STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165507	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Village	2571 Guthrie Avenue Des Moines, IA 50317

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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 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 observation, clinical record review, resident interview, staff interviews and facility policy review, the facility failed to follow physician orders for 3 of 18 residents reviewed (Residents #20, #30 & #67). Resident #20 consistently received medications significantly past the ordered time, Resident #30 was administered a treatment that had been previously discontinued, and the facility failed to obtain ordered daily weights for Resident #67. The facility reported a census of 75. Findings include: 1. The Quarterly Minimum Data Set (MDS) Assessment of Resident #20, dated 4/22/24 identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The Care Plan of Resident #20 documented a Focus Area of Preferences dated 9/12/23. The Care Plan identified the goal, with a target date of 7/17/24 to be My preferences will be respected to the extent able, provided consideration of mine and other's safety. The Care Plan additionally documented a Focus Area of Cognition/Communication dated 5/16/23 which stated I am alert and oriented. I am able to make needs known to staff, though I can be forgetful at times. On 5/28/24 at 12:08 pm, Resident #20 stated that his bedtime medications are sometimes administered as late at 1:00 am. He stated he wishes to go to sleep earlier in the night and does not want to be woken up for medications after he goes to sleep. He voiced that there are two regular night shift nurses, and one of the two usually brought his medications before 9:30 pm but the other nurse was consistently late in administering the medicines. The undated document titled Medication Pass times provided by the facility during the survey documented HS (hour of sleep/bedtime) medications are to be administered between 7:00 pm and 10:00 pm. The Medication Administration Record of Resident #20 for the month of May, 2024 revealed the following seven medications were ordered for HS, 7:00-10:00 pm which were administered significantly late multiple times throughout the month: Donepezil, 10 milligrams (mg) (treat memory loss and mental changes) Doxazosin 4 mg (for high blood pressure) Memantine 10 mg (treat memory loss) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Omeprazole, 20 mg (for increased acid in stomach) Quetiapine 50 mg (for depression) Simvastatin 20 mg (for high cholesterol and triglycerides) Venlafaxine 75 mg (for depression) The MAR documented the following information: On 5/2/24 the HS meds were administered on 5/3/24 at 12:01 am. On 5/7/24, the HS meds were not administered due to resident being asleep, documented at 11:56 pm. On 5/10/24 the HS meds were administered at 11:15 pm. On 5/11/24 the HS meds were administered at 11:14 pm. On 5/21/24 the HS meds were administered at 10:52 pm. On 5/26/24, the HS meds were administered at 11:20 pm. On 5/30/24, at 11:25 am, the Director of Nursing (DON) stated that she is aware of the situation and that Resident #20 had previously expressed his concerns regarding this to her. She stated she has provided education to the nurse and is continuing to work with her. The orders of Resident #20 revealed an order dated 8/8/23 which stated Facility May Use Liberal Med Pass Times The facility policy Medication Management, review date of March 4, 2024 documented: Point 12 - Medications may be given 1 hour before or 1 hour after scheduled administration time unless there is a specific order or indication otherwise. Facilities using liberalized medication pass times will administer meds during the ranges given in the liberalized medication pass times and will not have an additional hour before or after those times. 48886 2. The Significant Change MDS dated [DATE] documented Resident #67 had a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS further documented the resident had diagnoses to include medically complex conditions, diabetes mellitus, hip fracture and respiratory failure. The Care Plan for Resident #67, with a start date of 2/21/24, documented nutritional status under a problem area with a goal no significant weight changes will be observed and an approach weights and medications per doctor of medicine (MD) order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Electronic Health Record (EHR) for Resident #67 showed a Physician Order with a start date 5/10/24 with an order for daily weights and to notify the physician if weight gain of 3 pounds in between weights or weight gain of 5 pounds in 1 week. Review of the EHR for Resident #67 revealed no weights recorded for the dates of 5/16/24 and 5/17/24 and no explanation as to why weights were not recorded. The resident's weight on 5/15/24 was recorded as 276. 