STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165555	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adel Acres	1919 Greene Street Adel, IA 50003

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview the facility failed to assure resident's or their representatives completed the Skilled Nursing Facility (SNF) Advanced Beneficiary Notices (ABN)/clarified their wishes for 2 of 3 residents reviewed (Resident #10 and #37). The facility reported a census of 40 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #10 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The SNF ABN form notified Resident #10 beginning on 2/9/24 he may have to pay out of pocket for (skilled) care. The resident signed the form, but the rest of the writing was someone else's. The resident did not choose an option for how he wanted to proceed. The clinical record lacked documentation that the facility asked Resident #10 about choosing an option. 2) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #37 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The SNF ABN form notified Resident #37 beginning on 12/12/23 she may have to pay out of pocket for (skilled) care. The resident's representative signed the form choosing option #1, indicating they wanted the care listed (PT, OT, ST), and wanted Medicare billed for an official decision on payment . The clinical record lacked documentation that the Resident #37 received the care and the facility billed Medicare, or the facility clarified the accuracy of the option with the Representative. On 5/22/24 at 10:43 a.m. the Administrator stated the Social Worker left late last year. The Administrator was helping with things, and he did some of the notices. He didn't know on 1 they had chosen option #1, and another had not chosen an option. The Form Instructions, Advance Beneficiary Notice of Noncoverage (ABN) OMB Approval Number: 09238-0566 directed the ABN must be verbally reviewed with the beneficiary or his/her representative and any (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questions raised during that review must be answered before signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABN's are never required in emergency or urgent care situations. Options on the form include: OPTION 1. The resident wanted the care listed above and wanted Medicare billed for an official decision on payment. The beneficiary or his or her representative must choose only one of the three options listed. If the beneficiary could not or would not make a choice, the notice should be annotated, for example, the beneficiary refused to choose an option.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49628 Based on personnel file reviews, staff interviews, and policy review the facility failed to complete the Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License information prior to employment for 1 of 5 employees reviewed (Staff C). The facility census was 40. The personnel file for Staff C, Certified Nursing Assistant (CNA), reflected a rehire date of 3/11/24. The file lacked the background check. On 5/22/24 at 1:37 PM the Business Office Manager reviewed Staff C's personnel file and confirmed the only Iowa Criminal History, Iowa Sex Offender Registry, Iowa Central Abuse Registry and Professional License in the file was dated 10/24/23. The staff completed an online verification via the facility's The Single Contact Repository (SING) account for Staff C's background check. The Business Office Manager acknowledged the facility failed to complete a background check for Staff C prior to rehire. The staff stated the facility practice was only the Business Office Manager was to complete the background checks. The background checks would be for new employees and if staff had been gone from employment for 6 weeks or greater. On 5/22/24 at 4:09 PM the Administrator confirmed Staff C did not have a background check prior to rehire. The Administrator stated a background check must be completed if length of time is greater than 30 days between the end of employment and rehire. The facility followed the standard of practice for completion of background checks prior to hire and did not have a specific policy or procedure for pre-employment. The facility's Abuse Prevention Policy '' revised 4/28/21 revealed the facility would pre-screen all potential new employees for history of abusive behavior.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on record review and staff interview, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASSR) evaluations for a change in diagnoses or treatment for 2 of 4 residents reviewed (Resident #40 and #18). The facility reported a census of 40. Findings include: 1) The Quarterly Minimal Data Set (MDS) dated [DATE] documented Resident #40 had a Brief Interview for Mental Status (BIMS) of 1 indicating a severe cognitive impairment. The MDS further documented the resident had diagnoses including depression, anxiety, and a psychotic disorder (other than schizophrenia). The MDS reports the use of high-risk medications including an antianxiety, antidepressant, and antibiotic medications. Current medication orders, as of 5/23/24, include Lamotrigine 25 milligram (mg) daily related to unspecific psychosis (medication initiated on 3/5/24), Sertraline HCl 50mg daily related to anxiety disorder and depression (medication initiated on 2/2/24), Lorazepam 0.5mg three times daily related to anxiety disorder (medication initiated on 3/13/23), and Buspirone HCl 30mg two times daily related to anxiety (2/9/23). Resident #40's current Care Plan, dated 2/9/24, indicated a focus behavioral problem related to anxiety and delusions/hallucination with a goal of no evidence of behavioral problems. Other focus areas include the use of an antidepressant related to depression, use of antianxiety medications related to anxiety disorder, and use of antipsychotic medications related to behavior management. Interventions include: 1. Administering medications as ordered 2. Monitor/document/report As Needed (PRN) any adverse reactions to the antidepressant, antianxiety, antipsychotic medications for adverse reactions 3. Refer to pharmacy for gradual does reduction Documentation from Deer Oaks Med Management Associates show current medications as well as recommended changes (2/28/24, 3/29/24, 4/19/24). The only documented PASSR located in the clinic record is dated 09/21/22. This noted depression/depressive disorder and anxiety diagnoses with the use of Escitalopram 10mg daily. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Adel Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Greene Street Adel, IA 50003	

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Social Worker interviewed on 5/22/24 at 3:15 p.m. reported being in this position a couple of months. At this time, she is in the process updating resident PASSRs if indicated. When reviewing specifics of Resident #40's PASSR, the social worker acknowledged that an updated revision is indicated due to medication changes. However, she has experienced technical issues when attempting to complete. This error message was verified when she tried to initiated a change on 5/22/24. She explained that calls to PASSR have been made, but this situation remains unresolved. The social worker believed that nursing was completing PASSR during the time frame when the social work position was vacant. The Assistant Director of Nursing (ADON) interviewed on 5/23/24 at 1145a.m. verified that the MDS coordinator completed/updated PASSRs during the time the facility was without a social worker. The MDS coordinator stopped completing PASSRs during the first or second week of March 2024. 49628 2) Review of Resident #18's Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive impairment. The MDS further revealed diagnoses of Non-Alzheimer's Dementia, Depression, and Bipolar Disorder. Review of a facility provided document titled, PASRR Notice of Nursing Facility Approval, dated 6/3/21 revealed a summary of findings indicating that Resident #18 did not meet the criteria for intellectual disability or serious behavioral health condition. The document revealed no mental health diagnoses, dementia/neurocognitive disorders, mental health medications, and no recommended services/supports. The admitting Agency/Facility was Pine Acres Rehabilitation and Care Center. The Electronic Health Record Review(EHR) Admission Record form documented Resident #18 was admitted to the facility on [DATE] from another facility. The EHR, Admission Record form documented the resident had diagnoses including unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety diagnosed [DATE], bipolar disorder, unspecified diagnosed [DATE], and depression, unspecified diagnosed [DATE]. Clinical Physician Orders documented the following orders; a. Donepezil HCI oral tablet 10 MG, give 1 tablet by mouth at bedtime for unspecified dementia b. Sertraline HCI oral tablet 25 MG, give 1 tablet by mouth in the morning related to depression c. Namenda oral tablet, give 1 tablet by mouth 2 times a day related to unspecified dementia d. Clonazepam oral tablet .5 M, give 1 tablet by mouth every 12 hours as needed for restlessness related to bipolar disorder e. referral to hospice services on 4/8/24. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 2:40 PM the Social Services/Admissions Coordinator (SS/AC) stated employment to this position for a couple of months. The staff confirmed Resident #18 did not have a PASRR newer than 6/3/21. The SS/AC indicated that the resident should have had a new PASRR completed with mental health diagnoses, and when the resident transitioned to hospice services. On 5/22/24 at 3:41 PM the Director of Nursing (DON) confirmed that the social services department completed PASRRs when needed to be updated, and would expect they would be completed as required. The DON confirmed the current SS/AC had been in the position for a few months, and during an interim between SS/ACs the MDS Coordinator completed the PASRRs. On 5/22/24 at 4:09 PM the Administrator reported the completion of a PASRR for a resident admitted from another facility would be left to the discretion of the SS/AC. If a resident was admitted to the facility from a hospital, the hospital completed the PASRR. The Administrator acknowledged Resident #18 was admitted from a different facility with a PASRR from 2021 and had mental health diagnoses. The Administrator reported the facility did not have a policy specific to PASRR.