STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235324	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Healthcare Center	1149 West Monroe Rd Saint Louis, MI 48880

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview and record review, the facility failed to ensure updated and accurate advanced directive information was in place for two residents (R7 and R39) of 38 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility or other healthcare providers. Findings include: Resident #7 (R7) Review of the medical record reflected R7 was an initial admission to the facility on [DATE] with a readmission on 03/07/25. Diagnoses of Psychosis not due to a substance or known Physiological condition, Diabetes 2, Post Traumatic Stress Disorder, Obesity, Generalized anxiety, Depression, Chronic Pain, Chronic Pulmonary Disease and muscle wasting. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/08/2025 revealed R7 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R7 requires set up for meals and assistance with all care. Record review revealed of R7's Advanced Directives had a signature from the guardian and dated 09/24/24. Witnesses were Social Worker (SW) F dated for 09/30/24 and Business office Manager (BOM) M signed as a witness for 10/01/24. During an interview on 03/24/25 at 4:47 PM, SW F stated the last Advanced Directives for R7 was dated 09/24/24, stated her process was, when she received it back from the guardian, she put it in the doctor's box to sign, once he signed it, then she signs it. Writer asked SW F why the delay in signing and dating after the guardian signed? Writer asked SW F whose signature was she witnessing? SW F read through the instructions on completing this document above her signature line. SW F stated she was to witness the Guardian or residents' signature. Writer asked SW F why she signed the document after the guardian/resident signed it and after the doctor signs it. SW F stated that was how she was taught to do it when she started working here. SW F asked writer what way should she follow? Writer encouraged her to discuss this with her Administrator. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 (R39) Review of the medical record reflected R39 was an initial admission to the facility on [DATE] with a readmission on 03/07/25. Diagnoses of Cerebral Infarction, Hemiplegia, affecting the left nondominated side, General Anxiety, Adjustment Disorder, Dysphagia, Cognitive Communication deficit and Dementia. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2025, revealed R39 had a Brief Interview of Mental Status (BIMS) of 09 (cognitively impaired) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R39 dependent of all care. Record review revealed R39 signed his advanced directive on 01/28/25. Provider signed the advanced directives on 01/28/25, 2 witnessed signatures dated 01/29/25, not at the time the R39 signed his advanced directions/ DNR to witness his signature. During an interview on 03/24/25 at 4:47 PM, SW F stated the last Advanced Directives for R7 was dated 09/24/24, stated her process was, when she received it back from the guardian, she put it in the doctor's box to sign, once he signed it, then she signs it. Writer asked SW F why the delay in signing and dating after the guardian signed? Writer asked SW F whose signature was she witnessing? SW F read through the instructions on completing this document above her signature line. SW F stated she was to witness the Guardian or residents' signature. Writer asked SW F why she signed the document after the guardian/resident signed it and after the doctor signs it. SW F stated that was how she was taught to do it when she started working here.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 45038 Based on interview and record review the facility failed to ensure that an accurate and timely Notice of Medicare Non-Coverage (NOMNC) was provided for three Residents (#5, #8, #35) and an accurate Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) was provided for two Residents (#8 #35) out of three residents reviewed for Beneficiary Notification. Findings Included: Resident #5 (R5) Review of the medical record revealed R5 was admitted to the facility 09/23/2019 with diagnoses that included subarachnoid hemorrhage (stroke), bipolar disorder, hypertension, anxiety, depression, peripheral venous insufficiency, lymphedema (swelling caused by lymphatic system blockage), dysphagia (difficulty swallowing), type 2 diabetes, hyperlipidemia (high fat in blood), chronic obstructive pulmonary disease (COPD), chronic pain, seizures, gout (increase in uric acid in bone joints), and gain and mobility abnormalities. The most recent Minimum Data Set (MDS), with an assessment reference date of 03/05/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During review of the SNF (Skilled Nursing Facility) Beneficiary Notification Review (completed by the facility) revealed that the facility failed to provide R5 with an Notice of Medicare Non-Coverage (NOMNC) that notified R5 of when his services will end. Review of the same NOMNC demonstrated that it was signed by the representative on 08/09/2024. Review of R5's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) revealed that his last covered day of services was to be 08/11/2024. Resident #8 (R8) Review of the medical record revealed R8 was admitted to the facility 02/22/2025 