5 pounds, the resident's weight on 5/18/24 was recorded as 281.2 pounds, a weight gain of 4.7 pounds in between weights. Review of the EHR for Resident #67 revealed lack of documentation of notification to the physician of the 4.7 pound weight gain on 5/18/24. During an interview 5/29/24 at 2:00 PM, the Administrator advised the weight for Resident #67 was not recorded 5/16/24 or 5/17/24. Review of email documentation on 5/29/24 at 2:53 PM from the Administrator. The Administrator documented in email the nurse on 5/16/24 was contacted and recalls Resident #67 refused weight and will make a late entry. At this point, we are unable to reach the nurse from 5/17/24 but messages have been left. The Administrator documented our expectation would be that we would notify the doctor if the resident refused his weights and was showing symptoms of increased fluid retention. During an interview 5/29/24 at 03:10 PM, the Director of Nursing (DON) stated an expectation physician orders are followed and Resident #67's weight would be taken every day, and if not, a reason why should be documented. The DON acknowledged weights were not obtained on the 16th and 17th of May, and no documentation is present as to why. The DON stated an expectation staff contact the physician on the 18th of May to inform the physician of the weight gain. The DON acknowledged the physician was not contacted on 5/18/24. 50500 3. The Comprehensive Skin Risk assessment dated , of Resident #30, reflected a Braden score of 14, which indicates a moderate risk of pressure wound development. The Care Plan revision date of 5/13/24 indicated Resident #30 to be at risk for alteration of skin integrity related to poor skin turgor, poor safety awareness, impulsivity, and Foley catheter. Resident #30 had a prior treatment order to the left buttock/gluteal fold wound which read: Apply Calmoseptine to pressure ulcer on Left buttock every shift until healed. This treatment was initiated on 4/17/24 and discontinued on 5/11/23 as the site had healed. Resident #30 has an active wound care orders for the right buttock initiated on 5/20/24 which reads: Cleanse wound on right buttock with wound cleanser of choice. Pat dry. Cover with bordered foam dressing. Change 2 times weekly until healed. Check Placement of dressing every shift. Progress note entries from 5/26/24 and 5/27/24 document that Resident refused turns, Calmoseptine treatment during the night. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound care observation completed on 5/28/24 at approximately 3:15 pm for Resident #30 with Staff A, Registered Nurse (RN), and the Assistant Director of Nursing (ADON). Wound care to the right buttock started after cares to the calf and heel completed. Staff A, RN and the ADON wore personal protection as per Enhanced Barrier Protection. Supplies were set up on a barrier on bedside table which include Calmoseptine and wound cleanser. No copy of treatment administration record observed in room for staff to compare and verify treatments. When Staff A, RN began treatment on the right buttock, Staff A, RN noted a dressing on the wound and asked the ADON about it. The ADON ungowned and went to verify the wound care order. The ADON returned with the ordered dressing as this was not brought into the room prior to cares. Resident #30 had a large bowel movement with incontinent care completes. A reddened wound bed observed. The wound was cleansed with normal saline; No wiping observed. Staff A, RN applied Calmoseptine followed by the dressing. Staff A, RN then dated the dressing.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on observation, resident interview, staff interview, record review and policy review, the facility failed to provide necessary services to maintain grooming for nail care for 1 of 1 residents (Resident #67) reviewed for Activities of Daily Living (ADL). The facility reported a census of 75 residents. Findings include: The Significant Change Minimum Data Set (MDS) dated [DATE] documented Resident #67 had a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition. The MDS further documented the resident had diagnoses to include medically complex conditions, diabetes mellitus, hip fracture and respiratory failure. The Care Plan for Resident #67, dated 4/26/24, with a problem area for ADL, documented resident admitted to facility for skilled services, had a hospitalization after a fall with femur fracture and surgery. Resident needed assistance with ADL's, unable to complete them without assistance. The approach section of the Care Plan documented staff to provide assist with grooming. During an observation 5/28/24 at 2:11 PM, Resident #67's fingernails were long and jagged, they were brown in color and dirty under the nails. During an interview 5/28/24 at 2:11 PM, Resident #67 advised the facility has not trimmed his nails in a while and stated he relies on the facility to trim his fingernails, especially due to his diagnosis of diabetes mellitus. During an observation 5/29/24 at 1:50 PM, Resident #67's fingernails were long and jagged, brown in color with dirt under the nails. Review of the Electronic Health Record (EHR) for Resident #67, under the observation section, a skin inspection form was completed on 5/23/24 and 5/16/24, the form directed staff to observe resident nails and provide nail care as indicated. The form did not contain documentation nail care was completed. Review of the progress notes section of the EHR did not contain documentation regarding nail care. During an interview 5/29/24 at 2:30 PM, the Administrator advised she is not aware of other documentation regarding nail care for Resident #67 being completed. During an interview 5/29/24 at 3:15 PM, the Director of Nursing (DON) advised Resident #67's fingernails were just observed by her to be long and dirty. The DON stated the resident's fingernails should have been trimmed prior to this date given their length and appearance. The DON stated an expectation the resident's nails are observed weekly during the skin assessment, and trimmed regularly. The DON stated there is no documentation regarding the resident refusing to have his nails trimmed. The resident has diabetes mellitus and requires assistance with trimming fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Nail Care, with a revision date of 3/27/24, documented all residents will receive medically indicated nail care as required. Nails will be maintained in a clean and neat manner to support resident dignity and to avoid problems associated with rough, cracked, overly long, or broken nails. Nail care will be provided with the resident's weekly bath and/or as needed.