STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Senior Living Campus	100 Glen Oaks Drive New London, MN 56273

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47497 Based on observation, interview, and document review, the facility failed to ensure nail care was provided for 2 of 5 residents (R20 and R26) Findings include: R20's 3/27/25, quarterly Minimum Data Set assessment identified he admitted to the facility in September of 2021, his cognition was severely impaired, and he was dependent on staff for activities of daily living (ADL)'s. R20 had diagnoses of Alzheimer's disease, cerebral palsy, bipolar disorder, and arthritis. Interview on 4/21/25 at 12:35 p.m., with family member (FM)-A reported she has asked the facility staff to clean and trim R20's nails several times. She states his nails look terrible. Observation on 4/21/25 at 12:36 p.m., of R20's nails on both hands were observed to be untrimmed and extended beyond the tip of his fingers with an unknown black substance observed under each nail from edge to edge. Observation on 4/22/25 at 1:23 p.m., of R20's nails identified they remained the same as above. Observation on 4/23/24 at 2:34 p.m., R20's nails remain overgrown with an unknown black substance under the nail of each finger. Review of R20's undated current care plan identified R20 had a self care deficit requiring assistance with ADL's. Staff were to trim and clean his nails as needed two times weekly on bath day. Review of R20's 4/21/25 Nursing Assistant Bath Worksheet identified R21 had his nails trimmed on 4/21/25. The Worksheet was signed by the charge nurse on duty, however, neither the nursing assistant nor the nurse were available for interview. R26's 2/18/25 admission Minimum Data Assessment identified her cognition was severely impaired, and she had diagnoses of Alzheimer disease, anxiety, depression, and arthritis. Observation on 4/23/25 at 5:08 p.m., R26's nails on both hands were unkept and overgrown approximately 1/4 beyond the tip of her fingers with sharp, broken, crooked edges. All nail has an unknown black dirt like substance under the tip. (continued on next page)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's 4/19/25 Nursing Assistant Bath Sheet identified the nursing assistant completing the bath did not report she had completed nail care. Interview on 4/23/25 at 4:25 p.m., with licensed practical nurse (LPN)-A reported when a nursing assistant completes a bath they fill out a bath sheet to identify if they completed nail care, vitals, and check skin. The bath sheet is given to the charge nurse and recorded in the record. She identified she does not check the resident to ensure nail cares are completed. Interview on 4/23/25 at 4:26 p.m., with registered nurse (RN)-A identified staff do the bath then fill out a bath sheet and returned it to the charge nurse. She would make a progress note and enter the information provided on the form from the nursing assistant. She reported the licensed nurse does not do anything else unless the nursing assistant reports a new skin concern. She stated I see nail care as a delegation She did not see the need to follow up to ensure the tasks were been competed. Interview on 4/24/25 at 5:09 p.m., with the facilities RN nursing consultant agreed with the above-mentioned findings and identified she would expect nursing assistants to provide nail care on bath day and would expect the charge nurse to provide oversite by following up with the resident to ensure the task was completed. A policy was requested but was not provided by the end of the survey period.

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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. 47497 Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility care plan for 1 of 1 resident (R)17 to delineate services provided between the facility and hospice. Findings include: R17's 2/20/25, significant change Minimum Data Set (MDS) identified his cognition was severely impaired, and he was dependent on staff for activities of daily living (ADL)s. R17 had diagnoses of Parkinson's disease, respiratory failure, and diabetes. Review of R17's current care plan identified he was on hospice. The care plan lacked any indication what services hospice was to provide during their visits to the facility. Interview on 4/24/25, at 5:05 p.m., with the nurse consultant identified she agreed with the above findings and would expect nursing staff to ensure the hospice care plan is integrated with the facility care plan. Review of the facilities 2017 Hospice Care policy identified residents receiving hospice services would have coordinated care plans that would include the most recent hospice plan of care and the care and services provided by the facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.

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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. 47497 Based on observation and interview the facility failed to ensure hazardous chemicals were appropriately secured in 1 of 2 unlocked soiled utility rooms located in hall A. This had the potential to affect 16 of 29 residents residing in that hall. Findings include: Observation on 4/21/25 at 1:49 p.m., of the unlocked soiled utility room a bottle of Lysol toilet bowl cleaner was sitting on the counter next to the sink. Some of the cleaner was spilled on the countertop. Interview on 4/21/25 at 1:54 p.m., with the maintenance director confirmed the above findings. He does walk through the building but was unable to recall the last time he had checked the utility rooms. He identified they have a locked closet off the nursing floor that is supposed to be used to store cleaning supplies and other hazardous chemicals. He was not certain who had left the toilet bowl cleaner in the unlocked utility room. Interview on 4/24/25 at 4:58 p.m., with the nurse consultant and administrator identified they would expect staff to ensure all hazardous chemicals are always kept in a locked closet away from the resident areas to ensure there was no risk of injury. Review of the 2017 Hazardous Areas, Devices and Equipment policy identified the facility will be assessed for hazards on an on-going basis. When a hazard is identified the safety committee will give recommendations for measures to ensure that vulnerable residents cannot access hazardous areas in the facility with locks, alarms, supervision, etc.

