STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235605	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry House Inn	3905 Lorraine Path St Joseph, MI 49085

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration for 1 resident (Resident #84) of 7 residents reviewed for medication administration, resulting in medication being administered without a physician order, and the potential for less than therapeutic effects of medications, and the worsening of medical conditions. Findings include: Resident #84 Review of an Admission Record revealed Resident #84 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes mellitus (a disorder in which the amount of sugar in the blood is elevated) . In an interview on 12/3/24 at 11:32 AM, Resident #84 reported that she had been managing her blood sugar using insulin for [AGE] years, and that the facility didn't seem to understand how to manage her Type 1 diabetes. Review of Resident #84's Physician Orders revealed, Insulin (helps to regulate blood sugar levels) Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector. Inject as per sliding scale .before meals and at bedtime for DM (diabetes mellitus). Active 12/3/2024. During a medication administration observation on 12/04/24 at 12:10 PM at the medication cart, Registered Nurse (RN) R was preparing to administer insulin to Resident #84. RN R reviewed the orders and prepared 5 units of Insulin Lispro via pen-injector, then entered Resident #84's room and administered the medication. During a subsequent medication administration observation on 12/05/24 at 12:06 PM at the medication cart, RN J was preparing to administer insulin to Resident #84. RN J reviewed the orders and prepared 3 units of Novolog insulin via a glass vial using a syringe, then entered Resident #84's room and administered the medication. RN J reported that Novolog and Insulin Lispro were the same medication. RN J reported that Resident #84 had both types available to use, and that they would notify the doctor to discuss getting an order for the Novolog insulin. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/5/24 at 3:20 PM, Director of Nursing (DON) B reported that she was not aware that Resident #84 had two different types of fast acting insulin in the medication cart. DON B reported that Resident #84 did not have an order for Novolog insulin, and the vial may have been the resident's insulin from home, and was inadvertently placed in the medication cart.

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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. 41027 Based on observation, interview and record review the facility failed to ensure residents received coordination of care in accordance with physician orders and professional standards for skin conditions in 1 resident (Resident #13) of 1 resident reviewed for skin conditions, resulting in burning pain, the potential for an exacerbation of stasis dermatitis and an increased risk for infection due to compromised (weakened) skin integrity. Findings include: Resident #13 Review of Resident #13's Skin Integrity Care Plan revealed, .BLE (bilateral lower extremity) redness from stasis dermatitis (a skin condition caused by poor blood circulation in the lower legs) .Interventions: Monitor for signs and symptoms of infection (swelling, redness, increased pain, firmness, drainage) . There were no interventions specific to dry skin, and/or the lower legs. During an observation on 12/03/24 at 10:17 AM in the hallway, Resident #13 was walking with Occupational Therapist (OT) T. Resident #13's lower legs were observed with brown ace wraps around them. In an interview on 12/03/24 at 01:54 PM, Resident #13 reported that his legs have been wrapped for a while now, and he did not know how long the wraps had been in place. Resident #13 reported that the facility does not change the wraps regularly, and that when they apply the lotion to his legs, it causes a burning pain. Review of Resident #13's Concern Form dated 10/14/24 revealed, .observed (Director of Nursing (DON) B) scraping his legs very roughly while telling (Resident #13) no pain, no gain .told (DON B) to stop and she didn't, and continued to put a dressing on his legs against doctors order . The follow up and resolution did not include a review of the residents treatment orders to ensure appropriateness. In an interview on 12/04/24 at 02:33 PM, Registered Nurse (RN) U reported that they had not observed Resident #13's legs that day, but that there were orders to apply Ammonium Lactate lotion twice a day to his legs, and stated that the lotion helped to remove the dead skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/04/24 at 02:35 PM in Resident #13's room, the resident was observed sitting in a chair, and both of his lower legs were wrapped with brown ace bandages. Resident #13 reported that the wraps had been in place for a long time, that his legs were raw. RN U and RN R removed multiple ace wraps and thick absorbent pads that were in place on the resident's lower legs. The wraps did not have a