STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165602	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, interviews, and the facility policy, the facility failed to give the resident meal choices prior to the meals for 1 of 1 resident reviewed for choices (Resident #58). The facility reported a census of 61 residents. Findings include: Resident #58's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included a diagnosis of Stage 4 chronic kidney disease. During an interview on 6/25/24 at 11:16 AM, Resident #58 described the quality of the food as not good. During an interview on 6/25/24 at 11:27 AM, Resident #58 stated the staff brought her meals without letting her pick what she wanted. She heard other people got choices. She states no one came around and told her what the meals are and they didn't give her a menu. Resident #58 stated if she didn't like the food, she just wouldn't eat it. On 6/27/24 at 8:14 AM, Resident #58 stated they just brought her breakfast. She repeated they just brought it to me. Observed a plate covered with foil with a glass of white milk. The resident sat up, removed the foil, and revealed one small waffle with 3 sausage links laid on the plate. Resident #58 reported the amount of food she had, wouldn't fill her up. During an interview on 6/27/24 at 10:56 AM, Staff A, CNA (Certified Nurse Aide), stated the girls from the kitchen go ask the residents what they want for their meals and then wrote it down. She stated the kitchen staff asked Resident #58 what she wanted, but Staff A didn't know for sure if they asked her 100% of the time. Staff A stated she heard the residents complain that they no one asked them what they wanted from the kitchen, so Staff A called down to the kitchen to let them know what the residents wanted. During an interview on 6/27/24 at 12:16 PM, Staff C, CNA, stated sometimes she saw kitchen staff ask the resident what they wanted, but not all the time. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 1:12 PM, Staff E, Dietary Staff, stated the resident could always select from the always available menu if they didn't like the main menu. Staff E stated between 2:00 PM and 4:00 PM, two of them from the kitchen went to the 3 halls and asked the residents what they wanted for meals. Staff E stated she went into Resident #58 room. Staff E stated Resident #58 never picked her meals, but never complained. During an interview on 6/27/24 at 1:19 PM, the Dietary Manager stated they provided an always available menu to the residents. She stated the kitchen staff went and asked all the cognitive residents what they wanted unless they were asleep or not in their room. The Dietary Manager stated they would try and circle around to get the residents they missed earlier. The Dietary Manager stated sometimes they asked Resident #58 and sometimes she wasn't in her room. The Dietary Manager stated the kitchen didn't keep the papers they used to take the residents requests for their meals. The Dietary Manager stated some residents said they didn't receive a choice and others forgot they ordered something. During an interview on 6/27/24 at 3:12 PM, the Dietitian stated Resident #58 had every right to choose what she wanted to eat. The Dietician added Resident #58 could pick other things and should receive choices regardless. During an interview on 6/27/24 at 4:44 PM, the Administrator said they gave the residents alternatives. She stated felt confident the staff asked her and knew the Dietary Manager went into her room. During an interview on 6/27/24 at 4:51 PM, the Corporate Nurse stated they needed to figure out why no one went into Resident #58's room. The Facility Food Preparation Guidelines Policy dated January 2023 directed to offer residents appropriate alternatives when they chose not to consume food/drink when the first receive it or when they request a different food/drink choice.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review, staff interview, and facility policy review, the facility failed to notify the Ombudsman of a resident's hospitalization for 1 of 2 residents reviewed for hospitalization (Resident #28). The facility reported a census of 61 residents. Findings include: Resident #28's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The Progress Note dated 3/11/24 at 1:40 PM indicated someone called the nurse to Resident #28's room for a need to transfer to hospital. The facility's provider saw resident that afternoon with new orders (N.O.) to send to them to the emergency room (ER). The nurse called report called to the ER nursing staff and completed a situation, background, assessment, recommendation (SBAR) assessment, transfer assessment and sent them with Resident #28. The Nursing Note dated 3/12/24 at 4:38 PM reflected, Resident #28 returned to the facility around 4:00 PM. The March 2024 Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #28's hospitalization on [DATE]. On 6/27/24 at 4:01 PM when queried about ombudsman notification, the Social Worker, explained received training if a resident went out of the facility for overnight, then she would notify, but if they only left for an hour or so they told her not to do that. The Facility Policy titled Transfer and Discharge (including AMA (against medical advice)) revised April 2023 instructed the Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman. They may send them when practicable, such as a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, interviews, and the facility policy, the facility failed to accurately code antiplatelet medication, insulin, and hospice services for 4 of 23 residents reviewed for Minimum Data Set (MDS) assessment (Residents #21, #22, #25, and #34). The facility reported a census of 61 residents. Findings include: 1. Resident #34's MDS assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included a medical diagnosis of diabetes mellitus (DM). The MDS reflected Resident #34 received insulin 7 out of 7 days in the lookback period. The Care Plan Focus dated 10/20/23 indicated Resident #34 had type II DM and used insulin glargine. The interventions dated 10/20/23 directed to give diabetes medication as ordered by the doctor. The EMR (Electronic Medical Record) revealed the medical diagnosis for type II DM without complications. The Clinical Physician Orders reviewed on 6/27/24 included an order dated 10/19/23 for Insulin Glargine subcutaneous (SubQ - just under the skin in the fat tissue) solution pen injector 100 unit/milliliter (ML). Inject 10 units SubQ one time a day. - The order discontinued on 2/9/24 The EMR lacked insulin orders after 2/9/24. During an interview on 6/27/24 at 4:56 PM, the Administrator stated the MDS needed coded for hypoglycemics and not the insulin injections for Resident #34. 2. Resident #22's MDS assessment dated [DATE] identified an incomplete BIMS exam due others rarely or never understanding her. The MDS included a diagnosis of Alzheimer's disease with late onset. The MDS indicated Resident #22 didn't receive hospice services while a resident. The Care Plan Focus dated 6/2/24 reflected Resident #22 received Hospice Services. The Interventions dated 6/2/24 indicated Resident #22 chose Hospice, but needed the staff to continue to offer her food, fluids, and assist her as long as she could consume them. The Intervention instructed to coordinate all of her needs with the Hospice team. Resident #22's Census reviewed on 6/26/24 listed her primary payer as Hospice Medicaid starting 11/7/23. The Clinical Physician Orders reviewed on 6/26/24 identified an order on 9/1/23 for a Hospice evaluation and treatment per spouse's preference. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/24 at 4:56 PM, the Administrator stated Resident #22 MDS needed checked yes for hospice services. The Maintaining MDS Assessments policy revised on September 2023 instructed the staff to make the MDS information available to all professional staff members who needed to review the information in order to provide care to the resident. The policy lacked documentation regarding the accuracy of the MDS assessment. 45338 3. Resident #21's MDS assessment dated [DATE] identified they had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #21 took an anticoagulant medication and didn't take antiplatelet medication. The Clinical Physician's Order reviewed on 6/27/24 included an order dated 10/19/22 for clopidogrel bisulfate (Plavix - antiplatelet medication) tablet 75 milligrams (MG). Give 1 tablet by mouth one time a day for Cerebrovascular accident. Resident #21's April 2024 Medication Administration Record (MAR) lacked administration of anticoagulant medication for Resident #21. 4. Resident #25's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS listed Resident #25 took an anticoagulant (blood thinner) medication and did not receive antiplatelet (makes the blood cells less sticky to prevent them from sticking together) medication. The Clinical Physician Orders reviewed on 6/24/25 included orders from March 2024 for clopidogrel (Plavix) and Aspirin medications daily. The National Library of Medicine regarding Antiplatelet Medications dated 11/7/22 listed Aspirin and clopidogrel as antiplatelet medications. Resident #25' April and 2024 MARs lacked administration of anticoagulant medication. On 6/27/24 at 5:15 PM, the Administrator acknowledged Plavix as an antiplatelet medication.

