STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillar of Cedar Valley	1410 West Dunkerton Road Waterloo, IA 50703

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, clinical record review, and resident, family, and staff interviews, the facility failed to treat residents with dignity and respect while affirming each resident's individuality during random observations of staff and resident interactions conducted during our unannounced visit. This was found during review of 3 of 3 residents (Resident #29, Resident #27, and Resident #52). During an observation of Resident #29's room it was noted that there was no curtain hanging between Resident #29's designated room space and his roommate Resident #64's room space, removing all privacy for Resident #29. Resident #29 did not have decision making abilities to approve that there be no curtain. It was observed that Resident #64 could not enter or exit their shared room without walking through Resident #29's designated room space. During an observation Resident #27 turned her call light on and wanted assistance to get out of bed as she was hot and visibly sweaty. Staff returned to the room [ROOM NUMBER] minutes later with a lift to transfer Resident #27 out of the room. An observation revealed that Resident #52's tube feeding was hooked up in a common area in front of several other residents. The facility reported a census of 132. Findings include: 1. A Minimum Data Set (MDS) assessment dated [DATE], documented diagnoses for Resident #29 included schizophrenia. A Brief Interview for Mental Status (BIMS) documented that this resident was rarely/never understood. It documented this resident knew the location of his own room and knew staff names and faces. On 10/1/24 at 8:54 AM, Resident #29 was lying in his recliner on his side with recliner reclined. There was no curtain between this resident and his roommate. His roommate was also lying in bed with covers on him. Resident #64 stated he did not mind there being no curtain. Resident #29, was not able to respond. On 10/1/24 at 1:39 PM, Staff A, Assistant Director of Nursing (ADON) and the Maintenance Supervisor acknowledged there was no curtain between Resident #29 and Resident #64. This ADON and the Maintenance Supervisor noted there was a track on the ceiling for a curtain but did not know why there was not a curtain in place. They stated maybe it was being laundered. They stated they would look for a work order to figure out why the curtain was not in place. Staff A and the Maintenance Supervisor concurred that there was no way for Resident #64 to enter and/or exit his allotted space in the room without walking through Resident #29's space. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 10:20 AM, the Maintenance Supervisor acknowledged the concerns with no direct access to the door without passing through another resident's room space, and no curtain hanging between the above two residents. He stated they think that Resident #64 tore down the curtain. 42134 2. The MDS for Resident #27 dated 6/10/24 documented diagnoses including anxiety disorder and schizoaffective disorder. The MDS documented a BIMS score of 15 indicating intact cognitive functioning. The interventions on the Care Plan for Resident #27 included assist of 1 for turning and repositioning in bed, transfer with assist of 2 using mechanical lift and encourage use of call light During an interview on 9/30/24 at 2:13 PM with Resident #27, Staff E, CNA, answered the resident's call light. The resident explained to the CNA she was hot and wanted to get out of bed. The resident was visably sweating. Staff E explained to the resident that she was just coming on shift and could not get the resident out of bed at this time. She explained she would be back in 5-7 minutes. She then asked the resident to turn off her call light. While under continuous observation on 9/30/24 from 2:13 PM until 2:28 PM Staff E entered the resident's room at 2:33 PM. She did not take the mechanical lift or the resident's w/c in the room. She was in the room at 2:34 PM. As soon as the CNA left the room the resident's call light came back on. At 2:37 PM the resident was calling out that she wanted to get out of bed. At 2:39 PM Staff E and Staff F, CNA, entered the resident's room with the mechanical lift and turned off the call light. At 2:40 PM Staff F exited the room and took the w/c into the resident's room. At 2:48 the resident, Staff E and Staff F exited the resident's room. During an interview on 10/2/24 at 4:56 PM the DON explained she would expect call lights to be answered in no more than 15 minutes. She further explained if a resident was given a timeframe when the staff would return, they would return during that time frame. She explained that even if the staff needed to get assistance or was otherwise unable to meet the resident's need fully, they should attempt to alleviate the immediate discomfort. 