date written on them to indicate when they were applied. The absorbent pads were observed with a small amount of clear fluid. The skin on Resident #13's lower legs was bright red, firm, and slightly shiny. RN V was called to the room, and reported that Resident #13 should have the Ammonium Lactate lotion applied to his lower legs as ordered, and they had a new physician's order to wrap Resident #13's legs as needed if they were weeping. RN V reported that she would call the physician for further instructions regarding if Ammonium Lactate lotion was recommended when the skin on Resident #13's legs was draining fluid. Resident #13 then stated, when they put that white stuff on there it burns for days . In an interview on 12/04/24 at 02:55 PM, RN V reported that the physician (Medical Director (MD) O) had said to discontinue using the Ammonium Lactate lotion for Resident #13, due to his legs being open and draining fluid. RN V reported that she was informed that Resident #13's legs were draining fluids that morning, but could not remember where that information came from. RN V reported that she did not assess the skin on Resident #13's legs, but observed that they were wrapped with brown ace bandages, therefore she called MD O and put an order in for as needed application of the wraps. Review of Resident #13's Treatment Administration Record (TAR)/Physician Orders revealed, Ammonium Lactate External Lotion 12 % (Lactic Acid) apply to BLE topically every shift for Stasis Dermatitis. Start Date 11/13/24. The lotion was documented as refused for 3 of 6 opportunities, administered for 2 of 6 opportunities, and not documented for 1 of 6 opportunities. There was no additional documentation for the refused treatments. According to the Food and Drug Administration (www.fda.org) Ammonium Lactate is used to treat dry, scaly skin. Apply a thin layer of this medication to the affected areas of the skin, usually twice daily or as directed by your doctor. Be careful to avoid your eyes, lips, inside your mouth/nose, the vaginal area, and any areas of broken skin. This medication may cause stinging or burning when applied to skin with fissures, erosions, or abrasions. (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 12/05/24 at 02:15 PM, DON B reported that Resident #13 admitted in a couple months ago with thick dry skin on his lower legs, and an order to use ammonium lactate lotion to the dry skin on legs was in place already. DON B reported that Resident #13 had been in and out of the hospital twice since his admission to the facility, and the order for ammonium lactate lotion had been re-ordered upon hospital discharge. DON B reported that Resident #13's thick dry scaly skin had improved since admission, but that the Ammonium Lactate lotion order had not been discontinued. DON B reported that Resident #13 did not have any record of a skin condition being monitored on his lower legs, except for the ammonium lactate lotion orders, that indicated he was being treated for the dry skin and/or stasis dermatitis. DON B reported that Resident #13 did not have any documentation related to his lower legs draining fluids, and there were no notes about the lotion causing a burning pain. DON B reported that she did not know who applied the wraps and absorbent pads to Resident #13's legs, and/or how long the dressings had been in place, prior to being changed the day before (as noted in above observation). DON B reported that she did not know the current status of Resident #13's skin condition on his legs because there were no assessments documented, and that the current order for as needed application of wraps to the resident's legs, did not include how long the wraps should stay in place, therefore the orders were not appropriate. DON B reported that Resident #13 should have scheduled dressing changes, and regular monitoring of the skin condition on his lower legs. In an interview on 12/05/24 at 03:15 PM, MD O reported that they were not informed that Resident #13's legs were open and draining, until this surveyor questioned RN V about the Ammonium Lactate lotion orders. MD O reported that they did not give an order for the residents legs to be wrapped as needed for the fluid drainage. Review of Resident #13's initial admission from the hospital on 10/10/24 revealed, Physician Discharge Summary: .Ammonium lactate 12% cream, apply topically if needed for dry skin, apply to legs .