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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** 47336 Based on record review, interviews, and the facility policy, the facility failed to follow the special recommendations as directed by the Preadmission Assessment Screening and Resident Review (PASRR) Level II for 1 of 2 residents reviewed (Resident #34). In addition, the facility failed to submit the PASRR level II in a timely manner for 2 of 2 residents reviewed (Residents #2 and #34). The Level II Special Recommendations directed the facility to designate a Power of Attorney (POA) for Resident #34. The facility reported a census of 61 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS included diagnoses of anxiety, depression, and post traumatic stress disorder (PTSD). The MDS revealed resident took antianxiety and antidepressant medications during the 7 day lookback period. The Care Plan Focus dated [DATE] indicated PASRR identified Resident #2 needed specialized services due to their mental health diagnoses. The interventions dated [DATE] reflected activity not a specialized service, but an important component in the delivery of effective behavioral health services and must be implemented in order to see the completion and comprehensive mental health treatment records. As the records follow Resident #2 to her various providers in order to facilitate most effective delivery of services. The Electronic Medical Record (EMR) included the following Medical Diagnoses: a. agoraphobia with panic disorder b. panic disorder (episode paroxysmal anxiety) c. major depressive disorder, recurrent, mild d. PTSD, unspecified The Notice of PASRR Level II Outcome completed on [DATE] identified the facility submitted a level 1 Screen seeking approval of continued nursing facility level of care to ensure Resident #2 had the help she needed to take care of herself due to the expiration of her prior 30-day hospital exemption on [DATE]. The facility submitted the Level I screen on [DATE], almost 1 year after the expiration of the prior PASRR approval thus causing a federal compliance issue for the nursing facility. During an interview on [DATE] at 4:42 PM, the Director of Nursing (DON) confirmed the PASRR shouldn't lapse During an interview on [DATE] at 4:43 PM, the Administrator confirmed the PASRR shouldn't lapse. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #34's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS included diagnoses of schizophrenia. Resident #34 took antipsychotic medications during the 7 day lookback period. The Care Plan Focus dated [DATE] indicated Resident #34 had a short term nursing facility approval from PASRR. The approval expired on [DATE], resulting in the need to address all PASRR identified specialized or rehabilitative services on the care plan. The EMR revealed the medical diagnosis for paranoid schizophrenia. The Notice of PASRR Level II outcome dated [DATE] listed the expiration for their short-term approval as [DATE]. The PASRR level II outcome dated [DATE] directed the following information for rehabilitative services: a. Resident #34 needed the following services and/or supports: - The individual needs to designate [NAME] of Attorney (POA) for Healthcare and Financial matters in order to serve as substitute decision makers in the event of incapacity, assist with decision making, and support the individual's health, resource management, and/or safety. Resident #34's EMR (Electronic Medical Record) lacked documentation regarding a designated POA. The facility provided a screenshot for Resident #34 for a PASRR assessment submission on [DATE] at 10:01 AM. During an interview on [DATE] at 7:46 AM, the Administrator stated a 6-month PASRR in May and they told her she needed to submit a brand new PASRR and she didn't know she needed to do that. During an interview on [DATE] at 2:29 PM, the Social Worker stated she couldn't find anything for the PASRR being put in earlier and so they put in a new one. The Social Worker stated the PASRR definitely shouldn't lapse. The Social Worker stated the resident currently had court appointed advocate. During an interview on [DATE] at 4:28 PM, the DON declared Resident #34's son as her person of contact and the resident court ordered. The DON stated the PASRR shouldn't lapse. During an interview on [DATE] at 4:38 PM Administrator stated she read the PASRR as Resident #34 only needed a POA in case of incapacity. The Administrator described Resident #34 as cognitive and made her own decisions. The Facility Resident Assessment PASRR Program Policy revised on [DATE] directed if a resident who didn't require a screening due to an exception and the resident remains in the facility longer than 30 days: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility must screen the individual using the State's Level I screening process and refer any resident who had or may have had mental disorder, intellectual disorder or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination. 2. The Level II resident review needed completed within 40 calendar days of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review, the facility failed to ensure each resident had a comprehensive individualized care plan that accurately reflected the resident's plan of care for 4 of 23 residents reviewed (Residents #22, #25, #28, and #60). The review of the 4 residents Care Plans failed to address diabetes, a peripherally inserted central catheter (PICC), use of antibiotics, wounds, hospice level of care, and use of oxygen therapy. The facility reported a census of 61 residents. Findings include: 1. Resident #25's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS included a diagnosis of diabetes mellitus. Resident #25's Medical Diagnoses reviewed 6/25/24 listed a diagnosis added in 2022 of type 2 diabetes mellitus without complications. The Care Plan Focus revised 3/20/23, indicated Resident #25 had a potential of alteration in nutritional status related to stroke (CVA), weakness, depression, and needed a mechanically altered diet due to (d/t) poor dentition (teeth). The Intervention revised 5/14/24 directed to encourage him to make healthier choices for his diabetic management. Resident #25 didn't have an interest in changing to a diabetic diet at that time. Resident #25's Care Plan lacked additional interventions or a focus area specific for diabetes mellitus. The Clinical Physician Orders reviewed on 6/25/24 included an order dated 6/11/24 for Basaglar (long-acting insulin) Kwikpen 100 unit/milliliter (UNIT/ML). Inject 25 units subcutaneously (subQ) at bedtime for type 2 diabetes mellitus. On 6/27/24 at 2:11 PM, when asked about a focus area related to diabetes to the Corporate Nurse and the Director of Nursing (DON), the Corporate Nurse explained she didn't see it, and explained if the facility monitored Resident #25 and did blood sugars, they expected the Care Plan include diabetes. 