STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165449	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spencer Post Acute Rehabilitation Center	711 West 11th Street Spencer, IA 51301

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical policy, observation, and staff interview the facility failed to provide a call light system within reach of a resident in contact precautions and accommodate the needs of a resident with closet door hanging unable to be opened for 2 of 18 residents reviewed, (Resident #9 and #22). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #22 documented a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. On 8/20/24 at 8:22 AM observation of Resident #22 lying in bed in his room with a call light not within reach lying on a recliner on the opposite side of the room as his bed . Resident #22 ' s door was closed related to transmission based precautions (TBP). On 8/20/24 at 8:22 AM Resident #22 stated he was unable to find his call light. Resident #22 stated he utilized the call light when in need of staff assistance. Review of Resident #22 ' s Care Plan documented contact and droplet isolation precautions related to severe acute respiratory infection related to Covid diagnosis. On 8/20/24 at 8:31 AM Staff D, Certified Nursing Assistant (CNA) acknowledged Resident #22 ' s call light was located on his recliner and not within his reach. Staff D stated she was in Resident #22 ' s room earlier that morning. On 8/20/24 at 4:34 PM the DON stated the facility ' s expectation was that the call light would have been within reach of Resident #22 while he was in bed. On 8/20/24 at 4:36 PM the Administrator stated the facility's expectation was the call light would have be within reach of Resident #22 while he was in bed. Review of policy titled, Policy / Procedure Subject Call light / Bell reviewed 8/23 documented the policy of that facility was to provide the resident a means of communication with nursing staff. 47079 (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Minimum Data Set (MDS) assessment for Resident #9 revealed a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated severely impaired cognition. It included diagnoses of dementia, anxiety, depression, psychotic disorder (other than schizophrenia), hallucinations, rheumatoid arthritis, and low back pain. It indicated she required set-up assistance with dressing. On 8/19/24 at 3:35 PM, Resident #9's closet door was observed not attached to the overhead track and required substantial effort to open. The resident stated she didn't understand why her closet door did not open. The right toilet safety rail was observed on her shower floor. On 8/20/24 at 4:30 PM and 8/21/24 at 2:30 PM, Resident #9's closet door and toilet safety rail had not been repaired. On 8/21/24 at 10:08 AM, the Maintenance Supervisor stated he is notified of repair needs by looking at the maintenance log book located at each nursing station. He stated he is also notified by staff leaving notes on his desk, door, or verbally telling him. He stated he checks the logs daily but did not keep a separate log of needed repairs. On 8/22/24 at 11:45 AM, the Maintenance Supervisor stated he makes notes when staff report maintenance needs and attempts to repair it immediately; otherwise, he checks it off when it's repaired. He stated the new computer system included a maintenance section but the facility had not transitioned to it yet. He also stated he didn't have a consistent process in place to identify maintenance repair needs nor did he perform scheduled (routine) maintenance rounds other than Life Safety Code items. He stated he was not aware of resident #9's closet door being off track nor her toilet handrail lying in the shower. A document titled Facility Maintenance reviewed 5/2022 indicated the facility utilizes a maintenance log to report and track any areas that are needing repair. It directed staff to write any maintenance issue down in the log and maintenance staff are to check the log book on days they are present in the facility. It also indicated all work requests must be in form of work orders, not verbal (unless emergency situations). On 8/22/24 at 1:40 PM, the Administrator stated staff should use the appropriate method to notify maintenance of issues. She defined the appropriate method was writing it in the maintenance log.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, clinical record review, staff interviews, and policy review, the facility failed to include psychotropic medications in the baseline care plan for 1 of 18 residents reviewed (Resident #8). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Diabetes Mellitus, Cerebrovascular Accident (stroke), depression, and metabolic encephalopathy (brain dysfunction caused be chemical imbalance). It indicted he took an antidepressant within the 7-day look-back period. It also indicated he was admitted to the facility on [DATE]. On 8/20/24 at 2:52 PM, Resident #8 stated he took antidepressant medication and had been on it for a long time. The hospital Discharge Home Medication List directed Resident #8 to continue taking duloxetine (Cymbalta) 60 mg capsule, delayed release daily, by mouth, for depression. The Baseline Care Plan medication section did not include the resident's psychotropic medication use. On 8/20/24 at 4:57 PM, the MDS Coordinator stated the resident's psychotropic medication was not included in the care plan until 10 days after admission. On 8/22/24 at 1:20 PM, the Director of Nursing (DON) stated when medications are reviewed, they should be added to the Baseline Care Plan. A policy titled Comprehensive Person-Centered Care Planning revised 3/2022 indicated within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Record Review (EHR), staff interviews, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for use of a diuretic or diagnosis of congestive heart failure, develop a comprehensive care plan that was personalized when a resident received hospice care, and did not follow a care plan for 4 of 18 residents reviewed (Resident #3, #20, #43, and #50). The facility reported a census of 53 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #50 entered the facility on 7/3/24. The MDS also documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS revealed diagnosis of essential (primary) hypertension and localized edema. The MDS documented use of diuretic. Review of Resident #50 ' s Physician Orders documented lasix oral tablet 40 mg (Furosemide), give 40 mg by mouth one time related to localized edema started 8/15/24 and lasix oral tablet 20 mg (Furosemide), give 20 mg by mouth one time a day related to localized edema started 8/10/24. On 8/21/24 at 3:02 PM Staff C MDS Coordinator stated she would expect interventions would be in place if a resident was on a diuretic. Staff C stated would want to see interventions such as lab work as ordered, change in blood pressure, administer medication as ordered, monitor dose medication may require modifications to minimize consequences, and notify doctor PRN with adverse reactions. Staff C acknowledged Resident #50 did not have any focus, goals, or interventions in place related to the use of a diuretic. On 8/21/24 at 3:45 PM the DON stated facility expectation was that Resident #50 would have a care plan with focus goals or interventions related to the use of a diuretic. 47079 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated moderately impaired cognition. On 8/20/24 at 12:07 PM, a Progress Note revealed the resident was transferred to acute care (hospital) on 7/01/24. A Progress Note dated 7/01/24 indicated the resident was non-emergently sent to the emergency room . A Nursing Home to Hospital Transfer Form dated 7/01/24 revealed Resident #20 was transported to the local hospital for a low oxygen saturation. It indicated she received 2 liters per minute (LPM) of oxygen and had a saturation of 93%. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Progress Note dated 7/02/24 revealed the resident was admitted to the hospital for Congestive Heart Failure (CHF) exacerbation. The Baseline Care Plan dated 7/05/24 included exacerbation of CHF. The Care Plan revised 7/10/24 did not include CHF focus nor diagnosis related interventions. 46873 3. The MDS of Resident #43 dated 4/18/24 documented the resident received hospice care while a resident of the facility during the 14 day look back period. The Nursing Note dated 4/18/24 at 1:50 pm documented the resident was admitted to hospice care, specifying the name of the hospice and the primary nurse who would be providing hospice services. The Care Plan of Resident #43 documented a Focus Area of Terminal Prognosis dated 5/8/24. The Focus Area failed to document what terminal prognosis the resident had, what hospice company the resident was receiving services from or any contact information for the hospice. On 8/21/24 at 11:09 am, the MDS Coordinator stated all hospice residents have an individual notebook at the nursing station for all hospice paperwork. She stated the hospice contract, diagnoses and other information is found in these books as well as the Care Plan written by the hospice company. She stated if facility staff need any information regarding hospice this is where they look. She stated she does not include this information on the facility Comprehensive Care Plan because it is in the hospice book. 4. The MDS of Resident #3 identified a BIMS score of 8 which indicated moderate cognitive impairment. The Care Plan of Resident #3 documented a Focus Area of Activities of Daily Living (ADL) Self Care Performance deficit related to disease process dated 7/11/24. The Care Plan directed staff for eating, Resident #3 required 1 staff participation to eat - assist and encourage as needed. The resident was to sit at the Assisted Table in the dining room. On 8/20/24 Resident #3 was observed sitting at the assisted table in the dining room with no staff present at the table. At 8:55 am, staff brought Resident #3 her meal. Resident #3 began to eat her meal. She continued to eat unsupervised until 9:11 am when a staff member sat down across the table to provide feeding assistance to another resident. Resident #3 ate unsupervised for 16 minutes. On 8/20/24 at 11:56 am, Resident #3 was observed sitting at the assisted table waiting for her meal service. At 12:21 pm, Staff B, Certified Nurse Aide (CNA) delivered the resident her meal. She assisted to cut her food up, and provide salt and pepper and butter to the food. She then walked away from