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00146244. Based on interview, and record review, the facility failed to maintain professional standards of care for 1 resident (Resident #83) of 1 resident reveiwed for accidents and hazards, from a total sample of 12 residents, resulting in the potential for unidentified internal bleeding when Resident #83, who was taking an antiplatelet medication (which decreases blood clotting ability) was not sent to the hospital after sustaining head trauma following a fall. Findings include: Resident #83 Review of Resident #83's Care Plan revealed, .Focus: .receiving an antiplatelet medication r/t (related to) CAD (coronary artery disease: common type of heart disease) . Review of Resident #83's Fall Report dated 8/3/24 revealed, .guest was seen laying on the floor in the hallway .Neuro's (neurological checks) initiated due to being unwitnessed. Resident taken to hospital? NO . Review of Resident #83's Fall Report dated 8/4/24 revealed, .Resident was on the floor next to the bed in front of wheelchair with foot pedals .Resident unable to give description .Resident taken to hospital? NO . Appears as if guest attempted to self-transfer and ambulate . Review of Resident #83's Fall Report dated 8/7/24 revealed, .Resident was being combative, and throwing items while being walked around by two CNAs (certified nursing assistant). She tripped over a decorative bag that she threw, CNA unable to avoid her falling. Witnessed by nurse and two CNAs .neuros initiated. Resident taken to hospital? NO .Injuries observed at time of incident: .Hematoma (a bump that forms after trauma due to a collection of blood), Face .Both CNA's and nurse state gait belt was in use and a second CNA was present due to increased agitation and guest wanting to speed up pace. Guest picked up a decorative sack outside of room [ROOM NUMBER] and as she threw it fell forward .momentum was too fast and was unable to keep guest from falling forward onto her face .sustained facial bruising and hematoma from fall . Review of Resident #83's Physician Orders revealed, .Clopidogrel Bisulfate Oral Tablet 75 mg . In an interview on 12/05/24 at 02:55 PM, Director of Nursing (DON) B reported that they did not send Resident #83 for an evaluation at the hospital after her unwitnessed falls, and/or after her witnessed fall with head trauma, considering that she was taking an antiplatelet medication. DON B reported that the facility policy was to monitor for neurological abnormalities post fall with head trauma, and the decision to send to the hospital would be strictly based on the neurological assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/05/24 at 03:08 PM, Medical Director (MD) O reported that the standard of care after an un-witnessed fall, and/or a fall with known head trauma for all residents that take antiplatelet medication, would be to send to the hospital for an evaluation. MD O reported that minor neurological changes may go unnoticed by facility staff, and it would be difficult to identify a slow bleed, without a brain CT (catscan:a detailed xray). MD O reported that antiplatelet medication increase the risk of a brain bleed, and if not identified timely could result in brain injury. MD O reported that they would expect nursing staff to be knowledgeable about these standards of care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41982 Based on interview and record review, the facility failed to ensure the physician reviewed and responded to the registered pharmacist's monthly medication regimen review recommendations for 1 (Resident #2) of 5 residents reviewed for medications, resulting in the registered pharmacist's recommendations not being addressed in a timely fashion and the potential for negative medication side effects as a result of unaddressed recommendations. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 was a female, with pertinent diagnoses which included: generalized anxiety disorder. Review of a Pharmacist Clinical Record Review dated 11/7/24 for Resident #2 revealed, .5. Recommendations I would make the following recommendations: Medication regimen reviewed see report . (also referred to as Prescriber Recommendations). On 12/4/24 at 1:40 PM, Nursing Home Administrator (NHA) A was requested, electronically, to provide this surveyor with a copy of Resident #2's 11/7/24 Pharmacist Medication Review Report. In an interview on 12/5/24 at 11:03 AM, NHA A reported she had received this surveyors request and was unable to locate the report for Resident #2 but had been in touch with the physician who had a copy of said report and was going to send it to the facility. In an interview on 12/5/24 at 11:56 AM, Director of Nursing (DON) B reported the physician was unable to locate a signed copy of the 11/7/24 Pharmacist Medication Review Report for Resident #2, but signed it today and, as a result, the facility would be making the recommended changes. Review of the Prescriber Recommendations report related to Pharmacist Clinical Record Review on 11/7/24 for Resident #2 revealed, The resident was started on the psychotropic Hydroxyzine 10 mg (milligrams) to be taken PRN (as needed). Per regulatory guidelines, orders for psychotropic medications on a PRN basis must be limited to 14 days with no exceptions. If a new order for the psychotropic medication is to be written, a direct examination of the resident by the attending physician or prescribing practitioner is required to determine if the medication is still needed .Please consider the continued need for this medication. If discontinuation is contraindicated, please document continued need, including any improvement and benefit experienced by