48888 3. The MDS dated [DATE], revealed Resident #52 had delusions and modified independence for decision making regarding tasks of daily life. Resident #52 required dependance upon staff for hygiene tasks, dressing, and transfers. Diagnoses included Schizophrenia, dysphagia (difficulty swallowing), and flaccid hemiplegia (paralysis of one side of the body) affecting left side. The Care Plan, revised on 3/27/24, revealed a focus area problem identified for psychosocial well-being due to diagnoses and symptoms of Paranoid Schizophrenia and Major Depressive Disorder. Intervention instructed staff to provide Resident #52 assistance and support to identify, reduce, or eliminate causative and contributing factors to feelings of isolation, anger, and frustration. The Medication/Treatment Administration Order, dated October 2024, revealed an order, started on 9/19/24, for Resident #52 to receive enteral feed, at a rate of 85 milliliters (mL) per hour for 12 hours, followed by a water flush of 100 mL per hour for 10 hours daily. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress Notes, dated 9/26/24 at 1:49 PM, revealed Resident #52 had expressed depressive thoughts related to new feeding tube. On 10/2/24 at 11:26 AM, note indicated Resident #52 had been verbalizing unhappiness with tube feeding related to being hooked up to tube during the day and also due to limitations on oral intake. On 10/1/24 at 11:10 AM, Resident #52 sat in wheelchair at dining room table disconnected from feeding tube pump. Staff G, Licensed Practical Nurse (LPN), entered dining room with feeding tube pump attached to rolling pole. Staff G lifted Resident #52's shirt to expose gastrostomy tube (g-tube) and with ungloved hands, cleaned g-tube port with an alcohol wipe and attached the end of feeding tube to the g-tube port. Staff G then resumed continuous enteral tube feeding at 85 mL per hour. On 10/1/24 at 2:00 PM, Staff G, LPN, stated Resident #52 had gastrostomy tube in place for approximately 2 weeks and received tube feeding for difficulty with swallowing and risk for aspiration. Staff G informed that enteral feedings are started daily between 4:00-6:00 AM in resident's room and that it did not bother Resident #52 to have enteral feeding in common areas. On 10/1/24 at 2:53 PM, Staff H, Registered Nurse (RN) and Assistant Director of Nursing (ADON), revealed that Resident #52 had been very depressed after having g-tube placed and does not like to have tube feeding out of his room. ADON planned to inform Dietitian and Physician with request to have tube feeding completed during the night shift. On 10/1/24 at 2:55 PM, Director of Nursing (DON) revealed that hooking a feeding tube to resident in dining room was a concern for resident dignity. The facility policy titled, Resident Rights, dated October 2022, revealed that resident's in the community have the right to be treated with dignity and respect in full recognition of the resident's individuality and be treated in a manner that enhances the resident's quality of life. The policy additionally informed that residents have the right to be fully informed in advance about care and treatment and any changes in that care or treatment that will affect the resident's well being.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42133 Based on observation and staff interview, the facility failed to post notice of the availability of the most recent survey reports and failed to have survey reports readily accessible to residents, family members and legal representatives of the most recent survey of the facility. The facility reported a census of 132 residents. Findings include: Observations 9/30/24 and 10/1/24 revealed a three-ring white binder labeled Department of Inspection and Appeals (DIA) Survey Book 1/6/22 to present lay flat on a rolling rack inside of double set of doors labeled community room. The area was a hallway that went down to the facility conference room and the therapy room. The area outside of the Community Room did not publicly display and post that facility survey results were available for review and where to find the survey book. During an observation on 10/2/24 at 9:52 AM the white three ring binder labeled DIA Survey Book 1/6/22 to present continued to lay flat on a rolling rack inside a set of double doors labeled community room. No residents had been observed accessing the area. Interview on 10/2/24 at 9:53 AM Staff B, Scheduler reported she didn't know why the survey book was on a rack inside the inner hallway. Staff B stated she only does the scheduling. On 10/2/24 at 1:13 PM the wheeled cart observed in a cove off of the main entrance hallway area with coat hooks and wet floor signs with a red and black broom sitting up against the wall. Observation at this time revealed no posting to notify residents, family, legal representatives or the general public of the location to review the facility's most recent survey results. During an interview on 10/3/24 at 9:15 AM the Director of Nursing reported she was not aware they needed to post survey reports were available and where to find the them. She reported they had recently repainted and the cart got moved, but the facility had not posted survey reports were available and where to find them. They would get a sign posted.