STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	640 Third Street Gaylord, MN 55334

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview, and document review, the facility failed to ensure resident rights and choices were protected for 1 of 1 resident (R16) when his recliner was removed from his room against his wishes. Findings include: R16's admission Minimum Data Set (MDS) dated [DATE], indicated an admitted [DATE], intact cognition, no rejection of care, and diagnoses of heart failure, kidney failure, and edema. R16's care plan dated 7/9/24, focus area titled cognition indicated R16 was at risk for alteration in cognition related to adjustment to placement with interventions listed as allow resident time to communicate his needs/wants, provide and maintain consistent environment. R16's Physician's orders dated 7/2/24, indicated elevating legs to the level of the heart or above for 45-60 minutes, pump ankles while sitting in chair, elevate foot of bed, prop feet up on a pillow when sitting in recliner every shift. R16's Behavior note dated 7/4/24 at 3:37 a.m., indicated R16 was annoyed with staff due to not having his (personal) recliner at the facility yet from his prior facility. Notes further indicated R16 stated he slept in his chair, couldn't sleep in a bed, and needed his chair by that night. R16's New Admission Note dated 7/5/24 at 3:38 a.m., indicated R16 had a hard time falling asleep that night because he was upset about not having his recliner from his prior facility. R16's New Admission Note dated 7/6/24 at 4:58 a.m., indicated R16's recliner had arrived from his prior facility, he was very happy to have his recliner since being without it since admission on 7/3/24, and was resting quietly in his recliner with his eyes closed. R16's Health Status progress note dated 9/15/24 at 3:37 a.m., indicated R16 rested well throughout the night and slept in his recliner with legs elevated for comfort. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/14/24 at 8:31 a.m., R16 stated his recliner was taken from his room several days ago to be cleaned and he was unsure when it would be returned. R16 further stated he slept in his recliner every night and had been sleeping in his wheelchair since his recliner was removed. R16 stated he wanted to put his feet up but could not due to his recliner being gone. R16 further stated he did not sleep in his bed due to it being too small and uncomfortable. During interview on 10/14/24 at 2:03 p.m., R16 stated he did not give permission for his chair to be taken, he had asked for a sheet to be put over it instead, he was sick of sleeping in his wheelchair, and he wanted his chair back by evening. During observations from 10/13/24 through 10/15/24, R16 was observed in his wheelchair with his legs down on footrests. His personal recliner was absent from his room. An alternate recliner from the facility common area was provided after 5 p.m. on 10/14/24. R16's personal recliner was returned on 10/15/24. During interview on 10/14/24 at 2:06 p.m., director of nursing (DON) stated R16's recliner was wet with urine and had a foul smell and she had to take it on 10/10/24 or 10/11/24. DON confirmed she did not ask permission to take the chair. DON further confirmed she was unsure who was going to clean the chair and if or when it would be returned. During interview on 10/15/24 at 10:20 a.m., social services director (SSD) stated she had not been involved in the conversation to remove R16's recliner and was informed after it was removed. SSD further stated R16's recliner was very important to him when he admitted to the facility, and she would have expected R16's chair to be cleaned and immediately returned or a replacement chair offered and accepted prior to removing the chair. SSD further stated due to resident rights, they should have had his permission to remove the recliner. During interview on 10/15/24 at 1:10 p.m., administrator stated they had a discussion about the recliner and decided to remove it due to odor and infection control. Administrator stated she was unsure if anyone confirmed permission from R16. A policy on resident rights and personal property was requested but not received.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R5) reviewed for hospice. Findings include: R5's Face Sheet dated 10/15/24, indicated R5 primary payer was hospice, care providers included hospice, and diagnoses hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status. R5's significant change in status MDS dated [DATE], section O, K1 under special treatments and programs, did not include hospice care services . Section J 1400 Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months indicated no. R5's hospice plan of care printed 10/15/24, indicated R5's hospice start of service date was 9/11/24. R5's care plan dated 10/13/24, indicated hospice Cares r/t (related to) end stage kidney disease, enrolled for services with hospice. On 10/15/24 at 11:49 a.m., registered nurse (RN)-A, also identified as MDS specialist, indicated R5 was admitted to the facility on hospice. Upon review of admission MDS, RN-A confirmed section 0 was not coded as R5 receiving hospice services. On 10/15/24 at 12:37 p.m., the director of nursing (DON) stated the MDS should have been completed accurately and hospice services should have been indicated on the admission MDS. On 10/15/24 at 2:54 p.m., the administrator stated the facility followed the RAI (resident assessment instrument) Manual and doesn't utilize a specific MDS policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on observation, interview and document review, the facility failed to follow physician orders for leg elevation for 1 of 1 resident (R16) reviewed for edema. Findings include: R16's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, no rejection of care, and diagnoses of heart failure, kidney failure, and edema. R16's care plan dated 7/9/24, focus area titled cognition indicated R16 was at risk for alteration in cognition related to adjustment to placement with interventions listed as allow resident time to communicate his needs/wants, provide and maintain consistent environment. Care plan focus area titled skin integrity indicated R16 had alteration in skin