staff L. Staff did not complete handwashing or hand hygiene. Staff provided privacy and stated to resident, assist with transfer and incontinent care. Staff hooked sling to equipment, transferred to bed, unhooked sling, and placed equipment by her door. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff removed pants, and unfastened incontinent product. Staff L gathered wipe from Staff M, wiped front to back the outer labia, disposed the soiled wipe, gathered wipe from Staff M, wiped front to back the outer labia, and disposed soiled wipe. With assistance from Staff M, Staff rolled resident to her right side toward the wall. Staff tucked the mechanical lift sling under the resident, Staff M held onto resident, Staff L took soiled incontinent product and wipe bowel movement from anus then disposed soiled incontinent product. Staff L gathered wipe from Staff M, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff M wiped perineum, anus, sacrum, disposed wipe, gathered new incontinent product and placed under resident buttocks. Staff L tucked incontinent product fastener under right buttock, Staff rolled resident to her left onto her back, Staff rolled resident to her left side, Staff removed the mechanical lift sling. Staff L adjusted the incontinent product fastener, and staff assisted resident to her back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves and completed hand hygiene. Staff assisted resident to comfortable position, covered resident, placed call light within reach, placed floor mat at bed side, and lowered bed to appropriate level. Staff L completed hand washing, Staff M took soiled bag and mechanical lift equipment to hallway, Staff M placed mechanical lift equipment against the wall, Staff M put soiled bag in soiled utility room, another staff member took the mechanical lift, mechanical lift was not disinfected. Staff M went back to resident's room, and performed hand washing, Staff shut off light and exited room. On 7/11/24 at 3:01 PM the Director of Nursing (DON) stated the staff should perform hand washing or hand hygiene before and after incontinent care, when soiled, and when gloves are removed. Stated the staff should change gloves before and after cares, during cares when soiled. Mechanical lift equipment should be cleaned per policy, routine cleaning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Perineal Care revised 4/13 included the following documentation: -Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. -Remove gloves, wash hands, and apply clean gloves if original gloves were visibly soiled. -Clean, rinse, and dry the anal area, starting at the posterior vaginal opening and wiping from front to back. -Remove gloves, wash hands, and apply clean gloves. The facility policy titled Infection Control Manual: Equipment revised 3/15 included the following documentation: -A facility specific cleaning schedule will be developed for the routine cleaning of noncritical equipment such as, but not limited to, the following: Resident/patient care equipment: Mechanical lifts 4. On 7/09/24 at 1:15 PM Staff L assisted resident #12 to his room. Staff K assisted Staff L. Staff gathered mechanical lift equipment, instructed resident of the task, permission granted, and staff completed hand washing. Staff hooked up mechanical lift to sling, Staff L controlled the mechanical lift equipment, Staff K guided resident to bed, resident positioned over bed, Staff L lowered resident onto the bed and Staff unhooked the sling from the lift. Staff moved the mechanical lift away from the bed. Staff gathered items for incontinent care. Staff L stated task steps to resident. Staff remove pants, and unfastened incontinent product. Staff L gathered wipe from Staff K, wiped right groin then left groin, disposed the soiled wipe, gathered wipe from Staff K, Staff L wiped left groin, disposed soiled wipe, with assistance from Staff K, and Staff rolled resident to his right side toward the wall. Staff tucked the mechanical lift sling under resident, Staff K held onto resident, Staff L disposed soiled incontinent product, Staff L gathered wipe from Staff K, wiped perineum, anus, sacrum, disposed wipe, gathered wipe from Staff K wiped perineum, anus, sacrum, and disposed the wipe. Staff failed to wash hands or change gloves. Staff gathered new incontinent product and placed under resident buttocks, Staff rolled resident to his left onto his back, Staff rolled resident to his left side, Staff removed the mechanical lift sling, Staff L adjusted the incontinent product, and then Staff assisted resident to his back. Staff L closed and fastened incontinent product. Staff L removed soiled gloves, and completed hand washing. Staff assisted resident to comfortable position, covered resident, placed call light within reach, and lowered bed to appropriate level. Staff removed soiled bag. Mechanical lift equipment was not disinfected. On 7/11/24 at 3:01 PM the Director of Nursing (DON) stated the staff should perform hand washing or hand hygiene before and after incontinent care, when soiled, and when gloves are removed. Stated the staff should change gloves before and after cares, during cares when soiled. Mechanical lift equipment should be cleaned per policy, routine cleaning. The facility policy titled Perineal Care revised 4/13 included the following documentation: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hold the shaft of the penis with one hand and wash with the other, beginning at the tip and working in a circular motion from the center to the periphery. -Gently retract the foreskin, if uncircumcised, and clean beneath it. -Replace the foreskin to avoid constriction of the penis. -Wash the rest of the penis, using downward strokes toward the scrotum. -Clean the top and sides of the scrotum gently. -Position resident to expose, clean the bottom of the scrotum and the anal area. -Remove gloves, wash hands, and apply clean gloves. The facility policy titled Infection Control Manual: Equipment revised 3/15 included the following documentation: -A facility specific cleaning schedule will be developed for the routine cleaning of noncritical equipment such