STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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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** 41785 Based on staff interviews, clinical record review, facility document review and policy review the facility failed to ensure that all residents were treated with dignity and respect for 1 of 14 residents reviewed. A staff member was demanding, forceful and demeaning to Resident #96 when she became restless and tried to get out of her chair unassisted. The facility reported a census of 43 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #96 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit). She required set up assistant for eating, and substantial assistance with sit to stand chair transfers. Her diagnosis included diabetes mellitus, urinary tract infection and arthritis. The Care Plan for Resident #96, dated 9/19/24, showed that she was admitted to hospice and was at high risk for falls due to poor mobility. The resident needed assistance with ambulation, transfers and bed mobility. Resident #96 used anti-anxiety medication related to anxiety disorder and was crying often. Staff were directed to use non-medical interventions including activities, distraction and calm reassurance. If the resident became resistive, staff were to leave her alone in a safe position for a few minutes and retry. In the facility Statement from Staff F dated 9/26/24, Staff F, Registered Nurse (RN) stated at the time of the incident, she was in the dining room and heard Staff D say don't do that. She looked in her direction and she noticed Resident #96 trying to stand up. Staff F stated she was concerned that the resident would trip on her wheelchair peddle and was solely focused on that and making sure she didn't trip so she didn't see what happened with Staff D. Staff F stated she then heard Staff D say she bit me. Staff F informed Staff D to go get the other nurse to help her while she stayed with the resident. A little while later the aide, Staff H, informed her that he saw Staff D push Resident #96's forehead away. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Interview with Staff D dated 9/26/24 at 12:00 PM documented Staff D told the Administrator she was with Resident #96 in the dining room waiting for supper to be served. The resident tried to stand up from her wheelchair and Staff D encouraged her to sit down to stay safe and explained that dinner would be coming soon. As she was about to walk away the resident tried standing up again, Staff D touched her shoulder and Resident #96 told her to get her hands off her. The resident then grabbed Staff D's hand and bit her right behind her right thumb. Staff D stated she lightly pushed the residents head back as she was panicking and trying to get Resident #96 to stop biting her. Staff D stated she didn't push hard as she knew the resident is elderly and she could hurt her if she did. Staff D stated the nurse, Staff F, was around and she got her attention and told her what happened. On 11/12/24 at 2:36 PM, Staff H stated that he was working the evening of 9/26/24 and saw Staff D sitting with Resident #96. He said that she was a CSA and not trained to monitor residents. A CSA was responsible for helping with filling waters, serving meals and stocking supplies so he didn't know if someone had asked her to monitor the resident. Staff H said that he saw Resident #96 bite the hand of Staff D. The resident was sitting and Staff D was standing next to her, as the resident tried to stand up on her own, Staff D became annoyed, and held the resident's hand or arm. He said that she used a very firm voice and ordered the resident to stay seated. He then saw Resident #96 take the staff's hand, put it up to her mouth, and bite her. Staff D then pulled her hand away from the resident and smacked the resident on the forehead. The aide then left the dining room area to find the nurse. On 11/12/24 at 2:44 PM, Staff E, Licensed Practical Nurse (LPN), stated that she was working the evening of 9/26/24 and Resident #96 was very agitated that evening. She said that Staff D was aggressive in her interaction with the resident. She used a harsh voice and told the resident what to do, rather than redirecting her and being patient. Staff E did not see the resident bite the CSA, but later, Staff H came and told her that Staff D had pushed the resident on the forehead after she got bit. Staff