2. Resident #28's MDS assessment dated [DATE] identified a BIMS score of 11, indicating moderately impaired cognition. The MDS indicated Resident #28 used oxygen while at the facility. Resident #28's Care Plan failed to address the use of oxygen. The Physician Order dated 4/29/24 revealed, Oxygen at 2 liters per nasal cannula (L/NC) to keep oxygen saturation (SPO2) above 88% continuously as needed for shortness of breath. On 6/24/24 at 12:50 PM observed Resident #28 receiving oxygen via the nasal cannula. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 2:22 PM when questioned about the inclusion of the use of oxygen on the Care Plan with the facility's Director of Nursing (DON) and Corporate Nurse, they initially responded they didn't know because Resident #28 received hospice services. The Corporate Nurse acknowledged yes. 48888 3. Resident #60's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #60 had infection of the foot, a diabetic foot ulcer, and other open lesions of the foot. Resident #60 required intravenous (IV) medications and used antibiotics on admission. The MDS lacked an area to chart the type of IV medications used after admission and before discharge. The Care Plan Focus created 4/8/24, reflected Resident #60 had a skin integrity impairment related to cellulitis and fragile skin. The Intervention instructed staff to monitor and document the location, size, treatment of skin injury, report abnormalities, failure to heal, and signs/symptoms of infection to Provider. The Care Plan lacked documentation of Resident #60's current wounds or interventions to prevent and heal their current wounds. In addition, the Care Plan lacked documentation for the monitoring and care of Resident #60's central venous line (PICC line) or instruction for infection monitoring related to antibiotic administration via PICC line. A Weekly Skin Assessment, dated 6/25/24, revealed Resident #60 had 5 wounds on his right foot which included ulceration to tip of right great toe, scabs with black (eschar) tissue to right 3rd, 4th, and 5th toes, and a scabbed, discolored red, boggy (squishy) texture wound to right inner foot. Assessment revealed ulcer initially observed on 5/7/24. On 6/27/24 at 10:10 AM watched Staff O, Registered Nurse (RN), perform wound care to Resident #60's right foot. The observation revealed pale, dry, flaky skin to the right lower extremity with a dark purple hue of discoloration scattered throughout the right foot and lower leg. The right ankle appeared swollen with an area of redness over his inner ankle bone. Resident #60 had limited range of motion of the right ankle and toes. Staff O cleansed the wounds to right great toe, 3rd, 4th, and 5th toes. She applied Betadine to the scabbed black colored wounds and Mupirocin (antibacterial) ointment to the outside of his right great toe. Staff O revealed the Nurse Practitioner visited Resident #60 weekly to monitor his wounds, in addition to his appointments with the Podiatrist, orders for IV antibiotics, and his weekly lab draw to monitor for signs of infection related to his right foot wound infection. On 6/27/24 at 2:29 PM, Director of Nursing (DON) reported she expected the Care Plan include his infections, IV infusions, and ulcerations. She confirmed Resident #60's Care Plan lacked the documentation of his right foot wounds, PICC line, and IV antibiotics. 47336 4. Resident #22's MDS assessment dated [DATE] identified an incomplete BIMS exam due others rarely or never understanding her. The MDS included a diagnosis of Alzheimer's disease with late onset. The MDS indicated Resident #22 didn't receive hospice services while a resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan Focus dated 6/2/24 reflected Resident #22 received Hospice Services. The Interventions dated 6/2/24 indicated Resident #22 chose Hospice, but needed the staff to continue to offer her food, fluids, and assist her as long as she could consume them. The Intervention instructed to coordinate all of her needs with the Hospice team. Resident #22's Census reviewed on 6/26/24 listed her primary payer as Hospice Medicaid starting 11/7/23. The Clinical Physician Orders reviewed on 6/26/24 identified an order on 9/1/23 for a Hospice evaluation and treatment per spouse's preference. During an interview on 6/27/24 at 2:00 PM, the DON stated the Care Plan addressed Resident #22's hospice level of care under the nutritional focus area dated 11/7/23 and related to the assistance with meals. The DON confirmed Resident #22's Care Plan needed a specific Focus related to hospice with interventions from when Resident #22 started those services. The Facility Care Plan Revision Upon Change policy dated January 2023 instructed to review and revise the comprehensive care plan as necessary, when a resident experienced a status change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on interviews, record review, and facility policy review, the facility failed to ensure a resident received their medication. In addition, the facility failed to ensure the Certified Medication Aide (CMA) administered a resident's medication under their name and did not hold the medication cup in their hand in their shirt pocket prior to administration to the resident for 2 of 2 residents reviewed for professional standards (Residents #33 and #45). The facility reported a census of 61 residents. Findings include: 1. Resident #33's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The Clinical Physician Orders reviewed on 6/27/24 listed the following medication orders of white pills: a. tramadol (pain medication) 50 milligrams (mg) 2 tablets b. gabapentin (pain medication) 600 mg 1 tablet c. meclizine (medication for dizziness) chewable 25 mg 1 tablet d. buspirone HCl (hydrochloride) (antianxiety medication) 5 MG 1 tablet e. Requip (restless leg syndrome medication) 0.5 mg 1 tablet f. potassium chloride 20 mEq (milliequivalent) 1 tablet g. acetaminophen 325 mg 2 tablets h. Vitamin C 500 mg 1 tablet Resident #33's June 2024 Medication Administration Record (MAR) lacked documentation that Staff I, CMA, administered medications. The MAR reflected Staff K, Licensed Practical Nurse (LPN), administered Resident #33 medications on 6/24/24. On 6/24/24 at 1:03 PM, observed Staff I tell Resident #33, she had her pills in her pocket. Staff I had her hand in her pocket and pulled her hand out of the pocket, then handed Resident #33 a medication cup with white pills in it. Resident #33 counted the pills and then took them. Staff I remarked Resident #33 had Tramadol and a few other pills in the cup. (continued on next page)

