STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165578	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Muscatine	3440 Mulberry Avenue Muscatine, IA 52761

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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. 50471 Based on clinical record review, observation, family and staff interview the facility failed to provide a call light system within reach and met the needs of 2 of 20 residents (Resident #29, #49) reviewed. The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) of Resident #29, dated 5/29/24 identified a Brief Interview of Mental Status (BIMS) score of 00 which indicated severe cognitive impairment. The Care Plan of Resident #29 dated 7/16/24 revealed the resident deficit with Activity of Daily Living (ADL). The care plan informed the staff to encourage the resident to use bell to call for assistance. During an observation on 7/29/24 at 9:25 am, Resident #29 did not have a call device or bell sitting on him or with in reach. During an interview on 7/29/24 at 10:40 am, Staff B, CNA stated the resident has one on the bed. Staff B attempted to locate the call device or bell, no call device or bell found. Staff B obtained new call device and clipped the call device to the Resident #29 shirt. During an interview on 7/29/24 at 10:43 AM, a family member stated does not have a call device or bell to notify the staff when he needs something. Daughter stated when the resident first arrived to the facility he did have a call device. The family member stated they visit every other day, and is unable to describe what the call device or bell. During observations on 7/30/24 Resident #29 in room, and without a call device/bell at: 1:45 pm, and 3:35 pm. On 7/31/24 the resident without a call device/bell noted in room at 7:32 am. During an observation on 7/31/24 at 1:20 pm, Resident #29 had call device clipped to shirt. 2. The MDS of Resident #49, dated 6/13/24 identified a BIMS score of 3 which indicated severe cognitive impairment.

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: 165578	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on employee file review, staff interview and facility policy review, the facility failed to ensure a current Dependent Adult Abuse certification for 1 of 5 staff members reviewed. The facility reported a census of 60 residents. Findings include: A employee file review on [DATE] revealed Staff G, Certified Nursing Assistant (CNA) revealed a hire date of [DATE]. The employee file lacked documentation of Iowa Department of Public Health (IDPH) approved Dependent Adult Abuse (DAA) Mandatory Reporter training at the time of review. The facility provided a DAA certificate dated [DATE], expired as of [DATE]. On [DATE] the facility provided a Dependent Adult Abuse Mandatory Reporter certificate dated [DATE]. A review of the nursing schedules for the time [DATE] to [DATE] revealed Staff G, CNA scheduled to work first shift on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 8:15 am the Administrator stated there had been a gap in Staff G's training. She stated the corporate office completes the verification check for new employees. The facility policy titled Abuse Prevention and Reporting Policy, issued ,d+[DATE], reviewed on ,d+[DATE] documented the following: Section IOWA Specific Instructions: Training of Employees: .Each employee shall be required to complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment. Each employee shall complete at least two hours of additional dependent adult abuse identification and reporting training every three years.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based clinical record review, staff interview, policy review and guidance from Resident Assessment Instrument (RAI) Manual, the facility failed to complete a Significant Change Minimum Data Set (MDS) Assessment within 14 days of a resident experiencing a fall with fracture, resulting in a decline in transfer and ambulation status and in increase in pain for 1 of 20 residents (Resident #50) reviewed for MDS. The facility reported a census of 60 residents. Findings include: The MDS of Resident #50, dated 3/20/24, assessed the resident independent in bed mobility, lying to sitting, sitting to standing, chair to chair transfers and toilet transfers. The MDS documented the resident denied having experienced any pain in the prior 5 days and had received no scheduled or as needed pain medications. The MDS of Resident #50, dated 5/2/24, revealed the resident sustained a major injury related to a fall since the prior MDS assessment. The MDS of Resident #50, dated 5/14/24, assessed the resident required substantial/maximum assistance independent in bed mobility, lying to sitting, sitting to standing, chair to chair transfers and toilet transfers. The MDS documented the resident received as needed pain medications, experiencing pain