E attended to the resident and tried to get her to eat after the incident, but she was even more agitated and wouldn't eat. On 11/12/24 at 3:30 PM Staff F, RN stated that she heard Staff D say let go of me! She assumed that Resident #96 had been trying to get up on her own because she had been restless. Later, Staff H came and told her that Staff D hit the resident's head with her hand after she had bitten her. She said that Staff D had been a new staff member. On 11/14/24 at 10:27 AM, Staff D stated that on the evening of 9/26/24, Resident #96 kept trying to stand up. The nurses were aware and had been telling her to sit back down. Staff D said that the nurses asked her to sit with the resident. She said that she had been educated to get a CNA or nurse for resident interactions such as this, but the nurses were busy. At one point, Staff D put a hand on the resident's shoulder and that was when the resident grabbed her hand and bit her. She explained that she was very new to the position and that this was the first time she had dealt with an agitated resident. She said that she wasn't thinking, and she was getting annoyed with her, used a harsh tone and said sit down! (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 10:20 AM, the Nurse Consultant (NC) and Administrator maintained that Staff D did the best she could, even though she was not trained to walk with or physically attend to residents. They said that she was trying to get the resident to sit down and the only other option was to allow her to fall. They maintained that it happened too quickly for her to get help from trained staff even though there were several others in the dining room area. A facility policy titled: Dignity, revised in February 2021, showed that each resident would be care for in a manner that promoted and enhanced his or her sense of wellbeing, level of satisfaction with life and feeling of self-worth and self-esteem. When assisting with care, staff would speak respectfully to residents. Staff were expected to treat cognitively impaired residents with dignity and sensitivity to address the underlying motives for behavior.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review and staff interviews the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment during the required timeline for 1 of 14 residents reviewed (Resident #35). The facility census was 43. Findings include: Resident #35's MDS Quarterly assessment dated [DATE] revealed Section GG (Functional Abilities) lacked data or reason for non-assessment. The previously completed Quarterly MDS dated [DATE] was completed in its entirety. On 11/13/24 at 11:19 AM the Director of Nursing (DON) stated the MDS is completed with coordination between the facility MDS Coordinator and Corporate MDS Consultant. The DON reviewed the MDS dated [DATE] and could not explain why Section GG had not been completed, and would expect the document to be completed in its entirety. On 11/13/24 at 11:25 AM Staff G, MDS Coordinator, stated she was not in the position in August of 2024 and could not provide details why Section GG was not completed. On 11/13/24 at 2:00 PM, the Administrator stated she would defer to nursing on the completion of the MDS assessment. On 11/13/24 at 8:13 AM, the Physical Therapist Assistant (PTA) stated she completed Section O of the MDS and provided input to the MDS Coordinator for Section GG. The Long-Term Care Survey Process form labeled MDS Indicator Facility Rate Report for the survey ending 11/14/24 generated by the MDS assessments completed by the facility listed a total number of assessments as 42. The CMS RAI Version 3.0 Manual dated October 2024 revealed The Quarterly Assessment is an Omnibus Budget Reconciliation Act (OBRA) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident ' s status between comprehensive assessments to ensure critical indicators of gradual change in a resident ' s status are monitored. The document further revealed the OBRA/Interim completion of Section GG utilized the assessment period as the Assessment Reference Date (ARD) plus 2 previous calendar days. The section is completed using a 6 point scale and if the area was not attempted the reason is to be coded. The facility provided policy, Comprehensive Assessments, revised October 2023 revealed the comprehensive assessment included the completion of the MDS, and were completed in accordance with the criteria of the RAI User Manual.

