STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165352	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmetsburg Care Center	2405 21st Street Emmetsburg, IA 50536

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure a resident with a history of pressure sores received adequate repositioning to prevent a new pressure sore from developing for 1 resident with a pressure sore (Resident #4). The facility reported a census of 43 residents. The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.Unstageable Ulcer: inability to see the wound bed.Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.Findings include: According to the Minimum Date Set (MDS) assessment dated [DATE], Resident #1 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident exhibited a functional limitation in Range of Motion of both lower extremities. The resident was dependent on staff for toileting and required substantial/maximal assistance with rolling in bed, and transfers, and did not walk. The resident's diagnoses included a pressure ulcer of unspecified buttock, stage 3. The Progress Notes dated 1/31/25 at 2 p.m. documented the resident arrived at the facility. The resident had previously admitted to the hospital on [DATE] with an open area to her coccyx, treated as a pressure ulcer stage 3 with maceration (softening and breakdown of skin due to prolonged exposure to moisture) of the buttock. The Progress Notes dated 5/1/25 at 8:08 a.m. documented the pressure ulcer healed.The Braden Scale for predicting the development of pressure ulcers dated 4/28/25 scored the resident at 16, indicating low risk. The resident assessment included the resident chairfast with very limited mobility. On the Braden Scale and Clinical Evaluation, the facility answered yes to the resident having a history of, or an existing pressure sore. If answered yes, the resident should be considered high risk.According to the MDS assessment dated [DATE], Resident #1 scored 9 on the BIMS indicating moderate cognitive impairment. The resident exhibited a functional limitation in ROM of both lower extremities. The resident was dependent on staff for toileting and required substantial/maximal assistance with rolling in bed, and transfers, and did not walk. The resident's diagnoses included non-Alzheimer's dementia, need for assistance with personal care, morbid obesity, and lymphedema. The resident did not have a pressure ulcer and utilized a pressure reducing device for the bed and the chair. The MDS did not mark the resident on a turning and repositioning program.The current Care Plan with a goal target date of 8/17/25 identified the resident had a pressure ulcer of the coccyx. Interventions included encouraging the resident to reposition, following the facility policy/protocol for the prevention/treatment of skin breakdown, observing skin condition with activity of daily living care, pressure reducing devices on her chair and bed, providing preventative skin care, and using pillows/positioning devices as needed.The Progress Notes dated 6/27/25 at 4:10 p.m. documented a call to the resident's Primary Care Provider (PCP) and notified them of a new skin wound finding (pressure ulcer of the coccyx). The PCP gave orders for treatment and repositioning.On 7/21/25 at 11:07 a.m. the resident stated she had a sore on her backside. It did not hurt, and was getting better.During an observation on 7/22/25 at 9:30 a.m. Staff C, Licensed Practical Nurse (LPN) completed the dressing change to the resident's pressure ulcer. The wound appeared as a deeper crater. On 7/24/25 at 9:24 a.m. the Administrator stated the resident did not sleep in the bed, and if in bed, she laid on her side. She slept in her recliner with a pressure reduction cushion, and they repositioned her in the chair. She said they documented in the record that they

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F 0689 Level of Harm - 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** Based on clinical record review, staff and resident interviews, facility policy review, and observations. The facility failed to provide adequate nursing supervision to prevent accidents and injuries for 3 out of 7 residents reviewed for falls. Resident #2 experienced a fall outside of the facility and was not receiving an appropriate level of assistance. Resident #4 and #37 had a fall from a mechanical stand. The facility failed to use the correct harness and provide the correct level of assistance with transfers. The facility reported a census of 43. Findings include: 1. Resident #2’s Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #2’s MDS included diagnoses of heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety and depression. The MDS coded Resident #2 substantial/maximal assistance, meaning the helper does more than half the effort, the helper lifts or holds the trunk or limbs and provides more than half the effort for toileting transfers. The MDS described Resident #2 continent of urine. Interview with Resident #2 on 07/23/2025 at 10:43 a.m. he stated that he had an appointment in another town approximately an hour and forty minutes away from the facility and was