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on direct observation, clinical record review, staff interviews, family interviews, and policy review, the facility failed to provide sufficient amount of properly trained staff to implement care plan interventions for 1 of 1 residents with self-injurious behavior. (Resident#37). The facility staff also failed to intervene when the resident displayed behaviors. This resulted in harm to the resident in the form of three occurrences of cellulitis and loss of the distal portion of the left index finger - the tip of the left index finger to the first finger joint. She was placed on antibiotics for the treatment of the cellulitis. The facility reported a census of 75. Findings include: Record review of Resident #37's Minimum Data Set (MDS) assessment dated [DATE] documented that a Brief Interview of Mental Status (BIMS) could not be completed due to the resident being rarely or never understood. The MDS also documented the need for significant assistance for transfers, dressing and toileting, supervision at meals with set up assistance, and assistance for bed mobility. The resident's diagnoses included, non-traumatic brain dysfunction, Alzheimer's disease, Non-Alzheimer's Dementia, diabetes, anxiety, depression, and pain. Record review of Resident #37's Care Plan last revised on 05/17/24 indicated staff should redirect self-harm behaviors by handing Resident #37 something to eat or giving her a stuffed dog. It indicated dependent care for oral hygiene. Review of oral hygiene charting revealed that oral cares were only recorded as completed on the following dates and times: 1. 04/29/24 at 10:52 AM 2. 04/30/24 at 12:24 AM 3. 05/07/24 at 02:48 PM 4. 05/08/24 at 09:23 AM 5. 05/09/24 at 04:25 AM 6. 05/10/24 at 12:35 PM 7. 05/11/24 at 03:55 PM 8. 05/12/24 at 10:21 AM 9. 05/13/24 at an undocumented time. Review of a Physician's Progress Note dated 04/15/24 revealed the following: (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	1. Resident #37 had a diagnosed history of advanced dementia. 2. She was placed on hospice services. 3. She had been persistently biting at her nails and fingers, ongoing for approximately two months as of the date of this progress note. 4. It began as minor wounds, but the patient had now chewed off the distal part of the left index finger near the distal interphalangeal (DIP) joint. 5. She had dementia related agitation, anxiety, and hallucinations. 6. The care team added Divalproex Sprinkles 125mg twice daily on 03/25/24. 7. This was reported to have slowed her behaviors, but staff reported finger chewing worsened as of the writing of this progress note. 8. Other measures have failed to stop chewing, included bandages and gloves. The Progress Notes for the resident documented the following: a. On 02/07/24 at 05:24 AM the resident was agitated, yelling, and biting an open area on the middle finger of the left hand. The area appeared swollen, red, and painful. The area was cleansed and covered. b.On 02/07/24 at 12:45 PM the resident was seen by the physician's assistant (PA) for an acute visit in which the resident presented with a swollen finger. The resident was prescribed Keflex 500mg two times daily for ten days, the wound to be covered, and triple antibiotic ointment to be applied to the left middle finger. c.On 02/12/24 at 07:31 AM the resident remained on antibiotics for cellulitis of the left middle finger. Resident #37 continued to bite at the area, and had removed the bandages, but fresh bandages were applied. It noted a scant amount of serosanguinous drainage present on the dressing. d.On 02/24/24 at 05:48 PM The resident continued to bite at her left index finger. e.On 02/25/24 at 06:23 AM The resident bit her left index finger nail causing mild bleeding. f.On 02/25/24 at 03:48 PM The resident had new wounds on left index and middle fingers. It noted the resident had been chewing on fingers, staff covered wounds with dressings, and resident continued to remove dressings and chew on fingers. g.On 02/29/24 at 01:45 PM Nursing staff dressed the left index finger and lower left extremities, at this time it was noted the left index finger nail had nearly fallen off. h.On 03/01/24 at 05:10 PM The resident continued to chew on her fingers. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	i.On 03/04/24 at 02:37 PM noted the resident had gloves added as an intervention which successfully prevented chewing behavior. j.On 03/05/24 at 06:19 AM the resident continued biting behavior and refused to allow staff to apply gloves or dressing. k.On 03/10/24 at 06:28 AM Noted the resident had bitten off nails on left index and middle fingers. A geri sleeve was placed over the dressing as a deterrent, which proved effective. l.On 03/15/24 at 03:13 PM The resident removed the dressing from her fingers. Nursing staff noted the fingers were red and warm to the touch. At 05:13 PM an order for Augmentin was clarified and changed to Doxycycline 100mg two times a day for ten days related to a second occurrence of cellulitis in the left fingers. m.On 04/12/2024 at 05:56 AM Noted that the resident had bitten her left index finger