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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** 47673 Based on electronic health record review, document review, policy review and staff interviews the facility failed to provide a comprehensive care plan that included goals or interventions for a diagnosis of methicillin-resistant staphylococcus aureus (MRSA) and or enhanced barrier precautions (EBP) related to the diagnosis of a multidrug-resistant organism (MDRO) for 1 of 5 residents reviewed (Resident #22). The facility reported a census of 43 residents. Finding include: The Electronic New Order dated 7/4/24 for Resident #22 documented a new order for Bactrim DS and a diagnosis of carrier or suspected carrier of methicillin resistant Staphylococcus aureus. Review of Resident #22's MDS dated [DATE] documented no active diagnosis of MDRO. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #22 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of Resident #22's Care Plan documented no focus, goals or interventions for a diagnosis of MRSA. On 11/14/24 at 8:30 AM Staff G stated she started writing care plans for the residents at the facility at the end of August or the beginning of September. Staff G acknowledged there was not a care plan created with the diagnosis of MRSA. Staff G stated a care plan with a focus, goal, or intervention in place should have been created with the diagnosis of MRSA. On 11/14/24 at 8:41 AM the DON stated Resident #22 should have a sign outside her door related to enhanced barrier precautions. The DON acknowledged there was no sign related to enhanced barrier precautions currently. The DON acknowledged there was not a care plan created with the diagnosis of MRSA. The DON stated a care plan with a focus, goal, or intervention in place should have been created with the diagnosis of MRSA. On 11/14/24 at 9:59 AM Staff Q, Nursing Consultant stated the facility's expectation was that a care plan would have been developed with the diagnosis of MRSA and or the requirement of enhanced barrier precautions. Review of policy revised 3/22 titled, Care Planning - Interdisciplinary Team documented comprehensive person centered care plans are based on resident and developed by an interdisciplinary team. Review of policy revised 10/23 titled, Comprehensive Assessment documented the facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident ' s functional capability using the Resident Assessment Instrument (RAI) specified by CMS.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49628 Based on clinical document review, resident interview, staff interview, and policy review the facility failed to provide services to increase mobility or prevent a loss in mobility for 1 of 2 residents (Resident #12) reviewed. The facility reported a census of 43 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 9/25/24 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further documented diagnosis of hypertension, diabetes mellitus, and neuropathy. The document further revealed the resident was severely visually impaired. Review of Resident #12's Care Plan revealed a focus area for ambulation restorative nursing program due to neuropathy and diabetes created on 4/8/24. The goal revealed the ability to ambulate 500 feet daily through the next quarter with a goal date of 3/19/25. Interventions included referral to therapy if needed, registered nurse (RN) to evaluate and make changes to the program, and the staff to report the changes in participation to nursing staff. Review of Resident #12's restorative program document for the last 30 days (10/15/24 to 11/13/24) revealed the task was to walk to and from meals with assist of 1, gait belt and walker to distance as tolerated. The document revealed 29 instances of the resident ambulating for a total of 19 days. On 2 days there were instances of documentation entry for multiple times. The document revealed on 10/16 there were entries for amounts of 10 at 12:27, 10 at 12:28, and 6 at 12:28. On 10/17/24 there were entries for amounts of 10 at 12:28, 10 at 12:28, and 5 at 12:28. On 10/30/24 the document revealed an amount of 75 at 8:55. The document revealed on 11/13/24 the amount of 30. The document revealed 40 entries indicating not applicable and 1 entry of Resident #12 not available. There were no refusal entries for Resident #12. On 11/12/24 at 11:58 AM Resident #12 stated there were lots of new nurses. The resident further stated she was supposed to walk to the dining room for every meal, and now she doesn ' t walk to meals anymore. On 11/13/24 at 11:10 AM observed Resident #12 walking with the Restorative Aide continuously from the chapel to the dining room. The observation revealed the resident walked this distance for 3 complete cycles and was returned to her room at the end of the session. On 11/13/24 at 11:20 AM the Director of Nursing (DON) reviewed the walking task document and stated the Certified Nursing Assistants (CNAs) were able to walk the resident to meals. The DON acknowledged Resident #12 was not being walked to meals as the program was written. On 11/13/24 at 2:04 PM the Administrator stated if a restorative program was written only for the Restorative Aide to complete then would expect that staff to complete as written. If the program was written for walking and CNAs could complete, then she would expect CNAs to complete the program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided policy, Restorative Nursing Services, revised 7/17, revealed the goals and objectives are individualized, resident-centered, and the resident would be included in determining the goals. The document further revealed the goals may include but were not limited to maintaining independence and self esteem, and maintaining physiological resources.