riding in the front seat of the transport vehicle because it was more comfortable for that long of a drive. He stated he didn’t take his wheelchair or his cane per his choice. Resident #2 stated that he had this driver before and had no issues. Resident #2 stated that they had stopped at a gas station on the way because he didn’t think he could make it to the clinic where his appointment was before using the restroom. Resident #2 stated he had been having diarrhea over the last couple of days and thought this was taken care of. Resident #2 stated he was utilizing the rock wall outside of the gas station to walk to the restroom and stated the transport driver was helping him. Resident #2 stated he got dizzy and fell to the ground. Resident #2 stated he hit his head and scraped his right knee. Resident #2 stated they called the ambulance to come get him and take him to the emergency room. Resident #2 stated he never made it into the restroom. Resident #2 stated the facility knew about the diarrhea, he stated he had been taking medication to help with that. Resident #2’s Care Plan with an initiated date of 5/23/25 revealed Resident #2 was at risk for falls related to generalized weakness, dependent on staff for mobility. Resident #2 needed assistance with transfers and ambulation. Resident #2 needed contact guard assist for long distance ambulation, and to utilize a gait belt and cane. Staff to do set up assist and check for accuracy and cleanliness for toileting. Resident #2 needed assistance from one staff member for dressing. Review of the clinical Physician Order’s revealed Resident #2 takes Apixaban (blood thinner) 5mg twice daily by mouth. Review of the Medication Administration Record (MAR) for July 2025 revealed Resident #2 requested Loperamide (antidiarrheal) 2mg to help with diarrhea on 7/8/25 and 7/9/25. Review of the fall risk evaluation through the admission assessment dated [DATE] revealed Resident #2 had a history of falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility Progress Notes dated 7/10/25 at 8:45 a.m. revealed Resident #2 left the facility for an appointment with a transport car to go to a doctor’s appointment. The Facility Incident Report (IR) documented in the Progress Notes on 7/10/25 at 10:33 a.m. revealed the facility received a call from a friend of Resident #2 informing the facility Resident #2 had a fall attempting to utilize a restroom at a gas station on the way to his appointment. Resident #2 was transported to the emergency room for further evaluation. The emergency room nurse reported Resident #2 was ambulating into a bathroom and felt dizzy leading to a fall. Per the Incident Report Resident #2 was to have contact guard assist (a therapist or caregiver provides occasional physical support, like light touch, to help a patient with balance or stability while they perform a task, but the patient is mostly doing the work themselves) with long distance ambulation, a gait belt and cane. The intervention documented is to have a staff member accompany Resident #2 to appointments. Review of the emergency department’s final report dated 7/10/25 revealed Resident #2 presented to the emergency room (ER) via Emergency Medical Services (EMS) for presyncopal (the sensation of lightheadedness, dizziness, or feeling faint without actually losing consciousness) episode, while ambulating in the bathroom had a bowel movement and became lightheaded. Resident #2 noted he had several loose stool bowel movements over the course the past couple days and had been having this paroxysmal (something that occurs suddenly and intensely, often in a recurring or periodic way) on and off diarrhea for the past few weeks which he had taken medication for however patient is unable to recall the medication. Resident #2 complained of acute, focal, persistent mild pain along the right chest, hip and leg. Resident #2 confirmed hitting his head. Resident #2 received a left posterior scalp dense subcutaneous hematoma (localized collection of clotted blood beneath the skin, often appearing as a raised, firm, and painful lump. It is a more significant form of bleeding than a typical bruise, involving larger blood vessels and a more substantial amount of pooled blood) measuring 2.1 x 1.4 x 0.7 centimeters (cm). Interview with the Administrator on 07/23/2025 at 11:19 a.m. revealed the nurses made the appointment for Resident #2, he utilized the medicaid transportation and the appointment is longer than 30 miles from the facility. The Administrator stated that they take into consideration the type of appointment, how long the resident will be gone and if they are going to need to utilize the restroom to determine if they need to send a staff member along. Review of the facility’s policy named Fall Occurrence revised 2/2024 revealed it is the policy of the facility to ensure that residents are evaluated for fall risks and implement interventions to minimize risk for falls and/or risk for injury from falls. A Fall Risk Assessment is completed by the nurse upon admission, readmission, and as necessary. Based on assessment, interventions are implemented and placed on a care plan. An incident report will be completed by the nurse each time a resident has a fall. Residents will be assessed by a licensed nurse prior to being moved after a fall. The nurse will notify the physician and resident representative. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Additional intervention(s) will be implemented post fall. Interdisciplinary Team (IDT) may change the intervention(s) if IDT investigation identifies a more appropriate intervention for the individual fall. The resident’s care plan will be updated with any new or revised intervention(s). Neurological assessment will be initiated for unwitnessed falls and/or falls that are witnessed and resident hits their head (neuros completed as directed on neuro flowsheet) Documentation and monitoring to be completed for 72 hours post fall. The Administrator reported the facility does not have a transportation policy. Interview with the Administrator on 07/24/2025 at 1:13 p.m. revealed the only Incident Report is in the Progress Notes and the root cause is the driver broke procedure/protocol and stopped for Resident #2. The Administrator stated the drivers are not supposed to stop. The Administrator stated they do not have a contract with this company, it is all done through the Managed Care Organization (MCO). The Administrator stated the driver is a friend of Resident #2, so they will be sending a staff person with him from now on. The Administrator stated this fell back on the facility anyway even when the driver broke protocol. 2. According to the Minimum Date Set (MDS) assessment dated [DATE], Resident #1 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident exhibited a functional limitation in Range of Motion of both lower extremities. The resident was dependent on staff for toileting, and required substantial/maximal assistance with rolling in bed, and transfers, and did not walk. The resident's diagnoses included a need for assistance with personal care, morbid obesity, and lymphedema. The resident had no falls since the previous assessment. The Care Plan with a goal target date of 8/17/25 identified the resident at risk for falls related to generalized weakness, and depending on staff for transfers. Interventions included the new sling for the sit to stand (lift)in house. The Care Plan identified the resident required assistance with activities of daily living (ADL's) related to weakness, and a history of falling. Interventions included transferring with substantial/maximal assist of 2 staff members. Sit to stand with assist of 2 per physical therapy (PT) 2-3-25. The Progress Notes dated 5/2/25 documented a CNA paged the Nurse to the resident's room where they noted the resident on the floor with the sit to stand lift in front of her, and the aide holding her back up. The CNA reported the resident slipped out of the sling by lifting her arms up. The Nurse noted the belt on the sling clasped together like it should be. The CNA reported the resident did not hit her head. The resident was incontinent of bowel at the time. They helped the resident off the floor by the Nurse and the CNA with the use of the gait belt, and placed in her recliner. Preliminary Recommendations for consideration as further preventative measures included use of the hip sling when using the sit to stand with the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 7/22/25 at 9:40 a.m. Staff C, Licensed Practical Nurse (LPN) and Staff D, Certified Nursing Assistant (CNA) placed the sit to stand lift up to the resident, hooked the lift sling to the lift on the harness hooks, with no safety tabs. Staff hooked the safety strap in front of the resident and tightened. They had the resident hold onto the handles and lifted, and rolled to the recliner and sat down. During the transfer, staff used the gray sling. On 7/22/25 at 1:24 p.m. Staff E LPN stated she recalled the incident with the resident. She said when she got to the room, the resident was on the floor and the sling off. The CNA told her the resident slipped through when she raised her arms up. She said the waist belt was clasped together, but she didn't know if it had been tightened. She didn't know how she would have slipped through if it was snug. She said the new intervention was the use of a hip sling. She said no education was provided. She did not know of any other incidents with the lift, or any other incidents with the staff involved. On 07/22/25 at 3:03 p.m. Staff F CNA stated he was assisting the resident with the sit to stand lift from the commode. He cleaned her and pulled her pad up and tried to get the commode back under her because she was weak. She let go of the handles of the sling and put her arms up and slipped through the sling up to her head and neck. He said he lowered her with the sling. He thought he used the green sling. He said he received no education after the incident. They were to have 2 staff with transfers with the the lift for this resident. He did not know about a different sling to use with her after the incident. The sit to stand lift Operator's Instructions revised 3/11/09 documented: Attaching the harness to the sit to stand included with the lift arm in the