STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235450	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Dr Allendale, MI 49401

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation and interview, the facility failed to provide a clean, safe, and comfortable environment for one resident on the 200 hall and all resident's on the 100 hall that use the spa room shower and utilize the 100 hall dining area. Findings: During an observation on 09/09/24 at 10:25 AM, the bedside table in room [ROOM NUMBER] contained 2 damp wash cloths and one had a light brown substance on it. R3, who lives in that room, stated that staff had been in earlier that morning to get him cleaned up. During an observation on 09/09/24 at 2:29 PM, the 100 hall spa room shower area contained an almond sized brown piece of fecal matter. During an observation on 09/10/24 at 12:20 PM, the 100 hall spa room shower area still contained an almond sized brown piece of fecal matter. During an observation on 09/11/24 at 11:00 AM, the 100 hall spa room shower area still contained an almond sized brown piece of fecal matter. During an observation on 09/10/24 at 8:00 AM, the small dining room off the kitchen contained a table near the entryway to the room. On the table were 2 trays that contained (from the evening of 09/09/24) dinner plates, bowls, and partially finished food portions. Resident's have access to and utilize the small dining room. During an observation on 09/10/24 at 8:20 AM, the unlocked mechanical room that housed the electrical service panel, had an over-head fluorescent light that was unsecured on one end and was leaning against the electrical panel.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100145189. This citation has 2 deficient practice statements. Statement A Based on observation, interview, and record review, the facility failed to ensure all medications and supplements were available/provided timely, had compatible administration times, and blood sugars were checked and acted upon for diabetic residents, and physicians were notified of unavailable medications/supplements as ordered for 5 Residents (R8, R15, R16, R17, R18) of 5 residents reviewed for medication administration and nursing services, of a total of 18 residents, resulting in residents not receiving ordered medications, supplements, and glucose monitoring per physician orders. Findings include: Review of a Face Sheet for R15 revealed he originally admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), sepsis, pressure ulcers, and diabetes. During an observation on 9/9/24 at 11:00 AM, a resident was at the nursing medication cart asking the nurse for his morning medications. Licenses Practical Nurse (LPN) C told the resident she was running late and would get him his medications as soon as she could. R15 During an observation and an interview on 9/9/24 at 11:12 AM, LPN C reported she is an agency nurse who slept in this morning and did not get to the facility until 8:00 AM and is behind on getting morning medications passed to the residents. LPN C reported she thought someone else would have at least started the medication pass before she got there. She was preparing R15's medications and reported some of his medications were not available this morning such as his vitamins, Mucinex and Protonix. LPN C reported if the resident receives the same medications in the morning and the afternoon, she will just skip the morning doses. No insulin's, nebulizers, or nasal sprays were offered or provided to R15 as ordered during his medication pass at this time. LPN C provided the names of 16 other residents who still had not received their morning medications yet. Review of the Medication Administration Record (MAR) for R15 retrieved at 1:21 PM revealed the following medications ordered via PEG (percutaneous endoscopic gastrostomy) tube from 7:00 AM - 11:00 AM were still not given on 9/9/24: Albuterol sulfate nebulizer treatment, guaifenesin (expectorant) liquid 400 mg, Lantus Solostar U-100 (Insulin glargine, long acting insulin) 24 units, pantoprazole (Protonix, a gastric acid reducer) 40 mg documented as not available, ipratropium bromide nasal spray, multivitamin, and vitamin C. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:00 AM - Insulin Lispro (short acting insulin) 100 units/ml (milliliter) 3 units subcutaneous every 4 hours was not given and documented as refused. Blood sugar documented at 4:00 AM was 200 and at 8:00 AM it was 263 (normal range is 140 - 180 for continuous enteral nutrition). No parameters for insulin documented. Review of the Nursing Progress Notes for R15 dated 9/9/24 at 2:14 PM revealed Resident received morning medications late, physician notified and ordered to hold any duplicate medications if within 2 hours of administration times. No notification to the physician of medications not being available or of elevated blood sugars with no insulin. Review of the Lantus Solostar U-100 medication insert revealed it is a long-acting human insulin indicated to improve glycemic control in patients with diabetes. Dosage and Administration: .Administer subcutaneous . at the same time every day. Review of a Nursing Progress note dated 9/9/24 at 2:14 PM for R15 revealed the physician was notified of the resident receiving late medications and ordered to hold any duplicate medications if within 2 hours of administration times. R16 Review of a Face Sheet for R16 revealed she admitted to the facility on [DATE] with pertinent diagnoses of chronic kidney disease, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Review of the MAR for R16 retrieved on 9/9/24 at 1:30 PM revealed she did not receive several medications as ordered on 9/9/24 as follows: 7:30 AM and 11:30 AM- insulin lispro 20 units and no blood sugars checked for both times as ordered. 8:00 AM- ferrous sulfate (iron) 325 mg, levothyroxine (Synthroid, a thyroid medication), Pro heal 30 ml supplement for wound healing, and Prozac (fluoxetine- an antidepressant). 7:00 - 11:00 AM- gabapentin (anticonvulsant) 100 mg, metoprolol tartrate (blood pressure medication) 25 mg (1/2 tablet), Senna Plus (sennosides-docusate sodium 8.6-50 mg, laxative), spironolactone (diuretic) 25 mg, and Voltaren Arthritis pain gel 1%. 12:00 PM- torsemide 20 mg. Review of a Nursing Progress note dated 9/9/24 at 2:23 PM for R16 revealed: Resident received morning medications late, physician notified and ordered to hold any duplicate medications if within 2 hours of administration times. Review of a Levothyroxine Medication insert revealed: DOSAGE AND ADMINISTRATION: -Administer once daily, preferably on an empty stomach, on-half to one hour before breakfast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administer at least 4 hours before or after drugs that are known to interfere with absorption. Inform patients that agents such as iron and calcium supplements and antacids can decrease the absorption of levothyroxine. R17 Review of a Face Sheet for R17 revealed she originally admitted to the facility on [DATE] with pertinent diagnoses of intellectual disabilities, psychosis, major depressive disorder, hypertension, and chronic kidney disease. Review of the MAR for R17 revealed she did not receive the following medications as ordered on 9/9/24: 7:00 AM - 11:00 AM- docusate sodium (Colace, a laxative) 100 mg, Morphine (pain relieving opioid) 30 mg (ordered 3 times a day), Prune juice documented as unavailable 5 times in September, Remeron (antidepressant), and Senna Plus 8.6-50 mg. 8:00 AM- Lidocaine patch for knee pain to be place on in the morning and off at bedtime is documented as unavailable on 9/5/24 and 9/9/24, Med Pass (nutritional supplement) 120 ml's, and multivitamin tablet. Review of the Physician Orders for R17 revealed: Assess nonverbal / cognitively impaired resident Q (every) shift for pain using the FLACC (a scale used to observe Face, Legs, Activity, Cry, and Consolability, which are the five categories of pain behaviors). This day she had a pain rating of 4 indicating moderate pain. Review of the pain assessments from 9/1/24 to 9/9/24, R17 is documented as having 0 pain. R18 Review of a Face Sheet for R18 revealed she admitted to the facility on [DATE] with pertinent diagnoses of diabetes (Brittle diabetic), major depressive disorder, disorder of personality and behavior disturbances. Review of the MAR for R18 retrieved on 9/9/24 at 3:23 PM revealed she did not receive the following medications as ordered on 9/9/24 as follows: 7:00 AM to 11:00 AM- Amlodipine (blood pressure medication) 5 mg, Fibercon (for constipation) 625 mg, gabapentin 300 mg, Humalog U-100 (short acting insulin) 5 units subcutaneous three times a day with meals and hold for blood sugars <110 (blood sugars were not checked), labetalol (blood pressure medication) 100 mg, Lantus U-100 25 units, sodium chloride 1 gram tablet, Tylenol (acetaminophen) 325 mg X 2, Wellbutrin XL (bupropion hcl (hydrochloride), antidepressant) extended release 150 mg 8:30 AM- Insulin lispro sliding scale before meals and at bedtime not documented as done and no blood sugars checked, As needed Glucose Gel (dextrose) 40% (Administer 1 tube for low blood sugar below 60 . no blood sugars checked. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8 Review of a Face Sheet revealed R8 admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease, protein-calorie malnutrition, major depressive disorder, heart failure, and anxiety. Review of the MAR for R8 retrieved 9/9/24 at 1:30 PM revealed the following medications not provided as ordered: 7:00 AM - 11:00 AM- acetaminophen 500 mg X 2, amlodipine 5 mg, and duloxetine (Cymbalta, for depression and anxiety). Review of the Nursing Progress notes for R8 revealed the physician was notified of the resident not receiving her morning medications and to hold any duplicative medications if within 2 hours of administration times. During an observation and an interview on 9/9/24 at 2:20 PM, the Assistant Director of Nursing (ADON)/LPN F was at the nursing medication cart on the 100 hall and reported she was getting caught up with the residents who did not receive their morning medications. She reported she notified they physician to let them know their medications were late and is not to give medications that are within a 2-hour window for the next dose. In an interview on 9/10/24 at 2:15 PM, the Director of Nursing (DON) reported she was aware medications were late for several residents on 9/9/24. The LPN who was responsible is an Agency nurse who was new, came in late, and was not familiar with electronic medical record system or the residents. The DON expects Agency nurses to be able to come in and hit the floor running. The DON reported she was not sure how to help LPN C because only one nurse can use the medication cart at a time due to the access of the narcotics. The physician was notified of the residents who received late medications and they received new orders. The DON reported she tried to assist with resident blood sugars. The MARs did not reflect those who needed blood sugars checked were done. When asked about some residents not having medications or supplements available to give, the DON reported their pharmacy does not deliver over the counter (OTC) medications, and they must order them from another distributor. They get ordered on a Tuesday and can be delivered on a Thursday. She acknowledged nurses were documenting medications were not available, but they were not following up and ordering the medications. The DON thinks the miscommunication is with the Agency nursing staff. The DON then verified that the Protonix for R15 is a pharmacy provided medication that was not available, and reiterated the nurses should take the initiative to order needed medications. When informed that R16s levothyroxine is ordered for 8:00 AM at breakfast time, the DON reported it should be given on an empty stomach and the facility is supposed to schedule thyroid medications for evening administration and not sure why hers was scheduled for that time. 37577 Deficient Practice Statement B Based on interview and record review, the facility failed to provide quality care for 1 of 4 resident's reviewed (Resident #11), resulting in failure to treat a diagnosed UTI (urinary tract infection). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: Resident #11 (R11) Review of a Face Sheet revealed R11 was an [AGE] year-old female, last readmitted to the facility on [DATE] after falling and fracturing her left hip. R11 had pertinent diagnoses of dementia and repeated falls. Review of a urinalysis for R11, collected and resulted on 07/10/24, reflected abnormal findings including a white blood cell count great than 100 (a finding that can be indicative of a urinary tract infection). The culture and sensitivity was pending at that time. Review of a vitals search for R11 revealed that the resident's blood pressure and temperature were not checked on 07/10/24 and were not checked between 06/26/24 and 07/17/24. Review of a laboratory service update for R11, faxed to the facility on [DATE], revealed that the culture and sensitivity required further incubation. Review of the residents EHR (electronic health record) showed that the facility did not have a copy of the resulted urine culture and sensitivity in the resident's health record. The resulted culture and sensitivity (which was completed 07/13/24) was requested from the facility and was obtained on 09/10/24. Review of an Emar (electronic medication administration record) for R11, dated July 2024, revealed the following order: Ciprofloxacin (an antibiotic also known as Cipro) tablet 500 milligrams, one tab twice daily for UTI. Start date 07/15/24. The same Emar reflected that R11 refused or was not offered all but 3 doses of Cipro (received one dose the evening of 07/16/24, one dose the evening of 07/17/24, and one dose the morning of 07/18/24). Review of the communication log for the 200 hall (a log that staff use to communicate concerns, requests, etc to the physician, that are deemed by nursing to be non-urgent matters) reflected an entry on 07/18/24 for R11 in which nursing documented .she (R11) is refusing her oral antibiotics for her UTI (urinary tract infection) .worried about her going septic (a wide spread infection causing organ failure and dangerously low blood pressure) .can an IM (intramuscular) injection be used? Review of a physician order for R11, dated 07/19/24, reflected .discontinue Cipro (an antibiotic prescribed to R11 on 07/15/24 for a UTI). Start Rocephin 1 gram IM (intramuscular) daily for 3 days. Review of R11's Emar (electronic medication administration record) for July 2024 indicated that the order, dated 07/19/24, for Rocephin IM did not get transcribed to the Emar and therefore was not administered to the resident. Review of a Nursing Progress Note (NPN) for R11, dated 07/17/24, recorded that on 07/17/24 the resident took the evening dose of Cipro with encouragement. There were no additional NPN's that reflected R11 received any additional antibiotics for the diagnosed UTI. During an interview with Nurse Practioner (NP)J on 09/11/24 at 9:05 AM, R11's urinalysis and orders for antibiotics were discussed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37577 Based on observation, interview, and record review, the facility failed to implement fall prevention safety measures for 4 of 6 residents (Resident #19, Resident #11, Resident #3, and Resident #20) reviewed for accidents/hazards. Findings: Resident #19 (R19) Review of a Face Sheet revealed R19 was a [AGE] year-old female, admitted to the facility on [DATE] with pertinent diagnoses of dementia, repeated falls, and cognitive communication deficit. R19 sustained unwitnessed falls on 08/29/24, 07/31/24, and 07/08/24. During an observation on 09/10/24 at 7:41 AM, R19 sat in the recliner resting with her eyes closed. The call light laid on the floor between the recliner and the bed, tangled with the cord for the bed controls. Two signs posted in the room read call for assistance .don't fall and please call for help when you need to get up. During an observation on 09/10/24 at 10:30 AM, R19 sat in the wheelchair, slumped forward, and resting with her eyes closed. The call light laid on the floor between the recliner and her bed, tangled with the cord for the bed controls. Review of a Care Plan for R19 reflected the following fall prevention interventions: do not leave resident in wheelchair alone in room, (initiated on 08/29/24 after the most recent unwitnessed fall), keep call light within reach, and instruct and remind resident to use call light to ask for assistance. Resident #11 (R11) Review of a Face Sheet revealed R11 was an [AGE] year-old female, last readmitted to the facility on [DATE] after falling and fracturing her left hip. R11 had pertinent diagnoses of dementia and repeated falls. During an observation on 09/09/24 at 11:55 AM, R11 laid in bed resting with eyes closed. A sign in the room instructed R11 to please call for help when you need to get up. The push button call light hung from the left side bed rail, almost touching the floor, out of sight and out of reach of R11. During an observation on 09/09/24 at 2:40 PM, R11 laid in bed resting with eyes open. Push button call light remained hanging from left side bed rail, almost touching the floor, out of sight and out if reach of R11. During an observation on 09/10/24 at 7:32 AM, R11 laid in bed resting with eyes open. The push button call light laid clipped to the pillow above R11's head and over the left shoulder, out of sight. When asked if the resident could find the call light, R11 just started blankly ahead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plan for R11 revealed the following fall prevention interventions: change call light to soft touch call light and call light to be within reach. Resident #3 (R3) Review of a Face Sheet revealed R3 was a [AGE] year-old male, admitted to the facility on [DATE] with pertinent diagnoses of dementia, mild intellectual disabilities, unsteadiness on feet, and the need for assistance with personal care. During an observation on 09/09/24 at 10:25 AM, R3 laid in bed resting with his eyes closed. The call light laid on the floor on the left side of the bed, out of sight and out of reach of the resident. During an observation on 09/11/24 at 7:40 AM, R3 laid in bed with eyes open and the call light laid on the floor near the head of the bed, out of reach and out of sight of the resident. Review of 'Nursing Progress Notes for R3 and dated 08/07/24 revealed the resident had an unwitnessed fall on 08/07/24. Review of a Care Plan for R3 reflected the following fall prevention interventions: call light to be within reach and instruct and remind resident to use the call light to ask for assistance. Resident #20 (R20) Review of a Face Sheet revealed R20 was a [AGE] year-old female admitted to the facility on [DATE] after sustaining a fall and fracture to her right femur and requiring skilled nursing rehabilitation. R20 had pertinent diagnoses of muscle weakness and epilepsy. During an observation on 09/09/24 at 10:37 AM, R20 laid in bed resting with her eyes closed and the call light was clipped to the cord just below where the unit plugged into the wall, rendering it out of sight and out of reach of R20. Review of a Nursing Progress Note dated 08/06/24 reveled R20 sustained a fall with injury in the facility on 08/06/24. Review of a Care Plan for R20 reflected the following fall prevention interventions: call light to be within reach. During an interview on 09/10/24 at 7:38 AM, certified nurse aide (CNA) I stated that each time staff entered a resident's room, they were expected to check call light placement.