integrity related to congestive heart failure (CHF), diabetes mellitus type two (DM2), chronic gout as evidenced by (AEB) wounds. Interventions included encouraging resident to sleep in his bed, monitoring skin integrity, and pressure reducing devices to bed and recliner. R16's Physician's orders dated 7/2/24, indicated elevating legs to the level of the heart or above for 45-60 minutes every shift, pump ankles while sitting in chair, elevate foot of bed, prop feet up on a pillow when sitting in recliner. During interview on 10/14/24 at 8:31 a.m., R16 stated his recliner was taken from his room several days ago to be cleaned and he was unsure when it would be returned. R16 further stated he slept in his recliner every night and had been sleeping in his wheelchair and had not elevated his feet since his recliner was removed. R16 stated he wanted to put his feet up but could not due to his recliner being gone. During interview on 10/14/24 at 1:22 p.m., R16's family member (FM)-J indicated she had not observed his legs elevated since removal of his recliner. FM-J further stated R16 had been sleeping in his wheelchair with his legs down since removal of his recliner and the only option he had been given was to sleep in his bed for elevation, which he didn't like due to the bed being too short and hard. FM-J stated the facility was aware R16 did not like the bed. During interview on 10/14/24 at 10:45 a.m., nursing assistant (NA)-A stated R16 usually sat in his recliner with his legs elevated. NA-A further stated she did not know how he would elevate his legs in his wheelchair or if his legs had been elevated since his recliner had been removed from his room. NA-A also stated R16 usually slept in his recliner. During interview on 10/14/24 at 1:49 p.m., registered nurse (RN)-B stated R16 had been without his recliner since the middle of last week. RN-B further stated he had been sleeping in his recliner and elevating his legs in his recliner prior to it being removed. RN-B was unsure if R16's order for elevating his legs had been completed since his recliner was removed and it would be concerning if R16 was not elevating his legs due to his edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/14/24 at 2:32 p.m., licensed practical nurse (LPN)-A also known as care coordinator stated they had offered to put R16 in bed to take swelling down in lower legs and feet but he refused. LPN-A further stated he often refused to elevate his legs. LPN-A stated she was unsure if R16's legs had been elevated since his recliner was removed and she would check the nurse charting. During interview on 10/24/24 at 2:06 p.m., director of nursing (DON) stated she was unsure if R16's legs were being elevated since his chair was removed. DON stated she talked to R16 and he told her he had not been sleeping in his bed and had been in his wheelchair since his recliner was removed from his room. DON further stated R16 frequently refused to elevate his legs and she would have expected staff to inform her if R16 was unable to elevate his legs and was sleeping in his wheelchair with his legs down. R16's treatment administration record (TAR) dated 10/1/24 through 10/14/24, indicated no refusals of leg elevation during the time period. A facility policy on edema was requested but not received.

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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** 50764 Based on observation, interview, and document review, the facility failed to conduct a comprehensive reassessment after a fall incident and ensure new interventions were implemented to prevent further falls for 1 of 1 resident (R11) reviewed for falls. Findings include: R11's admission record printed 10/15/24, indicated diagnoses of chronic obstructive pulmonary disease (a lung disorder), muscle weakness, and history of falling. R11's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, no rejection of care, use of a wheelchair for mobility, substantial assistance with transfers, and fall history prior to admission. R11's facility Kardex printed 10/14/24, indicated independent with toileting, assist of one staff with bathing, shaving, dressing, and bed mobility, assistance of one staff, walker, and gait belt for walking, and safety intervention of gripper socks at bedtime. R11's care plan dated 10/11/24, listed focus area of fall risk related to COPD, epilepsy, muscle weakness, and history of falls. Interventions included gripper socks or shoes to feet when not in bed and follow PT and OT instructions for mobility function. R11's progress note dated 9/28/24, listed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R11's progress note dated 9/29/24, indicated R11 attempted to self-transfer to the bathroom from his bed and had a fall. Staff educated R11 on call light use and waiting for assistance. R11 had a skin tear to right knee from the fall. A facility incident review and analysis dated 9/29/24, was started but not comprehensively completed. The incident review and analysis lacked review of the fall to determine cause and intervention to prevent future falls. In addition, no new intervention was identified on the care plan. A facility incident note dated 10/11/24, indicated R11 had an additional fall on 10/11/24 at 4:25 a.m., when found on the floor next to his bed after attempting to walk to the bathroom independently. An incident review and analysis was completed after this fall and intervention including gripper socks when out of bed. During observation on 10/13/24 at 1:16 p.m. and 2:33 p.m., R11 was observed walking in the hall without walker or staff assistance. During interview on 10/14/24 at 9:40 a.m., nursing assistant (NA)-B indicated she was not aware of what interventions were in place for R11 other than having him wear gripper socks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/15/24 at 10:00 a.m., licensed practical nurse (LPN)-A stated no comprehensive fall assessment had been completed after R11's fall on 9/29/24. LPN-A further stated an interdisciplinary team (IDT) risk assessment meeting was held on 9/30/24 and R11's fall was reviewed with suggested intervention of leaving R11's walker next to his bedside. LPN-A confirmed the intervention was discussed at the