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed to apply continuous oxygen at 2 liters (L) per minute via nasal cannula, as ordered by Provider, for 1 of 1 resident (Resident #52) reviewed for respiratory care. The facility reported a census of 132 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #52 had delusions and modified independence for decision making regarding tasks of daily life. Resident #52 required dependance upon staff for hygiene tasks, dressing, and transfers. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with hypoxia, Schizophrenia, dysphagia (difficulty swallowing), and flaccid hemiplegia (paralysis of one side of the body) affecting left side. The MDS indicated Resident #52 had shortness of breath both with activity and at rest but lacked indication that Resident #52 required oxygen therapy or respiratory treatments. The Care Plan, revised 3/27/24, revealed a focused area for Resident #52 diagnosis of COPD with a goal that resident would display optimal breathing patterns daily and intervention to give oxygen therapy as ordered by the physician. The Medication and Treatment Administration Record (MAR/TAR), dated September 2024, revealed an order for oxygen administration at 2 liters per minute to keep oxygen saturation above 89%, initiated on 3/12/24. The MAR/TAR, dated October 2024, revealed a new order for nursing to assess Resident #52 lung sounds twice per day and notify provider or any changes from baseline, order initiated 10/2/24. On 9/30/24 at 10:55 AM, Resident #52 sat in dining room, oxygen worn via nasal cannula with flow set at 6 liters per minute. On 9/30/24 at 2:16 PM, Resident #52 laid in bed, oxygen worn via nasal cannula with flow set at 5 liters per minute. On 10/1/24 at 11:10 AM, Resident #52 sat in dining room, no oxygen applied. Noted oxygen concentrator remained in resident's room running at 4.5 liters per minute. At 12:06 PM, Resident #52 continued to be without oxygen therapy. On 10/1/24 at 2:00 PM, Staff G, Licensed Practical Nurse (LPN), stated Resident #52 mainly wore oxygen when in bed and stated that oxygen is provided as needed to Resident #52 when he is in common areas. On 10/1/24 at 2:53 PM, Staff H, Registered Nurse (RN) and Assistant Director of Nursing (ADON) revealed Resident #52 had order for oxygen to be given continuously at 2 liters per minute but informed that at times Resident #52 refused to wear oxygen outside of his room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 2:55 PM, Director of Nursing (DON) revealed the expectation was that nursing staff follow physician's orders. On 10/3/24 at 11:57 AM, the Facility Administrator denied having a policy related to respiratory care or oxygen therapy.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed complete resident fall assessment or neurological checks following a resident reported, unwitnessed, fall for 1 of 3 residents (Resident #53) reviewed for accidents. The facility reported a census of 132 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderately impaired cognition. Resident #53 able to transfer, ambulate and perform personal hygiene tasks independently. Diagnoses included Schizoaffective disorder, anxiety disorder, depression, and polyneuropathy. The MDS indicated Resident #53 had 2 or more falls with minor injury since previous assessment. The Care Plan, revised on 7/31/24, revealed Resident #53 had been at risk for falls related to daily use of psychotropic medications, chronic pain, and hammer toes with the intervention to educate resident about safety and remind her what to do if a fall occurs. The Care Plan revealed that Resident #53 had a fall on 7/25/24 and 7/30/24. In a Nursing Progress Note, dated 9/29/24 at 6:32 PM, documentation revealed that Resident #53 had been yelling from inside room, staff approached, and noted Resident #53 had been on hands and knees, crawling around room. Resident #53 stated she was attempting to clean out the drawers next to her bed. The note revealed staff assisted resident into bed. On 9/30/24 at 1:12 PM, Nursing Progress Note included documentation that Resident #53 reported to non-staff that she had fallen and when asked, could not remember the details of when, where, or how she had fallen. Note revealed that no injuries related to a fall were noted. Review of Resident #53's Incident Reports and Electronic Health Record (EHR) assessment tab, lacked a fall incident report or completion of fall assessment related to observation of resident crawling on floor or resident self-report of a fall. On 9/30/24 at 12:08 PM, Resident #53 reported to Staff I, Certified Nursing Assistant (CNA), that she had fallen in room. Staff I went into nurses station, no additional questions or assessment observed