frequently over the last 5 days. On a scale of 1-10, 10 being the worst, resident rated pain at a 10. The Health Status Note, dated 5/2/24 at 11:08 AM, documented the resident found on the floor, her bed as high in the air as it could go, with no shoes or socks on, leaning against her bed and side table. The resident complained of severe left hip pain with any movement. The Active Diagnosis section of Resident #50's Electronic Health Record (EHR) documented a diagnosis, added on 5/8/24, of fracture of the unspecified part of the neck of the left femur. The Care Plan, dated 1/9/24, Focus Area addressed ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Trauma. With Intervention: The resident is independent with transfers/ambulation without the use of assistive devices. The Intervention, updated on 7/16/24: The resident is an assist x1 (one staff) with transfers utilizing a FWW (front wheeled walker) and gait belt. Resident utilizes wheelchair for mobility and is able to self-propel. Staff to assist resident with walk to dine utilizing gait belt, FWW and w/c (wheelchair) trail. The Care Plan, dated 5/21/24, Focus Area addressed acute/chronic pain r/t Unspecified part of neck of left hip fracture repair. The April 2024 Medication Administration Record (MAR) documented Resident #50 received acetaminophen 325 mg Give 650 mg (2 - 325 mg tabs) by mouth every 4 hours as needed for pain (PRN) a total of six doses. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 MAR documented starting on 5/10/24, the resident received 11 PRN doses of acetaminophen 625 mg every 4 hours as needed. The MAR for May of 2024 revealed the following new pain medication orders for Resident #50: a. On 5/8/24 tramadol HCL 50 mg by mouth every 6 hours as needed for pain per hospital discharge orders. The MAR documented 17 PRN doses administered for the month. b. On 5/14/24 oxycodone-acetaminiphen 5-325 mg 1 tablet by mouth every 6 hours as needed for pain per [doctor name redacted]. The MAR documented 20 PRN doses administered for the month. The MAR for July of 2024 revealed the resident rated pain as high as a 10 and continued to receive acetaminophen PRN (12 doses), and tramodol PRN (9 doses). During an interview on 7/30/24 at 9:26 am, the MDS Coordinator stated a significant change MDS should be done anytime a resident experiences a change in 2 or more areas, or if the resident enrolls or discharges from hospice. She stated Resident #50 should have had a Significant Change MDS completed and it was an oversight on her part. The Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October of 2023 documented the following: The Significant Change in Status Assessment (SCSA) is a comprehensive assessment for a resident that must be completed when the IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either major improvement or decline. A Significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting ; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. The RAI additionally documented: An SCSA is appropriate when: a. There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and b. The resident's condition is not expected to return to baseline within two weeks. The facility policy, Resident Assessment Instrument (RAI)/Minimum Data Set (MDS), dated ,d+[DATE], Procedure section revealed: (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Significant change .when identified as appropriate by the MDS Coordinator and interdisciplinary team following the guidelines, but not limited to as described in the current MDS/RAT manual. Within 14 days after the facility determines that there has been a significant change in the resident's status that will not normally resolve itself, which has an impact on one or more areas of the resident's health status and requires an interdisciplinary review and/or revision of the care plan. A significant change may be a decline or improvement that requires review or revision of the care plan. A Significant Change Assessment is completed when a resident either elects or revokes Hospice benefit even if no other change has occurred and regardless of when the last assessment was 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46873 Based on observation, clinical record review, policy review, and staff interviews the facility failed to follow the care plan for 1 of 20 residents (Resident #35) reviewed. The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) of Resident #35, dated 6/11/24, identified a Brief Interview of Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment. The MDS documented diagnoses included: non-Alzheimer's dementia, Parkinson's Disease, and prior stroke. The MDS documented the resident experienced coughing or choking during meals or when swallowing medications, and had a mechanically altered diet. The Care Plan, initiated 12/14/21, revised 7/29/24, Focus Area for Nutritional Problem the resident to have