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff interview, the facility failed to assure appropriate care of a catheter for 1 resident reviewed with a catheter (Resident #37). The facility reported a census of 40 residents. Findings include: According to the Quarterly Minimum Data Set (MDS) assessment dated [DATE], Resident #37 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toileting hygiene. The resident had an indwelling urinary catheter. The resident had diagnoses including obstructive uropathy (blockage in urinary tract). The Care Plan with a goal target date of 10/23/24 identified the resident had bowel incontinence related to immobility. The interventions included checking the resident every two hours and assisting with toileting as needed, providing pericare after each incontinent episode, and utilizing briefs for dignity. The Care Plan revised 5/15/24 identified the resident required an indwelling catheter due to a diagnosis of hydronephrosis (excess fluid in a kidney) with renal and calculus obstruction. On 5/21/24 at 8:17 a.m. the resident's catheter bag hung uncovered underneath the wheelchair, with urine in the bag. The catheter tubing touched the floor. On 5/22/24 at 7:30 a.m. Staff H Licensed Practical Nurse (LPN) , Staff F Certified Nursing Assistant (CNA) and Staff G CNA went to the resident's room. The catheter tubing laid on the floor. The CNA's placed the sit to stand lift and stood the resident. They removed the resident's incontinent pad and the resident had a bowel movement (bm). Staff G wiped the resident with disposable wipes times 3 to remove the bm. Staff F then wet a cloth from soapy water in the sink and wiped the resident from behind to reveal bm, turned cloth wiped more, 3rd more and then came clean. Staff F got another cloth from the water in the sink and sprayed with peri spray. She wiped over the buttocks and anal area multiple times, then used the same cloth to wipe around in the front. Staff F placed a new incontinent pad, and the 2 CNA's transferred the resident to the wheel chair, before changing gloves with hand hygiene. Staff H stated she would do catheter care after the resident laid down after lunch. Staff did not do complete perineal care or catheter care after the resident was incontinent of bm. On 5/22/24 at 1:05 p.m. Staff H and Staff F transferred the resident to bed. Staff H sent Staff F to get a basin. Staff H then ran water in the basin and placed it at the bedside. Staff H wiped each of the resident's groins changing the side of the cloth with each wipe, then over the genital area/urinary meatus (urine outlet). She obtained a new cloth to clean down the catheter tubing, then put the cloth in the basin. Staff H dumped the remaining water in the basin down the sink. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 5:12 p.m. the Director of Nursing (DON) stated staff should not put the washcloths in the sink to prepare them for cares. Water used to provide care should be dumped in the toilet, not the sink. Complete perineal care and catheter care should be completed after a bm. When going from back (anal/buttock area) to front (perineal area) staff should change gloves with hand hygiene and obtain a new cloth. The catheter bag and tubing should remain off the floor. The Incontinent Care policy last reviewed 7/21/22 included: performing hand hygiene, applying gloves, removing soiled incontinent pad, cleansing the perineal area, thighs, rectal area and buttocks, then removing soiled gloves, doing hand hygiene, and applying clean gloves before applying a clean incontinent pad and clothing. The facility Catheter Care policy last revised 7/13/22 directed performing incontinence care per facility protocol prior to providing catheter care. The procedure included cleansing down the length of the catheter at least 4 inches.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review, and staff interview the facility failed to assure residents received the recommended dietary interventions for a history of significant weight loss for 1 of 3 residents reviewed (Resident #37). The facility reported a census of 40 residents. Findings include: According to the Quarterly Minimum Data Set (MDS) assessment dated [DATE], Resident #37 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toileting hygiene. The resident had diagnoses malnutrition. The Care Plan revised 9/5/23 identified the resident had a potential nutritional problem related to depression, hypertension. The interventions included the resident ate in the dining room (DR), and the registered dietician to evaluate and make diet change recommendations as needed. An EHR Supplement Orders dated 5/22/24 documented Resident #37 had Supplement 2.0, 3 times a day for weight loss. A Nutritional Evaluation dated 5/15/24 documented the the resident had experienced a significant weight changes, and the resident's weight slowly declined - the resident had a history of weight loss due to diuresis - received Furosemide (diuretic). The resident's body mass index (BMI) of 24.7 indicated the resident was within normal limits (WNL). The resident received a regular diet with regular texture in the dining room (DR). She selected from a self select menu- fed self - no problem chewing or swallowing, consumed 50-100% at meals with 240-480 cc's fluid, fluids and snacks were taken between meals as desired, received 60 cc's supplement 2.0, 3 times a day (TID) for additional nutrition - resident able to make needs known. The resident had a Stage 2 pressure ulcer on her right buttock and was healing, no supplements were provided at the time. Recommendations included providing ice cream at lunch and supper. On 5/22/24 at 12:08 p.m. the resident received lunch, the main meal and 2 drinks. with no ice cream. At 12:38 p.m. the resident sat at the (DR) table with no ice cream. At 12:53 p.m. staff wheeled the resident away from the DR table and she had not received ice cream. On 5/22/24 at 2:04 p.m. the Dietician stated she had recommended the resident receive ice cream and the resident should have received ice cream for lunch. The Medication Administration Record for May 2024 showed the entry for supplement 2.0, 3 times a day for weight loss with a start date of 11/10/23. The MAR showed the staff initialed the administration at 8 a.m., 12 p.m. and 6 p.m. daily. The record lacked documentation of how much was given or how much taken. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 5:12 p.m. the Director of Nursing (DON) stated they were unable to put how much of the 2.0 supplement the resident received in Point Click Care (PCC) (computer documentation program) but the resident received the typical amount of 60 cc's 3 times a day. They did not document how much the resident took. The facility Weight Variances policy last reviewed 8/9/23 included all residents who experienced significant, insidious and/or unintentional/unplanned weight loss or gains shall be assessed for nutritional status by Registered Dietitian. Recommendations from the Registered Dietitian to include but not limited to adding calorie rich/preferred snacks between meals, fortification, supplements, liberalizing diet, and plan for expected weight changes. Residents receiving supplements would be monitored for acceptance by the Dietary Manager/Nursing Staff.

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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. 50500 Based on observations, staff interview, and policy review, the facility failed to ensure dietary staff practiced food safety procedures when preparing and serving resident meals to reduce the risk of cross contamination and foodborne illness. The facility reported a census of 40 residents. Findings include: During dining observation on 5/20/24 at 12 PM, Staff A, dietary aide, observed wearing a T-shirt with numerous small holes on the front as well as a large, wet stain covering approximately 25%. No apron or clothing protector seen. During kitchen observation on 5/22/24 from 1130 am-1230 am, Staff B, dietary cook, prepared hamburger patties while pureeing lunch items. When she obtained hot water for a puree item, she was seen flipping the hamburger patties as walking by and then resumed pureeing. No hand hygiene was observed in-between these tasks. Staff B, dietary cook, also failed to obtain a final cooking temperature prior to serving the hamburger to residents. Staff B, dietary cook, worked the steam table/prepared resident lunch plates. She was observed coughing and/or sneezing numerous times into her elbow/upper shoulder area. She did turn away from the steam table to cough/sneeze but failed to perform hand hygiene on a consistent basis. Hand hygiene was completed once. Staff A, dietary aide, observed wearing a shirt with a wet, large stain on the front covering approximately 25%. No apron or clothing protection seen as he delivered resident meals from the kitchen to the dining room or resident rooms. This same staff member was observed carrying resident drinking glasses with his fingers inside the glass itself. He proceeded to fill the glasses with the desired beverage and serve to residents. Throughout the kitchen observation, the male staff member was seen gathering dirty dishes, washing dishes at the dish machine, gathering drinks/items for meal trays. No hand hygiene was observed, especially after handling dirty dishes and then putting away clean dishes or prior to serving resident plates. Staff interview with the dietary manager completed on 5/22/24 at 1 pm. The dietary manager acknowledged and also observed that a final cooking temperature was not obtained on the hamburgers. She also acknowledged the limited hand hygiene observed on Staff A, dietary aide, and Staff B, dietary cook. The dietary manager explained that Staff A, dietary aide, needed frequent reminders to perform hand hygiene as he often overlooks this step. The Nutrition Services Hand Hygiene policy with a review date of 11/27/23, indicate employees shall wash hands: 1. After coughing, sneezing, using a handkerchief or tissue 2. After handling soiled equipment (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. As much as possible during food preparation to remove soil/contamination and to prevent cross contamination 4. When changing tasks. The Nutrition Services Personal Hygiene & Appearance policy with a review date of 8/23/23, indicates Personnel shall report to work in clean uniforms according to facility policy with the facility providing aprons and protective equipment. The Nutrition Services Food Safety & Food Handling policy with a review date of 8/16/23, indicate that safe food practices shall be consistent with The Food and Drug Administration (FDA) Food Code. This includes grooming and hygiene of personnel. The FDA Food Code 2017 (9th edition) code 2-304.11 Clean Condition, indicate food service employees to wear clean outer clothing to prevent contamination of food, equipment, utensils, linens, and single-use articles. The Nutrition Services Food Safety & Food Handling policy with a review date of 8/16/23, indicate food handling practices shall be completed in a manner to protect food safety and avoid cross-contamination, to include an internal temperature and rest time of 160 for ground meats.