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 29073 Based on observation, interview, and record review, the facility failed to ensure 1 resident (Resident 14) out of 5 residents reviewed for quality care had access to hydration according to the care plan. Findings: Resident #14 (R14) Review of a facility Resident Face Sheet reflected R14 admitted to the facility with diagnoses including dementia, age related osteoporosis, repeated falls and constipation. Review of a Care Plan indicated R14 had a potential for problems with bowel elimination related to the diagnoses of constipation, a history of bowel obstruction and limited mobility. Interventions to address the problem included Encourage fluid intake. Another problem identified in the Care Plan included being at risk for impaired nutrition and hydration related to R14's diagnoses. Interventions included Encourage fluids at bedside and with activities. During an observation on 9/9/2024 at 11:18 AM, instructions taped to R14's bedside table read Put water in dining room with her (sic) resident. Do not leave it here. A pink insulated cup full of water was sitting next to the sign. During an observation on 9/9/24 at 11:40 AM, R14 was seated at a table in the main dining room, no water was observed near the resident. During an observation on 9/10/2024 at 7:30 AM, R14 was seated at a table in the dining room, a cup of water was not placed next to the resident. During an observation on 9/10/2024 at 11:00 AM, a pink insulated cup full of water and a clear plastic mug with a blue lid, full of water was observed on R14's nightstand, next to the sign instructing staff to place water with R14 when she is in the dining room. During an observation on 9/10/2024 at 11:12 AM, R14 was seated at a table in the main dining room without water. During an interview on 9/11/2024 at 9:00 AM, the Director of Nursing (DON) reported that R14 would sit in the dining room for close observation related to her history of falling. The DON observed R14's room, with a pink insulated cup of water setting next to the sign instructing staff to put the water in the dining room with the resident. The DON said she thought staff needed more education about where to put R14's water. The DON also reported that it would be a good idea to get a cup holder for R14's wheelchair to make it easier to ensure R14 had water available at all times, including times when R14 would wander around the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100144670 Based on observation, interview, and record review, the facility failed to ensure appropriate positioning for tube feeding and tube feeding supplies are stored properly for best infection control practices for 1 Resident (R15), of 1 resident reviewed for tube feedings. Findings include: Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, A serious complication associated with enteral feedings in aspiration of formula into the tracheobronchial tree. Aspiration of enteral formula into the lungs .leads to necrotizing infection and pneumonia .Some of the common conditions that increase the risk of aspiration .lying flat keep the head of bed elevated a minimum of 30 degrees .Place patient in high Fowler's position or elevate head of bed a minimum of 30 (preferably 45) degrees during feedings and for 2 hours afterwards. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 1018 and 1022 Review of a Face Sheet for R15 revealed he originally admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia and hemiparesis (one sided weakness), sepsis, pressure ulcers, and diabetes. During an observation on 9/9/24 at 11:12 AM, R15 was in bed and his bedside table was on the other side of his privacy curtain on his roommate's side of the room. His plastic cylinder for his tube feeding was sitting in the shared bathroom on top of the sink that is in close proximity with the toilet. The cylinder had a large plastic syringe that is used to access his PEG (percutaneous endoscopic gastrostomy) tube and used to provide medications and water to the resident. Licensed Practical Nurse (LPN) C did not clean the table when she brought it closer to R15 and set multiple souffle cups filled with crushed medications on the table. She filled the plastic cylinder with water in the bathroom, put it on the bedside table, and proceeded with administering medications and water to R15 through the large plastic syringe. During an observation and an interview on 9/9/24 at 2:12 PM, R15 was observed laying down in the bed and the head of the bed (HOB) was flat while his tube feeding was infusing. A sign on the wall above his bed indicated the HOB is to be at a 30-degree angle. Certified Nursing Assistant (CNA) G reported the bed is not to be flat and raised the HOB to what he thought was a 30-degree angle but did not have a tool or any indicator to show it was a 30-degree angle, and then left the room. This surveyor used a tool to show the bed was at a 17-degree angle. During an observation and an interview on 9/9/24 at 2:20 PM, the Assistant Director of Nursing, (ADON) F reported the HOB for R15 should be at a 30-degree angle. The ADON then went to his room and confirmed it was not at a 30-degree angle and raised the HOB. (continued on next page)