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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** 41785 Based on clinical record review, observation, facility document review, staff interviews and facility policy review, the facility failed to use safe transfer techniques for 1 of 3 residents. Resident #37 had fell in the bathroom and sustained bruising and a skin tear after staff assisted him without the use of a gait belt or proper footwear. The facility also failed to implement new interventions with repeat falls to reduce the risk for Resident #37. The facility reported a census of 43 residents. Findings include: According to the Admission Minimum Data Set (MDS) assessment dated [DATE], Resident #37 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 11 (minimal cognitive deficit.) He required substantial/max assistance for toileting hygiene and transfers. Resident #37 had diagnosis including anxiety disorder, Post Traumatic Stress Disorder (PTSD) and Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation. The MDS documented the resident had fallen in the last month. According to a Nursing Advanced Skilled Evaluation note dated 9/18/24 at 10:02 AM, upon admission, Resident #37 was able to move all extremities and his gait was unsteady with poor balance. The Care Plan dated 9/24/24 for Resident #37 documented he was at high risk for falling due to falls at home preceding admission here. The care plan listed a goal the resident will not have a fall related injury. The care plan directed staff with the following interventions: -Fall risk evaluation. -Labs when ordered. -Monitor for side effects of medication: cardiac and psychotropic medications as ordered. -Toileting per urinary/bowel section of this care plan. The toileting plan created on 9/24/24 and revised on 11/5/24 documented intervention for staff to assist with transfer to the toilet. Offer and assist with toileting before and after meals, at bedtime and as needed. The Progress Notes for Resident #37 documented the following: On 10/29/24 at 10:39 PM one assist with transfer to wheelchair, toilet and bed. One assist for bedtime ADL's (activities of daily living). Education on call light location and use. Encouraged to voice needs. On 10/29/24 at 11:28 PM resident hit the back of his head on the glove holder in his bathroom removed the skin flap to a healed skin tear. Measures 1.3 cm x 0.5 cm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 11:45 PM it is unknown how long the wound has been present. The resident reports when up to the bathroom he hit the back of his head on the glove holder box on the wall by the stool. On 11/1/24 at 6:09 PM moderate assistance of 1 with most ADL's. One assist with toileting. Some confusion noted at times. Pleasant and cooperative with staff. On 11/2/24 at 8:30 AM fall at 7:45 AM in resident's room. Nurse 2 rooms down from resident when aide asked to immediately come to the resident's room. Observed resident lying on his back with his head propped against the air/heat unit. Noted blood on the unit and on the residents head and arms. Pressure applied with towel and ice. Noted skin tear with heavy amounts of bleeding. When asked what happened the resident stated he was trying to go to the bathroom so he got up and fell . Resident sent to the local emergency room for evaluation. On 11/2/24 at 12:28 PM call to hospital for update and notified the resident has a C3 fracture and will need to be referred to neurologist. On 11/2/24 at 4:16 PM the hospital called and resident being admitted . To have an MRI tomorrow. Dressing being applied to scalp and C-collar on. On 11/3/24 at 9:41 PM resident returns from the hospital. able to pivot transfer and take several steps. 15 minute visual checks initiated. The Discharge MDS dated [DATE] for Resident #37 documented the resident had an unplanned discharge to the hospital. The MDS documented the resident had fallen since admission/entry or the prior assessment and had an injury. The Care Plan for Resident #37 directed staff with the following interventions updated on 11/4/24: -15 minute visual checks upon return from the hospital. -Replace old gripper socks with new gripper socks. The Progress Notes for Resident #37 documented the following: On 11/4/24 at 10:31 AM reviewed incident thoroughly with IDT team. New interventions: replace old gripper socks with new, 15 minute checks upon return from the hospital, Social Services to check with family for permission to place sign in room reminding resident to use his call light and wait for staff assistance prior to rising. On 11/6/24 at 11:16 AM IDT team met and reviewed incident on 11/4/24. Current interventions are 15 minute checks, replace old gripper socks with new socks and staff to prompt resident to and from meals and activities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/6/24 at 11:41 AM late entry for November 4, 2024 at 3:40 PM interview with resident completed by Administrator and DON. The resident stated he got up out of bed, and sat himself in his wheelchair at bedside. He stated he stood upright and his feet went out from underneath