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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205170	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellows Health Care Center	85 Caron Lane Auburn, ME 04210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to promote care for residents in a manner that maintained the residents' dignity and respect when staff failed to cover the resident's briefs during resident observations and failed to dress a resident prior to being seated for breakfast on 1 of 3 days of survey (3/18/25) (Resident #116, #1 and #66). Findings: 1. On 3/18/25 at 8:58 a.m., Resident #116, was being assisted during ambulation with a walker, to his/her room from the dining room; the surveyor observed that his/her [NAME] was open exposing his/her incontinence brief. At this time, the surveyor discussed the dignity concern with the Activities staff who was assisting the resident. The Activities staff stated she was just helping him/her walk back because the floor was wet. The staff continued to allow Resident #116 to ambulate with his/her incontinence brief exposed. 2. On 3/18/25 at 9:05 a.m., during observation of dining, Resident #1 was sitting at the dining room table eating breakfast, wearing a [NAME] and a zip up sweatshirt. In a brief interview with Resident #1, the surveyor asked if it bothered him/her that he/she is eating breakfast in a [NAME], he/she stated, yes. The surveyor asked if he/she would like to be dressed prior to eating breakfast, he/she stated Yes and he/she likes to get dressed daily. 3. On 3/18/25 at 9:25 a.m., during observation of dining, Resident #66 was observed walking in the dining room to his/her bedroom with assistance from CNA #1, at this time the surveyor observed his/her [NAME] was open exposing his/her incontientce brief. At 9:27 a.m., during an interview with CNA #1 reguarding dignity concerns, the CNA stated that she usually covers the residents up so that their incontinence brief is not showing. The CNA then states they were just taking him/her to the bathroom. On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and the Director of Nursing.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that Minimum Data Set (MDS) Version 3.0 Assessments were accurately coded in the area of Active Diagnosis for 1 of 21 sampled resident. (#5) Finding: Review of the resident's medical record indicated he/she had diagnoses of Hypertension, Hyperlipidemia and Diabetes. Resident #5's Quarterly MDS assessment dated [DATE] and Quarterly MDS assessment dated [DATE] lacked coding under Active Diagnosis to indicate the resident had a diagnosis of Hypertension, Hyperlipidemia and Diabetes. On 3/19/25 at approximately 3:40 p.m. in an interview with the Director of Nursing, surveyor confirmed the MDS assessment dated [DATE] were not coded accurately to reflect the current status of the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Findings: 1. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #1 in the dining room with oxygen at 2 Liters Per Minute (LPM) via a nasal cannula. Review of the medical record showed a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) requiring continuous use of oxygen supplementation and peripheral neuropathy requiring pain management with most recent increase of Gabapentin 200 mg (milligrams) on 1/7/25. Review of Resident #1's care plan recently updated with a target date of 3/2025, lacks evidence of goals and interventions for either COPD or pain management. 2. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #6 in the dining room with oxygen at 2 LPM via a nasal cannula. Review of the medical record showed a diagnosis of congestive heart failure and respiratory failure requiring continuous use of oxygen supplementation and presence of a cardiac pacemaker with pacemaker checks every 3 months. Review of Resident #6's care plan recently updated with a target date of 3/31/2025, lacked evidence of goals and interventions for either congestive heart failure or the presence of a cardiac pacemaker. On 3/18/25 at 2:52 p.m., the above was discussed with the Assistant Director of Nursing. 3. Review of Resident #14 medical record shows an active medication order for Tramadol 50 mg take 1 tablet 2 times daily, with the start date of 9/16/24. Further review of Resident #14 medical record lacks evidence of goals and interventions being put into place for pain management. On 3/19/25 at 2:02 p.m., the above information was confirmed with the Director of Nursing. Based on observations, record review, and interviews the facility failed to update/implement goals and interventions for 2 of 2 residents reviewed for pain management, 1 of 1 resident reviewed for Chronic Obstructive Pulmonary Disease (COPD), 1 of 1 resdients reviewed for congestive heart faliure and a cardiac pacemaker (Resident #1, #6, #14).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to provide Activities of Daily Living (ADL) care in the area of personal hygiene for 1 of 1 residents reviewed for ADL care (Resident #1) for 3 of 3 days of survey. Findings: On 3/18/25 at 9:05 a.m., Resident #1 was observed in the dining room with his/her right hand having several rings, the pinky ring had white coated debris stuck to the ring. At 9:18 a.m., A Certified Nurses Aid (CNA) and him/her if he/she would like to get dressed and freshened up for the day, the resident agreed. At 10:14 a.m., the resident was observed in his/her recliner and dressed appropriately. The pinky ring was still coated with the white dried debris. On 3/19/25 at 7:25 a.m., on 3/20/25 at 7:55 a.m., and at 9:15 a.m., Resident #1 was observed, by 2 surveyors, in the dining room with his/her pinky ring coated with white dried debris. Review of the Minimum Data Set (MDS) 3.0 Quarterly assessment dated [DATE], section GG - Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands states Resident 31 requires substantial/maximal assistance to complete the task. Review of the CNA documentation for March 2025 indicates Resident #1 is dependent to substantial assist for personal hygiene. On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and the Director of Nursing.