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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. 47497 Based on interview, and document review, the facility failed to ensure pharmacy consultant recommendations were followed up on in a timely manner for 1 of 5 residents (R13) reviewed for pharmacy recommendations Findings include: R13's 3/12/25, quarterly Minimum Data Set (MDS) assessment identified his cognition was intact, he had no behaviors, and he was independent with activities of daily living (ADL)'s. R13 had diagnoses of adjustment disorder with depressed mood, hypertension, diabetes, anxiety, orthostatic hypotension, repeated falls, and stroke. Review of R13's pharmacy consultants monthly drug regimen review identified the following: 1. October 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The facility was unable to provide documentation showing the October review had been addressed by the physician or that the physician had been updated. 2. November 2024 pharmacy consultant recommendation: Please assess for continued use of divalproex 250 mg twice daily, CMS guidelines recommend periodic reassessment of psychotropic medication for trial dose reduction consideration in attempts to eventually discontinue unnecessary psychotropics or find lowest effective dose. If current dose is still appropriate for patient, please provide clinical rationale for continuing current dose in the patient medical record. Physician to address ASAP but no later than 60 days. The November review provided again had no indication that the physician had been updated. 3. January 2025 pharmacy consultant recommendation: Prednisone oral tablet 20 mg give 40 mg by mouth in the morning for preoperative dose related to irritable bowel syndrome, unspecified for three days. Prednisone oral tablet 5 mg Give 20 mg by mouth in the morning for preoperative exam prep for three days Prednisone oral tablet 5 mg, Give 20 mg by mouth in the morning for three days. Please verify if patient should be taking 20 mg, 40 mg, or 60 mg of prednisone for pre-op. Also, should he take 5 mg dose as well those days? The January pharmacy consultant recommendations did not include a response or signature from the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. February 2025 pharmacy consultant recommendation was to add a diagnosis for the use of: prednisone oral tablet 5 mg (prednisone) 5 mg by mouth in the morning. Pyridostigmine bromide oral tablet 60 mg (pyridostigmine Bromide) Give 1 tablet by mouth three times of day. The facility was unable to provide any documentation to show they had updated the physician. Review of the provided copy of the pharmacy review did not include a physician signature. Interview on 4/24/25 at 9:03 a.m., with the director of nursing identified she agreed with the above findings. She reported she does not have a good process in place and would like some help with getting these pharmacy consultant medication reviews organized. Interview on 4/24/25 at 5:00 p.m., with the nurse consultant identified she agreed with the above findings, she reported she has also looked for the documentation showing they had updated the physician and she was also unable to locate it in the medical record. It is her expectation the facility follow-up with the physician once they receive the monthly pharmacy consultant reviews, she would expect this to be completed timely and the facility should have a process to maintain this documentation in an organized fashion. A policy was requested but nothing was provided by the end of the survey period.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992 Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physicians orders and manufacturers guidelines for 2 of 7 (R24 and R30) residents observed to receive medications. A total of seven (7) errors out of 26 errors were identified, resulting in a 26.9% (percent) facility error rate. Findings include: On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including topical medication Voltaren External Gel 1 % (Diclofenac Sodium). The label for this prescription cream directed staff to apply two gm (grams). LPN-A stated she did not have the dispensing film to measure out the two grams as ordered, however, R24 only wished to receive a pea sized amount. LPN-A was unsure how much this was comparative to the two grams amount ordered. LPN-A stated the order on the med sheet, as well as on the label was to be administered, however, R24 preferred only a smaller amount. Immediately following observation of administration of medications, a review was completed of R24's electronic medical record, and Medication Administration Record. A review of the electronic Medication Administration Record indicated the following order: Voltaren External Gel 1 % Diclofenac Sodium (Topical); Apply to knees topically three times a day for knee pain. Apply 2 grams to affected joints. The start date for this order was 10/11/24. Upon review of the Voltaren gel information on https://www.drugs.com/dosage/voltaren-gel, it was identified the 2-gram line is 2.25 inches long. R30's Order Summary Report, dated 4/24/25, identified R30's current physician-ordered medications and treatments. These orders included the orders for Aspirin Delayed Release 325 mg by mouth in the morning for pain with order date of 1/15/25. The orders also included Colace (Docusate sodium) 100 mg by mouth twice a day for stool softener, effective 1/15/25. R30 had orders also noted for Furosemide 20 mg by mouth every morning for tachy-[NAME] syndrome and edema (swelling) effective 3/12/25. R30 had orders in place for Gabapentin 100 mg capsule ordered twice daily by mouth for pain effective 1/22/25. Additional orders were in place for Metoprolol 25 mg twice daily by for essential hypertension, effective 1/21/25. The orders directed staff to give with food. R30 also had orders in place, effective 1/22/25, for Tylenol (acetaminophen) 500 mg two tablets three times a day for pain management. The orders also included Vitamin D3/cholecalciferol (2000 IU)/50 mcg (a unit of measurement) one tablet daily for Vitamin D deficiency, effective 3/6/25. The orders also identified orders for Potassium Chloride Crystals ER (Extended Release) (K-Cl ER) 20 mEq by mouth in the morning for mineral balance. R30's EMAR, printed 4/24/25, identified the above listed medications. The instructions outlined on the EMAR lacked any additional instructions for administration of medications. The EMAR lacked direction to the staff to crush medications and mix with applesauce