by nursing staff following resident's fall report. On 9/30/24 at 12:22 PM, Resident #53 again stated she had fallen and crawled across the floor using the bed to get self up. Resident #53 informed she had hurt her hands and knees during incident. A small scratch noted to left pinkie finger with scant amount of blood. State Inspector notified Staff H, Assistant Director of Nursing (ADON) of Resident #53 self-reported fall and blood noted to left pinkie finger. Staff H checked Resident #53's hand, applied a Band-aid, and reminded resident to notify staff if fallen and not to try and get self up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 2:00 PM, Staff G, Licensed Practical Nurse (LPN) revealed that Staff I, CNA, had informed LPN that Resident #53 reported a fall on 9/30/24 at 12:08 PM. Staff G stated Resident #53 often had attention seeking behaviors and could not have fallen as she did not recall details of when, where, or how she had fallen. On 10/1/24 at 2:53 PM, Staff H, ADON, revealed that she had asked Resident #53 about a fall, resident had been unable to state details of fall, then reminded her to let someone know if she falls. On 10/1/24 at 2:54 PM Director of Nursing (DON) revealed the expectation that nursing would assess a resident, complete incident report, and neurological assessment for any resident self-reported or unwitnessed fall. The facility policy, titled Fall Prevention and Fall Review Policy, revised 1/2023, revealed the expectation for fall response to include: an investigation into fall circumstance, creation of risk management report in EHR, and completion of fall assessment to include checking for injury and pain. Nursing staff instructed to record and implement an immediate fall intervention.

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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** 48003 Based on observation, record review, and staff interview, the facility failed to ensure residents were safe from accidents and hazards for 1 of 3 residents reviewed (Resident #79). Staff failed to supervise Resident #79 in the shower room. The resident fell while in the shower. The facility reported a census of 132 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #79 revealed a Brief Interview of Mental Status (BIMS) score of 03 which indicated severe cognitive impairment. The MDS documented the resident had diagnoses of hypertension, dementia, Parkinson's Disease, anxiety and depression. The Care Plan for Resident #8 with a revised date of 9/26/24 with a focus area ADL Self Care revised on 7/03/24 directed staff for bathing the he required assistance of 1 with staff. Review of Resident #79's Electronic Health Record Progress Notes revealed a Nursing Progress Note dated 7/19/24 at 5:17 PM documented Resident #79 was in the shower unattended when staff found him on the floor in the shower room no injuries noted. In an interview on 10/1/24 at 3:49 PM, the Director of Nursing reported Resident #79 should have not been left in the shower unattended.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed to apply gloves or additional Personal Protective Equipment (PPE) for infection prevention during administration of enteral tube feeding for 1 of 1 residents (Resident #52) reviewed for tube feeding. The facility reported a census of 132 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed Resident #52 had delusions and modified independence for decision making regarding tasks of daily life. Resident #52 required dependance upon staff for hygiene tasks, dressing, and transfers. Diagnoses included Schizophrenia, dysphagia (difficulty swallowing), and flaccid hemiplegia (paralysis of one side of the body) affecting left side. The Care Plan, revised on 9/24/24, revealed Resident #52 had a Percutaneous Enteral Gastrostomy (PEG) tube placed 9/16/24 related to dysphagia with the goal for insertion site to remain free of signs and symptoms of infection through the review date. Interventions instructed staff to check for tube placement and gastric contents/residual volume per facility protocol, provide localized care to G-tube site as ordered, and observe for signs and symptoms of infection. The Medication/Treatment Administration Order, dated October 2024, revealed an order, started on 9/19/24, for Resident #52 to receive enteral feed, at a rate of 85 milliliters (mL) per hour for 12 hours, followed by a water flush of 100 mL per hour for 10 hours daily. On 09/30/24 at 12:43 PM, observed an Enhanced Barrier Precautions sign posted on Resident #52's door to room. On 10/01/24 at 11:10 AM, Resident #52 sat in wheelchair at dining room table disconnected from feeding tube pump. Staff G, Licensed Practical Nurse (LPN), entered dining room with feeding tube pump attached to rolling pole. Staff G lifted Resident #52's shirt to expose gastrostomy tube (g-tube) and with ungloved hands, no additional Personal Protective Equipment (PPE) worn, cleaned g-tube port with an alcohol wipe and