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all facility staff maintain training in cardiopulmonary resuscitation (CPR) for Healthcare Providers. Findings: On [DATE] at 11:17 a.m., During an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) state that it is not a requirement for facility staff to have their CPR certification besides nurses. Review of employee records show there are 2 full time staff members who are CPR certified and 2 per-diem staff members who are CPR certified. A review of the facility staffing with CPR certification for the month of March had the following shifts where there were no staff available with current CPR certification: -[DATE] night and evening shift did not have any staff who were current in their CPR certification. -On [DATE] evening shift did not have any staff who were current in their CPR certification -On [DATE] evening and night shift did not have any staff who were current in their CPR certification -On [DATE] night shift did not have any staff who were current in their CPR certification -On [DATE] evening and night shift did not have any staff who were current in their CPR certification -On [DATE] night shift did not have any staff who were current in their CPR certification -On [DATE] day and night shift did not have any staff who were current in their CPR certification -On [DATE] 5 hours on day shift and all of evening shift did not have any staff who were current in their CPR certification - On [DATE] night shift did not have any staff who were current in their CPR certification -On [DATE] evening and night shift did not have any staff who were current in their CPR certification -On [DATE] evening and night shift did not have any staff who were current in their CPR certification -On [DATE] night shift did not have any staff who were current in their CPR certification (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE] 4 hours on evening shift and all of night shift did not have any staff who were current in their CPR certification -On [DATE] evening and night shift did not have any staff who were current in their CPR certification -On [DATE] night shift did not have any staff who were current in their CPR certification -On [DATE] night shift did not have any staff who were current in their CPR certification -On [DATE]night shift did not have any staff who were current in their CPR certification Review of the facilities Cardiopulmonary Policy states: Personnel have completed training on the initiation of Cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest . Preparation for Cardiopulmonary Resuscitation 1. Obtain and/or maintain American Red Cross or American Heart Association certification in BLS/CPR for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel . 4. Select and identify a CPR team for each shift in case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue efforts and directing other team members during the rescue effort . 5. The CPR team in this facility shall include at least one nurse, one Licensed Practical Nurse, and two Certified Nursing Assistance, all of whom have received training and certification in CPR/BLS. On [DATE] at 3:00 p.m., the Facility Administrator confirmed there are 4 of 24 residents who are a Full Code and could potentially require CPR however, all residents are at risk for choking.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, interviews and the facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident # 1 and #6). Findings: 1. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #1 in the dining room with Oxygen (O2) at 2 Liters Per Minute (LPM) via a nasal cannula. The nasal cannula (nc) prongs were discolored with an orange color and the tubing was not dated. Review of the medical record showed a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) requiring continuous use of oxygen supplementation and a physician order dated 12/23/19 for O2 2LPM via NC for COPD and an order dated 3/12/18 to Change O2 tubing monthly on the 19th of each month. Review of the Treatment Administration Record (TAR) for February and March of 2025 indicated the O2 nasal cannula tubing is changed monthly. 2. On 3/18/25 at 9:05 a.m., observation of Resident #6 in the dining room with Oxygen at 2 LPM via an undated nasal cannula. On 3/19/25 at 7:25 a.m., observations of Resident #6 in the dining room with the nasal cannula, dated 2/22/25. Review of the medical record showed a diagnosis of congestive heart failure and respiratory failure requiring continuous use of Oxygen supplementation. A physician order dated 3/23/23 for O2 at 2LPM via nc continuous and an order dated 6/22/23 for O2 tubing change monthly on the 22nd. Review of the Treatment Administration Record (TAR) for February and March of 2025 indicated the O2 nasal cannula tubing is changed monthly. The facilities Oxygen Tubing change policy updated 10/20/24 states, Oxygen tubing will be changed at least every 2 weeks or as needed. Changing will be done by a nurse and they will document in the TAR. On 3/19/25 at 11:05 a.m., during an interview, the Director of Nursing confirmed the above stating, oxygen tubing should be changed every 2 weeks as per the policy.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interviews, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 resident reviewed with a diagnosis of PTSD (Resident #14) Finding: On 3/19/25, review of Resident #14's medical record contained several providers progress notes dated 1/28/25, 1/16/25, 11/26/24, 11/16/24, 10/22/24, and on 10/8/24 under the section Past Medical History indicates he/she has a diagnosis of Post Traumatic Stress Disorder. Further review of his/her medical record lacked evidence that the facility assessed the resident for what triggers they might have and ways to prevent re-traumatization. In addition, Resident #14's care plan lacked evidence of a trauma informed care plan with identified triggers and interventions to prevent re-traumatization. On 3/19/25 at 9:47 a.m., During an interview, the Licensed Social Worker states that the facility does not assess residents for PTSD/trauma informed care. At this time the above information was confirmed with the Director of Nursing and the Licensed Social Worker.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to adequately date and properly dispose of open medications according to manufacturer specifications, failed to ensure expired medications were removed from the supply available for use and failed to ensure only residents medications were in the medicine cart for 1 of 1 medication cart observed and 1 of 1 medication room observed. Findings: On 3/18/25 from 8:20 a.m., through 8:42 a.m., during observation of the medication room and medication cart with the Licensed Practical Nurse #2 (LPN #2), the following was observed: The medication room refrigerator contained an opened and unlabeled vial of Tuberculin Purified Protein Derivative with manufactures instructions, Once entered. Vial should be discarded after 30 days. The medication cart, top draw, had 2 opened bottles of Lumigan eye drops, one with expiration date of 2024/08 and the second with the expiration date of 2025/02. In addition, there was an unlabeled medicine cup with a small white pill in it. The LPN #2 stated the pill was one of the house cat's daily medicines. Upon further review, the cats medicine bottle containing Phenobarbital 16.2 milligrams (mg) tabs were stored in a cabinet in the medication room. LPN #2 stated it's the nurse's responsibility to give the cat the pill, and it was in the medication cart because she could not find him. On 3/19/25 at 11:05 a.m., the above was discussed with the Director of Nursing