as, but not limited to, the following: Resident/patient care equipment: Mechanical lifts 46873 5. Observation of morning medication pass began on 7/9/24 at 7:35 am. Staff A, Registered Nurse was passing medications. She stated she would begin with Resident #26. Staff A brought the medication cart to the doorway of Resident #26. She knocked on the door to verify the resident was awake and let her know she was preparing her medications. Staff A brought the Medication Administration Record of Resident #26 up on the computer screen and opened the medication drawer to remove the medications. She prepared the oral medications and administered them. After administering the medications, she stated she needed to check the resident's blood sugar. She gathered supplies, donned gloves, swabbed the resident's finger with an alcohol wipe and obtained her blood sugar. She held a cotton ball to the resident's finger to stop any bleeding. She disposed of the contaminated items in a sharps container and removed her gloves. She placed the glucometer back in the medication cart near the front of the top drawer. The State Surveyor asked Staff A if the glucometer was dedicated to a single resident or if it was shared. She stated it was dedicated to Resident #26 and she moved the glucometer from a general area in the cart to a divided area in the cart which was labeled with Resident #26's name. The glucometer was not sanitized before or after use. She also failed to sanitize the top drawer of the medication cart where the glucometer was initially placed. Staff A then prepared the first of three insulin shots for Resident #26. After preparing the insulin pen, she donned gloves, and administered the insulin appropriately. After administering the insulin and disposing of sharps, she removed her gloves. She repeated this for two more injections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff A then administered an inhaled medication and a nasal spray medication to Resident #26 which completed medication pass for this resident. No hand hygiene was witnessed during the observation. 6. Staff A then moved the medication cart across the hall to Resident #3. With no hand hygiene witnessed, Staff A prepared and administered all morning medications to Resident #3. The facility policy Medication Administration, dated 01/2013 documented the following: Point 6: Wash hands Point 7: Assemble equipment for administering medications Point 15: Administer oral medication with a full glass of water unless otherwise ordered. Point 18: Wash hands.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement required training for multiple topics for 5 of 5 staff reviewed (Staff F, G, H, I, J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff F 3/1/23 Staff J 3/28/23. The New Hire Report listed the following staff hire dates: Staff G 11/16/23 Staff H 10/6/23 Staff I 4/6/23 The facility lacked documentation that Staff F, Staff G, Staff H, Staff I, and Staff J completed training in communication, Quality Assurance and Performance Improvement (QAPI), compliance and ethics, and behavioral health. The facility lacked documentation that Staff J completed training in resident rights and infection control. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement communication training for 5 of 5 staff reviewed (Staff F, G, H, I, J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff F 3/1/23 Staff J 3/28/23. The New Hire Report listed the following staff hire dates: Staff G 11/16/23 Staff H 10/6/23 Staff I 4/6/23 The facility lacked documentation that Staff F, Staff G, Staff H, Staff I, and Staff J completed training in communication. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement resident rights training for 1 of 5 staff reviewed (Staff J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire date: Staff J 3/28/23. The facility lacked documentation that Staff J completed training in resident rights. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement Quality Assurance and Performance Improvement (QAPI) training for 5 of 5 staff reviewed (Staff F, G, H, I, J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff F 3/1/23 Staff J 3/28/23. The New Hire Report listed the following staff hire dates: Staff G 11/16/23 Staff H 10/6/23 Staff I 4/6/23 The facility lacked documentation that Staff F, Staff G, Staff H, Staff I, and Staff J completed training in QAPI. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement infection control training for 1 of 5 staff reviewed (Staff J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff J 3/28/23. The facility lacked documentation that Staff J completed training in infection control. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement compliance and eithics training for 5 of 5 staff reviewed (Staff F, G, H, I, J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff F 3/1/23 Staff J 3/28/23. The New Hire Report listed the following staff hire dates: Staff G 11/16/23 Staff H 10/6/23 Staff I 4/6/23 The facility lacked documentation that Staff F, Staff G, Staff H, Staff I, and Staff J completed training in Compliance and Ethics. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 35434 Based on personnel file review, the facility mandatory education calendar, and staff interview, the facility failed to implement behavioral health training for 5 of 5 staff reviewed (Staff F, G, H, I, J). The facility reported a census of 30 residents. Findings include: The Employee List Report listed the following staff hire dates: Staff F 3/1/23 Staff J 3/28/23. The New Hire Report listed the following staff hire dates: Staff G 11/16/23 Staff H 10/6/23 Staff I 4/6/23 The facility lacked documentation that Staff F, Staff G, Staff H, Staff I, and Staff J completed training in Behavioral Health. The 2024 Mandatory Education calendar included the following topics: effective communication, resident rights, QAPI, infection control, compliance and ethics, and resident behavioral health. The calendar stated all courses were required for all staff. On 7/11/24 at 12:07 p.m. via phone, the Director of Nursing (DON) stated she expected all staff to be current with required training.