meeting but a fall assessment had not been completed and the intervention had not been implemented or added to the care plan. LPN-A stated without the intervention on the care plan staff would not be able to see it on their Kardex tool and would not know the intervention had been put in place. During interview on 10/15/24 at 12:28 p.m., director of nursing (DON) stated she would expect a post fall assessment done within 48 hours of a fall and an intervention be put in place immediately, reviewed at the next facility risk management meeting, and then placed on the care plan. DON confirmed R11's fall dated 9/29/24, was discussed at the facility risk management meeting and an intervention of leaving R11's walker at bedside was discussed but had not been implemented. DON further stated timely implementation of interventions was important for reducing fall risk for residents. Facility policy Fall Prevention and Management updated 2/2024, indicated the following; Assessing and Evaluating Falls and Causal Factors When a fall occurs: Nursing staff will complete an incident review and analysis. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and minimize complications from falling. Staff may implement relevant interventions to try to minimize serious consequences of falling and monitor and document each resident's response to interventions.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to follow provider's order of catheter flush for 1 of 1 resident (R12) reviewed with indwelling catheter to minimize the risk for urinary tract infections (UTI). Additionally the facility failed address urinalysis (test of the urine to detect infection) results for 2 of 2 residents (R5 and R12) reviewed for UTI. Findings include: R5's significant change Minimum Data Set (MDS) dated [DATE], indicated R5 was dependent on staff for toileting hygiene, toilet transfer, and utilized a wheelchair, frequently incontinent of urine, taking an antibiotic, diagnoses included: chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (conditions that cause weakness or paralysis on one side of the body after a stroke), dementia, and altered mental status R5's care plan dated 10/13/24, indicated alteration in elimination r/t (related to) dx (diagnosis) of urinary incontinence, will be free from signs/symptoms of UTI, obtain/review labs per MD (medical doctor) order R5's progress note dated 9/10/24 at 3:09 p.m., the director or nursing (DON) indicated R5 returned from hospital and does have a UTI, antibiotics initiated. R5's progress note dated 9/10/24 at 5:24 p.m., registered nurse (RN)-B indicated R5 returned from the hospital with an order for cefdinir (antibiotic used to treat infections) 300 mg bid (twice a day) for 7 days due to a UTI. Family aware. Order faxed to pharmacy. R5's document transfer report dated 9/10/24, emergency provider notes dated 9/10/24, indicated R5 urinalysis consistent with UTI, will plan to discharge back to facility with prescription for cefdinir pending urine culture. R5's urine culture results with a fax dated 9/24/24, to the facility indicated R5's urine culture results. The document did not list the the current antibiotic, cefdinir, R5 was prescribed. R5's record review failed to indicated R5's urine culture results were addressed by the facility. On 10/15/24 at 11:11 a.m., licensed practical nurse (LPN)-A, known as the nurse manager, stated the urine culture result was scanned into electronic medical record (EMR) without the nurse reviewing the result. LPN-A stated the results are dated and signed by the nurse when reviewed. LPN-A stated health information was expected to make sure documents were signed and dated by a nurse prior to scanned into the EMR to ensure results were addressed. LPN-A confirmed R5's UC result dated 9/10/24, and faxed to the facility 9/23/24, was not reviewed by a nurse as expected and was important to ensure R5 was on the correct antibiotic for her UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 12:26 p.m., during a telephone call consulting pharmacist stated the facility was expected to timely review and address urine culture results and follow up with the provider regarding UC results. CP-A stated failure to address or follow up with the provider regarding urine culture results can lead to ineffective treatment, specifically, if the prescribed medication is not susceptible with the culture results, it may exacerbate the infection or prolong treatment. On 10/15/24 at 12:37 p.m., the DON, stated the nurse manager were expected to be aware of residents who had a UC pending and confirmed there was a breakdown in the process. The DON further stated HIM was not expected to scan documents in the EMR until signed and dated by nursing. On 10/15/24 at 1:33 p.m., health information management (HIM)-D stated she scanned documents in the EMR, and confirmed the documents were expected signed and dated prior to scanned into the EMR. HIM-D stated documents not signed or dated by nursing were expected brought back to nursing to ensure the document or order was reviewed and entered. HIM-D stated UA's and UC's results were also expected signed and dated prior to scanned into the EMR. HIM-D confirmed documents were scanned into the EMR without nurse signature or date and the facility had provided education ensuring nursing had reviewed prior to her scanning into the EMR. R12's quarterly MDS dated [DATE], indicated R12 was cognitively intact, had an indwelling urinary catheter, dependent on staff for toileting hygiene and toilet transfers, utilized a wheelchair, diagnoses included traumatic spinal cord dysfunction, neurogenic bladder (a condition that affects bladder control due to nerve damage or brain disorders), and quadriplegia (paralysis that affects all of a person's limbs). R12's physician orders start date 6/26/24, indicated flush and irrigate catheter every other day with 60 cc (cubic centimeter) normal saline for oliguria (low urine output) and progress note needed at 8:00 p.m. R12's treatment administration record (TAR) dated 9/1/24-9/30/24, indicated the provider order flush and irrigate catheter every other day with 60 cc normal saline for oliguria and progress note needed scheduled at 8:00 p.m., was completed 10 out of the 15 times, and was not completed five times. R12's progress note dated 9/27/24 at 6:13 a.m., licensed practical nurse (LPN)-B indicated R12 was bypassing her catheter catheter, nurse flushed her catheter at that time, there was 250 cc out at the time she flushed it. R12's progress note dated 9/28/24 at 5:37 a.m., LPN-B indicated R12's brief was wet, nurse flushed her catheter and emptied her bag to ensure that it was following [flowing] properly, catheter has sediment that was clogging it. R12's progress note dated 10/3/24 at 3:53 a.m., LPN-B indicated R12 requested for her catheter flushed because she could feel it bypassing, nurse flushed it and had CNA's apply a brief. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's progress note dated 10/7/24 at 4:30 a.m., LPN-B indicated R12 was having trouble with her catheter, R12 indicated her catheter had been clogged for a while and they had to change her brief a total of six times, nurse attempted to flush her catheter without any success, there was so much sediment that the water was not going through. Nurse then proceeded to change her catheter, it is currently patent, she had 700 cc's out. Nurse sent an email to the provider requesting an order for UA/UC, her urine is dark, odorous, and full of sediment. The lat time time it was changed was eight days ago, she is to have it changed every 14 days , but it has not been lasting that long. R12's progress note dated 10/9/24 at 5:33 a.m., LPN-B indicated nurse applied a new catheter bag and collected a UA, urine dark with slight odor, a lot of sediment, urine sample in the refrigerator, waiting for it to be sent to lab. R12's progress note dated 10/11/24 at 1:45 p.m., LPN-A indicated writer collected UA and sent over with order to pharmacy, awaiting results. R12's progress note dated 10/12/24 at 12:54 a.m., LPN-B indicated received the UA results from lab department, the following results were abnormal; urine appearance was turbid (murky or unclear, instead of its normal clear or slightly cloudy appearance), urine ph is higher than 9 (normal urine pH ranges from 4.6 to 8.0), urine leukocyte esterase 3 (sign of infection), urine protein 3 (can be a sign of kidney problems), urine blood 2 (sign of infection), results faxed to provider waiting for response. On 10/13/24 at 6:16 p.m., R12 was seated in her motorized wheelchair in her room with family member (FM)-E. R12 stated she had problems with her urine and clogging of the catheter tubing within the last month. R12 stated staff were supposed to flush the catheter every other day so sediment does not build up in the catheter tubing. R12 stated the staff do not routinely flush the catheter tubing every other day. R12 stated she had in the last month problems with the catheter not flowing properly due to the sediment built up and was urine was leaking around the catheter and she had to wear a brief due to the urine leaking from the catheter. R12 stated she had a recent urine collection to see if she had an infection and stated she must not because she had not heard from the staff. R12 stated the urine test was due to the smell, dark color, and lots of sediment in the urine. FM-E stated R12 had never had a UTI prior to her admission the facility. On 10/15/24 at 9:59 a.m., physician assistant (PA)-H stated he was R12's medical provider and comes to the facility on ce a week. PA-H stated the facility was expected to fax UA results on the weekend to the on call provider and was not aware of any pending UA results for R12. PA-H stated the staff were expected to follow the order and flush R12's catheter every other day. PA-H stated not flushing the catheter every other day could cause sediment to build up and could cause a UTI. PA-H stated staff were expected to follow up with the provider within 24 hours if a provider had not addressed a residents UA results. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 10:56 a.m., LPN-A, known as the nurse manager stated R12 was known to have sediment build up in her catheter. LPN-A stated she was not aware staff were not flushing R12's catheter as ordered every other day, and would expect staff follow provider orders LPN-A was observed to check the EMR for R12 and confirmed there were five dates in September when R12's catheter was not flushed as ordered. LPN-A stated R12 had problems with her catheter not flowing and her catheter leaking and R12 had to wear a brief. LPN-A stated R12's catheter not flushed could cause sediment to build up. LPN-A further stated a UA was cooled on 10/11/24, and the results were faxed to the provider on 10/13/24, and confirmed the UA result had not been addressed by the provider, LPN-A further stated the facility was responsible to follow up within 24 hours if a result was not addressed by the provider. On 10/15/24 at 12:53 p.m., the DON stated staff were expected to follow provider orders and flush R12's catheter every other day. The DON stated nurse managers were expected to run a daily report that indicates residents missed orders. The DON was observed to run report on the EMR and confirmed R12 had missed catheter flushes in September. The DON stated the catheter flushes were important so sediment does not build up and could cause a UTI. The DON stated she has educated facility staff all orders were expected completed prior to staff leaving their shift. Further, the DON stated R12's UA result from 10/13/24 was expected to be addressed by the provider and if not addressed would expect the nurse manager to reach out the provider within 24 hours. Policy on UA/UC results was requested and not received. Facility policy Infection Prevention and Control Program dated 3/13/23, indicated : The infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. s surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: a. whether physician management of infections is optimal; b. whether antibiotic usage patterns need to be changed because of the development of resistant strains; c. whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion; and d. whether there is appropriate follow-up of acute infections Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. 2. Medical criteria and standardized definitions of infections are used to help recognize and manage infections.