attached the end of feeding tube to the g-tube port. Staff G then resumed continuous enteral tube feeding at 85 mL per hour. Various residents and staff remained in area as nurse reattached and resumed Resident #52's enteral feeding. On 10/01/24 at 2:00 PM, Staff G, LPN, stated Resident #52 had gastrostomy tube in place for approximately 2 weeks and received tube feeding for difficulty with swallowing and risk for aspiration. Staff G stated that enteral feedings are started daily between 4:00-6:00 AM in resident's room and that it did not bother Resident #52 to have enteral feeding in common areas. Staff G stated the Enhanced Barrier Precautions (EBP) sign, posted on Resident #52's door, was for additional PPE to be worn when completing wound care related to an open area on bottom. On 10/01/24 at 2:53 PM, Staff H, Registered Nurse (RN) and Assistant Director of Nursing (ADON), revealed that the EBP sign on Resident #52's door was to instruct staff to don additional PPE (gown, gloves) when attaching or removing the feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 2:55 PM, Director of Nursing (DON) revealed that hooking a feeding tube to resident in dining room was a concern for resident dignity and expected nursing staff to provide appropriate infection control practices when administering tube feedings. The facility policy titled, Gastrostomy Tube Care, not dated, instructed staff to wash hands and don gloves before handling gastrostomy tubes and attachments to decrease the risk of infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on policy review, Center for Infection Control and Prevention (CDC) Guidelines, and staff interview, the facility failed to perform an assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread; and failed to identify measures to monitor and prevent the growth of opportunistic waterborne pathogens and facility staff failed to use enhanced barrier precautions when assisted a resident with a tube feeding, (Resident #52). The facility identified a census of 132 residents. Findings include: According to the CDC Legionnaires' disease is a serious type of pneumonia caused by bacteria, called Legionella, that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. During an interview on 10/02/24 at 10:50 AM Staff A, Maintenance Supervisor reported they did not have a water mapping or plan, but the facility does have a Legionella Policy. He verbalized they have never had low census so resident rooms are never vacant. They have not had to flush rooms, kitchens, water fountains or shower rooms, because everything is always in use. All laundry, kitchen, fountains and showers are in use daily so they have not identified any dead ends in the water system that require flushing at this time. On 10/02/24 at 1:05 PM Staff A verbalized they had always just given the Legionella Policy to the State and it was fine. He reported he did not have a written assessment pertaining to where Legionella could grow and he did not have a water plan that identified measure to prevent the growth of Legionella and how to monitor for Legionella. Staff A confirmed the facility had municipal water lines coming into the facility, an eye wash station in the laundry room with a back-flow valve, several shower rooms in use and a large kitchen with an ice machine. During an interview on 10/02/24 at 1:48 PM the Administrator reported she had only been with the facility for a month, but she had worked on Legionella assessment and water plans for facilities back in 2019. She stated she understood the facility needed a water management plan and the facility would be working on developing one. During an interview on 10/03/24 at 9:05 AM the Director of Nursing (DON) reported she had gone to a meeting on Legionnaires disease. She brought the information back and reviewed with maintenance, but honestly there has been no communication between the infection control preventionist and maintenance to work on the Legionnaires and a water management plan. She reported they had just gone through a water main break not that long ago and they did not have a water plan in place. (continued on next page)

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	165307	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillar of Cedar Valley	1410 West Dunkerton Road Waterloo, IA 50703