prior to administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/25, at 7:29 a.m. TMA-B prepared R30's medication at a mobile cart in the hallway near the nurses station. TMA-B proceeded to set up medications for R30 upon review of the EMAR. TMA-B informed surveyor medications were crushed for R30. The following medications were removed from the med cart, compared to the EMAR for accuracy, and set up by TMA-B: Aspirin (ASA) 325 mg one tablet daily by mouth; Colace (Docusate Sodium) 100 mg one tablet twice daily by mouth; Furosemide 20 mg one tablet daily in the morning by mouth; Metoprolol 25 mg one tablet twice daily by mouth; Acetaminophen 500 mg two tablets three times a day; and Vitamin D3/cholecalciferol (2000 IU)50 mcg one. Upon preparation of the Gabapentin 100 mg one capsule twice daily by mouth, the capsule was opened and contents placed into applesauce. TMA-B prepared the K-Cl ER 20 mEq one tablet every morning by mixing this with a small amount of water to prepare a slurry (dissolving the medication in water to give in a suspension). Upon setting up all medications as outlined, with the exception of the Gabapentin and K-Cl ER, the medications were subsequently crushed and placed into applesauce. The medications were then administered to R30. On 4/23/25, at 12:50 p.m. TMA-B was interviewed in follow up regarding the process to determine whether or not to crush meds. TMA-B stated she knew orders to crush medications came from therapy (speech therapy). TMA-B stated the staff would perform a trial to see what worked best for the resident, then a crush order would be obtained if indicated. TMA-B stated she was unsure where the order was found on the electronic medical records (EMR). TMA-B stated this information was relayed to the oncoming staff at shift reports. The information was also displayed on the resident banner within the EMR, and was generally noted in red. Upon review of the banner for R30, TMA-B stated the order crush meds was not observed in the banner. On 4/23/25, at 1:50 p.m. inquired of TMA-B if there have been any problems to date with administration of crushed meds for R30. TMA-B stated R30 had no problems with crushed meds. On 4/24/25, at 3:45 p.m. the assistant director of nursing (ADON) stated the provider must provide the order allowing crushed meds before this would be initiated. The ADON went on to say medications would then be crushed unless it was contraindicated to do so. The ADON stated this order would be placed on the order sheet, and would be found under Other orders. If the orders were entered correctly, it would also be displayed on the resident banner in the EMR. A review of the R30's EMR lacked indication of orders by the provider, as well as information in the banner regarding authorization to crush medications. During interview on 4/24/25, at 3:51 p.m., the director of nursing (DON) stated orders must have been obtained from the provider before medications were given crushed. The assistant director of nursing (ADON) was in the office during this discussion, and upon review of the concerns regarding crushing of meds for R30, verified there were no orders in place in the EMR. In regards to R24, DON stated medications were to be given as prescribed. DON stated if a lesser dose was requested, as in the Diclofenac amount for R24, the provider was to be contacted in update and an alternate order was to be obtained. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/25, at 4:17 p.m. the consulting pharmacist (CP) was provided an overview of the medications being given without a provider order to crush medications. CP stated a provider order was needed before medications were crushed and given to the resident, and medications were not to be given crushed without first consulting the provider. CP stated prior to authorization to crush the medication, the provider reviewed the residents medication and a determination would need to be made as to if the medications were acceptable to crush. If the provider deemed it was not appropriate to crush medications, an alternate method of administration/or alternate medication with a different delivery source would need to be considered. A review was completed with the medications which were given crushed. CP stated upon review of the medications, CP stated ASA was a medication which was not to be crushed. When asked if this was considered a significant medication error, CP stated she did not wish to give things a label. A facility policy, noted to have been revised April 2018, indicated The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify the appropriate indications and procedures for crushing medications. The policy identified the order to crush medications must come from the physician. The policy identified the MAR or other documentation must indicate why it was necessary to crush the medication. A facility policy, titled Administering Medications, last revised December 2012. identified: If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992 Based on observation, interview, and document review, the facility failed to ensure prescribed medications were labeled with current physician-ordered administration instructions to reduce the risk of administration error for 1 of 6 residents (R24) observed to receive medication during the survey. Findings include: R24's quarterly Minimum Data Set (MDS), dated [DATE], identified R24 had intact cognition with several medical diagnoses which included a medically complex condition, restless leg syndrome, muscle weakness, and difficulty walking. On 4/22/25 at 3:56 p.m., licensed practical nurse (LPN-A) was observed to prepare medications at a mobile medication cart in the hallway of the unit. R24 was in the hallway and approached the medication cart for medication administration. LPN-A proceeded to set up medications, including obtaining the med card for Tramadol from the locked box. LPN-A stated R24 received Tramadol HCl 50 mg one tablet every eight (8) hours, and this was given on a routine basis A review of the label indicated the dosing for the medication was for every eight hours, as needed, and did not identify that it was scheduled. LPN-A reviewed electronic medical record with surveyor, and orders reflected the order was for three times a day, and was not listed as a medication to be given as needed. LPN-A stated the label on the prescriptions were to accurately reflect the orders for the medications by the provider and indicated she was going to send a request to pharmacy for a label change to accurately reflect orders. A