STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Some	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** 41787 Based on observation, interview, and record review, the facility failed to ensure the dignity of all residents was maintained when staff failed to provide a dignity bag for urine collection bags for three residents (Residents #29, #2, and #61) with an indwelling urinary catheters (tubing placed internally to drain the bladder). A sample of 29 residents was selected for review in a facility with a census of 115. Review of the facility's policy titled Resident Rights, dated 06/2006, showed residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must protect and promote the rights for each resident. 1. Review of the facility's policy titled, Urinary Catheter Care, undated, showed a catheter with a closed drainage system is preferred to be covered with a dignity bag. 2. Review of Resident #29's face sheet (brief information sheet about the resident) showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should),. Review of the resident's care plan, dated 04/10/24, showed the following: -The resident had an indwelling catheter; -Staff should position and anchor catheter tubing and bag below the level of the bladder. (Staff did not care plan related to the use of a dignity bag.) Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility), dated 04/17/24, showed the resident had an indwelling catheter. Observations of the resident showed the following: (continued on next page)

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 - Some	-On 05/06/24, at 10:07 A.M., the resident was in bed facing the wall. The resident's catheter bag was hanging on the lower bed rail facing the doorway. The bag was not covered by or inside of a dignity bag. The urine in the bag was clear yellow and up to the 200 milliliter (ml - unit of volume for liquids) line on the collection bag. The bag could be seen from the doorway/hall; -On 05/07/24, at 2:00 P.M., the resident was in bed with eyes closed. The catheter bag was hanging on the lower bed rail facing the doorway. The bag was not covered by or inside of a dignity bag. The urine in the bag was clear yellow and above the 100 ml line on the collection bag. The bed was in the lowest position and the catheter bag was touching the floor. The bag could be seen from the doorway/hall; -On 05/08/24, at 9:31 A.M., the resident was in bed with eyes closed. The catheter bag was on the lower bed rail and was facing the doorway. Clear yellow urine was visible in the collection bag and tubing. The bag was not covered by or inside of a dignity bag. The bag could be seen from the doorway/hall; -On 05/10/24, at 10:30 A.M., the resident was in bed facing away from the door. The catheter bag was on the lower bed rail inside of a catheter bag and was touching the floor. The bag could be seen from the doorway/hall. 37358 3. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included personal history of frequent urinary tract infections (UTI's), neuromuscular dysfunction of bladder (when the brain does not communicate with the bladder), and retention of urine (when one is unable to completely empty the bladder). Review of the resident's care plan, dated 06/11/22, showed the following: -Resident had an indwelling urinary catheter; -Staff are expected to maintain, clean, and position catheter tubing and bag below level of bladder and provide daily care. (Staff did not care plan the use of a dignity bag.) Review of the resident's annual MDS, dated [DATE], showed the following: -Resident required an indwelling urinary catheter; -Total dependence on staff for toileting needs. Observation on 05/09/24, at 4:05 P.M., showed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident lay in his/her bed with the resident's urinary catheter hooked to the side of the bed; -The catheter drainage bag was visible from the hallway; -The catheter drainage bag did not have a dignity bag covering it. 50185 4. Review of Resident #61's face sheet (resident information at quick glance) showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease and benign prostatic hyperplasia (age associated prostate gland enlargement that can cause urination difficulty) with lower urinary tract symptoms. Review of the resident's care plan, last revised on 01/14/24, showed the following information: -Indwelling catheter; -Change catheter as needed, by orders; -Maintain catheter for diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow); -Position and anchor catheter tubing and bag below the level of the bladder; -Provide catheter care daily and as needed; -Report changes in output, color, and odor. (Staff did not care plan the use of a dignity bag.) Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, dressing, and mobility; -Indwelling urinary catheter. Observation of the resident on 05/06/24 showed the following: -At 9:40 A.M., the door to the resident's room open and the resident lay in the bed with his/her eyes closed. The resident's urinary catheter drainage bag was hooked to the side of the bed, visible from the hall. The catheter bag did not have a dignity bag covering it; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 4:06 P.M., the resident's room door was open with the resident in the bed on his/her back. The resident's catheter bag was hooked to the side of the bed, visible from the hall. The resident's urinary catheter drainage bag did not have a dignity bag to cover the urine. Observation on 05/07/24, at 8:36 A.M., showed the resident's room door was open with the resident in the bed on his/her back. The resident's catheter bag was hooked to the side of the bed, visible from the hall. The resident's urinary catheter drainage bag did not have a dignity bag to cover the urine. Observations on 05/08/24, at 9:14 A.M. and 11:22 A.M., showed the resident's room door was open with the resident in the bed on his/her back. The resident's catheter bag was hooked to the side of the bed, visible from the hall. The resident's urinary catheter drainage bag did not have a dignity bag to cover the urine. 5. During an interview on 05/09/24, at 10:34 A.M., Certified Nurse Aide (CNA) J said the catheter drainage bag should always have a dignity bag on it regardless of the resident's location. People should not be able to walk past the resident's room and see it. During an interview on 05/09/24, at 1:02 P.M., CNA K said the dignity bags are found under the resident's wheelchairs. He/she believes the catheter drainage bag should be always covered with a dignity bag. If a dignity bag is unavailable, he/she covers the bag with the resident's blanket. During an interview on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said catheter drainage bags should be inside a dignity bag. That is the expectation for all residents. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said the catheter drainage bag should be always covered with a dignity bag. During an interview on 05/10/24, at 12:00 P.M., the Administrator said catheter drainage bags should be placed inside a dignity bag. 31464

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, interview, and record review, the facility failed to determine all residents who self-administered medications were clinically appropriate to do so when staff left medications at bedside for one resident (Resident #99) to administer to his/herself unattended without an assessment, order, or care plan to do so. The facility census was 115. Review of the facility policy titled Specific Medication Administration Procedures, revised 01/01/19, showed the following information: -Administer medication and remain with resident while medication is swallowed. Do not leave medications at bedside, unless specifically ordered by prescriber; -Chart medication administration on Medication Administration Record (MAR) immediately following each resident's medication administration. 1. Review of Resident #99's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), major depressive disorder, type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), and autoimmune hepatitis (disease that happens when the body's immune system attacks the liver). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/09/24, showed the resident was cognitively intact. Review of the resident's care plan, reviewed 04/03/24, showed the following: -Resident was prescribed clonazepam (used to treat seizures, panic disorder, and anxiety) and duloxetine (used to treat depression and anxiety) to help manage her anxiety and depression; -Staff should administer psychoactive (drug affecting the mind) medications as ordered; -Staff should observe for potential adverse effects; -Resident may experience intermittent generalized pain; -Staff should administer medications as ordered and assess for effectiveness. (Staff did not care plan self-administration of medications by the resident.) Review of the resident's record showed the facility did not have documentation of an assessment to determine if the resident was to safely able to self-administer his/her medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current Physicians' Orders showed no order for the self-administration of medication by the resident. Review of the resident's May 2024 MAR showed on 05/08/24, at 10:19 A.M., staff documented medications as administered at 10:19 A.M. The medications administered included aldactone (used to treat high blood pressure and heart failure) tablet 50 milligram (mg), duloxetine capsule 60 mg, lisinopril (used to treat high blood pressure) tablet 5 mg, polyethylene glycol 3350 powder 17 gram/dose (used to treat constipation), and sennosides-docusate sodium tablet 8.6-50 mg (used to treat constipation). During an interview and observation on 05/08/24, at 1:14 P.M., the resident was seated in his/her bedside chair. The resident said he/she had returned from a medical procedure at about 11:30 A.M. and had not been given his/her 9:00 A.M. medications yet. The resident then looked at his/her bedside table and said Oh, I remember they brought the pills and left on bedside table when I returned at about 11:30 A.M. I just had not taken them yet. There were four tablets in the medication cup. During an interview and observation on 05/10/24, at 10:45 A.M., the resident rested in bed with