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	235450	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Dr Allendale, MI 49401

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tube Feeding policies were requested and received. Review of the policies do not include continuous enteral feedings and positioning of the resident during that time. It does address the HOB is to be at a 30-degree angle when checking for residual. In an interview and a record review on 9/10/24 at 2:15 PM, the Director of Nursing (DON) reported the bed for R15 should be at a 30-degree angle while his continuous tube feeding is infusing. The facility does not have a tool for staff to ensure the HOB is at least at a 30-degree angle. Staff have access to the care plans that address R15's plan of care, and the aides have access to the Profile Care Plan Approaches which is driven by the Care Plan. The DON provided a copy of the Profile Care Plan Approaches for R15 which revealed no information for ensuring the HOB is at least at a 30-degree angle while tube feeding is infusing. The DON confirmed that the Care Plan was not updated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37573 This citation pertains to intake M100144670. Based on interview and record review, the facility failed to operationalize policies and procedures to ensure controlled substances are continuously and accurately accounted for between staff rotations, involving 4 of the 4 controlled substance logs in the facility, resulting in the potential for medication diversion. Findings include: Review of a policy titled Controlled Substances Standards of Practice last reviewed 1/2024 revealed: In order to accurately account for all controlled substances through the process of ordering, receiving, storage, administration and destruction, the following procedures have been provided. The Narcotic Page count sheet is updated with the addition of controlled substances at the time of delivery to include resident name, drug, and amount at the time of delivery. The Proof-of-use sheet is to be placed in binder and to be counted each change in nurse ownership of narcotic keys. Both on-going and off-going Nurses will count the number of containers and narcotic Proof-of-Use sheets to ensure accuracy reconciliation and provide signatures on the Narcotic Page and Card Count sheet. Both on-going and off-going nurses reconcile the Narcotic EDK (sic) and Narcotic Refrigerator EDK by checking and signing that the tag numbers on the boxes to ensure accuracy of safekeeping. Counts will occur with each change in ownership of narcotic keys, at shift change and change in assigned. If the Emergency Controlled Substance Box (EDK) is opened, nurse must sign the removal on an EDK Usage sheet, a new tag is placed on the box, and the number of the tag is documented on the Emergency Controlled Substance Inventory Kit Verification log sheet. Review of the August Narcotic Page Count Sheets for the 100-hall cart 1 and 2, and the 200-hall cart 1 and 2 revealed several missing nursing signatures verifying complete and accurate narcotic counts, incomplete information documented in the column for adding or subtracting narcotics and several entries missing resident information. Review of the August Emergency Controlled Substance Inventory Kit Verification log sheets on the medication carts revealed there were several opportunities of nursing signatures not verifying that the Emergency Controlled Substance storage was locked with a numbered green or red tag to ensure its locked and secured. There are 3 tags to be tracked and logged. Some entries show all 3 tags were changed with new numbers and no other nurse signature verifying or witnessing the change. There are several days of documentation missing. In an interview on 9/10/24 at 2:15 PM, the Director of Nursing (DON) reported the Narcotic Logs were not complete and accurate. The Pharmacy Representative comes to the facility on ce a month to do reviews and not sure if they look at the narcotic logs. She was not aware the documents were incomplete until this survey and reported she had some education to do.