the table. On 8/20/24 at 12:33 pm, staff arrived at the assist table to sit and provide feeding assistance for two other residents. Resident #3 ate unsupervised for 12 minutes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 11:30 am, the Administrator stated some residents at the assist table just need supervision and not eating assistance, and can be supervised from anywhere in the dining room, not necessarily at the assist table. She stated if the care plan states staff assistance the resident should receive assistance. The facility policy Comprehensive Person-Centered Care Planning, revision date 3/2022 documented the policy statement: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. The policy documented: Point 4 - The comprehensive care plan will be developed by the IDT within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident ' s needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident ' s goals and desired outcomes, preferences for future discharge and discharge plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46873 Based on clinical record review, staff interview and facility policy review, the facility failed to revise a comprehensive care plan for 1 of 18 residents reviewed, (Resident #19). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #19 dated 6/7/24 documented diagnoses that included: non Alzheimer's dementia and depression. The MDS documented the resident received antidepressant medications during the assessment reference period. The current Care Plan of Resident #19 documented a Focus Area dated 5/7/24 of antidepressant medication use (mirtazapine and sertraline) related to depression. The Medication History of Resident #19 reflected that the resident's order for Mirtazapine (an anti depressant medication) was discontinued on 6/11/24. The Psychotropic Med Use Detail Report from the facility's pharmacy, dated July 2024, also reflected Mirtazapine to have been discontinued 6/11/24. The Nursing Note dated 6/11/24 at 1:50 pm documented Received signed medication review for Mirtazapine 'Stop Mirtazapine' . On 8/21/24 at 11:07 am, the MDS Coordinator stated all care plans were re-written in May of 2024 due to the name change of the facility when they went under new ownership. She stated her process to update care plans for medication changes is to run a daily report on medication changes and to read progress notes. She stated a care plan review is done with each resident's MDS as well. She stated a medication change from June should have been updated. The Care Plan review for Resident #19 was last completed 2/2/24. The next review date was labeled as 5/2/24 which the care plan reflected as not being done. The facility policy Comprehensive Person-Centered Care Planning, revision date 3/2022 documented: Point 5 - The resident's comprehensive plan of care will be reviewed and/or revised by the IDT (interdisciplinary team) after each assessment.

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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** 46873 Based on clinical record review, staff interview and resident interview, the facility failed to follow physician orders to obtain a resident's weight following admission for 1 of 18 residents reviewed (Resident #106). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) Assessment of Resident #106 dated 8/15/24 documented the resident admitted to the facility on [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) score of 14 which indicated cognition intact. On 8/19/24 at 2:10 pm, Resident #106 reported she does not care for the food. She stated the food is cold and she has to supply her own seasonings. The Medication Administration Record (MAR) for August of 2024 for Resident #106 documented an order for Obtain weight upon admission, daily x 3 days, then weekly on Monday day shift x 4 weeks. The MAR reflected that Staff A, Licensed Practical Nurse (LPN) had documented the weight being done on August 10th, August 11th, August 12th, August 14th, and August 19th, 2024. The Weight Summary section of the Electronic Health Record (EHR) of Resident #106, reviewed on 8/22/24 revealed the resident had weights documented on 8/9/24 and on 8/21/24 only. The Plan of Care Response History for weight for Resident #106, reviewed on 8/21/24, revealed no weights had been entered in Plan of Care (the portion of the EHR where the Certified Nurse Aides do charting). On 8/21/24 at 10:44 am, Staff A, LPN stated she enters weights in the EHR prior to signing the MAR. She stated weights are not recorded anywhere else and she did not know why the recordings were not present in the EHR. On 8/21/24 at 11:21 am Resident #16 reported she had been weighed earlier in the day. She stated she did not recall having been weighed any other time since admission except once. On 8/22/24 at 11:30 am, the Administrator stated nursing staff are expected to follow physician orders. She stated resident weights should be documented in the Weight Summary of the resident's chart. The facility policy Physician Orders, reviewed 8/2023, documented a policy statement of: It is the policy of this facility that drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs. It is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident ' s plan of care.