review of the electronic Medication Administration Record indicated the following orders: Tramadol HCl 50 mg one tablet by mouth three times daily. The start date of the prescription was on 8/31/24. A review of the R24's orders printed 4/24/25, identified R24 was to receive Tramadol HCl one tablet by mouth three times a day for pain effective 8/30/24, with a start date of 8/31/24. On 4/24/25 at 3:51 p.m., the director of nursing was interviewed regarding medication labeling and label checks during medication administration. DON stated the medication labels were to reflect current order. DON stated if a discrepancy was noted, the staff were to verify the correct dose ordered and request a label correction as needed. DON stated medications are to be given as prescribed. A facility policy, titled Administering Medications, last revised December 2012. identified: Medications shall be administered in a safe and timely manner, and as prescribed. The policy directs staff must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47497 Based on observation, interview, and document review, the facility failed to assure cleanliness and monitoring of temps, and undated foods in 1 of 2 refrigerators in dining rooms, and 5 of 5 residents'(R7, R11, R13, R16, and R29) personal refrigerators located in resident rooms. Findings include: R16's 3/3/22, quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she had verbal behaviors towards others two-three days a week, and she was independent with meals and hygiene but required assistance with set up for dressing. R16 had diagnoses of morbid obesity, vascular disease, chronic kidney disease, adjustment disorder, and history of stroke. Observation on 4/22/25 at 5:03 p.m., of R16's room identified she had a small dorm style refrigerator. Inside the refrigerator she had 7 plastic containers with left over foods in them. The containers were not labeled and did not have dates on them. One container had tuna, one container had chicken, and one container had rice. The refrigerator also had condiments and cans of pop. The refrigerator did not have a log to monitor temperature and no thermometer was observed. Interview on 4/23/25 at 7:52 a.m., with the kitchen manager identified nursing is responsible for maintaining personal refrigerators located in resident rooms. Interview on 4/23/25 at 9:33 a.m., with the director of nursing (DON) identified she was not aware that nursing was supposed to monitor the refrigerators in resident rooms for temperature, outdated food, and cleaning. Nursing does monitor the medication room and the dining room refrigerator. She identified she thought it was kitchens responsibility but had just asked them and they said it was nursing's responsibility. She said they had five residents in the facility that had a small refrigerator in their room but she did not know if they were being monitored. Observation on 4/23/25 at 10:13 a.m., of the refrigerators located in resident rooms identified the following: 1.) R29's refrigerator did not have anything in it, there was a thermometer located inside fridge but did not have a log to monitor temperatures. 2.) R11's refrigerator contained beef sticks, and an open container of cheese did. There was a thermometer inside the fridge, but no log was observed in the area for monitoring the temperature. 3.) R13's refrigerator was dirty; it had a glass of juice that was not covered and not dated and a banana that had turned completely black. There was a thermometer, but no log observed in the area for monitoring. 4.) R7's refrigerator had cookies and cans of pop in it. There was no thermometer in the fridge and no log observed in the area for monitoring. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/23/25 at 10:00 a.m., of the refrigerator located in the memory care resident dining area, had a temp log located on the refrigerator door. The log had a column for daily temperatures in the a.m. and p.m. The April 2025 log had entries indicating the refrigerator temperature from 4/1/25 through 4/23/25 on the following dates and times, 4/1/25 a.m., 4/7/25 p.m., 4/8/25 p.m., 4/13/25 p.m., 4/17/25 p.m. The other 25 days had no documented monitoring of the refrigerator temperatures. The outside of the door had a functioning ice dispenser, that had a black and yellow substance on the lever and the tray beneath. The inside of the freezer was observed to have hair sticking to the shelves and the inside of the door, food crumbs, and a brown sticky substance on the shelves, and a piece of Styrofoam laying in a bin at the bottom of the freezer. TMA-B was observed to use the ice dispenser to fill a glass with ice and water and then served it to a resident seated at the table. Interviewed on 4/23/25 at 10:05 a.m., with TMA-B identified she was not sure who was responsible to log the temperatures, but she thought it was the over-night staff. She reported they do not have a cleaning schedule for the refrigerator but they try to clean it as they go. She looked at the ice dispenser and inside the freezer and agreed the log had not been completed and the freezer and ice dispenser was dirty. Review of the facility provided Refrigerators and Freezers policy dated December 2014, identified the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. The facility would use monthly tracking sheets for all refrigerators and freezers and the logs would be posted. The food service supervisor or designated employees will check and record refrigerator and freezer temperatures daily withy first opening and at closing in the evening. All food shall be appropriately dated to ensure proper rotation by expiration dates and all refrigerators and freezers will be kept clean and free of debris on a scheduled basis. The policy made no mention of personal refrigerators located in resident rooms.