him and he started to fall backwards so he leaned forward losing his balance and fell to the floor. The resident stated he hit his head on the armoire in his room during the fall to the floor. He could not remember if he put on his call light or not. On 11/6/24 at 11:51 AM reviewing incident with IDT team. Current interventions are every 15 minute checks, replace gripper socks, discarded gripper socks with little grippers left and ordered more. An Incident Report dated 11/6/24 at 10:25 PM, documented Resident #37 was up to the bathroom with assistance of one when he let go of his walker, reached out to grab the handle attached to the toilet, and lost his balance. A staff member was present and able to lower him to the floor. The nurse came in to assess the situation and noted that the resident was not wearing a gait belt. He had on one gripper sock with the grippers on the top of his foot, and a black sock on the other foot that did not have grippers. The resident sustained a skin tear to his elbow and his right foot was turned outward. He was sent to the emergency room for evaluation. The Care Plan for Resident #37 lacked updates/new interventions following the fall on 11/6/24. According to the Emergency Department Provider Notes dated 11/7/24 at 1:11 AM, Resident #37 had a large band-aid over the top of his head. No other areas of erythema, edema or ecchymosis. Range of motion without pain or discomfort. Minimal discomfort mid portion of the neck with no crepitus of step-off. The resident able to walk with his walker with no other injuries or trauma. A Post Fall Evaluation dated 11/7/24 at 8:43 AM, documented Resident #37 reason for fall was he lost his balance and fell in front of the stool while being assisted by staff with no gait belt or proper footwear. The resident had a trauma wound to the scalp related to a fall on 11/2/24, with partial flap loss and full thickness stripping of the skin. The skin tear measured; 10.5 centimeters (cm) x 5 cm x 0.1 cm. There was epidermis and dermis tissue loss with a yellow wound bed. The left posterior elbow skin tear measured 1 cm x 1.5 cm with edges non-attached and area bleeding was acquired on 11/6/24. In an observation on 11/12/24 at 10:54 AM, Resident #37 was laying in bed with supplemental oxygen per nasal cannula and had a bandage on the top of his head. The resident said that he lost his balance and fell . On 11/12/24 at 3:50 PM, Staff B, Registered Nurse (RN) stated that she remembered the fall in the bathroom. She had just started her shift when a Certified Nurse Aide (CNA) told her they needed her in the room of Resident #37. When she walked into the room, the resident was on the bathroom floor, his back was up against the wall, and the walker was next to the toilet. He was wearing one gripper sock that was upside down with the grips on the top, and a black sock that was not gripper. He did not have a gait belt on. The nurse noticed that his right foot was turned outward and he had a skin tear on his right elbow that was bleeding. They sent him to the emergency room and they found that he didn't have any broken bones. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/13/24 at 8:40 AM, Staff C, Certified Nurse Aide (CNA), stated that she worked at the facility just 2 times. She said she had limited orientation and was only given verbal report on the status of residents. She said that she wasn't able to get into the electronic chart to find resident information because she didn't have access. She said that on 11/6/24 she had gotten report from other CNAs that Resident #37 required 2 staff assistance. There had been another CNA in with her initially, but that aide left the room and went to help another resident. She walked Resident #37 to the bathroom with help of the walker, but when he got into the bathroom, he let go of the walker, reached out to grab the handle next to the toilet and he missed and started to go down. Staff C said that she had ahold of the resident with her arm under his armpit and lowered him to the floor. Staff C acknowledged that she had not used a gait belt because he had a walker, she didn't think he needed one. She added that there weren't any gait belts in the resident's room for her to use. On 11/13/24 at 12:25 PM, the Administrator, Director of Nursing (DON) and Nurse Consultant said that before a new staff (CNA) member was put on the floor, they were given verbal report from the previous shift. They were given access to the electronic chart so they could check on specifics needs of the residents. They said that they had an orientation checklist but they were unable to locate a list for Staff C. On 11/14/24 at 10:38 AM, the DON said that it was their policy to always use a gait belt and gait belts were kept in the resident's rooms. She said that agency staff were taught that they must use them as well as checking for the proper footwear before transferring a resident. According to a facility policy titled: Gait Belt Use updated on 3/22/07, gait belts would be used for residents needing limited, extensive or total assistance with manual transfers and/or ambulation.