down to the distal interphalangeal joint and had bitten the fingernail off of her left middle finger. n.On 04/19/2024 at 03:43 PM Noted resident was placed on Bactrim for ten days due to another occurrence of cellulitis in the left finger. o.On 04/28/2024 at 10:42 AM Noted the resident continued to chew on fingers and is quickly removing bandages and dressings. Review of a Provider Progress Note dated 04/15/24 recorded Resident #37 had been persistently biting at her nails and fingers; ongoing for approximately two months. These began has minor wounds, but patient had since chewed off distal part of the left index finger, nearly to the distal interphalangeal joint. Divalproex sprinkles 125mg twice daily was added at 03/25/24, which first appeared to have slowed the chewing behavior, but was reported to have failed as of the writing of this note. A direct observation on 05/28/24 at 01:00 PM revealed wounds on Resident #37's legs and bandages on her left hand with no blood visible on the bandages at the time of this observation. A continuous direct observation on 05/29/24 from 12:12 PM to 12:40 PM revealed the following: 1. At 12:12 PM, Resident #37 in the dining room attempting to free herself from her wheelchair. When attempts failed to free herself from her wheelchair she began to bite the bandage on her left middle finger. A red mark on the bandage was present. 2. At 12:14 PM, Staff B, Therapeutic Activities Coordinator, walked past Resident #37. No attempts were made at redirection and the nurse was not notified. Resident continued to chew the bandage on her left middle finger. 3. At 12:17 PM, Staff C, CNA, seated another resident next to Resident #37, then placed a clothing protector on Resident #37. No attempts were made to redirect the resident from chewing. Nurse was not notified. Resident continued to chew on the bandage on her left middle finger. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	4. At 12:19 PM, Staff D, CNA, walked past Resident #37 as she freed her finger from the bandage. Staff D commented That didn't last long and continued to seat residents at the dining tables. No attempts were made to redirect at this time. The nurse was not notified. Resident #37 began to chew on the proximal interphalangeal joint of her left middle finger - the middle joint of her middle finger. 5. At 12:25 PM, Resident #37 continued to chew on the proximal interphalangeal joint of her middle finger, but asked for help from Staff F, Culinary Assistant. Staff F did not acknowledge Resident #37. Staff F left the dining room without informing nursing staff. 6. At 12:27 PM, The Director of Food and Nutrition Services offered Resident #37 a glass of water. Resident #37 accepted the drink and stopped chewing. The chewing did not resume until the glass of water had been consumed. At 12:32 PM Resident #37 resumed chewing on the proximal interphalangeal joint of her left middle finger. Redness is noted on the finger at this time. 7. At 12:32 PM, Resident #37 had a dessert placed just out of her reach by the Director of Food and Nutrition Services. She continued chewing behavior in clear sight of Staff C and Staff D. No attempts to redirect were made. 8. At 12:40 PM, Staff G, RN noted resident was actively engaged in chewing behavior. Staff G placed the dessert in reach of Resident #37. Resident immediately ceased chewing behavior and began eating the dessert. In an interview on 05/29/24 at 03:23, PM Staff C stated they do not feel they have enough staff to handle the needs of residents in the Memory Care unit. She noted that several residents require a mechanical lift with an assist of two, leaving only on person on the floor to monitor all residents in Memory Care. She acknowledged the biting behavior but noted it happens so frequently it fades into the background. She acknowledged that staff should attempt to redirect when they notice. In an interview on 05/30/24 at 09:28 AM, Staff D noted staff are to attempt to redirect Resident #37 when they notice her biting or attempting to free herself from her wheelchair. She noted that interventions are not always successful, but staff are still supposed to attempt to distract or redirect the resident. She stated she feels they need more staff in Memory Care. She stated that it is hard to tend to resident needs when they are dealing with a two person assist. She noted it leaves only one staff member to monitor the rest of the floor. In an interview on 05/30/24 at 09:06 AM A family member of Resident #37 stated he feels the facility does not have enough staff to adequately care for all of the residents in the Memory Care Unit. He noted when a resident is being assisted it often leaves only one person to watch the entire floor. He noted he visits every morning and most evenings. The family member gave permission to take pictures of Resident #37's fingers. These pictures were taken on 05/30/24 at 01:05 PM. They revealed scabs on the distal phalangeal joint, with a finger missing above that point on the left index finger. The fingernail of the middle left finger had been removed and there was an open wound with a small white area protruding from the nail bed. There was recent trauma to the proximal phalangeal joint present with some scabbing noted. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/29/24 at 4:46 PM The Director of Nursing (DON) acknowledged the expectation is for nursing staff to attempt redirection as soon as they witnessed the self-injurious behavior. She noted kitchen and activities staff are expected to say something to nursing staff when they witness the behavior so that nursing staff can attempt to implement interventions in accordance with Resident #37's care plan. She stated she did not believe the facility could provide one on one care for Resident #37 at this time. Review of a visual body inspection dated 05/24/24 documented that the resident had no new injuries or damaged skin present. Review of a facility document titled Behavioral Health Services last reviewed on 03/18/24, documented the facility's interdisciplinary team (IDT) will evaluate behavior health symptoms to determine the degree of severity, distress and potential safety risk to the resident and effectiveness of interventions. If necessary, safety strategies will be implemented immediately to protect the resident or others from harm. If a resident is having behaviors that are not responding to current interventions, staff will complete a behavioral expression-elevated event and this will be reviewed by the IDT. Facility staff will receive education to ensure competency in meeting the behavioral health needs of residents. Review of a facility document titled Dementia Care last reviewed on 03/28/24, documented the facility will use consulting psychologists as needed for assessment and intervention, and should it be deemed necessary for the well-being of the resident, safety of other residents, and/or staff, the use of geriatric inpatient mental health units. The facility did not provide evidence that this occurred.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on clinical record, provider interview, and policy review, the facility failed to document a reason for declining a Gradual Dose Reduction (GDR) for 1 of 5 residents reviewed (Resident #42). The facility reported a census of 75. Findings include: The Significant Change Minimum Data Set (MDS) dated [DATE] shows a Brief Interview for Mental Status (BIMS) score of 4, which indicated a severe cognitive impairment. Active diagnoses include Huntington's Disease, anxiety disorder, and cognitive-communication deficit. The MDS documents improved behaviors since the last submitted MDS on 2/12/24. The Care Plan documented a Problem with the start date of 3/30/21 as follows; I receive an antipsychotic medication for my diagnosis of Huntington's disease with a goal of I will not require an increase in my antipsychotic mediations during my stay at this facility Interventions include attempt at dose reduction per regulatory guidelines as condition warrants, per physician/nurse practitioner (NP) order, pharmacy review monthly and as needed. Clinical record review documented a GDR recommendation on 10/5/24 with the primary care provider PCP) responding on 10/25/23. The PCP agreed to a dose reduction for Lorazepam but failed to address the request for a dose reduction for Risperidone. A second documented GDR recommendation for Risperidone noted on 4/2/24 with the primary care provider PCP) responding on 4/15/24. The PCP agreed to a dose reduction for Sertraline but failed to address the request for a dose reduction for Risperidone. An email received from the PCP on 5/30/24, provided rationale for not addressing the Risperidone. This was not documented in the clinical medical record or on the Pharmacist's Recommendation to Prescriber forms. No further documented attempt by the nursing staff identified. The policy Psychotropic Medication Monitoring, review date 3/4/24, documented As part of routine medication regimen reviews, the consultant pharmacist will review all psychotropic medications for appropriate indications of use, monitoring for efficacy, potential adverse effects and potential for dose reduction. The policy Medication Review Management, reviewed on 3/4/24, outlines the produce for regulatory compliance: 1. For documentation of non-clinical related concerns related to regulatory compliance, the consultant pharmacist may use a supplemental medication regimen review communication form to alert the director of nursing of issues requiring clarification or follow-up. 2. The attending physician will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. These non-urgent recommendations should be reviewed and acted upon during the next scheduled physician visit (within 60 days). (continued on next page)

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	165507	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Village	2571 Guthrie Avenue Des Moines, IA 50317

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If the attending physician has not responded to the medication regimen review within 75 days the Director of Nursing (or designee) will notify the Medical Director to respond to the pending medication regimen review reports. If the attending physician is also the medical director, the DON (or designee) will escalate the issue to the facility administrator. 4. If there is potential for serious harm and the attending physician does not concur with the recommendation, or the attending physician refuses to document an explanation for disagreement, the director of nursing and/or consultant pharmacist will contact the medical director for review. 5. If the attending physician disagrees with the consultant pharmacist and is also the medical director, the consultant pharmacist and the director of nursing will arrange a meeting with the medical director to discuss the identified irregularities. All parties must come to an agreement or a formal complaint should be initiated according to facility policy. If there is potential for serious harm to the resident, this process must be completed in a manner to ensure no actual harm occurs.