lowest position, attach the harness to the hooks at the end of the sit to stand lift arm using the loops at the end of the harness. The manufacturer suggested the following components and operating points be scheduled for inspection at intervals not greater than a month. Any detected deficiency must be rectified before putting the stand back into service. Safety tabs need to be checked to make sure they were installed correctly, not missing or torn. 3. Resident #37 MDS dated [DATE] identified a BIMS score of 15, which indicated intact cognition. The MDS identified Resident #37 required substantial/maximal assistance with all transfers. The MDS documented Resident #37 was non-ambulatory. The MDS included diagnoses of cerebral palsy (abnormal development or damage to the area of the brain that controls movement, balance and posture), anxiety, depression and hypertension (high blood pressure). The Care Plan with a target date of 9/10/25 documented Resident #37 required assistance with activities of daily living (ADL’s) and was at risk for falls due to diagnosis of cerebral palsy. The Care Plan directed staff to use a sit to stand lift for all transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Progress Note titled Incident Report dated 6/22/25 at 11:38 PM documented Staff C, Licensed Practical Nurse (LPN) was called into Resident #37’s room by Staff F, Certified Nursing Assistance (CNA). Upon entering the room Staff C observed Resident #37 lying on the floor on her left side with a pillow under her head next to the sit to stand lift. According to the note, the sit to stand lift sling belt was around Resident #37’s waist and the straps were disconnected. The note documented when Staff F lifted Resident #37 with the sit to stand lift, the first strap of the two straps that were connected slid causing the Resident #37’s left side to drop a few inches. Staff F then lowered Resident #37 to the ground and placed a pillow under her head. The note documented further preventive measures were to assess the sit to stand lift and use the gray sling. The green sling was placed at the nurses station to be assessed further. A Progress Note dated 7/1/25 at 8:51 AM documented Resident #37 was seen for a 60 day recertification visit by her Physician. The note documented Resident #37 reported she was lowered to the floor. Resident #37 complained of continued left thigh pain and pain when standing. The note documented new orders were received to obtain left hip/pelvis x-ray due to diagnosis of fall/pain. A Progress Note dated 7/6/25 at 2:14 PM documented the facility received signed x-ray results of Resident #37’s femur/pelvis with no acute abnormalities. On 7/21/2025 at 2:01 PM, Resident #37 reported a couple weeks ago she had a fall from the sit to stand lift. She reported she thought something had happened with the equipment and the sling had slipped off from the stopper. She said she was lowered to the floor. Resident #37 said she had x-rays done and there were no fractures. On 7/22/25 at 9:30 AM, observed a sit to stand lift in the hallway by Resident #37’s room with two different slings made by two different manufacturer’s lying on top of the machine (one sling was gray in color and the other sling was blue). Observations of the slings revealed they were not made by the same manufacturer as of the sit to stand lift. The tag on the gray sling was dated 6/13/25 and directed the sling only to be used with lifts that were made by the same manufacturer. The tag on the blue sling was not dated, worn and very hard to read. On 7/22/25 at 9:50 AM, observed Staff A, CNA and Staff B, CNA transfer Resident #37 with the sit to stand lift. They placed a gray sling behind Resident #37’s back and then fastened the safety belts around Resident #37’s waist and legs. They then hook the sling onto the harness hooks and raised the sit to stand lift up while Resident #37 held onto the handle with her left hand. The safety belts loosened around the waist and legs while Resident #37 was raised up and the CNAs did not adjust or tighten the belts. They positioned Resident #37 with the sit to stand lift in front of the commode, pulled down her pants, removed the incontinence brief and then lowered her onto the commode in a sitting position. Observation revealed the gray sling used during the transfer was not manufactured by the same company as the sit to stand lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/22/25 at 1:26 PM, Staff F, CNA reported he had put the sling under Resident #37's arms and hooked the sling to the sit to stand lift. He said the sit to stand lift had rubber boots on the handles. He said he thought the straps must have gotten stuck on the rubber boot. He said when he stood her up she started to fall as the straps on the left side of the lift became unhooked and came off the ring. He stated that he had not double checked the straps before standing the resident up. He said the belt around the waist was attached and pulled tight. He reported that he did not have the leg strap in place. He said he lowered Resident #37 to the floor using the sit to stand lift. He said he has never had any issues before