a texture altered diet with choking episodes; requires cueing at times to slow down when eating and regularly coughs with meals. Interventions, dated 3/22/24, included: resident is to eat all meals in the assisted dining room; staff member to sit with resident during meals and assist with feeding and cue on taking small bites, chewing thoroughly/swallowing prior to giving a new bite. The Care Plan identified a Focus Area of ADL (Activities of Daily Living) Self Care Performance Deficit, initiated 2/16/24. Interventions included the following dated 6/7/24: staff educated to ensure they are sitting with resident at all meals, and assisted with feeding; staff to give resident cues to take small bites, chew and swallow prior to taking another bite; take a drink in between bites, slow down when eating etc.; resident is working with ST (Speech Therapy) requesting ST to eval, to determine if diet downgrade is appropriate for resident. The Active Diagnoses section of Resident #35's Electronic Health Record (EHR) documented a diagnosis of dysphagia, oropharyngeal phase (a difficulty moving food or liquid from the mouth to the upper esophagus during the oropharyngeal phase of swallowing) dated 8/30/22. The Orders Section of the EHR identified the resident had an order of regular diet, mechanical soft texture with no bread dated 2/8/24, and discontinued 6/7/24. The resident then received an order for Regular diet, puree texture on 6/7/24. The Weight Loss; Provider Notification Note dated 2/5/24 documented: Resident must be cued to slow down as he will continue to put food in his mouth before fully emptying mouth of previous bite. Resident regularly coughs at meals despite being on a texture-altered diet; SLP (Speech Language pathologist) aware. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note, dated 3/21/24, documented the nurse paged immediately to the dining room, along with another nurse. Nurse informed Resident #35 choking on eggs. Nurse obtained the crash cart and ran to where the resident was sitting in his wheelchair. The resident was safely placed on the floor on his right side, and the nurse took over performing the Heimlich maneuver from another nurse. An additional nurse called 911. When emergency services arrived, the Heimlich successful and the resident was taken to the hospital for an overnight observation. The Health Status Note, dated 6/624, documented the resident in the dining room eating chili and choked. The Heimlich maneuver performed successfully on the resident. The note stated the nurse sat with the resident through the remainder of the meal. The Risk Management document #2816, dated 3/21/24, identified Resident #35 had a choking incident in the dining room. Note authored by Staff H, Licensed Practical Nurse (LPN). Root Cause Analysis identified as eating too fast, inhaled food and eggs got caught in throat. The Solution documented: Speech therapy, 1:1 during meals, assist with feeding, cues and reminders. The Risk Management document #2936, dated 6/6/24, identified Resident #35 had a choking incident in the dining room. Note authored by Staff I, Registered Nurse (RN). The Root Cause Analysis identified as eating too fast, not taking breaks between bites to chew/swallow. The Solution documented: staff re-educated to sit with the resident during all meals, assist with feeding, give cues to take small bites, chew/swallow prior to taking another bite. Taking drinks of fluid. ST working with resident, requesting to eval to determine if diet downgrade is appropriate. During an interview on 7/30/24 at 3:59 pm, Staff I, RN stated she saw the resident choking at the dining room table on 6/6/24. She stated a Certified Nurse Aide (CNA) was present at the table but was feeding someone else at the time and did not alert her to the episode. She stated staff should always be present at assisted tables. During an interview on 7/30/24 at 4:07 pm, Staff H, LPN stated during the incident on 3/21/24 she was at the back nursing station. She stated the resident was eating breakfast in the dining room. Staff J, LPN was monitoring the dining room. She stated a staff member came to her and told her help was needed immediately in the dining room. When she arrived, Staff J had all ready began the Heimlich. She stated she was not in the dining room at the beginning of the episode so she could not state if staff were at the table with the resident. During an interview on 7/31/24 at 7:17 am, Staff J, LPN stated she was supervising the dining room on 3/21/24. She stated Resident #35 had been served his food, and she was providing drinks to other residents. She stated she heard him cough, and turned to look at him and began to walk over to him. She stated he took another bite of food and she instructed him to stop and his coughing got worse. She stated a CNA was with her and the resident began to turn purple. She stated another staff