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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 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** 49628 Based on observations, clinical record review, and staff interviews the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 1 residents reviewed, requiring the use of a nebulizer (Resident #6). The facility reported a census of 43 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 9/15 indicating mild cognitive impairment. The MDS documented diagnoses that included heart failure, hypertension, and asthma/chronic obstructive pulmonary disease (COPD) or chronic lung disease. Resident #3's Physician Orders dated 9/27/24 revealed Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML. 1 vial inhale orally 3 times a day for shortness of breath and wheezing with a start date of 9/27/24. An additional order with a start date of 9/29/23 revealed to clean NEB mask with soap and water after each use in the room, letting air dry, every 24 hours as needed. There was no current order for oxygen tubing change. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 12/23 through 11/13/24 found 1 instance of the NEB mask being cleaned on 10/12/24. A Care Plan for Resident #3 identified a focus area of COPD dated 7/25/24. Interventions included giving aerosol or bronchodilators as ordered with monitoring for side effects. An additional focus area of altercation in respiratory function was identified with interventions including administering prescribed respiratory treatments as ordered, and assessments of lung sounds and oxygen saturations as needed. An observation on 11/12/24 at 10:15 AM revealed Resident #3 had a nebulizer present with tubing wrapped, connected to the nebulizer without a date sitting on a washcloth on the nightstand. An observation on 11/13/24 at 11:39 AM revealed Resident #3's nebulizer present on the nightstand with tubing, mask, and cup all attached, placed on a washcloth. Observation further revealed no documentation of last change or who had completed. On 11/13/24 at 11:50 AM Staff J, Registered Nurse (RN) stated nebulizer tubing is changed weekly, primarily on the overnight shift. Staff J further stated when the tubing is changed the nurse should put a piece of tape on tubing indicating date changed with initials. On 11/13/24 at 11:55 AM Staff K, Health Unit Coordinator (HUC) stated the TAR would reflect the order to change the tubing/mask to ensure the order was completed. On 11/13/24 at 2:00 PM the Administrator stated the expectation would be for staff to follow the facility policy for nebulizer management. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 7:57 AM the Director of Nursing (DON) stated the oxygen tubing and mask should be changed and manager per policy. The DON acknowledged without a piece of tape on the tubing it would be hard to know when the tubing was last changed. The DON further concurred that without the TAR reflecting the need to change the tubing or mask it would be hard to know if or when it had last been changed. The facility provided policy, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/10, revealed the following: *Disconnection of the T-piece, mouthpiece and medication cup when the treatment is completed. *Rinse and disinfect the nebulizer equipment according to facility protocol or following the instructions provided, and allow to air dry on a paper towel. *When the equipment is completely dry, store in a plastic bag with the resident's name and the date on it. *Change the equipment and tubing every 7 days or according to facility protocol.