using the sit to stand lift before. When asked what type of sling was being used during the incident, he said it was a gray sling with rubber grip and padding under the arms. He said it was one of the new slings that the facility had gotten in because the old slings were bad and not in good shape. On 7/22/25 at 2:30 PM, the Administrator reported after Resident #37 had a fall involving the sit to stand lift, she walked around the facility to make sure the staff knew how to use the sit to stand lift and she thought they did. The Administrator reported the facility had gotten new slings for the sit to stand lifts recently. When brought to the attention of the Administrator that the new slings were not the same manufacturer as the sit to stand lifts, she said that the slings worked with the machines. When asked what the facility expectation was with following the sit to stand operator’s manual, she said she would have to check with Corporate to see what they wanted her to do. She said she felt the sit to stand operator’s manual was a recommendation. On 7/22/25 at 2:48 PM, Staff G, Nurse Consultant reported the facility was going to order the correct slings for the sit to stand lifts. She said the staff would use the mechanical full body lifts for transfers until the new slings arrived. The sit to stand Operator’s Instructions revised 3/11/09 documented the manufacturer’s sling/harnesses are made specifically for the sit to sand lifts. The operator’s instructions documented for the safety of the resident and caregiver, only the slings/harness made by the same manufacturer as the sit to stand lift should be used. In addition, the operator’s instructions, directed when transferring a resident, for the safety of the resident, securely fasten the safety strap around the resident’s torso and pull the strap to tighten. As the resident is being raised, simultaneously tighten the safety strap buckled around their torso.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, and policy review the facility failed to prepare and serve pureed food to meet the nutritional needs of 4 of 4 residents reviewed (Residents #18, #19, #21, #23). The facility reported a census of 43 residents. Findings include: A facility form titled Diet Type Report dated 7/21/25 identified four residents (Resident #18, #19, #21, #23) who received a pureed texture diet.On 7/23/25 at 11:15 AM, observed Staff H, [NAME] put 4 servings of pork tenderloins into the robo coupe (blender). She then added chicken broth and blended the contents. Staff H put the blended meat into a measuring cup and reported there were 2 1/2 cups. Staff H reviewed the Pureed Diet Portion Sizes/Scoop Chart and reported the serving/scoop size was a #12 scoop and a #16 scoop.On 7/23/25 at 11:45 AM, observed Staff H, [NAME] use a #10 scoop to serve the pureed meat to the four residents who received pureed meat. Observation at the end of the meal service revealed there was pureed meat left over in the pan (approximately 3/4 of a #10 scoop). On 7/23/25 at 1:00 PM, Staff H, [NAME] verified she used a #10 scoop for the pureed meat. She said she thought a serving size for meal was 3 ounces and used the #10 scoop instead of the #12 and #16 scoop. The cook acknowledged she had prepared 4 servings of pureed meat for 4 residents and that there should not be any pureed meat left over at the end of the meal service.On 7/23/25 at 1:10 PM, the Certified Dietary Manager (CDM) reported she would expect the cook to follow the Pureed Diet Portion Sizes/Scoop Chart for the appropriate serving and scoop sizes.On 7/24/25 at 1:30 PM, the Administrator reported she did not have a policy on the puree process. She said the facility used the Pureed Diet Portion Sizes/Scoop Chart.

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165352	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmetsburg Care Center	2405 21st Street Emmetsburg, IA 50536

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on diet orders, staff interviews, clinical record review, hospital record review and facility policy review the facility failed to serve the appropriate therapeutic diets to meet resident's needs according to their diet orders for 1 of 6 residents reviewed (Resident #3). The State Agency informed the facility of the Immediate Jeopardy (IJ) on 7/24/25 at 11:27 AM that began as of 7/17/25. The Facility Staff removed the IJ on 7/24/25 through the following actions:-Education to the nursing staff started on 7/24/25 to ensure they confirm the diet order and serve the appropriate diet and diet modifications. -Like residents include residents with orders for modified or altered diets. An audit was completed for residents with orders for modified or altered diets to ensure the diets are correct. The scope was lowered from a J to a G at the time of the survey after ensuring the facility implemented education.The facility reported a census of 43 residents.Findings include: Resident #3's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 14, indicating intact cognition. The MDS identified Resident #3 required set up or clean-up assistance with eating. The MDS included diagnoses of diabetes