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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.

Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for floors, walls, and the dish washer for 3 of 3 days of survey. Furthermore, the facility failed to ensure staff were wearing proper hair/beard coverings and maintaining proper hand hygiene while serving food for 1 of 3 days of survey.

Findings:

1. On 3/18/25 through 3/20/25, a surveyor observed the following:

> The kitchen floor was dirty with food debris and trash around the entire floor and under the equipment and shelving.

> The kitchen walls were covered with dirt and food debris.

> The dish washer was covered with dirt and debris.

>The stand mixer was covered with dirt and debris

>The food processor was covered with dirt and debris

On 3/18/25 at 11:50 a.m., the above information confirmed with the Director of Food Services.

On 3/20/25 at 8:27 a.m., the above information was confirmed with the Facility Administrator.

2. On 3/19/25 at 7:25 a.m., Observation of Certified Nursing Assistant #1 (CNA) serving 11 trays without hair protection. Hair protection was applied at 7:35 a.m. with surveyor intervention. The surveyor then observed CNA#1 serve 4 more trays without doing proper hand hygiene after touching her hair and clothing, after surveyor intervention the CNA then washed her hands.

Review of facility policy Hygiene Staff Cleanliness last revised on 1/24/25 states Wear a hair-net or hat continuously during shift in kitchen, dish room, and dining room and Staff should wash their hands: .after touching any part of the body- ie. Forehead, chin, ears, etc. (including clothes).

On 3/19/25 at 9:16 a.m., During an interview with the Facility Administrator, the above information was confirmed.