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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. 47673 Based on observation, facility record review, staff interviews and policy review the facility failed to follow proper sanitation to prevent the spread of illness according to professional standards by serving residents on dishes that had not been rinsed in the hot water dish machine at an appropriate temperature to prevent the spread of illness. The facility reported a census of 43 residents. Findings include: Observation on 11/12/24 at 9:50 AM of a high temperature dish machine in use revealed a temperature of 140 degrees for the wash cycle and 170 degrees for rinse cycle. Observation of 3 loads of dishes ran though the dish machine with temperatures of 140 degrees for wash and 170 degrees for rinse. Review of document titled, Temperature Monitoring Form -1 Compartment Dishmachine for the month of October documented wash temperatures under 150 degrees on 10/24, 10/28 and 10/3 and rinse temperature under 180 on 10/1, 10/3, 10/5, 10/6, 10/20, 10/25, 10/27, 10/28 and 10/29. On 11/12/24 at 10:00 AM Staff M, Dietary Aide stated when the temperatures are below 150 degrees for wash and 180 degrees for rinse she notified the kitchen manager was at the facility. Staff M stated if he was not at the facility the dishes still needed to be washed and in the past she just kept washing them and putting them away to use. Staff M stated if the temperature during the rinse cycle was above 150 degrees she felt that was hot enough because the food temperature only needed to be 135 to be safely served. Staff M stated that she put the dishes away that were washed with the temperatures below 150 degrees for wash and less than 180 degrees for rinse. Staff M stated that she would continue to wash dishes and eventually the temperature would get to 180 degrees and she would draw an arrow on the temperature log acknowledging the temperature had reached above 180. Staff M ran a temperature strip through the dish machine that would change to a dark brown if a temperature above 170 was reached. Staff M acknowledged the strip did not change color. Staff M stated that the temperature was checked with a strip twice a day. Staff M opened a book and revealed a bag of used temperature strips with dates on them. Staff M acknowledged that all strips in the bag did not have any color change indicating there was not a temperature above 170 reached. On 11/12/24 at 10:30 AM Staff N, Certified Dietary Manager acknowledged that the dish machine was not reaching a minimum of 180 degrees on the rinse cycle. Staff N stated the company that does maintenance on the dish machine was at the facility on 11/8/24. Staff N stated the dish machine not reaching 180 degrees on the rinse cycle was addressed then. Staff N stated he would be calling the company that does maintenance on the dish machine right away to repair the issue. Staff N acknowledged that none of the strips that were dated in the bag utilized during previous tests had revealed that a temperature above 170 had not been met. Staff N stated dishes would be cleaned with the 3 sink process until the dish machine was repaired or the facility would utilize the dish machine on the assisted living side of the facility. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 10:45 AM the Administrator stated the facility's expectation was the temperature on the wash cycle of the dish machine would be above 150 degrees and above 180 degrees on the rinse cycle. The Administrator stated the facility would be calling the company that does maintenance on the dish machine to have it repaired. The Administrator stated the facility's expectation was the staff would notify the kitchen manager if the temperatures were not being met during the wash and rinse cycles. The Administrator stated if the staff were not able to get a hold of the kitchen manager the staff would call the Administrator. The Administrator stated the facility's expectation was dishes would not be used if temperatures of 150 degrees were not met on the wash cycle and / or if a temperature of at least 180 degrees was not met on the rinse cycle. On 11/12/24 at 2:30 PM Staff P, Dish Machine Maintenance Technician stated the most recent service at the facility was completed on 11/6/24. Staff P stated he was the technician that serviced the machine on 11/6/24. Staff P stated on 11/6/24 he was at the facility for routine service and monthly maintenance. Staff P stated his company was not at the facility on 11/8/24. Staff P stated there was never a service request for a concern about low temperatures from the dish machine wash or rinse cycle. Staff P stated the last time his company was at the facility prior to 11/6/24 was in August and that was related to an issue in laundry. Staff P stated the last temperature he could find obtained by the company that he worked for was in May and the temperature was 186. Staff P stated he did not look at or obtain a temperature from the dish machine when at the facility on 11/6/24. Staff P stated the wash cycle should be a minimum of 150 and the rinse cycle should be a minimum of 180 on the hot water dish machine. Staff P stated he had run several cycles on 11/12/24 at the facility and the dish machine never reached 180 for the rinse cycle. Review of undated policy titled, Cleaning Dishes / Dish Machine revealed that prior to use staff would verify proper temperatures and machine function. Confirm that soap and rinse dispensers are filled and have enough cleaning product for the shift. Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify actual temperatures. Those machines installed after the Food Code 2001 were implemented must automatically dispense detergents and sanitizers, and must incorporate visual means or other visual audible alarm to alert the user to any concerns (such as the soap or sanitizer not dispensing properly). High temperature dish machine wash cycle should be 150 degrees - 165 degrees and rinse cycle should be 180 degrees.