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 35992 Based on interview and record review, the facility failed to provide a Quality Assurance and Performance Improvement (QAPI) plan that identified necessary policies and procedures describing how the facility will identify and correct quality deficiencies. This had the potential to affect all 29 residents residing in the facility. Findings include: When interviewed on 4/23/25 at 1:29 p.m. the administrator indicated there was no formalized QAPI plan in place to track and measure performance, no goals established to measure performance, and no development or implementation of corrective action or performance improvement activities. The administrator stated although there were attendance rosters available for quarterly QAPI meetings from the past year, the facility lacked any documentation to reflect the QAPI process. The administrator stated awareness of the need for and importance of the QAPI process, however, was new to the facility and this had not yet been implemented. During follow up interview on 4/24/25 at 4:54 p.m., the administrator stated she had again reviewed all documentation in place for QAPI and had not located any information for the past QAPI program. The administrator reported information was present for 2023, however, there was not documentation for 2024 to present. During an interview on 4/24/25 at 3:51 p.m., the director of nursing (DON) stated the facility held quality assurance meetings quarterly, which she had attended. The DON stated during these meetings, she presented updates regarding infection control, and current status within the facility. The DON lacked any documentation related to QAPI presentation of information, or of any previous, or current QAPI programs in place. The facility policy and procedure, titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan, updated on 1/2/25, was provided for review. The policy identified facility specific QAPI goals were to implement the QAPI process successfully as evidenced by the formulation of effective Performance Improvement Plans. In addition, the policy identified specific QAPI goals were to be found within the QAPI committee documentation and Performance Improvement Committee(s) documentation.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35992 Based on interview and document review the facility failed to ensure the quality assurance (QA) team developed, and revised, a quality improvement program to correct infection control concerns identified through tracking and trending and the infection control process as presented by the director of nursing (DON) during routine QAPI meetings. This had the potential to affect all 28 residents residing in the facility. Findings include: On 4/23/25, at 8:28 a.m., the administrator provided information for review related to the Quality Insurance Performance Improvement (QAPI) meeting attendance rosters, and meeting minutes for the current QAPI program. A review of the attendance roster and meeting minutes lacked indication as to what the overall program focused on, as well as what the Performance Improvement Plan (PIP) focus was. The information following the attendance roster of 1/17/24 included hand written notes, however, these notes provided no context as to what the QAPI program was focusing on, benchmarks and goals, or information regarding the current PIP programs. The minutes did reference infection control, and identified no patterns of infection. The meeting minutes referenced 22 staff days lost [related to illness], and also identified 11 Covid in December. A review of the remainder of the meeting attendance sheets lacked further agendas, meeting minutes, or documentation until 3/19/25. Upon review of the final document provided by the facility, the meeting minutes identified the PIP review as Anti-psychotic will begin 3/20/25 in weekly meeting. Upon further review, it was noted under the area titled Infection Control, there was no Covid, four infections, no trends. The document identified the following under the area titled action plan/follow up : auditing TB (tuberculosis), PPE (personal protective equipment), Peri-Care audits performed. During follow up interview on 4/23/25 at 4:54 p.m., the administrator stated she was unable to locate any program specific information regarding the QAPI program, or PIP initiatives, prior to her arrival as the administrator approximately one month ago. The administrator stated at this time, the facility is in the beginning stages of formalizing the QAPI program, and development of the PIP. The administrator stated they were planning to utilize the current survey results to identify focus areas for the PIP. The administrator stated upon receipt of the survey results, the QAPI team would review, and further their process at this time. The facility policy and procedure, titled Quality Assurance Performance Improvement (QAPI), Quality Assessment Assurance (QAA) Plan, updated on 1/2/25, was provided for review. The purpose statement indicated the purpose of QAPI was to develop a culture of proactive leadership and identify plans for improvement leading to systematic changes. The policy identified under guiding principles the following; QAPI program will be ongoing and comprehensive, dealing with the full range of services that we provide, including all departments; and, the organization expects areas for improvement to be identified.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47497 Based on observation, interview, and document review, the facility failed to have a current, ongoing system of infection control (IC) surveillance to identify potential outbreaks of infectious disease, analyze data, and track infections through to resolution or identify the need to alter treatment. The facility also failed to ensure employee illnesses were tracked to identify when staff last worked and the criteria for when they would be allowed to return to work. The facility also failed to ensure staff appropriately wore a gown (personal protective equipment (PPE)) and/or bagged soiled linen during transport. This had the potential to affect all 29 residents in the facility. In addition, the facility failed to appropriately disinfect 1 of 1 resident's (R7) glucometer prior to returning it to the medication cart, Findings include: RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked yes. R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation as part of infection control surveillance to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. 4) R13 was noted to have an infection to a neck surgical incision dated 2/29/25. R13 was given an IV antibiotic. No isolation precautions were noted. R13's progress notes identified R13 had cervical (neck) surgery on 2/6/25 and began showing signs of potential infection on 2/17/25, with surgical site swelling and a non-productive cough was noted. On 2/19/25, R13 had a temperature of 100.4 and complained of vomiting. R13 was sent to the physician's office, who then admitted him to the hospital for treatment. R13 returned to the facility again on 2/24/25 and had a peripherally inserted central catheter (PICC) line (catheter placed into a vein to administer medication directly into the bloodstream for serious infections). There was no indication R13 was placed on enhanced barrier precautions (EBP) upon his return. In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was old peg tube site/skin. No culture was taken. R15 was placed on augmentin (antibiotic). No isolation precautions were noted as having been placed. There was no indication R15 was on enhanced barrier precautions (EBP) prior to the infection to reduce the risk of infection before it had occurred. There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, R16 was placed on augmentin. No isolation precautions were implemented. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. Review of the National Library of Medicine October- December 2013 article, located at https://pmc.ncbi.nlm.nih.gov/articles/PMC3836000/ identified that bacteria was known to be emerging as a multi- resistant pathogen (MDRO). There was no indication R5 was placed on EBP or if the infection preventionist had provided appropriate oversight to ensure the potential to spread the infection was limited or if R5's strain of bacteria was resistant to the antibiotic ordered or if the antibiotic was appropriate. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No isolation was noted to be implemented and no culture was noted. There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precautions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. The information obtained from surveillance was to be compared with data from other facilities with use of acknowledged standards and used to assess effectiveness of IC practices. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's time card for 2/17/25 identified she had worked 5 hours on 2/17/25, and returned for a full day (8 hours) on 2/18/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to have established policies and procedures for infection control among employees where staff should report their infections or avoid the facility. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. PPE/SOILED LINEN Observation on 4/21/25 at 4:45 p.m., of medication aid (TMA)-B walking down the hallway carrying a ball of rolled up sheets, a reusable pad (used as an additional barrier on residents' beds), and a pair of pants. The clothing and linens were touching her clothing, she dropped the pad on the floor and bent over and picked it back up and continued down the hall to the soiled utility room. Interview on 4/21/25 at 5:20 p.m., with TMA-B confirmed she was carrying the linens and clothing down the hall, the items were touching her clothing, and she had dropped some of them on the floor. She confirmed they were not bagged, and she reported they were soiled with urine. She identified she was aware she was supposed to bag soiled linens before taking them out of the room due to risk for cross contamination. She identified she normally bags soiled linens but was in a hurry. Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The facility was to educate staff and ensure they adhered to proper IC techniques and procedures. There was no indication a policy was developed to include when staff would be excluded from work, or if they met criteria to return to work. It is also not indicated the IC policy had been reviewed or updated since 2022 to ensure it met current standards of practice. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. 35992 Glucometer cleaning R7's significant change Minimum Data Set assessment of 1/28/25, indicated R7 had moderate cognitive impairment. R7 was identified as receiving help with activities of daily living. R7's medical diagnoses included diabetes (a group of diseases that affect how the body uses blood sugar (glucose), as well as endocrine (the system which released hormones into your blood while continuously monitoring the levels), nutritional, and metabolic diseases (any of the diseases or disorders that disrupt normal metabolism, the process of converting food to energy on a cellular level). On 4/22/25 at 4:30 p.m., licensed practical nurse (LPN)-A was observed during routine medication pass. At this time, R7 was due for blood sugar monitoring (checking the level of blood sugar in the blood to help determine if medication or additional interventions are needed). LPN-A performed hand hygiene and set up equipment to complete blood sugar check, using R7's monitor. LPN-A brought gloves to room along with equipment, and donned gloves before starting the procedure. R7's finger was cleansed with an alcohol prep, blood was drawn with the use of a disposable lancet (needle used for blood sugar checks), and blood sugar was checked with glucometer (a machine used to check blood sugars). LPN-A gathered supplies and exited room. The lancet was disposed of appropriately, machine was placed on cart, gloves removed and hand hygiene performed. LPN-A then applied gloves and wiped the machine with an alcohol wipe to clean/sanitize the machine. LPN-A stated this was the process she was trained in when she started at the facility. LPN-A proceeded to return the machine to the med cart in the area designated for R7's machine. LPN-A then removed gloves and performed hand hygiene before proceeding to the next task. On 4/22/25, at 4:35 p.m., an interview was held with the director of nursing (DON) to inquire of the process for sanitizing glucometers following performing a blood glucose test. DON stated the glucometer should be cleaned with the use of a disinfectant wipes, wrapping the glucometer in the wipe and allowing to dry to complete the sanitation process. Nurse Consultant (NC) was also present at this time, and verified EPA (Environmental Protection Agency) approved wipes should be used for sanitation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy, Blood Glucose Monitoring Policy and Protocol, undated, identified All glucometers will be cleaned per manufacturer recommendations prior to performing bedside test. The policy then later identified The glucometer will be cleaned prior to each use and after after each use per manufacturer recommendation. The policy lacked indication as to what product was to be used with cleaning, aside from identifying per manufacturers recommendations. The manufacturer's policy for the glucometer, with the recommendations for cleaning, was requested and not received.