3. On 3/19/25 at 7:50 a.m., Observation of a Kitchen [NAME] prepping food with no beard protection.

On 3/19/25 at 8:05 a.m., Observation of a Dietary Aid in the kitchen not wearing a hair net.

Review of facility policy Hygiene Staff Cleanliness last revised on 1/24/25 states Wear a hair-net or hat continuously during shift in kitchen, dish room, and dining room and All facial hair must be covered with an effective hair restraint which must be worn continuously throughout shift while in kitchen, dish room, and dining room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 9:16 a.m., the above information was confirmed with the dietary supervisor.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews, observations and record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents observed for medications (Resident #6) and 1 of 1 reviewed for Activities of Daily Living (ADL's) (Resident #1). Findings: 1. On 3/19/25 at 7:29 a.m., during observation of medication administration with the Licensed Practical Nurse #2 (LPN#2). The LPN#2 signed off the Medication Administration Record (MAR) that she put Resident #6's bilateral hearing aids on in the AM. She then stated, I sign them off but not put them in. Only when [him/her] family comes in, unless family request it. Review of the physician orders dated 10/6/23 stated, bilateral hearing aids on in AM, off at HS (hour of sleep). The most recent care plan with a goal target date of 3/31/25 states, Give [him/her] hearing aids when family requests. Do not use them routinely, per family. Further review of the MAR indicates by nursing documentation that Resident #6 as having his/her hearing aids put in and taken out daily for the month of February and March of 2025. 2. On 3/20/25 during review of Resident #1's ADL documentation from Certified Nurses Aides lacked completed documentation for ADL care for 3 of 19 days reviewed. On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and Director of Nursing.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record review and interview, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to conduct ongoing surveillance for a Healthcare- Associated Infections (HAI,) failed to apply appropriate interventions including Transmission Based Precautions (TBP) to prevent further spread of a gastrointestinal symptoms, failed to develop and implement elements of a Legionella Water Management Program, failed the wear appropriate personal protective equipment (PPE) while administering eye drops and failed to ensure the facility cats remain off the kitchenette countertops and the dining room table. This has the potential to affect all 23 residents.

Findings:

1. On 3/3/25, the Division of Licensing and Certification received an anonymous complaint stating, from the end of February into March, both residents and staff had experienced gastrointestinal symptoms of nausea, vomiting and diarrhea which started on the Residential Care side and spread to the Long-Term Care residents and staff, and stated the Director of Nursing/Infection Preventionists (DON/IP) claimed she tested residents for COVID-19, but only had some people wearing regular masks, failed to provide appropriate PPE when the symptoms started to spread rapidly and no precautions were being taken for the residents or the workers.

From 3/18/25 through 3/20/25 the above complaint was investigated. During this investigation several interviews were completed with staff, who wish to remain anonymous.

Staff interview #1: The surveyor asked this staff about any recent outbreaks or sickness including nausea, vomiting and diarrhea (n/v/d). The staff stated, maybe Norovirus, It was fast and furious, bunch of people sick including him/herself. We had some people sent home. The surveyor asked what PPE was available, staff stated, gloves, no gowns, we have masks. The surveyor asked if gowns were accessible, staff stated, they are down in the stock room. The surveyor asked if PPE and Transmission Based Precaution signage was placed outside of the resident's rooms who were sick, the staff stated, No, we kept people in their room and brought them liquids and broth, if they didn't vomit overnight, they came out the next day. The staff stated both the DON and the Assistant DON knew about the gastrointestinal symptoms occurring.

Staff interview #2: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. This staff stated, nothing I could name, nothing diagnosed, we had some about 24-48 hours, diarrhea mainly a couple people vomited .If they had diarrhea and vomiting, we kept them in their rooms, it was 1 -2 people at a time. The surveyor asked if the residents with only diarrhea were kept in their rooms, he/she stated No. They were only kept in their rooms if they had both vomiting and diarrhea. The surveyor aske if PPE is available, he/she stated, we have everything always available, gowns, shields, masks N95 . In the storage room The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, I don't believe so.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellows Health Care Center	85 Caron Lane Auburn, ME 04210