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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. 46873 Based on observations, record review and staff interview, the facility failed to provide a Restorative Exercise Program to prevent a worsening of range of motion for 1 of 1 resident reviewed, (Resident #27). The facility reported a census of 53. Findings include: The Minimum Data Set (MDS) of Resident #27 dated 8/9/24 identified a Brief Interview of Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS documented the resident to have a functional limitation in range of motion affecting all 4 limbs. The MDS revealed the resident to be totally dependent upon staff for eating, bed mobility, dressing, toileting and transferring. The MDS documented the resident as unable to walk. The initial Care Plan for Resident #27 documented a Focus Area of Idiopathic Neuropathy/Radiculopathy, Lumbar Region, with a history of Cerebral Infarction. It indicated the resident used a mechanical lift to transfer and had an inability to ambulate, revision date 11/27/21. The Care Plan directed staff to follow a Restorative Exercise program for Functional Maintenance. The current Care Plan of Resident #27, initiated on 5/3/24, failed to reveal any Restorative Exercise Program. On 8/19/24 at 2:47 pm, Resident #27 was observed lying in bed. It was noted the resident had contractures of both arms. Body pillows were in place on either side of the resident as he laid in bed with signs present on the wall instructing the use of body pillows for positioning. On 8/20/24 at 9:10 am, Resident #27 was observed sitting in a specialty wheelchair in the dining room. He was receiving feeding assistance from the staff. The resident made no attempts to feed himself any food or drink and was fully dependent on staff assistance for meals. On 8/20/24 at 1:49 pm, the MDS Coordinator stated all residents are being reassessed for restorative programs. She stated the facility received a deficiency on the prior survey for not following restorative programs so all of the programs were discontinued. She stated some of the residents who are able to walk do have walking programs but they are not being documented on MDS Assessments are restorative. She stated the facility does not have any restorative staff at this time. On 8/22/24 the Administrator stated the facility does not have a policy on Restorative Exercise. She stated when the facility changed ownership, the staff was directed to discontinue all restorative programs. She said some residents have walking programs but she is not aware of any residents who have a range of motion programs at this time. She clarified the facility does not have a restorative aide employed but that the Certified Nurse Aides are able to do restorative programs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Records (EHR), policy review, resident interview, and observations the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 5 of 18 residents reviewed (Resident #1, #6, #17, #37, and #106). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of EHR documented Resident #1 resided in NN09-2. Observation on 8/20/24 at 1:05 PM of room NN09, Resident #1's room revealed the call light was on. Staff B, Certified Nursing Assistant (CNA) entered Resident #1 ' s room at 1:32 PM and answered the call light. Staff B told Resident #1 to let her find another CNA and would be right back. Staff B returned to Resident #1 ' s room at 1:34 PM with mechanical lift. On 8/20/24 at 1:40 PM Staff B stated Resident #1 ' s call light was on because she wanted to use the toilet. On 8/20/24 at 1:33 PM Resident #1 stated she needed to use the toilet that is why her call light was on. Resident #1 stated she was not incontinent during the time she was waiting for her call light to be answered. 2. The MDS dated [DATE] for Resident #17 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. Review of EHR documented Resident #17 resided in NN11-2. Observation on 8/20/24 at 1:14 PM of room NN11, Resident #17's room revealed the call light was on. On 8/20/24 at 1:36 PM Staff B entered Resident #17 ' s room and answered the call light. On 8/20/24 at 1:40 PM Staff B stated Resident #17 wanted help to transfer into her bed. Staff B stated the facility's expectation was whoever turns the call light on first would be tended to first. Staff B stated she was not sure what the facility ' s expectation was for answering call lights. Staff B stated she believed answering a call light within five minutes would be reasonable, but she could ask the Administrator. Staff B stated anything over five minutes would be too long. On 8/20/24 at 1:42 AM Resident #17 stated her call light was on because she wanted to be transferred to her bed. 3. The MDS dated [DATE] for Resident #37 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/24 at 3:40 PM Resident #37 stated she spoke with the Administrator about how short staffing was at the facility. Resident #37 stated the staff frequently took longer than 15 minutes to answer call lights. Resident #37 stated she has a clock on the wall and knows how long it takes for staff to answer the call light when she would turn it on. 46873 4. The Minimum Data Set (MDS) Assessment of Resident #6 dated 8/9/24 identified a Brief Interview of Mental Status (BIMS) score of 14 which indicated cognition intact. On 8/19/24 at 2:52 pm, Resident #6 reported call lights can be up to 45 minutes long. She additionally reported she is unable to take herself from the dining room back to her room. She stated she gets left in the dining room for long periods of time waiting for staff to take her back to her room. 5. The Minimum Data Set (MDS) Assessment of Resident #106 dated 8/15/24 identified a Brief Interview of Mental Status (BIMS) score of 14 which indicated cognition intact. On 8/19/24 at 2:10 pm, Resident #106 reported it is difficult to get staff to answer call lights. She stated it can be over an hour at times. She stated some staff will come and answer the call light and turn if off and tell her they will be back. But they leave and do not address her needs which the call light was turned on for. She further reported when staff tell her they will be back to help her, they do not return. Resident #106 does not have a clock in her room but has a cell phone and reports she watches the time on her phone when the call