member went to get the other nurse and 911 was called. She stated a CNA was present at the table but had not alerted her to the incident, she had heard him coughing and observed him in distress. During an observation which began on 7/31/24 at 12:00 pm, Resident #35 was observed sitting in the assisted area of the dining room eating a meal. Several staff were in the area, but no staff were sitting at the table with the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the observation Staff K, Dietary Aide was passing out bowls of pudding for dessert. Resident #35 stopped her and asked if he could have a pudding. Staff L, Certified Nurse Aide (CNA) was sitting at the next table assisting another resident with their back turned to Resident #35. Staff K asked Staff L if it was ok for Resident #35 to have pudding. Staff L turned to look at the table, and told Resident #35 it was ok for him to have pudding. Staff M, LPN was also sitting at the same table as Staff L, CNA feeding another resident. She did not appear to be looking at or monitoring Resident #35. During an observation on 7/31/24 at 12:07 pm, Staff N, CNA brought food to the table of Resident #35 and then sat down at that time to feed that resident. Resident #35 was eating for at least 7 minutes without staff being at the table with him as directed in the Care Plan. During an interview on 7/31/24 at 1:14 pm, the Director of Nursing (DON) stated staff is always in the dining room when residents are eating. She stated per Resident #35's Care Plan, they should be sitting with him. She stated Dietary staff should not serve his meal prior to staff being present. She stated staff was present during his choking episodes and the Risk Management form stating re-education provided was given as an emphasis on the importance of it. During an interview on 7/31/24 at 1:16 pm, Staff L, CNA stated the resident has dysphagia and is provided cueing as needed and eats a puree diet. He stated as long as he is being observed, it is ok for him to eat without a staff member being at the table with him. During an interview on 7/31/24 at 1:36 pm, the Dietary Supervisor stated no resident who sits in the assisted area is to receive food until a nurse is present in the assisted area. During an interview on 7/31/24 at 1:38 pm, the Registered Dietitian stated for any resident in the assisted dining room, a nurse needs to be present and no food is served until a nurse is there. She stated the dining department had received no education or instruction that Resident #35 was not to be served unless a staff member was specifically present at his table. The facility policy Care Plan Development, dated August 2015 documented the following: Care Plan Development: An individualized, comprehensive care plan using the results of the RAI/MDS assessment, resident/family/legal representative and interdisciplinary input will be developed for each resident in the facility . and describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental and psychosocial well-being. Procedure: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The care plan is integral to the provision of care to the resident and will be available to team members who are responsible for providing care and services. The completed care plans will be maintained in the resident's clinical record. All team members are responsible for reporting any changes to the resident's condition to the primary/charge nurse and of any goals or objectives not being met. Any changes must be reported to the MDS coordinator for review. Documentation must be consistent with the resident's plan of care and revisions will be done on an as needed basis and can be done by any member of the Interdisciplinary team.

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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. 50471 Based on observation, clinical record review, policy review, and staff interviews, the facility failed to follow physician orders for 1 of 20 residents (Resident # 44). The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) assessment of Resident #44, dated 6/26/24, identified a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS listed diagnoses included: hypotension, diabetes mellitus, depression, and seizure disorder. The MDS revealed Resident #44 prescribed insulin and an antidepressant. The Care Plan, dated 3/18/24, Focus Area to address The Resident has impaired visual function r/t (related to) Diabetes. Interventions included: Arrange consultation with eye care provider practitioner as required. During on observation on 7/29/24 at 9:08 AM Resident #44 in room, lying on bed. The resident wore a blue and white eye patch on their left eye. During an interview on 7/30/24 at 8:20 AM Staff D, Registered Nurse (RN) stated the Resident #44 had LASIK eye surgery on 7/26/24. Staff D stated the eye patch is on at HS (at night) and off in AM only