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	245473	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Manor LLC	640 Third Street Gaylord, MN 55334

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on interview and document review the facility failed to ensure the provider's response to the monthly medication review was followed for 1 of 5 (R18) residents reviewed for unnecessary medications. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 had moderate cognitive impairment, diagnosis included diabetes mellitus, and received insulin injections. R15's consultant pharmacist (CP)-A recommendation to physician dated 9/10/24, indicated consider redrawing A1C (measures your average blood sugar levels over the past three month) and adjusting insulin doses as needed. The provider responded to the recommendation on 9/17/24, and ordered A1C. R15's provider and nursing orders were reviewed and lacked documentation the facility had completed the physician ordered A1C. On 10/15/24 at 7:28 a.m., licensed practical nurse (LPN)-A confirmed R15's physician ordered A1C was not addressed by nursing staff as expected. LPN-A stated the order for the A1C was not sent to nursing before the order was scanned into the electronic medical record (EMR) by health information management (HIM)-A. LPN-A stated HIM-A was expected to make sure documents including orders were signed and dated by a nurse prior to scanned into the EMR to ensure orders were addressed. On 10/15/24 at 12:51 p.m., the director of nursing (DON) stated the pharmacist emailed the nurse managers with the provider recommendations, and stated the nurse managers were responsible to follow up with the pharmacy recommendations and provider response. The DON stated she would expect HIM to bring the order back to nursing if the order was not signed and dated by nursing. The DON stated she would expect the order for 9/17/24, addressed and completed. A facility policy was requested and not received.

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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. 44630 Based on observation, interview, and document review, the facility failed to ensure dietary staff followed appropriate infection control practices when handling cups and performing hand-hygiene during food service in the dining room and passing meal trays to resident rooms. In addition, the facility failed to ensure dishwasher chemical sanitization solution was monitored to ensure dishes were properly sanitized. This had the potential to affect all 34 residents who resided in the facility. Findings include: Meal tray delivery On 10/13/24 at 11:52 a.m. dietary aide (DA)-C was observed and pushed a cart with meal trays through the hallway and entered R20's room. R20 was observed lying in bed and DA-C placed R20's tray on R20's stomach area. DA-C used bare hands and touched R20's bed remote to adjust R20's bed, moved R20's bedside table, and touched R20's blankets on her bed. DA-C was observed to exit R20's room and failed to disinfect hands. DA-C proceeded to push the meal cart through the hallway and entered R50's room with a meal tray and used bare hands and gave R50's family member a glass of apple juice from the meal tray, and then DA-C exited the room with no hand washing observed entering or exiting R50's room. DA-C proceeded to push the meal cart through the hallway and entered R51's room with a meal tray. R51 was seated in a recliner with a tray table in front of the recliner, DA-C placed the meal tray on a tray table placed in front of R51. DA-C with ungloved hands, opened the seal off a butter container, and took of clear plastic wrap off a piece of pie, then picked a piece of debris off the floor and placed in R50's garbage, and used a Kleenex to pick a bug off the floor and placed in R50's garbage and exited the room with no hand hygiene observed, and pushed the two meal carts through the hallway back into the kitchen. On 10/15/24 3:35 p.m. dietary director (DD)-F stated dietary staff were expected to complete hand hygiene prior to entering and exiting a resident room during meal delivery. 42073 Dining room food service During observations on 10/13/24, at 12:07 p.m., culinary services aide (CSA)-B was passing beverages to residents seated in the dining room. CSA-B was observed holding plastic drinking cups by the rim when serving juice and water to R5. At 12:17 p.m., CSA-B served chocolate milk, juice, and water to R16, holding cups by the rim when setting them on the table. During observation on 10/14/24, at 11:58 a.m., CSA-A passed beverages to residents R8 and R19, holding cups by the rim. At 12:11 p.m., CSA-A was observe picking her nose or teeth (not able to clearly determine which) and did not clean hands before serving beverages to R4. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 10/14/24, at 12:24 p.m., observed CSA-A put her finger in her right ear. CSA-A was informed of the observations and the need to clean her hands after touching any part of her body before passing beverages or food to residents. CSA-A stated she touched her face a lot -- it was a habit. CSA-A was also informed of observations of her holding cups by the rim as she placed them on tables. CSA-A stated she understood a resident would place his/her mouth on the rim and stated she should hold the cup closer to the bottom. During an interview on 10/15/24, at 9:55 a.m., CSA-B was taken aside and with a cup, asked to demonstrate the proper way to hold it when serving residents. CSA-B held it by the lower half of the cup. Surveyor informed CSA-B of observations on 10/13/24, when she held cups by the rim. CSA-B stated