the resident as a result of the medication .signature: (prescriber name omitted) 12/5/24. Review of a Physician's Order for Resident #2 revealed, hydrOXYzine HCl Oral Tablet (Hydroxyzine HCl) Give 10 mg by mouth every 6 hours as needed for Anxiety Pharmacy Active 11/6/2024 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 12/5/24 at 12:05 PM, DON B reported the process to address pharmacist medication review reports was that the pharmacist sent the recommendations to the facility via electronic mail to the DON, the Minimum Data Set (MDS) Nurse, and the doctor. At that point, either the DON or the MDS Nurse printed the report from the computer and placed it in the doctor book for the next time the doctor came to the facility and if there were any recommendations that needed to be addressed, the facility would contact the doctor for an immediate response. Once completed, the doctor signed the report and placed it into the pile to be scanned in the resident medical record. DON B reported was unsure why this process was not followed for Resident #2's 11/7/24 Pharmacist Medication Review Report.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41982 Based on interview and record review, the facility failed to discontinue psychotropic medications (drugs that alter brain chemistry and can affect mood and behavior) prescribed on an as needed (PRN) basis after 14 days and/or document rationale to extend PRN psychotropic medication use in 2 of 5 residents (Resident #2 and #134) reviewed for unnecessary medications, resulting in the potential for unnecessary medication use with the increased potential for adverse side effects. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 was a female, with pertinent diagnoses which included: generalized anxiety disorder. On 12/4/24 at 2:40 PM, a review of Resident #2's current physician's Order Summary revealed a Physician's Order for hydrOXYzine HCl Oral Tablet (Hydroxyzine HCl) Give 10 mg by mouth every 6 hours as needed for Anxiety Pharmacy Active 11/6/2024 It should be noted that there was no stop date identified for this PRN psychotropic medication. Review of a pharmacist clinical record review report for Resident #2 dated 11/7/24 and titled Prescriber Recommendations revealed, The resident was started on the psychotropic Hydroxyzine 10 mg (milligrams) to be taken PRN (as needed). Per regulatory guidelines, orders for psychotropic medications on a PRN basis must be limited to 14 days with no exceptions. If a new order for the psychotropic medication is to be written, a direct examination of the resident by the attending physician or prescribing practitioner is required to determine if the medication is still needed .Please consider the continued need for this medication. If discontinuation is contraindicated, please document continued need, including any improvement and benefit experienced by the resident as a result of the medication .signature: (prescriber name omitted) 12/5/24. In an interview on 12/4/24 beginning at 2:54 PM, Social Services Director (SSD) I confirmed that Resident #2 was prescribed Hydroxyzine 10 mg as needed for anxiety. SSD I reported when the order was entered, there should also have been a 14-day stop date entered to prompt a review of the medication effectiveness and continued need. Resident #134 Review of an Admission Record revealed Resident #134 was a male, with pertinent diagnoses which included: anxiety disorder, unspecified. On 12/4/24 at 2:45 PM, a review of Resident #134's current Order Summary revealed a Physician's Order for KlonoPIN Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth every 12 hours as needed for anxiety Pharmacy Active 11/18/2024 It should be noted that there was no stop date identified for this PRN psychotropic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/4/24 beginning at 2:54 PM, Social Services Director (SSD) I reported Resident #134's order for the psychotropic medication Klonopin should have been discontinued after 14 days or there should have been a documented rationale for continued use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41982 Based on observation, interview, and record review, the facility failed to ensure food products were served at a palatable temperature for 2 of 12 sampled residents (Resident #22 and #133) reviewed for food palatability, and 5 of 6 residents from the confidential resident meeting, resulting in dissatisfaction with meals, and the potential for decreased food acceptance and nutritional decline. Findings include: Resident #22 Review of an Admission Record revealed Resident #22 was a male. Review of a Minimum Data Set (MDS) assessment for Resident #22, with a reference date of 9/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #22 was cognitively intact. In an interview on 12/3/24 at 11:16 AM, Resident #22 reported concerns with food served at the facility. Resident #22 reported despite going to the dining room for some meals, his food was not consistently hot enough (not served at a palatable temperature). Resident #133 Review of an