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease, sleep apnea, obesity, hypoxemia (low blood oxygen levels), type 2 diabetes, hypertension, anemia (low red blood cells), hyperlipidemia (high fat in blood), aortic valve stenosis, atrial fibrillation, and heart failure. The most recent Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/28/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. R8 discharged home 03/06/2025. During review of the SNF (Skilled Nursing Facility) Beneficiary Notification Review (completed by the facility) revealed that the facility failed to notify R8 with a Notice of Medicare Non-Coverage (NOMNC) that notified R8 48 hours prior to the end of skilled services on 03/05/2025. R8's NOMNC was not signed until 03/04/2025. Review of R8's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN), provided to R8 on 03/04/2025, did list the reason that Medicare may not pay for her inpatient skilled services starting 03/06/2025 and did not show the estimated cost that services will cost per day/item or services. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 (R35) Review of the medical record revealed R35 was admitted to the facility 08/09/2024 with diagnoses that included type 2 diabetes, cerebral infarct (stroke), adjustment disorder with depressed mood, hypokalemia (low potassium levels), hypertension, dysphagia (difficulty swallowing), cognitive communication deficient, muscle weakness, hyperlipidemia (high fat content in blood) and breast cancer. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/15/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During review of the SNF (Skilled Nursing Facility) Beneficiary Notification Review (completed by the facility) revealed that the facility failed to provide R35 with an Notice of Medicare Non-Coverage (NOMNC) that notified R35 of when her services will end. Review of the same NOMNC demonstrated that it was signed by the resident 10/29/2024. Review of R35's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN), provided to R35 on 10/29/2024, did list the reason that Medicare may not pay for her inpatient skilled services starting 11/02/2024 and did not show the estimated cost that services will cost per day/item or services. During an interview on 03/26/2025 at 10:16 a.m. Business Office Manager (BOM) M explained that she was the person that provided residents with the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) once resident no longer qualified for Medicare Skilled Services. BOM M reviewed 5's (NOMNC) and confirmed that he had not been notified of the date that services would no longer be provided. BOMM could not explain why the date had not been include on the NOMNC. BOM M reviewed R8's NOMNC and confirmed that it had not been signed within 48 hours of services not provided. BOM M also confirmed that R8's SNFABN did not include the reason that services were no longer provided or listed the estimated cost that services will cost per day/item or services. BOM M could not explain why the information was not completed on the SNFABN or why the NOMNC had not been completed prior to 48 hours before the end of services. BOM M confirmed that R35's NOMNC did not include the information that listed when her services would end. BOM M confirmed that R35's SNFABN did not include the reason that services were no longer provide or listed the estimated cost that services will cost per day/item or services. BOM M could not explained whey the information was not completed on the SNFABN or why the NOMNC did not list when the dates of services would end.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to develop a Baseline Care Plan with necessary healthcare information for one (R37) of 14 reviewed. Findings include: Review of the medical record reflected R37 admitted to the facility on [DATE], with diagnoses that included quadriplegia (paralysis of both arms and legs) and neuromuscular dysfunction of the bladder. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/24, reflected R37 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had an indwelling urinary catheter. On 03/24/25 at 11:30 AM, R37 was observed seated in a wheelchair, in their room. R37 reported having a Foley catheter (indwelling urinary catheter). On 03/26/25 at 9:46 AM, R37 was observed in bed, watching TV. A urinary catheter drainage bag was observed hanging on the right side of the bed frame. R37's Baseline Care Plan, which was initiated on 12/23/24, did not reflect the presence of a Foley catheter. R37's Care Plan reflected, .I am on Enhanced Barrier Precautions relate [sic] to wounds and indwelling catheter . The start date of each Approach (intervention) was 12/23/24, however, the approaches/interventions were created on 1/13/25. In an interview on 03/26/25 at 3:43 PM, Certified Nurse Aide (CNA) O reported they used the Care Plan to identify the care needs of a resident. If a resident had a Foley catheter, it would be included in the Care Plan, according to CNA O. In an interview with Registered Nurse (RN) B and Nursing Home Administrator/Director of Nursing (NHA/DON) A on 03/26/25 at 11:58 AM, it was reported that Baseline Care Plans were initiated upon admission. NHA/DON A reported R37's Foley catheter was not on their Baseline Care Plan. It was reported that Foley catheter care was ordered upon admission, so the CNAs would have been able to chart on catheter care.