light is turned on. On 8/20/24 at 4:36 pm the Administrator stated the facility's expectation is that the call would be answered within 15 minutes. On 8/20/24 at 4:42 pm the Director of Nursing (DON) stated the facility's expectation that the resident's call lights would be answered within 15 minutes. The DON stated she would like to see call lights answered within 5 minutes. The DON stated 30 minutes would be excessive. The facility policy titled Policy/Procedure - Nursing Clinical, Routine Procedures, Call Light/Bell documented a policy statement of It is the policy of this facility to provide the resident of means of communication with nursing staff. Point 1: - Answer the light/bell within a reasonable time frame Point 4: - Respond to the request. If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46873 Based on observation and staff interview, the facility failed to post the daily census sheet including the facility resident census and the actual working hours of nurses and nurse aides on duty for the current date. The facility reported a census of 53 residents. Findings include: On 8/21/24 at 10:52 am, the Longhouse portion of the facility, where the census posting is to be posted, had no census posting visible. Staff A, Licensed Practical Nurse (LPN) stated it had not been completed yet for the day. She stated the prior day's posting was probably in the medication room. On 8/21/24 at 10:55 am, Staff A, LPN obtained keys to the medication room and found census sheets dated 8/16/24 - 8/19/24. When asked if a census sheet had been completed for 8/20/24 she stated she was off work that day and did not know if one had been done. A census for 8/21/24 was filled out and hung on a board in the dining room. On 8/22/24 at 11:30 am, the Administrator stated the daily census posting is to be done by the charge nurse for each shift. She stated it should be initiated by the day shift at 6:00 am when the shift begins. She stated the census for the prior day should not be removed until the new one is hung.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview and facility policy review, the facility failed to attempt a Gradual Dose Reduction for 2 of 5 residents reviewed, (Residents #14 and #19). The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #19 dated 6/7/24 documented diagnoses that included: non Alzheimer's dementia and depression. The MDS documented the resident received antidepressant medications during the assessment reference period. The MDS recorded the residents experienced no mood symptoms of feeling down, depressed or hopeless during the previous 2 weeks look back period. The MDS recorded the resident had no documented behaviors during the 7 day look back period. The Medication History of Resident #19 reflected the resident's order for Sertraline (an anti depressant medication) was decreased from 25 mg to 12.5 mg on 7/21/2023. The Psychotropic Med Use Detail Report from the facility's pharmacy, dated July 2024, also reflected Sertraline to have been lowered on 7/21/23. The Progress Notes failed to document any episodes of the resident showing any depressive symptoms since the lowering of the medication. The facility was unable to provide any documentation of any attempts at stopping the use of Sertraline in the past 13 months since the time the dose was lowered to see if the resident could maintain to be free of symptoms of depression without the use of medication. 47673 2. The Minimum Data Set (MDS) dated [DATE] for Resident #14 documented a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. Review of Medication Administration Records (MAR) for Resident #14 documented physician orders for mirtazapine tablet 15 mg give 1 tablet by mouth at bedtime related to other recurrent depressive disorders started 4/7/23 and escitalopram oxalate tablet 20mg, give 20 mg by mouth in the morning related to other recurrent depressive disorders started 4/8/23. On 8/21/24 at 2:11 PM the DON stated she would like to see a new system for ensuring the GDR ' s are returned and kept in a separate file. The DON stated with the transition of files from previous owners it was difficult to find previously completed GDR ' s. The DON stated with the transition of ownership the facility went from paper to electronic and would like to have seen better organization of the scanned documents. The DON stated the facility's expectation was that GDR ' s were completed per federal regulations. The DON stated the facility was unable to provide GDR recommendations or physician follow-up for the last 13 months on Resident #14 ' s mirtazapine and escitalopram. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Psychotropic Medications with review date of 12/23 documented that residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47079 Based on observation, menu review, clinical record review, staff interviews, and policy review, the facility failed to serve the correct therapeutic diet for one of one resident who was ordered a renal diet, (Resident #15). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #15 dated 6/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, Coronary Artery Disease (CAD - heart disease), Heart Failure (HF), hypertension, renal (kidney) disease, and Diabetes Mellitus. It indicated the resident received a therapeutic diet within the 7-day look-back period. The Electronic Health Record (EHR) included a Physician Order for a renal diet dated 10/05/22. On 8/21/24 at 12:15 PM, Staff G, cook, placed a small steam pan of carrots on the steam table. At 12:20 PM, lunch meal service began and Staff G was observed serving Resident #15 regular diet menu items. At 12:58 PM, Staff G stated she did not know why the carrots were sent from the main kitchen. She stated they may have been extra from another meal service time. The Dietary Manager stated the carrots were not on the menu for today and all diets included green beans. A week 5 menu indicated modified renal diets included frozen green beans. On 8/22/24 at 9:10 AM, Staff I, Dietary Aide (DA) stated the facility did not have frozen green beans and frozen carrots were used as a substitution for the renal diet residents. A document titled Meal, Serving the revised 10/2020 directed staff to make sure the right tray is served to the right resident. On 8/22/24 at 1:20 PM, the Administrator stated staff should follow the renal diet menu items.