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Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:40 AM, Staff I stated she just finished the CMA orientation that Monday. She went to Staff J, Human Resources, around 1:00 PM to 2:00 PM, but she didn't have access yet. Staff I stated she worked under a nurse's log in. Staff I explained she had Resident #33's pill cup in her hand in her pocket since her cart sat at the end of the hallways and she didn't want the pills exposed. Staff I stated the pills never touched her hand and she didn't put anything else in her shirt pockets. Staff I stated she didn't remember what medications she gave Resident #33 as she just started learning the medications. During an interview on 6/27/24 at 4:06 PM, Staff J stated the CMAs should have their own log in and should not pass medications under another staff member. Staff J stated on Monday, Staff I stated she needed a log in because she didn't need to do her shadowing anymore. Staff J stated she didn't see where she administered any medications that day. Staff J stated Staff I had medication administration access, but the computer didn't show she passed medications on Monday. During an interview on 6/27/24 at 4:22 PM, the Director of Nursing (DON) said the medications should never be in a pocket and the CMA told her about it. The DON explained with Staff I being brand new to the position they considered her training and someone should have signed them out or been with her. During an interview on 6/27/24 at 4:40 PM, the Corporate Nurse confirmed she didn't see Staff I sign out Resident #33 medications on 6/24/24 on the MAR. During an interview on 6/27/24 at 5:13 PM, Staff K reported she didn't work on 6/24/24 and as a CMA worked that day. Staff K stated the CMA might have used her log in. Staff K stated no, it wasn't a common practice and the CMA should have used a day shift nurse's log in or called Staff J for a log in. 2. Resident #45's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. During an interview on 6/24/24 at 2:23 PM, Resident #45 stated one nurse gave her the wrong pills 4 times. Resident #45 said she caught it twice. She reported it happened on a Saturday and Sunday, then on a Wednesday and Thursday by the same nurse. Resident #45 stated she didn't want to identify the nurse. The Progress Note dated 6/18/24 at 10:24 PM, reflected Resident #45 received the wrong medications at bedtime (HS). The provider said to take her blood pressure (BP) about 3 times and to notify her if the systolic (top number of the blood pressure) number was less than 85. First time the blood pressure read 142/58 and an hour later read 136/55. The resident said she felt fine. The Incident Report #1566 for Medication Error dated 6/18/24 at 10:33 PM reflected Resident #45 received wrong medication at HS. Resident #45 said she thought they were hers to take. The nurse called the provider notified her of the error. The provider said to take her BP 2 3 times and if systolic gets below 85 notify her. The Intervention directed to review the medication pass rights. The Progress Note dated 6/18/24 at 10:46 PM, indicated Resident #45 took the wrong pills at HS and said she thought they were hers. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 6/19/24 at 3:33 AM, indicated a BP of 130/70 at midnight and 124/64 at 3:00 AM, Resident #45 stated she felt fine. The Interdisciplinary Team (IDT) Note dated 6/19/24 at 9:26 AM identified the IDT met on 6/19/24 to review Resident #45's medication error on 6/18/24 with receiving the wrong medication. Resident #45 didn't have any adverse reactions. The facility followed through with the physician orders to monitor for any potential reactions. The facility notified the Physician, Power of Attorney (POA), Administrator, and DON. Since the error occurred Resident #45 didn't have adverse reactions. The staff continued to monitor for any potential side effects and reported to Advanced Registered Nurse Practitioner (ARNP). Per email from the Administrator on 6/26/24 at 3:29 PM, Resident #45 received Resident #58's medications of carvedilol (high blood pressure medication), nifedipine (high blood pressure medication), and trazodone (antidepressant). Resident #58's Electronic Medical Record (EMR) included the following medication orders: a. nifedipine tablet 60 mg extended release (ER) take one tablet twice daily b. trazodone tablet 100 mg take 1 tablet at bedtime c. carvedilol tablet 6.25 mg take 1 tablet by mouth twice daily During an interview on 6/27/24 at 1:38 PM, Staff N, Registered Nurse (RN) stated she filled out the incident report for Resident #45's medication error. Staff N stated she didn't administer the medications, she stated she had someone else's medications in her hand. A CNA came out of Resident #45's room and asked her for help, so she went into Resident #45 room, put the medication down, and helped Resident #45. When Staff N finished helping Resident #45, she walked out of the room and when she got down the hall, she realized she left the pills in Resident #45 room. By the time she got back to Resident #45's room, she took the pills because the CNA told her to. Staff N stated Resident #45 usually counted her pills. During an interview on 6/27/24 at 4:52 PM, the DON stated the nurse caught the medication error and notified the physician. The DON reported it as a miscommunication and Resident #45 told her to come to her room. The DON stated it shouldn't have happened, the nurse had no intent, and it wasn't a significant medication error. The DON stated the nurse should have followed the medication rights. The DON described the medication rights as the right resident, right medication, right time, right dose, and right route. The Facility Medication Administration Policy dated September 2023 directed to remove medication from the source, taking care not to touch medication with their bare hand. The policy instructed to sign the MAR after administering the medication. Compare medication source (bubble pack, vial, etc.) with the MAR to verify the resident name, medication name, form, dose, route, and time.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review, the facility failed to follow-up after a resident had documentation of no bowel movement from 6/17/24 through 6/23/24. In addition, the facility failed to perform adequate assessment of a non pressure wound for two of three residents reviewed for assessment and intervention (Residents #3 and #51). The facility reported a census of 61 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status score of 11, indicating moderately impaired cognition. The MDS listed Resident #3 had frequently incontinence of bowel without constipation. The Clinical Physician Orders reviewed on 6/25/24 included an order dated 4/19/23 for Dulcolax (bisacodyl) rectal suppository 10 MG. Insert 1 suppository rectally every 24 hours as needed for constipation. The Physician order dated 4/19/23 revealed, Milk of Magnesia Oral Suspension (Magnesium Hydroxide) with directions to give 30 ml orally every 24 hours as needed for constipation. The Task documentation reflected Resident #3 didn't have a bowel movement (BM) on 6/17/24, 6/18/24, 6/19/24, 6/20/24, 6/21/24, 6/22/24, and 6/23/24. Resident #3's June 2024's Medication Administration Record (MAR) identified lacked documentation indicating she received the following medications: a. Dulcolax suppository not given from 6/17/24 through 6/23/24. b. Milk of Magnesia (MOM) not administered on 6/22/24 at 12:37 PM. On 6/27/24 at 10:19 AM, when questioned about who charted BMs, Staff L, Certified