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/02/24 at 11:58 the facility provided the Legionella Policy. The Section T Legionella Policy reviewed 2/2024 directed when the facility maintenance director identifies potentially hazardous conditions that promote Legionella, the facility will conduct a Legionella Environmental Assessment. There will also be a risk assessment completed annually only upon any major alteration of the physical plant or new structure erected that may cause water condition to change. The assessment provided by the CDC will assist the facility to assess water systems, determine if Legionella environmental sampling is required and developing a plan. When conducting a hazard assessment, the maintenance director will pay special attention to: a. Locations in the water system where water may stagnate, such as storage tanks, and components that have been isolation and no longer maintain a significant flow of water or infrequently used faucets. b. Hot water recirculation systems. c. Side-stream plumbing equipment not experiencing regular flow, such as expansion tanks, hammer arrestors, or by-pass lines. d. Cross-connections between domestic and process water system. d. Backflow prevention devices. 48888 2. The Minimum Data Set (MDS), dated [DATE], revealed Resident #52 had delusions and modified independence for decision making regarding tasks of daily life. Resident #52 required dependance upon staff for hygiene tasks, dressing, and transfers. Diagnoses included Schizophrenia, dysphagia (difficulty swallowing), and flaccid hemiplegia (paralysis of one side of the body) affecting left side. The Care Plan, revised on 9/24/24, revealed Resident #52 had a Percutaneous Enteral Gastrostomy (PEG) tube placed 9/16/24 related to dysphagia with the goal for insertion site to remain free of signs and symptoms of infection through the review date. Intervention instructed provide localized care to G-tube site as ordered, and observe for signs and symptoms of infection. On 09/30/24 at 12:43 PM, observed an Enhanced Barrier Precautions sign posted on Resident #52's door to room. On 10/01/24 at 11:10 AM, Resident #52 sat in wheelchair at dining room table disconnected from feeding tube pump. Staff G, Licensed Practical Nurse (LPN), entered dining room with feeding tube pump attached to rolling pole. Staff G lifted Resident #52's shirt to expose gastrostomy tube (g-tube) and with ungloved hands, no additional Personal Protective Equipment (PPE) worn, cleaned g-tube port with an alcohol wipe and attached the end of feeding tube to the g-tube port. Staff G then resumed continuous enteral tube feeding at 85 mL per hour. Various residents and staff remained in area as nurse reattached and resumed Resident #52's enteral feeding. On 10/01/24 at 2:00 PM, Staff G, LPN, informed that the Enhanced Barrier Precautions (EBP) sign, posted on Resident #52's door, was for additional PPE to be worn when completing wound care related to an open area on bottom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/01/24 at 2:53 PM, Staff H, Registered Nurse (RN) and Assistant Director of Nursing (ADON), revealed that the EBP sign on Resident #52's door was to instruct staff to don additional PPE (gown, gloves) when attaching or removing the feeding tube. On 10/01/24 at 2:55 PM, Director of Nursing (DON) revealed the expectation that nursing staff provide appropriate infection control practices when administering tube feedings. The facility policy titled, Gastrostomy Tube Care, not dated, instructed staff to wash hands and don gloves before handling gastrostomy tubes and attachments to decrease the risk of infection.

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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews and record review, the facility failed to ensure a minimum of 80 square feet of personal room space for residents with roommates for 1 of 1 resident reviewed (Resident #29). During an observation it was noted that Resident #29 had a smaller room space than his roommates. The facility reported a census of 132 residents. Findings include: A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #29 included schizophrenia. A Brief Interview for Mental Status (BIMS) documented that this resident was rarely/never understood. It documented this resident knew the location of his own room and knew staff names and faces. A Care Plan with a Bed Mobility intervention initiated on 4/20/21, directed staff that Resident #29 chose to sleep in a recliner; Resident #29 did not have a bed. On 10/1/24 at 1:39 PM, the Maintenance Supervisor measured the room space for Resident #29. The measurements were 82 inches by 98 inches. Both Staff A, Assistant Director of Nursing (ADON) and the Maintenance Supervisor confirmed the measurements. On 10/2/24 at 10:20 AM, the Maintenance Supervisor stated they were having discussions regarding moving Resident #29 to the room next door and to keep room [ROOM NUMBER] a 3 resident room instead of a 4 resident room. He stated the room above room [ROOM NUMBER] on the 3rd floor was currently a 3 person room and mirrored room [ROOM NUMBER]. He stated that room [ROOM NUMBER] was certified for 4 resident occupancy at some point and what they think might have happened was when the facility was mandated to add a bathroom to each of the resident's rooms, the square footage per resident decreased. This Maintenance Supervisor acknowledged that Resident #29's room was less than 80 square footage and that the measurements of 82 inches by 98 inches was a little over 55 square feet. The facility did not have a policy that addressed square footage in resident rooms.