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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** 38383 Based on observation, interview and record review, the facility failed to prevent constipation and ensure medication orders specified dosing and route instructions for one (Resident #15) of one reviewed. Findings include: Review of the medical record reflected R15 admitted to the facility on [DATE], with diagnoses that included diabetes, constipation and hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided weakness) following nontraumatic intracranial hemorrhage (brain bleed) affecting the left side. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/24, reflected R15 scored six out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was always incontinent of bowel and bladder. On 03/24/25 at 9:57 AM, R15 was observed in their room, watching TV. R15 reported issues with constipation since their admission to the facility, which they felt staff was doing very little about. R15's medical record reflected Physician's Orders for one 0.52 gram Metamucil capsule (medication used to treat constipation) by mouth twice daily and two tablets of Senna Plus (medication used to treat constipation) 8.6-50 milligrams (mg) by mouth twice daily. In addition, R15's medical record included the following Physician's Orders for constipation: -Senna 8.6 mg by mouth every 12 hours as needed (PRN) -If no bowel movement within 72 hours, give Milk of Magnesia PRN (medication dose and route not specified in the order) -10 mg bisacodyl suppository, every three days, PRN, if Milk of Magnesia was not effective (medication route not specified in the order) -10 mg bisacodyl rectal suppository As Needed (specified frequency not noted in the order) -Fleets enema to be given PRN, every third day, if the bisacodyl suppository was not effective -Dulcolax rectal suppository (dose not specified in the order), PRN, if there were no bowel movement results within approximately 12 hours of Milk of Magnesia administration -Fleets enema rectally, PRN, if results of the suppository were not satisfactory within two hours Documentation of R15's bowel movements for 2/25/25 to 3/25/25 reflected R15 did not have a recorded bowel movement for the dates of 3/7/25, 3/8/25, 3/9/25, 3/10/25, 3/11/25, 3/12/25, 3/13/25 and 3/14/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/25/25 at 11:10 AM, Registered Nurse (RN) B reported the night shift nurses pulled bowel movement reports and looked for any resident that had not had a bowel movement in three days. The report was then provided to the day shift nurse. If constipation needed to be addressed, they obtained orders, if needed. RN B acknowledged that it did not appear that R15 had a bowel movement from 3/6/25 to 3/15/25. On 3/25/25, review of R15's March 2025 Medication Administration Record (MAR) did not reflect that any as needed medications had been provided to them for constipation.

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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. 45135 Based on observation, interview, and record review, the facility failed to ensure a safe environment and provide adequate supervision of smoking or screening them with form named PHCM Smoking risk to determine if they can smoke independently for two of two sampled residents (Resident #5 and Resident #2) reviewed for accidents and safety. Resident #2 (R2) During an interview and observation on 03/26/25 at 4:23 PM, R2 stated he had to turn in his lighter and cigarettes to nursing staff every time he goes inside, and he can get them back whenever he wants to go back outside. R2 also stated he can go outside anytime he wants to smoke. Did not respond to writer asking him if he had a lighter and marijuana hide outside from everyone. R2 stated he is independent with smoking, so he can come and go as he pleases. Observation of burn marks on his hoodie sweatshirt. During an interview on 03/27/25 at 10:39 AM, LNA/DON A stated the document PHCM Smoking risk, was under the assessments found under observations. Record review did not reveal that a smoking risk assessment was completed on admitted d 05/31/24. 45038 Resident #5 (R5) Review of the medical record revealed R5 was admitted to the facility 09/23/2019 with diagnoses that included subarachnoid hemorrhage (stroke), bipolar disorder, hypertension, anxiety, depression, peripheral venous insufficiency, lymphedema (swelling caused by lymphatic system blockage), dysphagia (difficulty swallowing), type 2 diabetes, hyperlipidemia (high fat in blood), chronic obstructive pulmonary disease (COPD), chronic pain, seizures, gout (increase in uric acid in bone joints), and gain and mobility abnormalities. The most recent Minimum Data Set (MDS), with an assessment reference date of 03/05/2025, demonstrated a Brief Interview for Mental Status (BIMS) of 12 (moderate cognitive impairment) out of 15. During observation and interview on 03/24/2025 at 10:00 a.m. R5 was observed sitting up in his wheelchair at the side of his bed. R5's left side of his bed was observed to be against the wall and the right side of his bed a half bedrail was observed. When R5 was asked why he had a bedrail on the right side of his bed, he explained that it was placed there to keep him from falling out of bed. Review of R5's medical record did not demonstrate a physician order for the use of a bedside rail. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's plan of care did not demonstrate that R5 currently used a bedside rail for assistance of mobility or as a means of restraint to prevent falls. R5's medical record did not demonstrate that R5's bedrail and bed had been measured for possible entrapment at the time the bedrail was applied or on a quarterly basis. Review of R5's medical record did not demonstrate that any alternative interventions were attempted prior to the placement of a bedrail on R5's bed. Review of R5's medical record did not demonstrate that an evaluation had been completed evaluating the independent use by R5 for lowering or raising the bedrail. In an interview on 03/24/2025 at 04:15 p.m. Director of Nursing (DON) A explained that the facility does have residents that use bedrails. DON A explained that if bedrails were used, the resident would be evaluated for independence of use, a physician order would be written, and the bed rail would be care planned for use. DON A also explained that the bed and bedrail would be measured (for possible entrapment) when initiated, quarterly, and when the resident's condition would change. DON A reviewed R5's medical record and confirmed that no physician order was present for the use of a bedrail, no plan of care was present for the use of a bedrail, no assessment for the use of the bedrail was in the medical record. During an interview on 03/25/2025 Director of Nursing (DON) B explained that the facility had not completed measurements of R5's bedrail or bed on implementation of the bedrails for possible entrapment. DON B explained that the facility had not completed quarterly measurements of R5's bedrail or bed for possible entrapment. DON B explained that she could not determine when R5's bedrails were applied to his bed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38383 Based on observation, interview and record review, the facility failed to ensure daily nurse staffing information was posted for 38 facility residents, as well as visitors. Findings include: Upon touring the facility on 03/24/25 at 9:41 AM, a daily nurse staffing posting was not observed. Upon touring the facility on 03/26/25 at 2:18 PM, a daily nurse staffing posting was not observed. During an interview on 03/26/25 at 2:41 PM, Human Resources/Scheduler (HR) N reported the daily nurse staffing information had not been completed or posted in the facility for approximately two months. HR N thought they had been told they no longer needed to complete or post the daily nurse staffing information.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to ensure recommended laboratory monitoring was in place for one (R15) of five reviewed. Findings include: Review of the medical record reflected R15 admitted to the facility on [DATE], with diagnoses that included diabetes, constipation and hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided weakness) following nontraumatic intracranial hemorrhage (brain bleed) affecting the left side. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/24, reflected R15 scored six out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R15's medical record reflected Physician's Orders for 65 units of Basaglar insulin (used to treat diabetes) to be administered twice daily, 500 milligrams (mg) of Metformin (medication used to treat diabetes) by mouth twice daily and four units of Novolin R FlexPen 100 units per milliliter (u/mL) insulin (used to treat diabetes) to be administered three times daily. R15's medical record reflected they were to have a fasting blood sugar check daily, every Monday, Wednesday and Friday. A Note to Attending Physician/Prescriber, for a Pharmacy Medication Regimen Review dated 6/13/24, reflected to consider ordering current labs, which included A1C levels (blood test that measures the average amount of sugar in the blood over the past three months) and Lipid Panel (blood test that measures the amount of fats and cholesterol in the blood). The Physician agreed with the recommendation on 6/18/24. A laboratory report for 6/20/24 reflected R15 refused to have their A1C and Lipid Panel blood tests collected. R15's medical record reflected laboratory test results for 10/28/24, which included but was not limited to fasting lipids and fasting glucose (sugar). An A1C was not included in the laboratory results for 10/28/24. In an interview on 03/25/25 at 11:10 AM, Registered Nurse (RN) B reported A1C was generally checked every three months for diabetic residents. RN B reported R15 refused to have their A1C drawn in June 2024. RN B reviewed R15's laboratory results, dating back to February 2024, and acknowledged they did not see any A1C results.