Nurse Aide (CNA)/Certified Medication Aide (CMA), responded the CNA. Staff L explained the electronic health record (EHR) had an alert process to notify the nurse if a resident didn't have a BM, or the CNA would tell the nurse. On 6/27/24 at 5:17 PM during an interview with the facility's Administrator, Director of Nursing (DON), and Corporate Nurse, they explained the EHR sent a notification and would tell if the resident didn't go for three days. If they didn't go for three days, then the nurse should give MOM, then follow up to see if the resident had results. If not, the nurse should let the doctor know. The alert also came up on the dashboard, and the staff charted the BM under tasks. Resident #3 would say if they didn't have a BM, and the staff may not have charted her response. The Bowel Management Policy, dated 9/13/21 instructed the nurse to check the dashboard daily for BM's noted in the 3 day alerts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #51's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. The MDS reflected Resident #51 had a diabetic foot ulcer. On 6/26/24 at 9:48 AM observed Staff B, Licensed Practical Nurse (LPN) complete the wound treatment on Resident #51's right heel. Resident #51's May 2024's Treatment Administration Record (TAR) included the following orders a. Dated 4/29/24 until 5/7/24 to apply Mepilex to left inner heel blister every day shift every 2 days and as needed for wound care. - Documentation reflected the treatment completed on 5/1/24, 5/3/24, 5/5/24, and 5/7/24. b. Dated 5/8/24 to 5/11/24 to order apply calcium alginate to her right inner heel blister, cover with mepilex, change every day shift AND as needed for wound care. The Weekly Wound Skin Assessment (Single) dated 4/29/24 reflected Resident #51 had a blister on her left heel that measured 2.2 centimeters (cm) long by 2.5 cm wide. The Weekly Skin Review V3 assessment dated [DATE] indicated Resident #51 had a blister on her right heel, that measured 2.2 x 2.5 cm. On 6/27/24 at 2:14 PM during an interview with the Director of Nursing (DON) and Corporate Nurse, they explained Staff M, Registered Nurse (RN), did the wounds. The DON explained Resident #51's wound started out as a blister. The DON reported Resident #51 never had a left foot wound that she knew of. On 6/27/24 at 2:46 PM Staff M explained Resident #51 had a big wound on her heel. When queried as to which heel, Staff M responded her right heel. Staff M reported it started initially as a blister that ruptured. Staff M added Resident #51 never had a wound on her left side and since she knew, she never had two wounds on her heel. Staff M explained she should have corrected the order and the treatment order. The Facility Policy titled Wound Treatment Management revised January 2023, did not address the area of concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on record review, interviews, and facility policy review, the facility failed to keep a resident free from injury while repositioning them in bed for 1 of 3 residents reviewed for accidents (Resident #22). This resulted in Resident #22's head hitting the bed rail. The incident caused a bruise to Resident #22's forehead. The facility reported a census of 61 residents. Findings include: Resident #22's MDS assessment dated [DATE] identified an incomplete BIMS exam due others rarely or never understanding her. The MDS included a diagnosis of Alzheimer's disease with late onset. The Care Plan Focus dated 2/15/23 indicated Resident #22 had a potential for impaired skin integrity related to fragile skin. The Interventions dated 2/15/23 directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. The Incident Report #1542 dated 6/5/24 at 11:39 AM reflected as a Certified Nurse Aide (CNA) changed Resident #22. They rolled her to the left side, where she hit her head on the grab bar of her bed that resulted in a bruise. Resident #22 couldn't give a description of the incident. The nurse notified the Advanced Registered Nurse Practitioner (ARNP), completed neurological checks (neuro checks), and measured the bruise on her forehead. The predisposing physiological factors listed Resident #22 had fragile, sensitive skin, confusion, and incontinence. The Progress Interdisciplinary Team (IDT) Note dated 6/11/24 at 4:43 PM indicated the IDT met on 6/7/24 to review Resident #22's bruise on her forehead after hitting the grab rail while a staff member turned her to her side while completing peri care. The nurse notified the Power of Attorney (POA), Director of Nursing (DON), and of the bruise. During an interview on 6/26/24 at 3:55 PM, Staff B, Licensed Practical Nurse (LPN) recalled the incident and said they had 3 CNAs in the room changing Resident #22. As Resident #22 reached for the grab bar, they rolled her, and she hit her head on the grab bar. Staff B stated she thought they went to fast because sometimes Resident #22 can be hard to move and other times she moved easily. Staff B stated they told her that Resident #22 hit her head. Staff B didn't think they intentionally did it. Staff B stated she completed a neuro check and sent the picture of the bruise to the doctor, who directed to continue to monitor Resident #22 per protocol. On 6/27/24 at 2:26 PM, Resident #22 laid in her bed and lightly snored with the bed in low position. A pillow placed up against the bed rail on the side towards the wall and a floor mat in place beside her bed. During an interview on 6/27/24 at 10:01 AM, Staff F, CNA, said Resident #22 didn't really help much with repositioning and she pushed against the bed and grabbed and pinched at you. Staff F stated when he repositioned her, he pulled her towards him so she wouldn't push against the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 10:39 AM, Staff D, CNA stated Resident #22 sometimes pushed against you and held on to her brief when they tried to help her. Staff D described Resident #22 as hard to run but she put a pillow by the railing because she would rather her head hit the pillow than the bar. During an interview on 6/27/24 at 12:09 PM, Staff C, CNA, described the incident on 6/5/24. She said she rolled Resident #22 on her side, who hit her head on the grab bar. Staff C stated Resident #22 usually hit the staff, the wall, or grabbed the bar. Staff C stated she thought Resident #22 got nervous when they moved her. Staff C stated as she went to the put the sling under Resident #22, she grabbed her bed chux, lifted her to her side, when she hit the bed rail with her head. Staff C stated she went and told the nurse right away so she could look at it. Staff C stated she didn't think Resident #22 laid far enough in the middle of the bed and that the reason she hit her head. Staff C stated Resident #22 didn't hit very hard. During an interview on 6/27/24 at 4:33 PM, the DON, stated Resident #22 took her arms and resisted. The DON stated they did an evaluation for repositioning and therapy worked with Resident #22. During an interview on 6/27/24 at 4:34 PM, the Corporate Nurse stated they struggled because of Resident #22's size, her position too close to the side, and when she went forward hit her head. The Corporate Nurse stated they conducted competencies for turning and repositioning and conducted a screening on the bed rail. During an interview on 6/27/24 at 4:36 PM, the DON stated she expected the staff to ask for help when they had resistance. The DON stated Resident #22 responded to redirection. The Facility Safe Resident Handling and Transfer Policy revised on September 2023 instructed all residents required safe handling when transferring to prevent or minimize the risk for injury to themselves and the employees that assist them. Lift and transfer residents according to the residents' individual plan of care.