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff interview #3: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. The staff stated, a few weeks back there was a nausea, vomiting and diarrhea, we had that including him/herself, Some did. The surveyor asked if any residents and staff were tested, he/she stated, Not that I'm aware of. The surveyor asked how long was the gastrointestinal symptoms in the facility, he/she state, Maybe about a week. The surveyor asked if TBP were put into place, he/she stated, Not really, I did my own, I wore gloves and washed my hands. The surveyor asked if he/she had worn a gown in addition to the gloves and mask while providing care to a resident who had n/v/d, he/she stated, No gowns up here, they have some downstairs. The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, no. The surveyor then asked if he/she was given education on what to do and what to wear while providing care for a sick resident, he/she stated, I was told to wash my hands, there was a sign on the door (main entrance) that we had flu like symptoms. Staff interview #4: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. He/she stated, some resident's sick. One day it was this room the next day the other rooms, not at the same time The surveyor asked what PPE was worn while caring for the residents with the symptoms, he/she stated, Usually have mask and gloves at nurses' station, gloves are in the rooms. If symptoms they stay in room. The surveyor asked if he/she wore gowns, the staff stated, No, mask and gloves and wash hands all the time. The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, No, when we had covid. The surveyor asked how long was the gastrointestinal symptoms in the facility, he/she state, About 2 weeks, some staff, some patients, but not that long. The surveyor asked if he/she had access to gowns, he/she stated, Yes, we have it. If something serious they have a cart set up for us. Staff interview #5: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. He/she stated that there was a GI bug, nausea, vomiting and diarrhea going around, not last week but the week before, including him/herself. The surveyor asked how long this GI Bug lasted in the facility, he/she stated, No more than 2 weeks, it was like a few, then another few, but not all at the same time. Then the next day another person would get it. The surveyor asked if any of the residents experiencing the GI bug were placed on TBP and had a PPE cart outside of their rooms. The staff stated, No, we kept them in their rooms and doorways and gave them broth. The surveyor asked if he/she had access to PPE, he/she stated, We have gloves and masks. The surveyor asked if he/she had worn gowns in addition to the mask and gloves, while providing care for residents with the gastrointestinal symptoms, the staff stated, We were not instructed to where them. I know where they are. The surveyor asked if he/she was instructed to wear masks, he/she stated, It was optional. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 8:17 a.m., during an interview, the DON/IP was asked if the facility had a system in place for tracking and identifying infection trends. The DON/IP stated forms are filled out if a resident has symptoms and if an antibiotic is prescribed. The surveyor requested the facilities tracking forms for infections/outbreaks for the past 3 months. The DON/IP stated she doesn't have an all-inclusive form but uses different forms that she has to fill out when a resident is placed on an antibiotic. The surveyor asked if the facility had any recent outbreaks or sickness including nausea, vomiting and diarrhea. She stated, We have had a couple people with diarrhea. It was very, very quick started on ResCare . it came so quickly. I tested 5 residents for influenza and COVID, all came back negative. By the time I got the results back they were all done. The surveyor asked if the facility had Point of care (POC) tests for COVID-19 and rapid influenza tests, she stated, No, we don't have those. I swabbed them and sent them out. The surveyor asked again about the POC COVID tests due to previously in the interview the DON/IP stated she would test staff in the parking lot if they had symptoms of COVID, she stated, Oh, we have plenty of the COVID tests, we don't have the rapid influenza. The surveyor asked if the POC COVID test was used on residents or staff during this sickness, No, we had one staff go to the hospital and her flu and covid test came back negative, so they presumed it was Norovirus. By that time, it was all done. The surveyor asked if she had tested residents for norovirus, she stated No, we had 5 in the nursing home, they were kept in their room, they were kept on clear liquids for the day and but the next day they were all done. The Surveyor asked if PPE was placed out, she stated, Yes, we had mask, gowns and gloves, we had carts out. At this time, the surveyor requested the resident and staff line list for this n/v/d that occurred. The DON/IP stated she only had a list of who had symptoms that she had emailed to the Center for Disease Control. She provided an email list, dated 3/10/25 which had names of 14 Residential care residents, 5 nursing home residents and 26 facility staff. This list lacked the dates of when the symptoms began and ended, what the symptoms were, if TBP were initiated and resolved, if testing was completed and results. Review of the medical records from the