for protection. When queried regarding post operative orders, the Assistant Director of Nursing (ADON) presented Post -Operative Instructions, dated 7/27/24 . The instructions included orders: a. Neomycin (dark pink cap) - apply 1 drop to the operative eye four times a day for 1 week. Then you may discontinue the medication unless otherwise instructed. b. Atropine (red cap) - apply 1 drop a day to the operative eye (for sensitivity to light). c. Prednisolone acetate (light pink cap) - HOLD this drop the first week. Then, apply 1 drop to the operative eye on a taper as follows, unless otherwise instructed: 1 drop four times a day for 1 week; 1 drop three times a day for 1 week; 1 drop twice a day for 1 week; 1 drop once a day for 1 week; discontinue the drop. d. Wear eye protection such as glasses or sunglasses during the day, and a hard shield over the operative eye at night. A review of the July 2024 Medication Administration Record (MAR), and Treatment Administrator Record (TAR) revealed a lack of neomycin, atropine, and prednisolone acetate, and eye protection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 12:20 pm, the Assistant Director of Nursing (ADON) stated eye drop orders were not initiated. The ADON stated staff completed a medication error report, and the eye surgeon notified. During an interview on 7/31/24 at 3:14 pm, the Administrator stated the facility follows industry standards for initiating/following physician orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, clinical record review, staff and family interview, and policy review, the facility failed to provide supplemental oxygen as ordered for 2 of 2 resident reviewed for respiratory care (Resident #22 & #163). The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS) listed diagnoses for Resident #22 included: heart failure, respiratory failure with hypoxia (low oxygen in body), and diabetes mellitus. The MDS revealed the residents BIMS score as 8 out of 15, indicating a moderate cognitive impairment. The MDS documented Resident #22 experienced shortness of breath, or trouble breathing with exertion (activity such as walking, bathing), when lying flat, and received oxygen therapy. A Progress Note, dated 7/6/24, revealed inpart, Hospice nurse from [hospice provider name redacted] came to facility, new orders for 1. Change current oxygen order to 1-4 liters/min via nasal cannula. A review Physician Orders revealed an order, dated 7/6/24 for Oxygen inhale 1 to 4 L/min (liters per minute) via nasal cannula (tubing in nose delivering oxygen from source) continuous. During an observation on 7/28/24 at 5:15 PM, Resident #22 wearing a nasal cannula connected to an oxygen tank. The gauge on the oxygen take noted to be on 0 (zero) which indicated the tank was empty. A review of Weights and Vitals revealed on 7/18/24 and 7/26/24 documented oxygen saturation taken by Room Air (no supplemental oxygen being used) method. The Care Plan, dated 5/2/24, Focus Area addressed The resident has COPD (chronic obstructive pulmonary disease). Interventions included: Give oxygen therapy as ordered by the physician. 2. The Admission MDS, dated [DATE], for Resident #163 identified a BIMS score of 10 out of 15, indicating a moderate cognitive impairment. Diagnoses listed included: heart failure, atrial fibrillation (irregular heartbeat), and chronic obstructive pulmonary disease (COPD). The MDS revealed the resident received oxygen therapy. An review of Physician Orders revealed a 7/9/24 order for Oxygen at 2 liters per minute via NC at bedtime (HS), and as needed (PRN) for dyspnea (difficulty breathing). It also included an order dated 7/24/24 which directed staff to keep oxygen saturation between 89-91% with avoiding excessive oxygenation and to monitor every shift. During an observation on 7/28/24 at 5:50 pm, Resident #163 noted to be connected to an oxygen tank via nasal cannula (NC). The oxygen gauge was noted to be on 0, indicating an empty tank. During an interview on on 7/29/24 at 9:09 am, a family member stated oxygen tanks were discovered empty a few times when the resident first admitted [admitted [DATE]]. (continued on next page)

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Premier Estates of Muscatine	3440 Mulberry Avenue Muscatine, IA 52761

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record (TAR) dated July 2024 included shift monitoring documentation but lacked documentation of oxygen saturation levels. During an interview on 8/01/24 at 12:11 pm, the Director of Nursing (DON) stated staff should ensure tanks are full and monitor and notify the nurse to change oxygen tanks that are low or empty. A policy, dated 6/15/21, titled Oxygen Administration Nasal Cannula Purpose: To provide the resident/patient with enhanced oxygen concentration of inspired room air. Procedure #14. Monitor the oxygen flow rate and oxygen saturation, as ordered.