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50471 Based on clinical record review and staff interview, the facility failed to offer and complete the Veterans Administrator form for 1 of 3 residents reviewed for VA (Resident #30). The facility failed to file the residents paperwork for eligibility for 1 of 3 residents reviewed for VA (Resident #22). The facility reported a census of 40 residents. Findings include: 1. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident#30's admitted was 11/28/23. The facility's Action Summary, revealed Resident #30 admitted to facility on 11/28/2023. The VA paperwork was not found for Resident #30. 2. The facility's Action Summary, revealed Resident #22 admitted to facility on 8/1/2023. The paperwork was not submitted to the VA for eligibility status for Resident #22. On 05/23/24 10:55 AM the Administrator acknowledged unable to locate missing documentation for Resident #30. On 05/23/24 12:02 PM the Administrator acknowledged that paperwork was not submitted to the VA for eligibility for Resident #22. On 05/23/24 12:02 PM the Administrator stated the Social Worker completes the VA form upon admission and submits to VA.

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NAME OF PROVIDER OR SUPPLIER Adel Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Greene Street Adel, IA 50003	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49628 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (October 1 - December 31) review, facility staffing reports review, employee time cards review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 40 residents. Findings include: The PBJ Staffing Data Report run date 5/15/24 triggered for Excessively Low Weekend Staffing - submitted weekend staffing data is excessively low, and failed to have licensed nursing coverage 24 hours/day - 4 or more days within the quarter with <24 hours/day licensed nursing coverage with specific infraction dates. The report reflected 19 dates with failure to provide 24 hour/day nursing coverage. Review of Facility Daily Assignment Sheets for each day of the months of October, November and December staffing revealed staffing for nurses and Certified Nursing Assistants (CNAs) scheduled similarly for weekdays and weekends. The documents identified the CNA coverage of shifts by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) Coordinator during both weekday and weekend shifts. These specific staff worked in CNA status for 8 days in weekday coverage and 6 days of weekend coverage. Review of Facility Daily Assignment Sheets for the infraction dates revealed nursing shifts covered by the DON, ADON, and MDS Coordinator for 14/19 dates. Review of time cards for the remaining 5 infraction dates revealed nursing services were provided for 24 hours/day. On 5/21/24 at 10:40 AM the DON stated the nursing administrative staff (DON, ADON, MDS Coordinator) were salaried positions. The staff commented that the data turned in for the PBJ report was inaccurate as it was not reflecting the dates/hours the nursing administrative staff worked in CNA or nursing status, especially on the weekends. The salaried staff do not clock in and out. The DON was unable to explain why the 5 infraction dates not covered by nursing administration were triggered. In interviews on 5/22/24 at 9:36 AM and 1:20 PM the DON indicated staffing during the months of November and December were difficult requiring the nursing administrative staff work as CNAs and nurses. The DON stated that the corporation completed the PBJ reports. On 5/22/24 at 4:09 PM the Administrator confirmed the data submission for the PBJ and staffing reports were completed by the corporate office. On 5/23/24 at 12:10 PM the Regional Director of Operations confirmed the submission of the data for the PBJ was not submitted correctly, as it did not reflect the nursing administration hours worked. A third party submitted the data for the report.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on observation, record review and staff interview, the facility failed to provide care in a manner to prevent infection for 2 of 13 residents reviewed (Resident #30 and #37). The facility reported a census of 40 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #30 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toileting hygiene. The resident's diagnoses included a stroke. The Care Plan revised 5/14/24 identified the resident had potential/actual impairment to skin integrity of the buttock and arms related to fragile skin, incontinence, limited mobility moisture associated skin damage to the right and left buttock and sacrum. Interventions included providing peri care after each incontinent episode. On 5/21/24 at 11:45 a.m. Staff I Registered Nurse (RN), Staff