Admission Record revealed Resident #133 was a female. Review of a Minimum Data Set (MDS) assessment for Resident #133, with a reference date of 11/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #133 was cognitively intact. In an interview on 12/3/24 at 10:28 AM, Resident #133 reported the food at the facility was consistently not hot enough (not served at a palatable temperature). Resident Council Meeting During a confidential resident meeting held on 12/4/24 at 2:02 PM, 1 of 6 residents reported the food could be better; 1 of 6 residents reported they have had to send meals back due to hot foods being served cold. This same resident reported food temperatures were usually warm to cool. When asked about the lunch served that day, 5 of 6 residents reported the temperature of the food served was barely warm. During a tray line/meal service observation that began on 12/4/24 at 12:15 PM, noted pans of food set up in the steam table ready for service. Temperatures of the food on the tray line were as follows: Meatballs/Gravy - 128 degrees, Buttered Noodles - 126 degrees, and Spinach - 128 degrees. At 12:15 PM, dietary staff plated 4 plates of food, each with 3 meatballs, a scoop of buttered noodles, and a scoop of spinach. The plates were covered and placed on the non-heated portion of the steam table. At 12:28 PM, Certified Nursing Assistants (CNAs) retrieved the 4 plates of food for delivery to residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/5/24 at 9:22 AM, Certified Nursing Assistant (CNA) L reported residents had complained to her about the food, specifically that it was not hot enough when it was served to them.

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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. 41982 Based on observation, interview, and record review, the facility failed to: 1. Clean non-food contact surfaces; 2. Label and date cooked potentially hazardous food products with a prepared and discard date; 3. Repair or replace a water-damaged temperature gauge on the dish machine; 4. Ensure dish machine was at proper temperature prior to use; 5. Ensure food products reached safe internal temperature prior to service; and 6. Ensure prepared food was properly cooled. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness for all residents who consume food from the kitchen. Findings include: An initial kitchen/food service tour was conducted on 12/3/24 beginning at 9:15 AM with Food Service Director (FSD) M. The following observations/interviews/record reviews were completed: At 9:24 AM in the walk-in cooler it was noted that the floor had a build-up of dirt and debris under the food racks and in the corners. There was a pan of roast beef that was not labeled or dated. FSD M confirmed that the floor needed to be cleaned and that the roast beef had been cooked the day before for use at an upcoming meal. At 9:35 AM, Dietary Aide (DA) F was observed washing dishes from the breakfast meal. It was noted that there was a dish machine temperature log for December 2024 on the wall across from the dish machine that had no temperature entries on it. This surveyor queried DA F if he had taken the temperature of the dish machine prior to washing dishes to which DA F reported he had not. FSD M reported the dish machine was a high temperature dish machine, and the wash cycle had to get to 155 degrees in order for the dishes to be properly sanitized. Visual inspection of the wash cycle temperature gauge on the dish machine revealed water damage and condensation in the interior of the gauge rendering it potentially inaccurate and difficult to read. At 9:43 AM, a review of cooked food temperature logs in a blue binder across from the cooks' station revealed no documented food temperatures of cooked food since 9/17/24 (the last page in the temperature log binder was for the month of September 2024). [NAME] G was queried if she had checked the internal temperatures of the breakfast meal that morning before serving to the residents to which she stated she had not because she .didn't get to it . At 9:53 AM, it was noted that the vent above the meat freezer was caked with a moderate amount of dust build-up. At 9:54 AM in the salad cooler, the following items were noted: cut-up roast beef in a crock pot bowl that was not covered, labeled, or dated. FSD M reported it was more of the roast beef from the walk-in cooler that was going to be used for an upcoming meal. There was a large container of what appeared to be Spanish rice that was not labeled or dated. FSD M reported the rice had been prepared the day before and was for enchiladas that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235605	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry House Inn	3905 Lorraine Path St Joseph, MI 49085