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F 0913 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that have direct access to an exit hallway. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews and record review, the facility failed to ensure residents had direct access to an exit corridor from their designated room space in a room shared by 4 residents for 4 of the 4 residents reviewed (Resident #29, Resident # 60, Resident #64 and Resident #92). Resident #64 would need to exit through Resident #29's designated room space to exit the room and access the hall. Resident #60 would need to exit through either Resident # 64's space and then into Resident #29's designated space or would need to exit through Resident #92's designated space. The facility reported a census of 132 Residents. Findings include: On 10/1/24 at 1:39 PM, Staff D, Assistant Director of Nursing (ADON) and Staff A, Maintenance Supervisor concurred that there was no way for in and out of the room for the 2 residents in the back of the room Resident #29 and Resident #60 to enter and/or exit their allotted space in the room without walking through Resident #64's and/or Resident #29's space. On 10/2/24 at 10:20 AM, Staff A stated the facility was having discussions regarding moving Resident #29 to the room next door and then to keep room [ROOM NUMBER] a 3 resident room. Staff A stated the room above it on the 3rd floor was a 3 person room and mirrors room [ROOM NUMBER]. He stated that at some point room [ROOM NUMBER] was certified for 4 residents. Staff A stated that what they think might have happened was when the facility had to add a bathroom to each of the individual rooms, the square footage per resident decreased. Staff A acknowledged the concerns with no direct access to the door without passing through another resident's room space. The facility did not provide a policy regarding direct access to an exit corridor.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews and record review, the facility failed to provide a privacy curtain between 2 residents (Resident # 29 and Resident #64. During an observation of Resident #29's room it was noted that there was no curtain hanging between Resident #29's designated room space and his roommate Resident #64's room space, removing all privacy for Resident #29. Resident #29 did not have decision making abilities to approve that there be no curtain. The facility reported a census of 132 residents. Findings include: A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #29 included schizophrenia. A Brief Interview for Mental Status (BIMS) documented that this resident was rarely/never understood. It documented this resident knew the location of his own room and knew staff names and faces. On 10/1/24 at 8:54 AM, Resident #29 was lying in his recliner on his side with recliner reclined. There was no curtain between this resident and his roommate. His roommate was also lying in bed with covers on him. Resident #64 stated he did not mind there being no curtain. Resident #29, was not able to respond. On 10/1/24 at 1:39 PM, Staff A, Assistant Director of Nursing (ADON) and the Maintenance Supervisor acknowledged there was no curtain between Resident #29 and Resident #64. This ADON and the Maintenance Supervisor noted there was a track on the ceiling for a curtain but did not know why there was not a curtain in place. They stated maybe it was being laundered. They stated they would look for a work order to figure out why the curtain was not in place. On 10/2/24 at 10:20 AM, the Maintenance Supervisor acknowledged the concern no curtain hanging between the above two residents. He stated they think that Resident #64 tore down the curtain. The facility did not have a policy addressing privacy curtains.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on observations, policy review, resident and staff interviews, the facility failed to provide a call light for Resident #103. The facility reported a census of 103 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #103 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented the resident had diagnoses of seizure disorder, Benign paroxysmal vertigo, malnutrition, Bipolar and Schizophrenia. Review of Resident #103 census documents she moved from another room to her current room on 1/11/2022. An observation on 9/30/24 at 2:53 PM, Resident #103 did not have a call light noted in her room. During an interview on 9/30/24 at 2:53 PM, Resident #103 reported she has not had a call light in her room. An observation on 10/02/24 at 9:49 AM, Resident #103's room continued to not have a call light. During an interview on 10/02/24 at 9:49 AM, Resident #103 reported she didn't know all the rooms should have a call light because she didn't have one. During an interview on 10/02/24 at 9:52 AM, Staff C, Licensed Practical Nurse reported Resident #103 should have a call light and didn't know why she didn't. In an interview on 10/02/24 at 11:03 AM, Staff D, Assistant Director Of Nursing reported Resident #103 should have a call light in her room and was not sure why she didn't have one or how long it had been missing. Review of the facility policy titled Call Light and Availability and Response dated 1/01/2019 documented staff will ensure residents that change rooms have a call light in the room.