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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. 47079 Based on observation, staff interview, and policy review, the facility failed to maintain sanitary practices by failing to keep the ice makers clean and by improperly handling food during meal service. The facility reported a census of 53 residents. Findings include: On 8/19/24 at 11:55 AM, a north building kitchen observation revealed black and pink substance on the internal plastic ice cube guard edge. At 12:05 PM, a south building kitchen observation revealed black and pink substance on the internal plastic ice cube guard edge. On 8/20/24 at 8:17 AM, Staff G, Dietary Aide (DA), transported a gallon of milk on a cart from kitchen without the lid on it. At 8:35 AM, the Dietary Manager opened a salt & pepper packet for a resident, sprinkled the salt and pepper on the resident's eggs then put the opened packets on the resident's plate. On 8/21/24 at 11:35 AM, Staff G, cook, put a glove on her left hand and used her right hand to adjust the glove fingers. She then put a glove on her right hand, placed her right hand on a non-food preparation counter, opened a drawer, and grabbed a serving utensil to prepare pureed diets. She walked over to the steam table, picked up the serving tongs, peeled the aluminum foil back from the garlic bread steam pan, picked up three (3) slices of garlic bread, and placed them in the blender. She picked up the garlic bread with her gloved hands and tore the bread into smaller pieces. She did not change gloves or perform hand hygiene between touching the non-food preparation counter and handling bread. At 11:50 AM, Staff G removed the lid from the steam pan that held the pureed food in bowls and placed the lid top down on top of the serving ladle used for vegetables. At 11:55 AM, Staff H, Dietary Aide (DA) donned gloves, grabbed a loaf of bread, opened it, then grabbed two slices with the same gloved hands and placed them on a plate. No hand hygiene or glove change was performed after touching the outside of the bread packaging. A document titled Food Safety and Sanitation dated 2013 indicated staff will handle all foods safely and directed staff to wash their hands when they have used their hands in an unsanitary way. On 8/22/24 at 1:18 PM, the Administrator stated staff should follow the facility's policy.