end of February through March for the 5 nursing home residents provided on the list of symptoms, lacked evidence of any gastrointestinal symptoms, doctor and/or family notification, TBP in place or any measures put into place during the time period of the above gastrointestinal symptoms occurred. Review of the facility provided infection control reporting form for February 2025 had only one resident experiencing respiratory symptoms. As of the recertification exit on 3/20/25 at 5:15 p.m. the requested infection control surveillance and tracking for March had not been provided The facilities policies and procedures include: Surveillance of Infections policy updated on 6/12/24 states, The infection preventionist will conduct ongoing surveillance of Healthcare-Associated Infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Data collection and recording: 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information (i.e., residents name, age, room number, unit, and attending physician) b. Diagnosis (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. admission date, date of onset of infection (may list symptoms, if known, or date of positive diagnostic test). d. infection site e. pathogens f. invasive procedures or risk factors g. Pertinent remarks (additional relevant information . other symptoms .) h. treatment measures and precautions (interventions and steps taken that may reduce risk) . 3. Daily: record detailed information about the residents and infection on an individual infection report form. 4. Monthly: collect information from individual resident infection reports and enter line listing of infections by resident for the entire month . Infection Preventionist updated on 10/20/24 states, The Infection Preventionists (IP) will ensure that: staff appropriately use PPE including, but not limited to, the following: . An isolation gown is worn for direct resident contact if the resident had uncontained secretions or excretions . The IP will determine that appropriate Transmission-Based Precautions are implemented .For a resident with an undiagnosed respiratory infection: staff follow standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions . For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher level respirator if available . That there is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a residence room, wing, or facility wide) . that appropriate staff are aware of process/protocols for transmission-based precautions and how staff is monitored for compliance. COVID-19 Testing and Monitoring updated on 10/12/24, states . Staff - if they are at the facility, will be given a test and if positive, sent home to isolate . Residents - if residents have symptoms they will be tested, if positive, the resident will be isolated to their room or another room if necessary and they will be put on extra precautions for staff entering the room. Personal Protective Equipment - Using Gowns updated on 2/20/25, states To protect soiling of clothing with infectious material. To prevent splashing or spilling blood or body fluids onto clothing or exposed skin. 2. Review of the provided Water Management program was a one page Legionella Water Management Policy updated on 10/14/25 which stated, Odd Fellows' and Rebekah's Home conducts bi-weekly testing of water temperature at all faucets and bathing areas . Additional surveillance checks will be performed if the following situations occur: control limits are not met, major maintenance or water service change, diseases associated with the water system and changes in law, regulations, standards or guidelines. The policy lacks evidence of the buildings water systems flow diagram, what control measures are in place and where, monitoring of the controls including testing protocols, acceptable ranges, documents of testing results and ways to intervene when control limits are not met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 9:45 a.m., during an interview with the Administrator, the surveyor requested additional information which was lacking from the policy provided. The Administrator stated the city of [NAME] does the water testing of legionella and the one paper he provided (Legionella Water Management Policy) was all he had. As of the recertification exit on 3/20/25 at 5:15 p.m. the above requested documents were not provided. 3. On 3/19/25 at 7:29 a.m., during the medication administration observation with the Licensed Practical Nurse #2 (LPN#2), the following was observed: LPN#2 opened the bottle of artificial tears and without applying gloves, she opened each eye by pulling the lower lid down and administered the drops. She then handed the resident a tissue to use for both eyes. At this time, the surveyor asked LPN #2, when administering eye drops should you wear gloves? She stated, Yes. I should have worn gloves. Review of the Facilities policy on Instillation of Eye Drops updated on 10/20/24 states, Steps in Procedure . Put on gloves . gently pull the lower eyelid down. Instruct the resident to look up. Drop the medication into the mid lower eyelid .Gently dry the eyelid with cotton ball if dripping occurs. (Note: Use only one cotton ball per wipe.) .Remove gloves and discard into designated container. Wash and dry your hands thoroughly. On 3/19/25 at 11:05 a.m., the above was discussed with the Director of Nursing. 