mellitus and noninfective gastroenteritis (inflammation of the stomach) and colitis (inflammation of the colon). The MDS documented Resident #3 was on a mechanically altered and therapeutic diet. A Diet order dated 5/13/24 directed the staff to administer a mechanical soft, ground meat texture diet related to Barrett's esophagus with dysplasia (presence of precancerous cells in the lining of the esophagus (tube that carries food from mouth to stomach), replaced by intestinal like tissue due to gastroesophageal reflux disease (GERD). In addition the diet order directed staff to provide supervision/cues for pacing, give a drink after 1-2 bites of food, give one food item at a time, soft foods only and no bread. The Care Plan with target date of 9/28/25 documented Resident #3 was at risk for altered nutritional status related to obesity, diabetes mellitus and gastrointestinal complications. The care plan directed staff to provide diet as order, feed one item at a time and encourage Resident #3 to sit up straight. The Care Plan lacked information related to Resident #3 swallowing issues and diet restrictions. Review of the Kardex (used by the facility certified nursing assistants (CNAs) as a snapshot of resident care) lacked documentation regarding Resident #3's diet order and restrictions. A Progress Note dated 7/17/25 at 9:52 PM documented Resident #3's blood sugar was 49 mg/dl (milligrams per deciliter) and the resident was given orange juice and peanut butter toast. A Progress Note dated 7/17/25 at 11:19 PM documented at 9:55 PM, Staff E, Licensed Practical Nurse (LPN) entered Resident #3's room and the resident was groggy. Resident #3's blood sugar was checked and 49 mg/dl. The note documented Resident #3 was given 8 oz (ounces) of orange juice and peanut butter and a CNA sat with the resident. At 10:10 PM, Resident #3's blood sugar was 69 mg/dl and 4 oz of a protein shake was given. Resident #3 was sitting on the side of the bed heaving and bringing up small amounts of mucus. At 10:35 PM, Resident #3's blood sugar was checked and 63 mg/dl. Resident #3 was given 8 oz of orange juice with 2 packets of sugar. Resident #3 continued to sit on the edge of the bed heaving and bringing up mucus. The note revealed Resident #3 vitals were the following: Temperature 97.5, Pulse 114 per minute, Respirations 20 per minute, Blood Pressure 99/56 and oxygen saturation (oxygen in the blood) was 63% on room air. The note indicated oxygen at 2 liters per nasal cannula was applied. A phone call to the emergency room (ER) was placed informing the ER of Resident #3's condition. At 10:42 PM, a phone call to 911 was placed and informed them of the need for transport and Resident #3's condition. At 11:00 PM Emergency Medical Technicians (EMTs) arrived at the facility.A Prehospital Care Report dated 7/17/25 documented EMTs arrived and found Resident #3 seated on the side of the bed with staff present. The note documented when the staff checked Resident #3's blood sugar they discovered the blood sugar was low, they held the insulin and gave him orange juice and toast with peanut butter. A ED (Emergency Department) Note dated 7/17/25 documented Resident #3 presented to the ER with difficulty breathing and was brought by the local EMS for altered level of consciousness, low oxygen saturation and hypoglycemia (low blood sugar). The note documented the staff reported Resident #3 had low blood sugar after supper and was given orange juice, peanut butter sandwich and a supplemental shake. A Hospital Critical Care History and Physical Note dated 7/18/25 documented Resident #3 was admitted to the hospital related to acute hypoxic respiratory failure (lungs cannot provide enough oxygen to the blood leading to dangerously low blood oxygen levels) on AIRVO (high flow nasal cannula system designed to deliver warmed and humidified air and oxygen mixtures to patients that experience respiratory distress) in setting of aspiration pneumonia (foreign material like food, liquid or vomit is inhaled into the lungs) due to

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review, the facility failed to ensure food was discarded after product expiration date, ensure freezers were clean/sanitized and prevent cross contamination during meal service. The facility identified a census of 43 residents.Findings include: An initial kitchen tour conducted on 7/21/25 at 9:30 AM, of the kitchen revealed the following items were stored in the refrigerator ready for service:a. 2 large containers of Philadelphia Cream Cheese- Expired 6/2025b. 1 large container of Philadelphia Cream Cheese with an open date 4/25- No expiration date on container. c. Plastic container labeled chicken broth- dated 7/7/25During the initial kitchen tour revealed the following observations:a. Freezer #1- food debris on the bottom of the freezer, broken plastic container with a sign that said hamburger. The plastic container had dried/frozen red substance on the bottom of the container along with food debris. The freezer door rubber seal was coming apart and there was ice build up and frost on the inside of the door. b. Freezer #2- food debris on the bottom of the