E Certified Nursing Assistant (CNA) , Staff F CNA and Staff G CNA went in to change the resident before (wound) treatment. Staff E wet wash cloths in the sink. Staff G removed the resident's wet incontinent pad in the front, cleaned down each groin, then over the genital area including the urinary meatus (opening to urinary tract). On 5/22/24 at 11:45 a.m. Staff E, Staff F, and Staff G to do Resident #30's cares. Staff E put wash cloths in the sink to wet them with soapy water. Staff pulled back the residents incontinent pad and Staff E used a washcloth to perform cleansing of the bilateral groins and genital/urinary meatus areas. Staff E threw the wash cloth on the (carpeted) floor. Staff rolled the resident to her left. The resident had a bowel movement (bm). Staff E used disposable wipes to clean bm from the area, then used washcloths to finish cleaning the anal/buttock region. She had placed a trash bag on the floor to put the cloth in, but left the 1st cloth on the floor. When finished, she continued wearing the same gloves to place a new incontinent pad and assist to turn the resident before changing gloves. 2) According to the MDS assessment dated [DATE], Resident #37 scored 4 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident depended on staff for toileting hygiene. The resident had diagnoses including obstructive uropathy (blockage in urinary tract). The Care Plan with a goal target date of 10/23/24 identified the resident had bowel incontinence related to immobility. The interventions included checking the resident every two hours and assisting with toileting as needed, providing pericare after each incontinent episode, and utilizing briefs for dignity. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 7:30 a.m. Staff H Licensed Practical Nurse (LPN) , Staff F CNA and Staff G CNA went to the resident's room. The CNA's placed the sit to stand lift and stood the resident. They removed the resident's incontinent pad and the resident had a bowel movement (bm). Staff G wiped the resident with disposable wipes times 3 to remove the bm. Staff F then wet a cloth from soapy water in the sink and wiped the resident from behind to reveal bm, turned cloth wiped more, 3rd more and then came clean. Staff F got another cloth from the water in the sink and sprayed with peri spray. She wiped over the buttocks and anal area multiple times, then used the same cloth to wipe around in the front. Staff F placed a new incontinent pad, and the 2 CNA's transferred the resident to the wheel chair. Staff H stated she would do catheter care after the resident laid down after lunch. Staff did not do complete perineal care or catheter care after the resident was incontinent of bm. On 5/22/24 at 1:05 p.m. Staff H and Staff F transferred the resident to bed. Staff H sent Staff F to get a basin. Staff H then ran water in the basin and placed it at the bedside. Staff H wiped the resident each groin changing the side of the cloth with each wipe, then over the genital area/urinary meatus. She obtained a new cloth to clean down the catheter tubing, then put the cloth in the basin. Staff H dumped the remaining water in the basin down the sink. On 5/22/24 at 5:12 p.m. the Director of Nursing (DON) stated staff should not put the washcloths in the sink to prepare them for cares. Water used to provide care should be dumped in the toilet, not the sink. Complete perineal care and catheter care should be completed after a bm. When going from back (anal/buttock area) to front (perineal area) staff should change gloves with hand hygiene and obtain a new cloth. The Incontinent Care policy last reviewed 7/21/22 included: performing hand hygiene, applying gloves, removing soiled incontinent pad, cleansing the perineal area, thighs, rectal area and buttocks, then removing soiled gloves, doing hand hygiene, and applying clean gloves before applying a clean incontinent pad and clothing. The facility Standard Precautions policy last reviewed 10/25/2022 included Handling Soiled Equipment: a. Equipment with blood, body fluids, secretions, and excretions in a manner that prevented mucus membrane exposure, contamination of clothing and transfer of micro-organisms to others and to the environment. Linen: b. Handle, transport, and process used soiled linen in a manner that prevented skin and mucus membrane exposures and contamination of clothing and avoids transfer of microorganisms to the environment and others. The Incontinent Care policy last reviewed 7/21/22 included: performing hand hygiene, applying gloves, removing soiled incontinent pad, cleansing the perineal area, thighs, rectal area and buttocks, then removing soiled gloves, doing hand hygiene, and applying clean gloves before applying a clean incontinent pad and clothing.