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 47497 Based on interview and document review, the facility failed to have an antibiotic stewardship program to identify appropriate antibiotic use for 10 of 10 sampled residents (R1, R100, R18, R30, R18, R23, R15, R16, R5, and R101). Findings include: Review of the infection surveillance logs from January 2025 through March 2025 identified: In January 2025, two residents (R100 and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. R100's second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was also prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no information to identify what R100's symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, three residents (R30, R18, and R23) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. 2) R18 was diagnosed with a UTI on 2/11/25. A culture was noted to be taken; however, it was not noted what the organism was. R18 was given Keflex (antibiotic) 500 mg every 12 hours for seven days. No ATO was noted. 3) R23's UTI was listed as beginning on 2/17/25, A culture was reported as being taken, however, the causative agent (organism) was also blank. R23's corresponding progress notes indicated she was sent to the hospital and noted to have a UTI and given an oral antibiotic. R23's after visit summary made no mention of oral antibiotic. There was no further documentation to support staff had called the hospital to inquire about a culture result, nor had asked why R23 was not given an order for her oral antibiotic as indicated in the progress note to identify if the oral antibiotic was perhaps no longer needed. There was no indication any of the above-mentioned residents' symptoms were, or if there was a need to alter therapy during treatment or if symptoms resoled upon completion of the antibiotic. (continued on next page)

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Glenoaks Senior Living Campus	100 Glen Oaks Drive New London, MN 56273

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In March 2025, four residents were identified with infections (R15, R16, R5, and R101) as follows: 1) R15 was noted to have an infection on 3/4/25. The site of the infection was old peg tube site/skin. No culture was taken. R15 was placed on augmentin (antibiotic). There was no indication an ATO had occurred. 2) R16 was noted to have an infection on 3/1/25 to their bilateral lower legs. No culture was obtained, and R16 was placed on augmentin. There was no evidence an ATO was completed. 3) R5 was noted to have a urinary tract infection on 3/6/25. A culture was obtained. The organism causing the infection was a bacteria known as citrobacter freundii. There was no indication an ATO occurred. 4) R101 was noted to have pneumonia on 3/11/25 and was treated with doxycycline. No culture was noted. There was no mention what symptoms each resident had. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. R1's 3/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was moderately impaired and she was dependent on staff for activities of daily living (ADL)'s. R1 had diagnoses of dementia, heart failure, diabetes, multiple sclerosis, anxiety, and depression, and had been taking an antibiotic. R1's 4/9/25, physician order with lab results that identified her urine was positive for Aerococcus (a bacterium associated with urinary tract infections). The lab result included an order for R1 to start taking Macrobid 100 milligrams (MG) twice a day for 7 days. The order noted a susceptibility lab (test to identify what antibiotic the bacterium is susceptible to) was not completed. R1's April 2025, medication administration record identified she was administered 14 doses of macrobid 100 mg by mouth from 4/11/25 through 4/18/25. Interview on 4/22/25 at 1:50 p.m., with the director of nursing identified she was not the infection preventionist (IP) but she was certified in infection control. She was unaware of what an antibiotic time out was and did not know the facility was supposed to complete one. She reports they have an IP that works about 16 hours per week. Her responsibilities are wound care, ordering supplies, and infection control. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 4/23/25 at 1:14 p.m., with the IP identified she was the assistant director of nursing. She works about 20 to 30 hours per week. Her responsibilities included order supplies for the nursing department weekly, complete wound rounds with assessments and physician updates weekly, complete infection preventionist tasks, she occasionally picked up nursing floor shifts, and she was the assistant director of nursing (ADON) which came with several other tasks. Nursing staff document infection in the electronic medical record program (PCC). If the infection lasts one day, she reported she wouldn't add that to the surveillance log. She agreed she was missing information on the surveillance log to be sure a thorough analysis was being completed and had not performed any antibiotic time outs and had no documentation to support she followed and professional criteria for antibiotic appropriateness. She also only documented infections that had been treated with a medication. She noted she received all IC data from the corporate office. She had competed her previous training in 2023 but did not receive any competencies related to her oversight abilities of the infection control program. The corporate office reviews her logs. She felt she wasn't able to provide appropriate oversight as she was responsible for so many other tasks and noted she did not have enough time to complete her duties. I'm not just gathering information, I am working on the floor, updating physicians, writing orders, ordering supplies, doing wound care, and picking up floor shifts. The DON was to oversee the ICP when she was not working. Interview on 4/24/25 at 5:15 p.m., with the registered nurse consultant (RNC) identified staff are required to bag soiled linens prior to transporting them to another area. Staff received training online and were expected to adhere to those processes. The RNC provided documentation of the infection control training completed by TMA-B. She also noted her expectation for the role of the IP was to be deemed competent to provide the oversight and understanding with respect to all that entails, including antibiotic stewardship. The IP should be monitoring all infections, not just those treated with medication. Review of the undated, Antibiotic Stewardship policy identified the facility would monitor the use of antibiotics by residents, staff would receive education that will include inappropriate use of antibiotics and how they affect residents. The policy did not identify a process of how the infection preventionist should monitor and communicate with the prescribing provider of the effectiveness or