freezerc. Freezer #3- 1/2 inch of ice on the bottom of the freezer and ice build up on the back of the freezer on the water drainage system.d. Freezer #4- food debris on the bottom of the freezerOn 7/23/25 at 11:45 AM, during meal service observed Staff H, [NAME] held plates of food against her dirty uniform to cut up the pork tenderloins into pieces for four different residents. Observation revealed the serving utensil for the mini baker potatoes fell into the pan multiple times, Staff H reached into the potatoes, picked up the utensil with her bare hands and then continued to use the same utensil to serve the potatoes. On 7/23/25 at 1:45 PM, the Certified Dietary Manager (CDM) reported it was not appropriate for the plate of food to touch the cook's uniform. The CDM reported if a utensil fell into the food, she would expect the staff member to put on a glove to remove the utensil and then get a new utensil to serve with.A facility policy titled Food Handling revised 10/2023 documented the purpose of the policy was to adhere to the food safety standards described in the local Food Code and as per CMS (Centers for Medicare & Medicaid Services) food safety standards for long term care. The policy directed the following:1. Ready-to-eat food must not be touched with bare hands.2. Disposable gloves, tongs, or other dispensing devices must be used properly in accordance with safe food handling practices.3. All foods prepared in operation must be covered and labeled with date of preparation prior to storage in refrigerators and freezers. A use-by date should be specified.4. Staff to follow kitchen sanitation guidelines and center specific cleaning schedules.A facility policy titled Kitchen Sanitation and Cleanliness dated 6/17/10 documented the food service preparation, storage and service area will be maintained in clean and sanitary conditions. The policy documented food service preparation, storage and service areas to be assessed on a periodic basis to develop and edit appropriate cleaning schedules for each area. A system will be maintained to monitor and evaluate effective cleaning on a regular basis as part of the Quality Assurance process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident reviewed (Resident #37). The facility reported a census of 43 residents.Findings include: Resident #37's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #37 required substantial/maximal assistance for transfers and toileting. Resident #37's MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus, cerebral palsy, and anxiety disorder. On 7/22/25 at 9:50 AM, observed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA transfer Resident #37 onto the commode with a sit to stand lift. Staff A and Staff B entered Resident #37's room and applied gloves. Staff A applied compression socks and braces to Resident #37's lower legs with gloved hands. Staff A then removed her gloves and did not complete hand hygiene. Staff A and Staff B then hooked up Resident #37 to the sit to stand lift and stood Resident #37 up from the recliner. Staff B positioned Resident #37 with the sit to stand lift in front of the commode. Staff A pulled down Resident #37's pants, removed the incontinence brief, placed the brief in the commode and pushed the brief down inside the commode with her bare hands. Staff A did not complete hand hygiene after removing/touching the incontinence brief. Staff B then lowered Resident #37 on to the commode. Staff A unhooked the harness from the sit to stand lift and removed it. Staff A then went to the sink and put a wash cloth in the sink with soap and water. Staff A then put on a pair of gloves without completing hand hygiene prior. Staff A then proceeded to undress and change Resident #37's clothing while sitting on the commode with gloved hands. Staff A put Resident #37's dirty pants and shirt directly on the floor. After Resident #37 was redressed, Staff A hooked Resident #37 to the sit to stand lift and gave her the call light. Staff A then removed her gloves, picked up the clothes off of the floor and put the clothes in the hamper. Staff A then washed her hands at the sink. Staff A reported Resident #37's incontinent brief was wet when she had removed it. In addition, Staff A acknowledged she did not complete hand hygiene after she removed her gloves.On 7/23/25 at 9:41 AM, the Administrator reported it was an expectation for staff to complete hand hygiene after removing gloves per standard of practice. She said she had provided education to the staff and was working on ordering small bottles of hand sanitizer for the staff to carry with them. A facility policy titled Hand Hygiene revised 10/2023 documented the purpose of the policy was to prevent the spread of infection. The policy directed the staff to complete hand hygiene using alcohol- based hand rub during the following situations: Before and after direct resident contact. Before and after assisting a resident with toileting. Before moving from work on soiled body site to a clean body site on the same resident. After contact with blood, body fluids or surfaces contaminated with blood and body fluids. After removing gloves.