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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** 48888 Based on observations, staff interview, clinical record review, and facility policy review, the facility failed to follow the physician's order for continuous administration of oxygen for 1 of 3 residents reviewed (Resident #12) for respiratory care. The facility reported a census of 61 residents. Findings include: Resident #12's Minimum Data Set (MDS), dated [DATE], reflected she had severely impaired cognition. Resident #12 had shortness of breath at rest, while lying flat, and with exertion. The MDS included diagnoses of ventricular tachycardia (abnormal heart rate), atrial fibrillation (abnormal heart rate affecting breathing), heart failure, cerebrovascular accident (CVA), and non Alzheimer's dementia. The MDS indicated Resident #12 used oxygen therapy during the 7-day lookback period. The Care Plan initiated 6/6/24 included the following Focuses a. Resident #12 had an altered cardiovascular status related to atrial fibrillation and myocardial infarct (MI or heart attack). - The Interventions instructed the staff to provide oxygen as ordered by the physician. b. Resident #12 required oxygen therapy. - The Interventions directed staff to monitor for signs and symptoms of respiratory distress and report to the physician as needed. The Physician's Order Summary, dated 6/26/24, revealed an active order, initiated 6/6/24, to administer oxygen at 3 liters per minute via nasal cannula (L/NC) continuously, every shift. Review of a verbal order, dated 6/6/24, instructed to provide oxygen continuously every shift, at 3L/NC signed by Resident #12's medical provider on 6/7/24. On 6/26/24 at 9:58 AM, observed Resident #12 in the dining room, with an oxygen tank attached to the back of his wheelchair with no oxygen tubing connected to the oxygen tank. Resident #12 sat in the dining room, without his oxygen during the continuous observation from 9:58 AM until 10:45 AM. On 6/26/24 at 11:05 AM, observed Resident #12 again in the dining room without oxygen. The oxygen tank remained attached to back of wheelchair without oxygen tubing connected to oxygen tank for administration. On 6/26/24 at 11:15 AM, Resident #12 sat in his bedroom, with his oxygen concentrator on and connected to tubing. Resident #12 wore his nasal cannula for oxygen administration. Staff G, Certified Nursing Assistant (CNA), instructed Resident #12 to breath in through his nose and out through his mouth. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:37 AM, Staff G reported Resident #12 wore oxygen at all times but often didn't comply with keeping his oxygen tubing in place. On 6/25/24 at 12:12 PM, Resident #12 sat in dining room, oxygen tank remained attached to back of wheelchair without the oxygen tubing attached. Resident #12 remained without oxygen for the entire continuous observation from 12:12 PM until 12:29 PM. Resident #12's oxygen concentrator stayed in his room, on but not in use, set to 1.5 L of oxygen. On 6/27/24 at 04:12 PM, Director of Nursing (DON), revealed Resident #12 had continuous oxygen order for a diagnosis of Congestive Heart Failure (CHF) and reported Resident #12 often didn't comply with keeping his oxygen tubing in place. The DON said the staff should ask Resident #12 if he wanted to wear oxygen while he ate. The Nursing Services and Sufficient Staff policy, revised September 2023, instructed the facility have licensed nurses with the specific competencies and skill set necessary to care for resident's needs as identified through resident assessments and described in plan of care. In addition, the policy directed the facility to have nurse aides are able to demonstrate competency in skills and technique necessary to care for residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on observation, record review, interviews, and facility policy review, the facility failed to have enough staff in the dining room during lunch to assist residents with eating and help a resident out of the dining room to the bathroom. This resulted in an incontinent episode in the dining room for 4 of 10 residents reviewed for insufficient staffing (Residents #17, #33, #41, and #45). The facility reported a census of 61 residents. Findings include: 1. Resident #17's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. Resident #17 required total assistance with toilet hygiene and needed supervision/touching assistance with toilet transfers. The MDS included a diagnosis of non Alzheimer's dementia. The Care Plan Focus dated 2/5/24 reflected Resident #17 had a risk related to gait/balance problems, incontinence, poor communication/comprehension, and vision/hearing problems. The Interventions dated 2/5/24 directed the staff to anticipate and meet Resident #17's needs. The Care Plan Focus dated 6/3/22 indicated Resident #17 had mixed incontinence related to impaired mobility. The Interventions revised on 6/27/24 instructed the staff to offer frequent reminders of the location of their room and aide in timely toilet use due to her forgetfulness. If needed, or if urgent, the staff should assist Resident #17 to his room. During an observation on 6/26/24 at 12:49 PM, Staff B, Licensed Practical Nurse (LPN) sat in the dining room in the lower level hallway at a table with 4 other residents and assisted one resident eat. Resident #17 sat in his wheelchair at a table nearby and stated he needed to go to the bathroom. Staff B instructed the resident on how to get to his room to go to the bathroom. Resident #17 started to propel himself in his wheelchair towards the door and kept saying he wasn't going to make it. Staff B continued to encourage him to move towards his room as she helped assist another resident. Resident #17 stated it was too late and witnessed a wet spot under his wheelchair in the dining room. Staff B stood up from the table and pushed Resident #17 outside of the dining room doorway while calling down the hall for assistance. When she returned she performed hand hygiene and then went back to assisting a resident eat. Staff B was the only staff member present in the dining room during that time. Resident #22 sat in her wheelchair with her food in sippy cups in front of her and didn't receive assistance with her food until Staff B finished helping the other resident. On 6/26/24 at 12:55 PM, observed Staff B and another staff member at the table sitting next to each other to help assist residents with food. During an observation on 6/26/24 at 12:57 PM, Staff B assisted Resident #22 eat her food from sippy cups. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #33's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #33 required total assistance with toilet hygiene. The MDS listed Resident #33 as always incontinent of urine and frequently incontinent of bowel. During an interview on 6/24/24 at 12:43 PM, Resident #33 stated it took a long time for someone to help her change. She stated she will turn on her light, they come in, say they will be back, and no one returns. Resident #33 stated she wouldn't turn her call light on again and she goes off the shows she watched that ran between an hour and an hour and half. She stated it took them at least 20 minutes to show up and she believed it happened because they didn't have enough staff. Resident #33 stated they only had 2 aides to work the hall. 3. Resident #45's MDS assessment dated [DATE] identified a BIMS score of 13, indicating intact cognition. Resident #45 required partial to moderate assistance with rolling from left to right, sitting to lying, lying to sitting, sitting to standing, chair/bed to chair transfer, and toilet transfers. During an interview on 6/24/24 at 2:23 PM, Resident #45 stated the facility didn't have enough help. Resident #45 stated they only scheduled one nurse for the whole facility and she received the wrong pills 4 times but she caught it before she took them. Resident #45 stated the other night they gave her 5:00 PM medication at 8:45 PM. 4. Resident #41's MDS assessment dated [DATE] identified a BIMS score of 10, indicating moderately impaired cognition. Resident #41 required total assistance with toilet hygiene, rolling left to right, and chair/bed to chair transfer. The MDS listed Resident #41 as always incontinent of bowel. During an interview on 6/25/24 at 8:54 AM, Resident #41 stated when he used his call light it took a half an hour for anyone to come and sometimes it took longer. Resident #41 stated he knew how long it took because of his clock on the wall in front of him. During an interview on 6/26/24 at 1:27 PM, Staff B stated the Certified Nurse Aides (CNAs) usually helped the residents eat. Staff B stated they normally scheduled 3 aides in the hall and 2 helped with dining assistance and one aide worked the hall during meals. Staff B stated the hall only had 2 CNA because of one CNA being at an appointment with a resident. Staff B added they usually had a shower aide that assisted with meals but they didn't schedule bath aides on Wednesdays. Staff B stated when Resident #17 needed to use the restroom, he needed to go pretty quickly. Staff B stated they typically push him out to the hallway so an incontinent episode didn't happen. Staff B reported when the hallway had three CNAs working, they could manage the tasks. (continued on next page)

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	165602	A. Building B. Wing	06/27/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/24 at 10:58 AM, Staff A, CNA, stated on one hallway they assist one resident with eating in their room and then assist 4 residents in the dining room with eating. Staff A stated the staff needed to keep an eye on Resident #17 because of his incontinence and he would urinate in the hallway. Staff A stated the medication aide, the nurse, and the shower aide helped assist the residents with eating, while one CNA went down the hallway with the food cart, passed out meals, and answered call lights. Staff A stated it could be a stretch at meals times and sometimes no one worked the hall. Staff A stated the facility wanted staff in the dining room during meals. Staff A stated the facility asked staff to work their days off for appointments, but if they didn't want to, they pulled staff from the floor to go to the appointments. Staff B stated yesterday the hall downstairs started with 3 CNAs, but one left to go to an appointment with a resident, from 10:45 AM until around 3:00 PM, leaving 2 CNAs in the hall. During an interview on 6/27/24 at 12:14 PM, Staff C, CNA stated when 3 CNA staffed they had enough staff and when they only had 2 CNA, they made it work and got the work done, but the residents didn't get the care they deserved right away because they couldn't be everywhere. During an interview on 6/27/24 at 5:32 PM, the Director of Nursing (DON) reported they had pretty high staffing, and every day was different, but usually the dining room had plenty of staff. The DON stated they called us when they needed additional help. The DON stated the nurse called her and when she got down there, the nurse told her to get housekeeping to clean the floor and the CMA just got back to the dining hall. The DON stated she believed they had better staffing then they used to, and in this situation, they called her and she came down to help. The DON stated they hired a shower aide for Monday, Tuesday, Thursday, and Friday. The DON described the day before as a rare situation, they were overstaffed, and she came down to help. On 6/27/24 at 5:39 PM, the Administrator stated she believed the situation resulted from a lack of communication, not a lack of staffing, and if they knew they could grab a CNA from an upstairs hallway. The Nursing Services and Sufficient Staff Policy dated September 2023 direct the facility to provide sufficient staff with appropriate competencies and skills sets to assure residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. In addition, the policy defined providing care included, but not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45338 Based on observation, interview, and record review, the facility failed to ensure they followed the for residents who received a pureed diet. The meal lacked pureed cornbread as directed on the menu for one of one observation of the puree process. The facility reported a census of 61 residents. Findings include: The Week 4 Wednesday Diet Spreadsheet directed the following meal for pureed: a. 1 serving of puree barbecue pork b. 1 serving puree potato salad c. 1 serving puree creamy coleslaw d. 1 serving puree cornbread/margarine e. #8 scoop cinnamon applesauce f. 6 fluid ounces coffee or hot tea g. 8 fluid ounces milk On 6/26/26 at 11:08 AM observed Staff H, Cook, prepare the pureed pork, potato salad, and coleslaw. Staff H failed to puree cornbread as directed in the menu. The Diet Type Report sheet reviewed on 6/26/24 listed five residents had a pureed diet with one additional resident who requested a pureed diet. On 6/27/24 at 1:25 PM, the Dietary Manager explained the might have missed the cornbread the day before, and acknowledged the meal should have cornbread. The Food Preparation Guidelines policy revised January 2023, instructed the cook, or designee, shall prepare the menu items by following the facility's written menus and standardized recipes.