appropriateness of the antibiotic prescribed. Review of the 10/1/22, Infection Prevention and Control Program policy identified the infection control (IC) program was to consist of coordination and oversight, policies and procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The IC program was to be overseen by the infection preventionist (IP). Surveillance data was to include documented IC incidents and corrective actions taken, identify if physician management of infections is optimal, whether antibiotic usage patterns need to be changed because of resistant strains of bacteria, whether culture results or antibiotic resistance is transmitted accurately and in a timely manner, and ensure there would be appropriate follow-up of infections. The policy was to be reviewed annually and was to include updating or supplementing existing policies, assessing staff compliance with policies and regulation, and identifying trends or significant problems. Antibiotic Stewardship was to include culture reports, sensitivity data and usage reviews using medical criteria and standardized definitions, and be evaluated with feedback from physicians. There was no mention of having staff perform an antibiotic time out or what specific criteria was used to determine appropriateness of medication.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47497 Based on observation, interview, and document review, the facility failed to ensure the infection preventionist had the appropriate time allotted to have oversight of the facility infection control program and was deemed competent in providing that oversight. This had the potential to affect all 29 residents. Findings include: RESIDENT INFECTION SURVEILLANCE Review of the infection surveillance logs from January 2025 through March 2025 identified the columns for name, room #, infection date, site of infection, culture taken, causative agent, antibiotic treatment, isolation precautions and center acquired (obtained while in the facility). In January 2025, three residents (R100, R101, and R18) were listed with active infections as follows: 1) R100 was listed twice with two separate infections, COVID and a urinary tract infection (UTI). An antibiotic was given for each infection. COVID (a virus) was treated with amoxicillin (an antibiotic) 500 milligrams (mg) x three days. Isolation was marked yes. R100 second infection, identified to start the same day, was a UTI. No culture was marked as having been taken, but R100 was prescribed amoxicillin clavulanate potassium (a combination antibiotic) 875/125 mg, x six days, given twice per day. There was no date identified when R100 was put on precautions, what type of precautions were implemented, what their symptoms were, if an antibiotic time out (ATO) was performed (done to ensure the resident is on the correct antibiotic or if the antibiotic should be discontinued) or if there was a need to alter therapy during treatment or upon completion. It is also unknown why R100 was prescribed an antibiotic for the COVID viral infection, or why two antibiotics were listed as having been given. 2) R101 had a skin infection dated 1/31/25. No culture was marked as taken. Zesorb antifungal medication 2% powder was ordered for 14 days, twice daily. It is unknown where the infection was located, or if it resolved after therapy. 3) R18 was noted to have pneumonia. A culture was marked as obtained, and amoxicillin clavulanate potassium, 875/125 mg was given for five days. There was no evidence an ATO was completed. In February 2025, four residents (R30, R18, R23, and R13) were listed with active infections as follows: 1) R30's infection date listed was 2/11/25. R30 was diagnosed with a UTI. A culture marked as taken, and the organism from the culture listed was E-Coli (bacteria). R30 was started on Septra DS (antibiotic) twice daily x three days. There was no indication an ATO was performed. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no indication during any of the above-mentioned surveillance as to whether the infection date was the date when the resident had been diagnosed or if it indicated the onset of symptoms. There was no mention what symptoms each resident had, when transmission based precautions (TBP) were placed or what type of precautions were implemented. Furthermore, there was no evidence of a medication start and stop date. In addition, there was no evidence an ATO was performed nor was there evidence the facility had followed any criteria for an ATO. There was also no indication when symptoms had improved, resolved, or if there was a need to alter treatment. R1's 3/4/25, quarterly Minimum Data Set (MDS) assessment identified her cognition was moderately impaired and she was dependent on staff for activities of daily living (ADL)'s. R1 had diagnoses of dementia, heart failure, diabetes, multiple sclerosis, anxiety, and depression, and had been taking an antibiotic. R1's 4/9/25, physician order with lab results that identified her urine was positive for Aerococcus (a bacterium associated with urinary tract infections). The lab result included an order for R1 to start taking Macrobid 100 milligrams (MG) twice a day for 7 days. The order noted a susceptibility lab (test to identify what antibiotic the bacterium is susceptible to) was not completed. R1's April 2025, medication administration record identified she was administered 14 doses of macrobid 100 mg by mouth from 4/11/25 through 4/18/25. Review of the undated, Antibiotic Stewardship policy identified the facility would monitor the use of antibiotics by residents, staff would receive education that will include inappropriate use of antibiotics and how they affect residents. The policy did not identify a process of how the infection preventionist should monitor and communicate with the prescribing provider of the effectiveness or appropriateness of the antibiotic prescribed. EMPLOYEE SURVEILLANCE Review of the employee surveillance from January 2025 through March 2025 identified the social services designee (SSD) called in sick on 2/17/25 and was noted to have a a diagnosis of Strep (bacterial throat infection) with a fever of 102 degrees Fahrenheit (F) . There was no last day of work noted, if and/when the SSD returned to work, or if she received any antibiotic therapy. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. The SSD's time card for 2/17/25 identified she had worked 5 hours on 2/17/25, and returned for a full day (8 hours) on 2/18/25. (continued on next page)

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