she had training on the proper way to hold a cup when serving residents and was not aware she held it by the rim. CSA-B stated she understood the rim was where a resident would place his/her mouth. Dishwasher Chemical Sanitation During an observation and interview on 10/15/24, at 10:05 a.m., observed CSA-B test the chemical sanitizing solution at the dishwasher using a chlorine test strip. The dishwasher had been in use immediately prior to this. The test strip measured 25 parts per million (PPM). CSA-B was asked to run another load and test it again. Again, it measured 25 ppm. According to facility policy, the chemical solution should test at 50-100 ppm. The culinary services director (CSD)-F was requested to test the solution, which also tested at 25 ppm. CSD-F stated he would contact the dishwasher vendor. CSD-F stated he did not do periodic spot checks to ensure staff were performing testing properly and according to policy. CSD-F stated staff received training for testing the sanitizing solution upon hire, but he didn't document the content of the training, or when the training occurred. The water temperature on the dishwasher read 120 degrees Fahrenheit (F) which was correct according to regulation, but both CSA-B and CSD-F thought the temperature needed to be 150 degrees F. A paper log titled Dishwashing Record Low Temperature/Chemical posted on the wall by the dishwasher indicated for the month of October, three times a day, all ppm were read as 50 ppm and all but three water temperatures read as 150 degrees F. The log for September indicated the same. The log for August indicated ppm ranging from 10 to 50 ppm and temperatures ranging from 83 to 150 degrees F. During a telephone interview on 10/15/24, at 3:28 p.m., vendor representative (VR)-G for the dishwasher stated the facility utilized a low temperature unit. VR-G stated the water temperature should be set at 120 degrees F, and the chemical sanitizing solution should test between 50-100 ppm. While talking to VR-G, CSD-F came to the conference room and stated the test strips were darker now, but still not up to 50 ppm. Over speaker phone, VR-G advised CSD-F to switch to paper products until the dishwasher unit could be serviced, which CSD-F stated had been arranged for on 10/16/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Dishwashing Machine Use policy dated 2001, indicated food service staff required to operate the dishwashing machine would be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. A supervisor would check the dishwashing machine for proper concentrations of sanitizer solution (measured as parts-per-million [PPM] or mL/L) after filling the dishwashing machine and once a week thereafter. Concentrations would be recorded on a facility approved log. Corrective action would be taken immediately if sanitizer concentrations were too low. The operator would check temperatures using the machine gauge with each dishwashing machine cycle and would record the results on a facility approved log. The operator would monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures would be reported to the supervisor and corrected immediately. If hot water temperatures or chemical sanitation concentrations did not meet requirements, the dishwashing machine would cease immediately until temperatures or PPM were adjusted. Type of Solution: chlorine, and minimum concentration 50-100 ppm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was utilized for 1 of 2 residents (R136) reviewed for enhanced barrier precautions (EBP). Additionally, the facility failed to ensure proper glove use and hand hygiene was performed during wound care for 1 of 3 residents (R136) reviewed for pressure ulcers. Finding include: R136's admission Minimum Data Set (MDS) dated [DATE], indicated no cognitive impairment, one stage two pressure ulcer present on admission, two unstageable pressure ulcers present on admission, and diagnosis included stage two pressure ulcer of sacral region. R136's care plan printed 10/15/24, indicated R136 was on enhanced barrier precautions due to wound to coccyx requiring treatment and interventions included: staff to follow enhanced barrier precautions, use appropriate communication to follow EBP, explain reason for use of enhanced barrier precautions, staff to don/doff PPE per enhanced barrier precautions when providing high contact cares; admitted with ulcer on coccyx from prior facility and redness to right heel and interventions included: treatment to open areas per order, weekly measurements and assessment of wound. On 10/14/24 at 8:48 a.m., a sign was observed on R136's door and indicated Enhanced Barrier Precautions, . providers and staff must wear gloves and gown for the following .transferring, providing hygiene, wound care. A cart outside of R136's room was observed with PPE and included gowns and gloves. Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R136's room and failed to don PPE, and were observed to use a mechanical lift to transfer R136 from the wheelchair to the bathroom. TMA-A and NA-B used bare hands to move R136's feet from the wheelchair onto the mechanical lift and NA-B was observed to pull down R136's brief with ungloved hands. On 10/14/24 at 1:17 p.m. TMA-A confirmed no PPE was worn during the transfer of R136 earlier in the day. TMA-A stated gown and gloves were expected to be worn during transfers for residents placed on EBP. On 10/15/24 at 7:37 a.m., NA-C entered R136's room and put on gloves and assisted R136 with removing his shirt and washed R136's upper body with gloved hands and no gown. NA-C further was observed to remove R136's pants and removed the fastening tabs from R136's brief and washed R136's peri area with gloved hands and no gown. R136's coccyx had a dressing cover the pressure area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 8:15 a.m., licensed practical nurse (LPN)-C entered R136's room with gloves, gown, and wound care supplies. NA-C (with gloved hands and no gown) and LPN-C turned R136 to his right side in bed. LPN-A with gloved hands, removed the old dressing from R136's buttock, sprayed the wound with wound cleanser, used same gloved hands and opened a gauze package and used the gauze to dab the wound. NA-C (gloved not gowned), assisted LPN-C and again rolled R136 side to side and R136's brief was removed. LPN-C sprayed the wound again, measured the wound, and applied cream with same gloved hands, opened a clean dressing and placed the dressing on the wound, then applied skin prep around the wound . LPN-C further opened another dressing with same gloved hands and placed the dressing on the buttocks area, and then grabbed a clean brief and with assistance of NA-C a new brief was placed on R136. LPN-C removed gloves and placed in the trash and removed gown and exited R136's room. On 10/15/24 at 8:24 a.m., LPN-A confirmed gloves were not changed during R136's wound care and stated he was expected to change gloves and complete hand hygiene after removing the old dressing and place new clean gloves on prior to applying the new dressing. LPN-A stated gown and gloves were expected during wound care, however was not sure if staff had to wear PPE if they were not completing wound care and were assisting with the transfer. LPN-A proceeded to read the sign on R136's door and stated after reading the sign staff were expected to wear gown and gloves with transfers, hygiene, and dressing the resident with EBP. On 10/15/24 at 8:26 a.m., NA-B confirmed gloves or gown was not worn when she toileted or transferred R136. NA-B stated the facility had not provided education that PPE including gown and gloves was required when cares or transfers were completed for residents with a wound or catheter. On 10/15/24 at 10:54 a.m., LPN-A, known as the nurse manager, confirmed R136 was on EBP due to a wound on his coccyx, and stated staff were expected to wear gown and gloves during high contact care including transfers, brief changes, and dressing. LPN-A further stated staff were expected to change gloves after old dressing was removed, wash hands and place new gloves. On 10/15/24 at 11:21 a.m., NA-C confirmed R136 was in EBP and stated a gown was not worn during morning cares for R136, and stated a gown and gloves were expected to be worn for residents on EBP. On 10/15/24 at 12:45 p.m., during an interview the director of nursing (DON) confirmed R136 was on EBP and stated staff were not expected to wear gown and gloves when a resident on EBP during transfers. DON was observed to read the EBP signs that were posted on EBP residents doors. After the DON reviewed the EBP precautions, the DON stated for EBP, staff should wear gowns and gloves for all high contact resident care activities and not just with cares related to the reason for being on EBP. The DON further stated staff were not trained to wear gown and gloves during transfers for residents on EBP . The DON further stated, during a dressing change staff were expected to remove gloves, complete hand hygiene, and get new gloves prior to the clean dressing applied . On 10/15/24 at 3:35 p.m., registered nurse (RN)-C stated she was the infection preventionist at the facility and stated staff were expected to wear gown and gloves when providing cares and transfers for resident with EBP. RN-C stated staff were expected to change gloves and wash hands during wound care when the old dressing was removed. Facility policy Enhanced Barrier Precautions dated 4/1/24, indicated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. All staff receive training in high-risk activities and common organisms that require enhanced barrier precautions. Implement enhanced barrier precautions for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheotomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be followed outside the resident ' s room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activity. Facility Policy titled Wound Care Treatment procedure dated 2/24, indicated Steps to complete addressing change: Prior to starting, wash your hands and prepare the dressing supplies in an established clean field. Apply clean gloves Remove the previous dressing Dispose of previous dressing and designated container (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Remove your gloves and complete hand hygiene Evaluate the wound Clean the wound Remove gloves dispose of them in the designated container and complete hand hygiene Apply clean gloves and complete dressing change while following the provider's order When the treatment is completed remove your gloves dispose of any additional items and complete hand hygiene