4. On 3/19/25 at 2:26 p.m., a surveyor observed a cat sitting on a dining room table (East side) with a Certified Nurse Aid documenting at the same table, allowing the cat to remain on the table for approx. 1 min. The surveyor discussed the observation with the Assistant Director of Nursing. 5. Review of the Facility Pet Policy last reviewed on 10/20/24 states The pets are to be kept off tables and desks and when they violate this they are to be removed and the area disinfected. On 3/18/25 at 3:30 p.m., Observation of 2 white cats walking on the Long-Term Care Unit kitchenette countertops. Further observation shows the countertops containing food, coffee pots, toasters, face masks, and a microwave. On 3/18/25 at 3:36 p.m., During an interview with Licensed Practical Nurse (LPN) #1, who states that the cats often jump on the kitchenette countertops, but staff try to keep them off as much as possible. Follow up questions disclose that the countertops are mainly cleaned once a shift and not after each time the cats are on the countertops. On 3/19/24 at 7:24 a.m., the above information was confirmed with the Director of Nursing On 3/19/25 at 2:26 p.m., Observation of a white cat on the east side dining room table with a Certified Nursing Assistant documenting at the same table, not attempting to remove the cat from the table. At this time the surveyor got the Assistant Director of Nursing to observe the above infromation. On 3/20/25 at 12:09 p.m., the above information was confirmed with the Director of Nursing.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record review, the facility failed to designate a qualified staff member to function as the Infection Preventionist who works at least part time and who is responsible for the facility's Infection Control Program. This has the potential to affect all residents in the facility. Finding: On 3/19/25 at 11:05 a.m., during an interview, the Director of Nursing (DON) confirmed she works full time in the DON capacity, and she is also the Infection Preventionist (IP) for the facility and completed her online education on 3/30/22. At this time, the surveyor confirmed the facility did not have a dedicated IP who worked at least 24 hours in the IP role. The DON stated she was unaware that she could not function in the capacity of both the full time DON and the IP which requires 24 hours.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, interview and the facility's immunization policy, the facility failed to implement their pneumococcal immunization policy for 4 of 9 residents whose immunization records were reviewed (1, #3, #7, #69). Findings: On 3/20/25, clinical record review indicated: 1. Review of Resident #1's medical record stated he/she had the Pneumococcal conjugate vaccine 13 on 11/24/15. The record lacked evidence that Resident #1 had received, been offered, or refused further pneumonia vaccines. 2. Review of Resident #3's medical record stated he/she was admitted in March of 2023. The record lacked evidence that Resident #3 had received, been offered, or refused the pneumonia vaccines. On 3/20/25 at 9:29 a.m., the Assistant Director of Nursing (ADON) reviewed Resident #3's chart and stated, There is no proof of one, but [he/she] said [he/she] had it about 10 years ago. At this time, the ADON confirmed Resident #3 had not been offered and/or refused the pneumonia vaccine. 3. Review of Resident #7's medical record stated he/she was admitted in February of 2023. The record lacked evidence that Resident #37 had received, been offered, or refused the pneumonia vaccines. 4. Review of Resident #69's medical record stated he/she had a pneumonia vaccine in 1998. The record lacked evidence that Resident #69 had received, been offered, or refused further pneumonia vaccines. On 3/20/25 at 9:59 a.m., during an interview, the ADON confirmed the above stating, I know it hasn't been offered because we haven't had a clinic. The facilities Vaccination of Residents policy and procedure updated 2/20/25 states, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated and All new residents shall be assessed for current vaccination status upon admission. Pneumococcal Vaccine Policy and Procedure updated on 2/20/25 states, Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. and assessment of pneumococcal vaccine status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year. Furthermore, the facility failed to ensure that the CNA attended the mandatory yearly Dementia, Resident Rights, and Abuse and Neglect training for 3 of 5 CNA's employed greater than 1 year. (CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6). On 3/20/25 a surveyor reviewed the following employee files: 1. CNA #2 was hired on 7/2021. Review of CNA #2 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year 2024. 2. CNA #3 was hired on 10/2017. Review of CNA #3 Employee In-service/attendance Records lacked evidence of Resident Rights and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024. 3. CNA #4 was hired on 8/2012. Review of CNA #4 Employee In-service/attendance Records lacked evidence of Dementia, Resident Rights, and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024. 4. CNA #5 was hired on 3/2018. Review of CNA #5 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year 2024. 5. CNA #6 was hired on 2/2021. Review of CNA #6 Employee In-service/attendance Records lacked evidence of Resident Rights and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024. On 3/20/25 at 2:30 p.m., the above information was confirmed with the Director of Nursing