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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. 29073 Based on observation, interview, and record review, the facility failed to: 1. Properly date mark and discard food product; 2. Properly store food product; 3. Ensure cleaning of food and non-food contact surfaces; 4. Ensure proper working order of dish machine. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected 51 residents who consume food from the kitchen. Findings include: During an observation on 9/10/2024 at 8:00 AM, the following was observed: a) the paper towel dispenser over the handwashing sink in the kitchen did not have paper towel available for staff to dry their hands. Two dietary staff were observed entering the kitchen and did not wash their hands before obtaining supplies and food items to serve breakfast from the main dining room. b) There was no thermometer in the reach in freezer in the facility kitchen. c) The water supplying the low temperature dish machine in the kitchen did not reach the minimum required 120 degrees Fahrenheit. Dietary Manager (DM H inserted a digital thermometer used to test the temperature of the water indicated the water reached a maximum temperature of 114 degrees Fahrenheit after running two full cycles. During an interview on 9/10/2024 at 8:05 AM, DM H reported that staff should be checking the chemical concentration and temperature of the dishwasher before each meal service and was aware it was not being done at least daily. DM H also reported that facility staff were not checking refrigerator or freezer temperatures according to policy and said there were holes in the logs. Review of Low Temperature Dish Machine Temperature Log reflected areas to document the date, wash temperature, rinse temperature and chemical concentration as registered on a strip along with a place for staff to initial the competed duty. The bottom of the form indicated wash/rinse temperature needed to be between 120-140 Degrees; sanitizer needed to be 50-150 PPM (parts per million). Instructions at the bottom of the form reflected Note: Machines that do not meet the above minimum requirements on a shift/daily basis, notify your director immediately, stop washing dishes, start 3 sink method. Review of the September 2024 Low Temperature Dish Machine Temperature Log revealed that as of 9/10/2024 the machine had only been tested for breakfast and lunch service on 9/4/24 and 9/5/24. Logs from September 2023-August 2024 were reviewed and showed staff were not consistently monitoring the function of the dish machine every shift daily as required. Review of the Three Compartment Sink Sanitation Log for the months of May-September 2024 reflected the sanitizer concentration and water temperature were not being monitored during each meal and daily as required. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Temperature Log - Refrigerator/Freezer from May-June 2024 for the reach in freezer and refrigerator, the walk-in cooler and freezer and the freezer and refrigerator in the Bistro reflected staff were not monitoring temperatures twice daily as required. According to DM H, there were no logs for temperature monitoring for the months of July, August or September 2024. Review of Daily Food Temperature Log for Trayline for the months of July-September 2024 reflected food temperatures were not being taken for each meal every day. During a follow-up interview on 9/11/2024 at 9:36 AM, DM H reported that the dishwasher has not been serviced yet. DM H said that the issue had been reported to the Maintenance Director and it was determined the reason the temperature was not reaching the minimum temperature required was related to the boiler. DM H reported the facility did not implement a back-up plan for dinnerware and sanitizing dishes since it had been identified on 9/10/2024 at 8:00 AM that the dish machine was not working properly. 37577 During an observation on 09/10/24 at 7:50 AM, the refrigerator in the 200 hall meal service area contained an uncovered 8 ounce clear plastic cup that was 1/2 full of med pass (a fluid given to resident's to increase calories and nutritional intake) with no name or date on the cup. During the same observation, the freezer in the 200 hall meal service area contained a clear plastic bag with small round frozen cookie dough pieces that were covered with frost and the bag did not have a date on it. During an observation on 09/10/24 that began at 8:00 AM, the following were noted in the kitchen: (a) to the left of the hand/eye washing station, there was a brown substance splashed on the wall, (b) a clear 2 quart plastic container of brown sugar did not have a date on it and the purple handled scoop used to remove the brown sugar had a thick coating of brown sugar on the inside of the scoop, (c) the Savory brand mini toaster dials for the upper and lower heaters and for the conveyor speed were sticky and covered with crumbs, (d) the dry storage room contained an opened, unsealed (open to air) 50 pound bag of Quality Value Jiffy yellow cake mix that did not have a date on it indicating when it was opened, (e) the dry storage room Traulsen single door refrigerator contained an opened and partially used brick of cream cheese that did not have a date on it, (f) in the hall outside the dry storage room, the walk-in U.S. Cooler contained a cart with 12 cups of milk and juice that did not have dates and were not covered. Also on the cart were 2 trays of juices and milk that did not have dates, (g) and an undated opened loaf of bread sat on top of the microwave. During an observation on 09/10/24 at 1:52 PM , the refrigerator in the 200 hall meal service area still contained an uncovered 8 ounce clear plastic cup that was 1/2 full of med pass, with no name or date on the cup. The refrigerator also contained a sandwich in a clear plastic bag with no name or date on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code section 2-301.12 Cleaning Procedure. (A) Except as specified in (D) of this section, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under S 5-202.12 and Subpart 6-301.(B) FOOD EMPLOYEES shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: (1) Rinse under clean, running warm water; (2) Apply an amount of cleaning compound recommended by the cleaning compound manufacturer; (3) Rub together vigorously for at least 10 to 15 seconds while: (a) Paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and (b) Creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers; (4) Thoroughly rinse under clean, running warm water; and (5) Immediately follow the cleaning procedure with thorough drying using a method as specified under S 6-301. 12 .