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45135 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5% for one of four residents (Resident #37) reviewed for medication administration, resulting in an 10. 34% medication error rate and potential side effects as a result of the errors. Findings include: During an observation and interview on 03/25/25 at 720 AM, RN C prepared medications to be administered to R37. RN C did not wash her hands or use hand sanitizer prior to setting up medications. RN C prepared Lantus 20 units, Loratadine10mg, Lyrica 200mg, MiraLAX 17gm, Morphine 15mg 1 tab, Pepcid 20mg, Tizanidine 2mg and Buspirone 10mg. Protein drink was declined by R37. Lexapro 5mg tab and Betamethasone cream ointment .2ml topical were not administered or applied as ordered to take in the AM. RN C also set the medication cup with the medications in them and MiraLAX mixture on the over the bed table and walked away to the sink to wash her hands, not looking back to ensure R37 took his medications and drank his MiraLAX. Record review of the medication administration record noted that medications Lexapro 5 mg tab and Betamethasone cream ointment were not administered or signed out. During an interview on 03/27/25 at 9:22 AM, LNA/DON A and MDS/RN B stated nurses should wash hands before going into the room, administering medications, leaving the room, wash their hands, hand sanitizer. During this same conversation, writer asked MDS/RN B what her expectations were for leaving medications at bedside. MDS/RN B stated nurses should not leave meds at bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235324	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Healthcare Center	1149 West Monroe Rd Saint Louis, MI 48880

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45038 Based on observation, interview, and record review the facility failed to effectively clean and maintain food service equipment affecting 38 residents. Findings Included: On 03/24/2025 at 08:32 a.m. an initial tour of food services was conduced with Dietary [NAME] I. The following items were observed: Cardboard box, containing dinex cup lids, was observed to be on the floor in the dry storage room. The base boards, on the wall that the door swung into, was observed to have black substance on it the entire length of the wall. The door jam of the dry storage room was observed to be rusted along the floor. Observation of the freezer, which staff called the vegetable freezer, revealed soiled bottom shelf that appear to be dried liquid film. Observation of 7 pots and pans contained dark colored substance on the inside of the pains. The substance appeared to be backed on food substance that could not be removed. Observation of toaster grill appeared to have backed on substances on the grates of the toaster device and what appeared to be burnt on toast crumbs. Observation of the grill, oven, and gas grills appeared to be soiled. The upper porting of the grill revealed dark black substance. The oven door handle appeared to be covered with grease. The oven racks were observed to be discolored with food substances. The bottom of the oven appeared to be covered with burnt grease and food substances. The side of the oven door appeared to have old yellow dark grease covering it. During an interview on 03/24/2025 at 09:27 a.m. Dietary Manager (DM) J was shown concerned items above. DM J explained that items are cleaned daily and demonstrated a document entitled Dietary Aide Daily Cleaning Chart with initials present for cleaning equipment task. Review of the preceding document demonstrated absent charting for 03/22/2025 and 03/23/2025. DM J explained that cleaning of the equipment should have been completed. DM J agreed that the items listed above were not clean as observed during observation. DM J explained that the soiled pots and pans could not be cleaned, and they would be discarded, and new items would be ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 This citation has two deficient practice statements DPS A and DPS B. DPS A. Based on observation and interview the facility failed to ensure that accepted infection control protocols related to hand hygiene and glove use for one resident (#13) out of one resident sampled for infection control. Findings include: Resident #13 (R13) Review of the medical record reflected R13 was an initial admission to the facility on [DATE]. Diagnoses of Alzheimer's Disease with late onset, legal blindness, pressure ulcer of other part, stage 4, confined to bed, moderate protein-calorie malnutrition and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/2024 revealed R13 had a Brief Interview of Mental Status (BIMS) of 99 (unable to answer the questions) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R13 is dependent of all care. During an interview and observation on 03/26/25 at 