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:07 AM, FSD M was requested to show this surveyor the cooling log for the precooked roast beef and Spanish rice to ensure proper time/temperature cooling was followed. FSD M reported there was no cooling log. At 10:15 AM in the nourishment room, there was a half empty container of nutrition supplement drink that was not labeled with an opened or discard date; an opened gallon of French dressing that was not labeled with an opened or discard date; and leftover containers of prepared chicken salad and tomato soup that were not labeled with a prepared or discard date. FSD M reported the items should have been labeled with an opened and discard date in order to know when to discard them. In an interview on 12/4/24 at 11:58 AM, Dietary Technician (DT) E was queried about proper time/temperature cooling practices for foods prepared ahead of time. DT E reported they had not been keeping a cooling log for products prepared ahead of time. DT E reported since he and FSD M started, they have been polishing up on all temperature logging with the staff but they were still working on it. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41027 Based on observation, interview, and record review the facility failed to follow the standards of infection control for hand hygiene and glucometer (handheld machine used to check blood sugar level) cleaning for 3 residents (Resident #84, #8, and #85) of 3 residents receiving blood sugar assessments, resulting in the potential for cross contamination and the spread of disease to a vulnerable population. Findings include: During an observation on 12/05/24 at 12:06 PM in the hall at the medication cart, Registered Nurse (RN) J was preparing to perform a blood sugar check for Resident #84. RN J donned gloves, entered Resident #84's room, poked Resident #84's left right finger to obtain a blood specimen, and then picked up the glucometer with a test strip in it, and touched it to the drop of blood on the resident's fingertip. RN J sat the glucometer on the resident's table, wiped the blood from the resident's finger, removed his gloves, then picked up the glucometer and exited the resident's room. RN J did not perform hand hygiene after removing his gloves, returned to the medication cart and placed the uncleaned glucometer on the cart, with the used test strip still in place. There was no barrier sheet on the medication cart, and RN J did not clean the glucometer. RN J then used the computer to review the resident's orders, and then obtained a vial of insulin (medication used to manage high blood sugar levels) and prepared Resident #84's dose of the medication using a syringe. RN J donned clean gloves, entered Resident #84's room and administered the syringe of insulin. RN J removed his gloves and exited the room, and did not perform hand hygiene. During an immediate subsequent observation on 12/05/24 at 12:21 PM RN J donned gloves, and with the same glucometer, inserted a new test strip and then entered Resident #8's room. RN J poked Resident #8's right index finger to obtain a blood specimen, and then picked up the glucometer touched the test strip to the drop of blood on the resident's fingertip. RN J sat the glucometer on the resident's table, wiped the drop of blood off the resident's finger, removed his gloves, then picked up the glucometer and exited the resident's room. RN J did not perform hand hygiene after removing his gloves, returned to the medication cart where he removed the test strip without gloves on, and placed the uncleaned glucometer on the cart. There was no barrier sheet on the medication cart, and RN J did not clean the glucometer. During a third subsequent observation on 12/05/24 at 12:26 PM RN J put a new test strip into the same glucometer, donned gloves without performing hand hygiene, and entered Resident #85's room. RN J poked Resident #85's left index finger to obtain a blood specimen, and then picked up the glucometer and touched the test strip to the drop of blood on the resident's fingertip. RN J wiped the drop of blood from the resident's finger, removed his gloves, and then with the uncleaned glucometer in hand, exited the resident's room. RN J returned to the medication cart and placed the uncleaned glucometer on the cart. There was no barrier sheet on the medication cart, and RN J did not clean the glucometer. In an interview on 12/05/24 at 12:32 PM, RN J reported that he should have used hand sanitizer after every resident, and cleaned the glucometer with a bleach or alcohol wipe between each resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/05/24 at 3:15 PM, Director of Nursing (DON) B reported that it was expected that the nurses disinfect the glucometer between residents. Review of a facility policy Blood Glucose (sugar) Monitoring Machine Cleaning review date 5/2021 revealed, To provide guidance on how to clean the blood glucose monitoring machine between residents . 3. Take a pre-moistened disinfecting wipe and squeeze out any excess liquid in order to prevent damage to the meter, wipe down the body of the meter, being careful not to allow any liquid to get inside the battery compartment, strip port, or screen for appropriate length of contact time. 4. Cleanse and disinfect meter between each use. 5. Remove gloves and wash hands.