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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, psychiatry progress notes, and staff interview the facility failed to attempt a gradual dose reduction (GDR) of psychotropic medications when the resident no longer exhibited behaviors for which the medications were prescribed for 1 of 5 (Resident #3) residents reviewed. The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], identified a Brief Interview of Mental Status (BIMS) score for Resident #3 of 6 out of 15, indicating a severe cognitive impairment. The MDS recorded 2-6 days of the resident reporting little interest or pleasure in doing things and no days of feeling down, depressed or hopeless in the 2 weeks prior. The MDS documented no physical or verbal behaviors directed towards others during the 7-day look back period. The MDS dated [DATE] documented the identical scores and documentation as the prior MDS. No change in cognitive status, depression or behaviors. The Care Plan identified a Focus Area, revised 5/1/2020 of socially inappropriate behaviors. The Care Plan identified a Focus Area, initiated 8/7/23 of use of anti anxiety medication related to anxiety disorder. The Care Plan identified a Focus Area, initiated 8/7/23 of use of antidepressant medication related to depression. The Treatment Administration Record (TAR) for the months of April, May, June and July 2024 r/t Behavior Monitoring lacked documentation of the resident having any negative behaviors. The Psychiatry Progress Note dated 2/22/24 noted: No changes to Paxil (an anti depressant medication) or Klonopin (an anti anxiety medication) at this time. Reducing any of the medications would not achieve the desirable therapeutic effects and the current dose is necessary to maintain the resident's function and quality of life. Staff will continue to redirect the resident. The note documented the resident has continued making inappropriate sexual comments but tends to stop when redirected. The Psychiatry Intake Note dated 4/2/24 noted: the resident was started on Paroxetine (Paxil) on 12/31/23 for hypersexual behaviors, particularly sexually oriented comments and discussions about his penis. This medication has seemed to help. Then he fell on [DATE] and sustained a subdural hemorrhage. Since then, staff have continued to notice a decrease in his hypersexual behaviors and no apparent adverse changes to his mental health. The Plan section of the Intake note stated depression, anxiety and hypersexual behaviors are stable on current medication regimen and no medication changes recommended. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychiatry Progress Note dated 7/12/24 noted: Collateral from nursing reveals no concerns about his mood. He is occasionally sexually inappropriate in his conversation but is fairly easily redirected. They report he just has no filter. He has not had any falls. The note further stated no psychiatric medication changes today. Patient is stable on current regimen with no adverse reaction noted. Dose reduction not indicated at this time as it could be detrimental to the stability of the patient's mental health. The Progress Notes from the Resident #3's Electronic Health Record (EHR) failed to reveal any documentation of any anxiety, depression or sexually inappropriate behaviors in a review of the notes for 2024. During an interivew on 7/30/24 at 1:20 pm, the Director of Nursing (DON) stated the resident still has some behaviors and they should be charted in behavior monitoring. She noted no behaviors had been charted recently and stated the facility could attempt a GDR. The facility policy, dated 5/2014, titled Behavior Management Procedures section indicated: 6. Develop goals and interventions on the care plan with input from the resident/patient and/or family/responsible party. Refer to the Care Plan Development Process in this program. Care plan to include, but not be limited to: a. Parameters for monitoring condition b. Non-pharmacologic interventions c. Dose reduction/elimination 10. Monitor and document behaviors and response to interventions in the resident/patient medical record. 11. Attempt a gradual dose reduction as ordered by the physician unless clinically contraindicated.