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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** 48004 Based on clinical record review, observations, staff interviews, and facility policy review the facility failed to use universal infection control measures and Enhanced Barrier Precautions (EBP) during cares for 3 of 3 residents (Resident #9, #33 and #21). The facility reported a census of 43 residents. Findings include: 1. Review of Resident #33's Minimum Data Set (MDS) assessment dated [DATE] revealed diagnosis of renal insufficiency, neurogenic bladder, and septicemia. The MDS further revealed that Resident #33 utilizes an indwelling catheter. Review of Resident #33's Electronic Healthcare Record (EHR) page titled diagnosis revealed a diagnosis of carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA) dated 2/13/23. Review of Resident #33's Care Plan with a review date of 9/18/24 revealed special instructions for enhanced precautions. Observation 11/13/24 at 10:33 AM Staff I Certified Nurse Assistant (CNA) donned gloves without hand hygiene, and then placed a barrier on the floor. Alcohol swab utilized to clean drainage port pre and post drainage. No gown was donned during the procedure. Interview 11/13/24 at 10:45 AM with Staff I CNA revealed she should have completed hand hygiene, and was unaware of the enhanced barrier precautions for residents with catheters. 2. Review of Resident #9's MDS assessment dated [DATE] revealed diagnosis of hemiplegia, seizure disorder, traumatic brain injury, and gastrostomy status. The MDS further revealed that Resident #9 utilizes a feeding tube. Review of Resident #9's EHR page titled diagnosis revealed a diagnosis of carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA) dated 3/1/18. Review of Resident #9's Care Plan with a review date of 9/12/24 revealed special instructions for enhanced precautions. Review of Resident #9's EHR page titled Physician's Orders revealed an order for water flushes five times a day via G-tube (Gastrostomy tube). Observation 11/13/24 at 11:03 AM Staff L Registered Nurse (RN) completed hand hygiene. Resident #9 obtained the supplies for Staff L. Staff L then checked G-tube placement. Staff L then gave water order per gravity through Resident #9's G-tube. No gown was donned during the procedure. Interview 11/13/24 at 11:11 AM with Staff L RN revealed she was unaware that gowns should be worn when completing g-tube cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 11/13/24 at 10:53 AM with the Director of Nursing (DON) revealed her expectation would be for hand hygiene and personal protective equipment (PPE) to be completed at the appropriate times. The DON further revealed that Enhanced Barrier Precautions (EBP) should be followed when caring for catheters. Interview 11/13/24 at 10:56 AM with the Administrator revealed her expectations for hand hygiene to be completed at appropriate times as well as EBP to be followed at the appropriate times. Review of a facility provided policy titled, Enhanced Barrier Precautions with a date of March 2024 documented: a. EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MRO when contact precautions do not otherwise apply; or 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 11/14/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 41785 3. According to the MDS assessment dated [DATE], Resident #21 had a BIMS score of 12 (moderate cognitive deficit). She required partial assistance with toileting, dressing and transfers. The Care Plan updated on 10/16/24, showed that Resident #21 had a history of visual and swallowing deficits as well as left side unawareness related to a stroke. The electronic record showed that Resident #21 had orders for the following: -Dated 4/7/24 at 10:15 AM; Refresh Solution 1.4-0.6 % (Polyvinyl Alcohol-Povidone PF) Instill 2 drops in both eyes as needed for dry eyes. -Dated 8/8/24 at 3:00 PM; Patanase Nasal Solution (Olopatadine HCl (Nasal)) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 sprays in both nostrils two times a day for nasal congestion. In an observation of the medication pass on 11/13/24 at 7:12 AM, Staff A, Licensed Practical Nurse (LPN) prepared oral, nasal and ocular (eye) medications. Staff A set the medications on the bedside stand and administered the nasal medication to both nostrils. With the same gloved hands, she administered eye drops to both eyes. On 11/14/24 at 11:04 AM, the Director of Nursing (DON) said that she taught the nurses to change gloves between medications of different routes. She said the nurses should have changed gloves after the nose contact and washed hands before putting on a second pair of gloves. A facility policy titled: Handwashing/hand hygiene, single-use disposable gloves should be used when in contact with a resident who was on contact precautions. The use of gloves did not replace hand washing/hand hygiene.