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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** 47673 Based on observation, record review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices by not covering the clean linen cart when moving between buildings and in hallways at the facility, not disinfecting wheelchair after contaminated during personal cares for a resident with transmission based precautions, not completing hand hygiene and changing gloves in accordance with standards of practice and touched back of medication cards to cups used to distribute medications for 6 of 12 residents reviewed, (Resident #7, #20, #37, #14, #18 and #50). The facility reported a census of 53 residents. Findings included: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #50 entered the facility on 7/3/24. The MDS also documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS revealed indwelling catheter utilized by Resident #50. Observation on 8/21/24 at 8:35 AM Staff E cleansed the tip of catheter tubing with alcohol, urine emptied 775mL from catheter bag, catheter tubing tip cleansed with alcohol, and returned to the holder. Staff E emptied the urine into the toilet. Staff E returned to Resident #50 and removed the blanket and sheet. Staff E and Staff F completed peri care on Resident #50. Lift was obtained by Staff F. Staff F moved the wheelchair closer to Resident #50 ' s bed. Both the lift and the wheelchair were kept in Resident #50 ' s room. Staff F used the mechanical lift while Staff E guided Resident #50 to the wheelchair. Staff E assisted Resident #50 in the wheelchair moving the wheelchair under Resident #50. Staff F removed gloves, completed hand hygiene, applied gloves, and applied foot pedals to the wheelchair. Staff E removed gloves, completed hand hygiene, and applied gloves. Staff E cleansed wheelchair handles with sanitizing wipes at 9:00 AM. Gloves and gowns removed hand hygiene completed by both staff at 9:02 AM, and left Resident #50 ' s room. Handles of the wheelchair were visible dry. On 8/21/24 at 9:09 AM Staff E stated she touched the door and the wheelchair handles with her gloves that were contaminated after cleaning up Resident #50. Staff E stated she wiped the areas down. Staff E stated she was unaware of any time frame for the area to remain wet before the area was sanitized. Staff E stated she looked at the instructions and the sanitizing wipes required the surface to remain moist for a minimum of 2 minutes. Staff E acknowledged that the surface of the wheelchair handles and the door handles were not moist for 2 minutes and the wipes were not utilized correctly. Review of Resident #50's MDS revealed diagnosis of bullous pemphigoid and herpes viral infection. Review of Resident #50's Care Plan documented an intervention of enhanced barrier precautions related to indwelling catheter. Observation on 8/19/24 at 1:00 PM revealed Staff K walked between buildings with no cover over the laundry cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/19/24 at 1:45 PM revealed Staff K pushing a linen cart uncovered down the hall to room [ROOM NUMBER] on east hall. Staff K stopped at room [ROOM NUMBER], entered the room, left the room, pushed the linen cart down the hall, and stopped in front of room [ROOM NUMBER]. Linen cart remained uncovered the entire observation. On 8/19/24 at 1:47 PM Staff K Housekeeping stated she usually had the laundry cart covered up but had the cover off the laundry cart because she just had a couple items left and the towels to take back over. Staff K stated the linen is usually covered when she leaves any building. Staff K stated usually the linen was covered when the linen was passed. On 8/20/24 at 4:45 PM the DON stated the facility's expectation was that the linen would be covered when linen was transported between buildings and in hallways. Review of policy titled, Laundry Policy updated 4/22 documented clean linen will be covered when transported going between buildings and the cart being utilized will be disinfected on a regular basis. On 8/21/24 at 2:11 PM the DON stated the facility's expectation was that hand hygiene would have been completed between emptying the catheter and completing catheter care. The DON stated the facility's expectation was the sanitizing wipes would have been used as directed by the instructions with the surface to remain moist for at least 2 minutes. Review of document titled, General Guidelines for use documented to allow treated surface to remain wet for 2 minutes and let air dry. Review of document titled, Policy / Procedure for Hand Washing with Review date 6/20 documented hands should be washed at a minimum before and after each resident contact, after contact with any body fluids, and after handling any contaminated item. 47079 On 8/20/24 at 8:23 AM, Staff J, Licensed Practical Nurse (LPN) returned from medicating Resident #20 with a spoon and dose cup. She threw the items in the trash attached to the cart, grabbed Resident #37's medication dose cup, and carried them to the resident. Hand hygiene was not performed between residents' medication administrations. On 8/20/24 at 8:46 AM, Staff J, Licensed Practical Nurse (LPN) placed Resident #7's medication cup directly in contact with the back of the medication cards and push the medication out of the card and directly into the cup. On 8/20/24 at 8:53 AM, Staff D, Certified Nurse Aide (CNA) fed two residents Resident #14 and #18 during lunch. She used her right hand to spoon some applesauce into the Resident #18's mouth. She reached to her left with her right hand, gave Resident #14 some water, grabbed Resident #14's bib and wiped Resident #14's mouth. She grabbed Resident #18's spoon with her right hand and fed Resident #18 some applesauce. No hand hygiene was performed throughout the process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document titled Meal, Serving the revised 10/2020 directed staff to wash hands thoroughly or sanitize with alcohol-based hand rub (ABHR) before serving another resident if you attend to a resident during the serving process. A policy titled Hand Washing reviewed 6/2020 directed staff to wash hands before and after each resident contact and after touching a resident or handling his or her belongings. On 8/22/24 at 1:20 PM, the Director of Nursing (DON) stated staff should perform hand hygiene after using a resident's bib to wipe the resident's mouth. She also stated the resident's medication card should not contact the medication dose cup.