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, menu review, and policy review, the facility failed to serve appropriate diet for 1 of 1 residents (Resident #12) with a low sodium diet order, and 1 of 1 residents (Resident #5) with a double protein diet order. The facility reported a census of 60 residents. Findings include: 1. The Minimum Data Set (MDS), dated [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated intact cognition. The diagnoses list included: atrial fibrillation (A Fib - irregular heartbeat), anemia, heart failure, and osteomyelitis (bone infection). The MDS indicated the resident had Stage 3 and Stage 4 pressure ulcers present on admission. A review of Physician Orders, dated 7/5/24, identified a Regular diet, Regular texture, Regular fluid, thin consistency. Directions included: DOUBLE PROTEIN. The Physician Orders revealed Double protein at all meals directions started on 12/23/23. A Pressure Ulcer Notification document dated 3/07/24 revealed the resident's blood albumin (protein in the blood used for tissue repair) level was 3.1 grams/deciliter (g/dL). A normal albumin level is 3.4 - 5.4 g/dL. The document indicated the resident ordered double protein with meals. During an interview on 7/29/24 at 10:53 am, Resident #5 stated he is supposed to get double protein for wound healing. The resident stated he is not always getting double protein. During a continuous lunch service observation that began on 7/31/24 at 11:20 AM, Resident #5's lunch tray was plated with one (1) serving of turkey & rice casserole and one (1) serving of green beans. During an interview on 7/31/24 at 12:55 pm, Resident #5 stated he did not get a double portion of protein. During an interview on 7/31/24 at 1:30 pm, the Registered Dietitian stated a double portion for Resident #5 would have been two (2) servings of the turkey & wild rice casserole. During an interview on 7/31/24 at 2:00 pm, the Assistant Director of Nursing (ADON) confirmed Resident #5's double protein at meals was due to his low albumin level and was for wound healing. 2. The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, heart failure, peripheral vascular disease, hypertension, renal failure, hyperlipidemia, and Non-Alzheimer's dementia. The Care Plan revised 7/29/24 directed staff to provide and serve 2 g Na+ (sodium) regular texture, thin liquids diet as ordered. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order dated 5/01/24 identified the resident's diet as two (2) gram sodium diet, regular texture, regular fluid, thin consistency. During a continuous lunch service observation on 7/31/24 at 10:55 AM, Staff C, [NAME] was observed plating a regular diet serving of turkey & rice casserole for Resident #12. On 7/31/24 at 1:30 PM, the Registered Dietitian stated the resident doesn't adhere to her diet. A document titled Menu Planning Guide updated 3/2022 indicated a low sodium diet is needed for controlling edema or hypertension. During an interview on 8/01/24 at 12:11pm, the Director of Nursing (DON) stated staff should check and ensure the correct diet is served to the resident.

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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 facility policy review, the facility failed to maintain sanitary practices by improperly storing and serving food. The facility reported a census of 60 residents. Findings include: On 7/28/24 at 5:20 pm, an initial kitchen observation revealed: 1) An opened box of various yellow, green, and orange items in an opened blue plastic bag in the R-Plus freezer. 2) A shelf of opened, undated seasoning containers. 3) Two (2) pot roasts thawing out on a baking sheet on a tray cart beside the oven. During an interview on 7/28/24 at 5:30 pm, Staff C, Cook, stated the pot roasts were thawing out to use for dinner the following night. The manufacturer's thawing instructions direct staff to place roast in the refrigerator for 48 hours to thaw. During an observation on 7/28/24 at 5:45 pm, Staff C prepared a peanut butter sandwich with gloves on each hand. After making the sandwich, Staff C held the peanut butter container with her left hand and used her right hand to scoop some out on a knife. She spread the peanut butter on a slice of bread and repeated the process. She placed the knife on the food preparation table, put the lid back on the container, picked up the container and placed it on the shelf beneath the table. Without changing gloves or performing hand hygiene, Staff C picked up the sandwich with her gloved hands, placed it on a plate and put it on the serving counter. Another staff member served the sandwich to a resident. During a continuous observation on 7/31/24: a. At 11:35 am, Staff E, [NAME] touched kitchen utensils and equipment with gloved hands then placing her thumbs inside sandwich bags to dump the sandwich out. Each sandwich came in direct contact with the area where her thumb contacted. b. At 11:45 am, Staff E put on a pair of gloves and began placing slices of cheese on bread. She picked up a large, white bag of potato chips from under a food preparation table, placed the bag on the food serving counter, opened the bag and took some potato chips with the same gloved hands out of the bag and placed them on two (2) separate residents' plates. c. At 11:53 am, Staff C wore gloves and placed a resident's lunch ticket on a plate stacked on the food service counter. She rearranged other lunch tickets then moved the ticket off the plate. She picked up the plate, placed food for another resident on it, then served it through the food service window. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. At 12:07 pm, Staff C reached for a resident's tray to slide it back on a service rack and her ungloved fingers touched the resident's bread. She looked down at her hand, moved it from off the resident's bread, then covered the plate. Another staff member delivered the resident's tray to him. During an interview on 12:20 pm, Staff C stated the food preparation table used for pureeing residents' food was wiped with sanitizer and a rag. She identified the sanitizer bucket she used to clean the prep table. During an observation at 12:28 pm, Staff C performed a sanitizer solution test on the bucket she used to clean the prep table. She dipped the sanitizer test strip in the solution for 10 seconds, removed it and compared it to the color identifier on the test strip cartridge. She stated the solution did not change color which indicated 0 parts-per-million (ppm) of sanitizing solution was present in the sanitizer bucket. The Registered Dietitian stated the solution did not last as long as the manufacturer had indicated. A document titled Sanitation Storage dated 6/2015 directed staff to pour contents of opened canned goods into a plastic container with label and date. It also directed staff to place dry goods in plastic bags and sealed or plastic containers. It also indicated sanitizing solution may be maintained in a bucket or spray bottle if labeled and diluted according to manufacturer directions. A document titled Sanitation & Food Production dated 6/2015 directed staff to implement critical control points to prevent, reduce, and/or eliminate hazards related to food contamination such as: a) appropriate handwashing b) foods stored and thawed at proper temperatures c) food stored in appropriately labeled containers d) proper cleaning and sanitizing of surfaces and equipment On 8/01/24 at 12:11 PM, the Administrator stated staff should put a receive date, open date, and identifier on everything in the kitchen. She also stated staff should change gloves between food service and touching non-food items and should follow the facility's policies regarding the sanitizer solution.

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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** 47079 Based on observation, record review, staff interview, and policy review, the facility failed to implement infection control practices to prevent cross contamination of invasive medical devices. The facility reported a census of 60 residents. Findings include: The Minimum Data Set (MDS) dated [DATE], indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated severely impaired cognition. Diagnoses listed included: cerebrovascular accident (stroke), non-Alzheimer's dementia, hemiplegia, and seizure disorder. The MDS identified Resident #13 used an indwelling catheter. During an observation on 7/29/24 at 11:56 AM, Resident #13's indwelling urinary catheter tubing observed lying on the floor and the drainage bag in a dignity bag lying partially on the floor. During an observation on 7/29/24 at 1:56 PM, Staff A, Certified Nurse Aide (CNA) emptied Resident #13's catheter drainage bag. She performed hand hygiene and donned gloves, no gown worn. Staff A unhooked the drainage bag from the bed rail, and laid the tubing and drainage bag on the floor with part of the bag exposed. She obtained a graduated cylinder (container for measuring urine) from the bathroom, returned to the resident's bedside and picked up the drainage bag. Staff A unclamped the spigot and drained the urine into the container. She clamped the spigot and secured against the drainage bag. Staff A emptied the urine in the toilet, and removed her gloves. Without completing hand hygiene Staff A walked to the nurses' station and threw the gloves in the trash. Without completing hand hygiene, Staff A picked up a pen and put it in her right pocket, walked down the hall and got a mechanical lift and entered another resident's room. The Care Plan dated 7/02/24 included the indwelling catheter and directed staff to check tubing for kinks each shift, after cares, and as needed and to position the catheter bag and tubing below the level of the bladder and away from the entrance door. The Electronic Health Record (EHR) included progress notes which indicated the resident complained catheter discomfort on 7/02/24; 7/04/24, and 7/08/24 and was changed on 7/08/24. It also included an order for Foley output every shift for Foley care. A document titled Catheter Care dated 01/13 directed staff to remove gloves and wash hands immediately after emptying the urine in the toilet and rinsing the collection container. On 8/01/24 at 12:11 PM, the Director of Nursing (DON) stated staff should remove gloves and perform hand hygiene prior to leaving the resident's room.