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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. 50761 Based on interview and document review, the facility failed to implement a process for antibiotic review to determine the efficacy and resident outcomes (appropriate medication, dose, and duration) for 4 of 4 residents R12, R27, R1, and R31 reviewed. Further, this had the potential to affect all 34 residents living in the facility. Findings include: R12's Face Sheet dated 5/4/23, included diagnoses of quadriplegia, neurogenic bowel, and neuromuscular dysfunction of the bladder. R12's care plan dated 8/6/24, indicated R12 will be free from signs/symptoms of urinary tract infection (UTI). Interventions included morning bowel program, assistance with peri-care in the morning, bedtime, and as needed, provided incontinence products, monitored for signs/symptoms of UTI, monitored suprapubic catheter output, change the suprapubic catheter per physician orders, and suprapubic catheter care per facility policy. The facility's Monthly Resident Infection Statistics documentation for the month of August 2024, indicated R12 was treated for a catheter associated urinary tract infection (CAUTI). R12 was prescribed ciprofloxacin 250 mg two times per day for five days. No outcome/s was documented on the facility's Monthly Resident Infection Statistics log to determine the efficacy of R12's treatment plan. R27's Face Sheet dated 2/12/24, included diagnoses of a nondisplaced intertrochanteric fracture of the right femur, type 2 diabetes, dementia, and weakness. R27's care plan dated 9/9/24, indicated R27 was at risk for altered elimination related to mobility and recurrent UTI's. Interventions included assistance with peri-care in the morning, bedtime, and as needed, incontinence products were to be provided as needed, monitor for signs/symptoms of UTI and report suspected signs/symptoms of UTI. The facility Monthly Resident Infection Statistics documentation for the month of July 2024, indicated R27 was treated on two separate dates (7/5/24 and 7/17/24) for UTI. On 7/5/24, R27 was prescribed Macrobid capsule 100 mg two times per day for five days. On 7/7/24, the antibiotic was changed to Keflex due to aggressive behavior related to antibiotics. No outcome/s was documented on the facility Monthly Resident Infection Statistics log to determine the efficacy of R27's treatment plan. R1's Face Sheet dated 5/8/2, included diagnoses of type 2 diabetes, chronic kidney disease stage 3, and urinary tract infection. R1's care plan dated 10/8/24, indicated R1 had functional bowel and bladder incontinence related to persistent mood, hemiplegia, cerebrovascular accident (CVA), obesity, and frequently incontinent of urine and stool. Interventions included assistance to the bathroom before and after meals, at bedtime, as needed, and to wear incontinence pads. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Monthly Resident Infection Statistics for June and August 2024, indicated R1 was treated for a UTI once in June and once in August. On 6/15/24, R1 was prescribed cefadroxil 500 mg two times per day for five days. On 8/28/24, R1 was prescribed amoxicillin-pot clavulanate (Augmentin) tablets 875/125 mg two times per day for seven days. On 8/3/24, R1 was treated for pneumonia and acute cystitis and prescribed azithromycin 250 mg tablets daily for four days and cefuroxime tablets 500 mg two times per day for seven days. On 9/5/24, R1 was treated for sepsis of an unclear source and prescribed Augmentin 875/125 mg two times per day. No outcome/s was documented to determine the efficacy of R1's treatment plan for above noted infections. R31's Face Sheet dated 4/9/24, included a diagnosis of cough. R31's care plan dated 9/5/24, had no focus areas and/or interventions for R31's cough. Interventions indicated on the facility monthly resident infection statistics included a chest x-ray on 6/18/24. R31 was prescribed azithromycin 500 mg once, then 250 mg daily for five days. No outcome/s was documented to determine the efficacy of R31's treatment plan for upper respiratory infection (URI). On 10/15/24 at 2:03 p.m., during interview with the infection preventionist and director of nursing (DON), the facility's Monthly Resident Infection Statistics log documentation for 6/2024 to 9/2024, was reviewed for infection prevention and control. The documentation for 6/2024 to 9/2024, lacked documented outcomes for R12, R27, R1, and R31 including susceptibility, signs/symptoms of infection, any prolonged treatment, side effects, and/or change in antibiotic. After review of the documentation, the infection preventionist and DON acknowledged no resident outcomes were documented and stated that the resident outcomes needs to be documented when residents are prescribed antibiotics for appropriate antibiotic stewardship. Further, the infection preventionist stated it's expected that nursing monitored signs/symptoms of infection, monitored vital signs, followed the care plan, and notified the provider and family with the resident's condition. On 10/15/24 at 12:26 p.m., during a telephone call, the consulting pharmacist (CP)-A stated the facility was expected to complete timely and address urine culture results and follow up with the provider regarding UC results. CP-A stated failure to address or follow up with the provider regarding urine culture results can lead to ineffective treatment, specifically, if the prescribed medication is not susceptible with the culture results, it may exacerbate the infection or prolong treatment. The facility Antibiotic Stewardship policy revised on 3/13/23, indicated: 1. The medical director, consultant pharmacist, DON, and infection preventionist will be responsible for promoting and overseeing antibiotic stewardship activities in the facility. 2. Tracking- the infection preventionist, along with the consultant pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and thru monthly medication reviews. The information gathered will include resident name, unit and room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome, and adverse events if applicable. 3. Reporting- the infection preventionist and the pharmacy consultant will provide regular feedback on antibiotic use and outcomes to the facility staff and the QAPI committee.