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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. 45338 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner. In addition, the facility failed to test the low temperature dish machine temperature and chemical level. The facility reported a census of 61 residents. Findings include: On 6/24/24 at approximately 10:40 AM during the initial tour of the kitchen revealed the following: a. Bins of cornstarch and sugar contained scoops stored inside of the bin in the product. b. Observation of the chest freezer revealed two bags of hamburger in bags that had openings and exposed to air. A few loose tater tots observed in one storage compartment inside of the chest freezer. c. Loose debris observed on the bottom level inside of the bread refrigerator. d. One open and undated container of cultured sour cream observed in Refrigerator 5. When asked when the sour cream got open, the Dietary Manager responded probably over the weekend, and acknowledged they should have dated the sour cream. On 6/24/24 at 11:35 AM when questioned about testing the dishwasher, the Dietary manager acknowledged they didn't use strips to test at that time. The Dietary Manager explained they used an automatic chemical, there used to be strips, and if out of temperature they would call the supplier. On 6/27/24 at 3:35 PM, the Registered Dietician (RD) explained in communication with the Dietary Manager (DM), the RD told the DM they needed to test the temperature and PPM (parts per million), and that the food service provider should have a log for that. The Food Preparation Guidelines policy revised January 2023, instructed food shall be prepared by methods that conserve nutritive value, flavor, and appearance. This included, but not limited to storing food in a manner to minimize exposure to light and air. 48888 2. On 6/26/24 at 12:20 PM, observed the dietary staff bring the portable steam table from main kitchen to the upper level hallway dining room. They served plates from the steam table to the residents sitting in the dining room. On 6/25/24 from 12:32 PM to 12:47 PM, the dietary staff plated the food for residents who ate in room. Staff G, Certified Nursing Assistant (CNA), and Staff L, CNA, received the residents' plated food from the dietary staff, stationed at steam table. They carried the plates uncovered through the hallway to 6 different resident rooms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 1:19 PM, the DM, revealed the facility lacked lids to cover plates for residents who ate in their room but recommended the staff cover the food with foil during the transportation of plates in hallway.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47336 Based on staff interview, review of CMS 2567 reports, and facility Quality Assurance and Performance Improvement (QAPI) Plan, the facility failed to ensure an effective QAPI process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey previously identified during the surveys completed in the last fifteen months. The facility reported a census of 61 residents. Findings include: a. The CMS 2567 form from the recertification, compliant, and incident survey dated 3/13/23 to 3/20/23 reflected the facility received a deficient practice for no actual harm level citations for MDS (Minimum Data Set) accuracy, care plan timing and revision, professional standards, and respiratory care. b. The CMS 2567 form from a complaint survey dated 5/1/23 to 5/9/23 revealed the facility received a deficient practice for actual harm for free from accident hazards; and no actual harm level citation for care plan timing and revision, in addition to, assessment and intervention. c. Review of the facility's CMS 2567 form from a complaint and incident survey which occurred 5/20/24 to 5/23/24 revealed the facility received a no actual harm level citation for assessment and intervention, insufficient staffing, and food procurement and sanitation. The facility's current recertification survey, entrance date 6/24/24, resulted in a no harm level deficient practice for assessment and intervention of residents; services provided meet professional standards, care plan timing, MDS accuracy, respiratory care, free from accident hazards, and food procurement and sanitation. During an interview on 6/27/24 at 5:40 PM, the Administrator stated they kept a process in Quality Assurance (QA) until it met substantial compliance, usually between 3 to 6 months. The Administrator stated they go over the repeat tags and do a lot of audits. They involved QA in the process and make sure to check the completion of things. The Administrator stated if they miss a care plan, they fix it. During the interview on 6/27/24 at 5:50 PM, the Corporate Nurse stated if a process didn't work, they updated the process. She stated the facility did a whole new process with the new citation deficiencies. The QAPI Policy dated April 2022 instructed to develop and implement appropriate plans of action to correct identified quality deficiencies. Process how the committee conducted activities necessary to identify and correct quality deficiencies. The key components of the process included: a. Tracking and measuring performance b. Establishing goals and thresholds for performance improvements. (continued on next page)

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	c. Identify and prioritize quality deficiencies. d. Systemically analyze underlying causes of systemic quality deficiencies. e. Develop and implement corrective action or performance improvement activities. f. Monitor and evaluate the effectiveness of corrective action/performance improvement activities and revision as needed.