9:41 AM, Registered Nurse (RN) C donned personal protective equipment (PPE) to including a disposable gown and gloves. RN C placed a barrier on R13's bed and laid down the dressing supplies on it. RN C removed the soiled dressing from R13's left lateral foot with scissors. RN C cleaned the wound with normal saline wearing the same gloves. RN C applied an alginate dressing (specifically for a wound that has heavy drainage) over wound and surrounding tissue. RN C covered the left lateral foot wound with gauze dressing, cut the gauze dressing with the soiled scissors. RN C secured the gauze dressing with kerlix and taped it in place wearing the same pair of gloves. RN C did not change gloves throughout this treatment nor clean scissors after cutting and removing the soiled dressing or before using the scissors on the new dressing. RN C forgot dressing for the coccyx wound, so she removed her gloves and disposable gown and hung it on the back of R13's room door. Observation of 2 other disposable gowns hanging there as well. During an interview and observation on 03/26/25 at 9:50 AM, RN C gowned back up with the disposable gown hanging inside of R13's room and new gloves. RN C removed the soiled outer dressing and packing from R13's open coccyx wound. RN C used normal saline to clean the coccyx wound, moistened the gauze and repacked the coccyx wound. RN C changes her gloves, washed her hands and put on a new pair on gloves. RN C applied a barrier cream to surrounding skin. RN C then covered the coccyx wound with a gauze dressing and taped in place. RN C used the soiled scissors to cut off the new rolled gauze dressing and taped in place. During an interview on 03/27/25 9:04 AM, Wound Care Registered Nurse B pulled up the orders for wound care for both left lateral pressure ulcer and coccyx wound care due to surveyors not having access to these orders. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Registered Nurse B read the orders out loud, clean the wound with wound care wash or normal saline. Pack wound with a gauze dressing moistened with normal saline, cover surrounding skin with a skin barrier, cover coccyx wound with foam dressing and tape in place. Left lateral foot wound, wash the wound with normal saline, place alginate dressing over wound bed only, cover with a gauze dressing and tape in place. Wound Care Nurse B stated she did occasionally watch the nurse perform wound care. Wound Care Nurse B discussed infection control measures such as opening the packages, reaching into the packages, place dressing supplies on a barrier. Writer asked Wound Care Nurse B about the dressing alginate, she stated they would follow the order, applying it to the wound bed only, for wounds that has a lot drainage, adding that this dressing had a debriding property to it. Dressing changes were ordered 3 x a week and as needed. Writer asked Wound Care Nurse B about wound care product overlapping the wound and on healthy skin with a debriding product. Wound Care Nurse B stated she would not expect the product to be used over the healthy tissue. Wound Care Nurse B stated she expected nurses to wash their hands, put on PPE gowning and gloving, remove soiled dressing, change gloves and wash hands, put on new gloves, clean the wound, wash their hands, put on new gloves, apply the new dressing, clean up the waste, wash their hands, remove the PPE, exit room hand sanitizer. Wound Care Nurse B stated she would not expect to see disposable gowns hanging on the inside the room on the door. DPS B. Based on interview and record review, the facility failed to obtain consent prior to administration of a COVID-19 immunization for one (R3) of five reviewed. Findings include: Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included Huntington's disease. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/24, reflected R3 had short-term and long-term memory impairments. The medical record reflected R3 had a Guardian in place. R3's medical record reflected they received COVID-19 immunizations on 7/23/21, 12/1/23 and 11/27/24. Further review of the medical record reflected R3's COVID-19 Vaccine Consent Form was signed by their Guardian on 10/14/24, in the declination of vaccine section. During an interview with Nursing Home Administrator/Director of Nursing (NHA/DON) A and Registered Nurse (RN) B on 03/27/25 at 12:12 PM, it was reported that a pharmacy came to the facility to administer immunizations in 2024. It was reported the facility had a list of residents for which they had received verbal consent to administer immunizations. The list was provided to the pharmacy, as well as consents and face sheets. It was reported that R3's Guardian verbally consented to the COVID-19 immunization but may have signed the wrong section of the consent form. It was reported that the facility had not identified that the declination of vaccine section had been signed. Verbal consent to administer a COVID-19 immunization was not noted in R3's medical record.