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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. 49990 Based on observation, interview, and facility policy the staff failed to perform hand hygiene to prevent the spread of possible food borne illness for one of one meal observation. The facility reported a census of 75 residents. Findings include: Observation on 05/29/24 at 12:38 PM revealed Staff F, Culinary Assistant (CA) did not perform hand hygiene at the hand washing station before beginning to serve lunch plates. While serving plates of food, Staff F continually touched the top of the resident's plates, and on two occasions used his thumb to hold food in place. Observation on 05/29/24 at 12:41 PM revealed Staff F pick up and handle paperwork to a coworker, then continue to serve food. No hand sanitation was completed at this time. In an interview on 05/30/24 at 02:20 PM the Director of Food and Nutrition services acknowledged Staff F should not have used his fingers to hold food in place and should have washed hands after handling other objects. She agreed that Staff F required more training. Review of a facility policy titled Food Preparation and Services, last reviewed on 01/12/24, documented facility staff should wash their hands before serving food to residents. It further documented bare hand contact with food is prohibited.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50471 Based on observations, staff interview, and facility policy review, the facility failed to protect medical records in a confidential and secure manner for 2 of 19 (Resident #41, #26) residents reviewed for medication administration. The facility reported a census of 75 residents. Findings include: Observations revealed the following: 1. On 5/28/24 at 11:47 AM, medication cart with laptop was left unattended, no privacy screen initiated, displaying resident medication list (Resident # 41). 2. On 5/28/24 at 12:47 AM, medication cart with laptop was left unattended, no privacy screen initiated, displaying resident medication list (Resident # 26). 05/30/24 03:11 PM Director of Nursing (DON) said staff are to lock the computer screen and their cart before walking away. Staff are trained to lock their computer screen and complete the staff orientation checklist. The facility policy titled Resident Rights undated included the following documentation: Point 1- We are required by law to maintain the privacy and security of your protected health information.

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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. 50471 Based on observation, staff interview, and facility policy review, the facility failed to place a barrier prior to performing blood glucose monitoring for 3 of 3 residents reviewed (Residents #13, #26, #55), additionally the facility failed to have a sharp container when needed by staff for 3 of 3 residents (Residents #13, #26, #55), and the facility failed to properly locate the accu monitor while being cleansed by disinfecting wipe while using the same monitor for 3 of 3 residents (Residents #13, #26, #55). The facility also failed to follow infection control during dining service. The facility reported a census of 75 residents. Findings include: Observations revealed the following: a. On 5/28/24 at 11:25 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after use, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items. b. On 5/28/24 at 11:28 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after used, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items, used the same monitor from previous resident. c.On 5/28/24 at 11:33 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after used, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items, used the same monitor from previous resident. On 5/30/24 3:11 PM, The Director of Nursing (DON) reported staff should be using a paper towel or a barrier, sharp container is located on the medication cart, each resident has their own monitor that is stored in their own bag, and monitor should be on a barrier on the med cart to allow to dry. The facility policy title Blood Glucose Monitoring-Assure Prism revised 3/28/24 included the following documentation: Number 2- Gather the following equipment: test strips, glucose monitor, lancets, cotton balls, sharps container. Number 3- Place equipment on a clean barrier. The facility policy titled Clean-disinfect glucometer revised 7/24/23 included the following documentation: Policy statement- This glucometer is disinfected after use and stored in designated location. Number 1- Each resident's glucometer will be stored individually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Number 2- Clean per manufacturer's instructions. Number 3- Store individual glucometers in Ziploc bag or similar to keep separated from other machines.