eyes open facing away from the bedside table. The resident arranged self to sit on the side of the bed. There were four pills in cup on the bedside table. The resident rested in bed with eyes open. The resident said that staff trust him/her to take the medications, so they leave until he/she is more awake to take the medications. During an interview on 05/10/24, at 9:53 A.M., Licensed Practical Nurse (LPN) F said staff should not leave medications with residents. During an interview on 05/10/24, at 11:10 A.M., Registered Nurse (RN) D said that staff should not leave any medications in resident rooms or at the dining room table for residents to take later. During an interview on 05/10/24, at 12:00 P.M., LPN G said medications are not left with residents to take later. Staff can take medications out of the rooms and return when resident would prefer. During an interview on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said staff should not leave medications in a resident's room unless there is a physician's order to do so. Staff should not leave medications with a resident to take later. Staff should watch residents take their medications. It is not permissible for staff to leave medications at bedside or at the dining room table. Staff could step back and still observe a resident take the medications. During an interview on 05/10/24, at 1:32 P.M., the Administrator said medications should not be left at bedside or at table in dining room. Staff should monitor the resident taking the medication.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, interview, and record review, the facility failed to promote all residents' right for self-determination of schedule and cares when staff failed to provide showers as preferred and care planned for nine residents (Resident #9, #21, #23, #55, #108, #33, #8, #15, and #11) of 29 residents sampled. The facility census was 115. Review of the facility's policy titled, Bath, Shower/Tub, revised February 2018, showed the purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of residents' skin. The policy did not address the scheduling of showers/baths. 1. Review of Resident #9's face sheet (a document that gives a resident's information at a quick glance) showed the following: -Readmitted [DATE]; -Diagnoses include stroke, hemiplegia (paralyzed on one side of the body), anxiety disorder (feelings of worry, anger or fear), and depression (feelings of sadness). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/03/24, showed the following: -Cognitively intact; -Requires partial/moderate assistance with shower/bath. Review of the resident's care plan, revised 05/08/24, showed the following: -Provide and set up for him/her to do own hygiene and oral care; -Provide and encourage two baths per week. Review of the weekly shower sheet showed the resident scheduled for showers on Tuesdays and Fridays. Review of the the resident's April 2024 shower sheets showed the staff document shower/baths provided on the following dates: -On 04/04/24; -On 04/09/24; -On 04/16/24 (seven days after the previous shower); -On 04/22/24 (six days after the previous shower); (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/30/24 (eight days after the previous shower). Review of the resident shower sheets, dated 05/01/24 through 05/07/24, showed staff had not provided the resident a shower. During interviews on 05/06/24, at 8:59 A.M., and on 05/07/24, at 8:35 A.M., the resident said the following: -He/she is only receiving one shower per week and would like to have two; -He/she feels dirty, especially his/her hair and armpits. 2. Review of Resident #21's face sheet showed the following: -admitted [DATE]; -Diagnoses included Type 2 diabetes (body has problem with regulating and using sugar as fuel), chronic kidney disease stage 3 (kidneys have mild damage and are less able to filter waste), and heart disease. Review of the the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Requires partial/moderate assistance with shower/bath. Review of the resident's care plan, revised 03/06/24, showed the following: -The resident requires minimum to moderate assistance with activities of daily living (ADLs) related to generalized weakness/advanced age. Staff to support daily routines/preferences. Review of the weekly shower sheet showed the resident scheduled for showers on Tuesdays and Fridays. Review of the the resident's April 2024 shower sheets showed staff provided showers on the following dates: -On 04/01/24; -On 04/06/24; -On 04/18/24 (12 days after the previous shower); -On 04/26/24 (eight days after the previous shower); -On 04/30/24. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident shower sheets, dated 05/01/24 through 05/07/24, showed staff had not provided the resident a shower. During interviews on 05/06/24, at 1:40 P.M., and on 05/08/24, at 9:20 A.M., the resident said the following: -He/she is only receiving one shower per week and used to get two per week. He/she would like to received two showers per week; -Staff was supposed to come in on his/her day off to give him/her a shower last week and did not show up; -He/she doesn't remember when he/she had a shower last, the staff was supposed to give the resident a shower 05/07/24, but the shower staff didn't come to work. 3. Review of Resident #23's face sheet showed the following: -Readmitted [DATE]; -Diagnoses include Type 2 diabetes with chronic kidney disease stage, major depression disorder, and generalized anxiety. Review the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Required substantial assistance with shower/bath. Review of the resident's care plan, revised 04/17/24, showed the following: -The resident required minimum to moderate assistance with ADLs related to generalized weakness/advanced age. Staff to support daily routines/preferences. Review of the weekly shower sheet showed the resident scheduled for showers on Tuesdays and Fridays. Review of the the resident's April 2024 shower sheets showed staff provided on one shower on 04/18/24. Review of the resident's shower sheets, dated 05/01/24 through 05/07/24, showed staff provided on shower on 05/02/24. During an interview on 05/07/24, at 2:20 P.M., the resident said he/she usually gets a shower one time per week and would like a bath. He/she wasn't sure when the last shower was. 4. Review of Resident #55's face sheet showed the following: -Readmitted [DATE]; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included muscle weakness, major depression, and insomnia (sleep problems). Review the resident's significant change MDS, dated [DATE], showed the following: -Cognitive impairment; -Requires maximum assistance with shower/bath. Review of the resident's care plan, revised date 04/17/24, showed the following: -The resident needs assistance with ADLs during times of weakness and depression; -Offer and encourage two showers a week. Review of the weekly shower sheet showed the resident scheduled for showers on Tuesdays and Fridays. Review of the the resident's April 2024 shower sheets showed staff provided a shower on the following dates: -On 04/04/24; -On 04/10/24 (six days after the previous shower); -On 04/18/24 (eight days after the previous shower). Review of the resident's shower sheets, dated 05/01/24 through 05/07/24, showed staff;provided a shower to the resident on 05/02/24 (14 days after the previous shower). During an interview on 05/06/24, at 1:40 0 P.M., the resident said the following: -He/she would like a shower at least one time per week, but really would like two per week; -He/she said it had been two weeks since he/she had a shower. 5. Review of Resident #108's face sheet showed the following: -Admission on 03/22/24; -Diagnoses includes wedge compression fracture of fourth lumbar vertebra (back). Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Requires partial/moderate assistance with showers. Review of the resident's care plan, revised 04/17/24, showed the following: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident required minimal assistance with ADLs; -ADLs will be met with staff assistance. Review of the resident April 2024 shower sheets showed staff provided a shower on the following dates: -On 04/04/24; -On 04/06/24; -On 04/16/24 (ten days after the previous shower); -On 04/22/24 (six days after the previous shower); -On 04/30/24 (eight days after the previous shower). Review of the resident shower sheets, dated 05/01/24 through 05/07/24, showed staff had not provided the resident a shower. During an interview on 05/07/24, at 10:10 A.M., the resident said the following: -He/she has gone three weeks without a shower before and it has been almost two weeks since he/she had a shower; -He/she takes a washcloth and washes him/herself by the sink and goes to the beauty shop to get his/her hair washed weekly. Observation and interview on 05/08/24, at 9:08 A.M., with the resident showed the following: -He/she had his/her clothes beside of him/her; -Resident said he/she needed a shower; -He/she had been waiting a while to get a shower. 31464 6. Review of Resident #33's face sheet showed the following information: -admitted [DATE]; -Diagnoses included difficulty in walking, muscle weakness, chronic gout (arthritis that causes swelling, redness and tenderness in joints) to left ankle and foot, and spinal degeneration and stenosis (bones of spine too close together, can cause pain, tingling, or weakness, and/or bowel/bladder dysfunction). Review of the resident's admission MDS, dated [DATE], showed the following: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognition intact; -Limited range of motion; upper and lower extremities, one sided; -Required moderate assist of one person for personal hygiene; -Regarding making his/her own choice between tub bath, shower, bed bath, or sponge bath, resident responded very important. Review of the resident's care plan, dated 04/23/24, showed the following: -Required moderate/maximum assist with ADLs related to weakness while recovering. Staff to assist with toileting/incontinence care as needed and support daily routines/preferences. Review on 05/09/24, at 8:33 A.M., of the resident's shower sheets for April 2024 and May 2024, showed staff documented the following: -Shower given on 04/22/24 (six days following admission); -Shower given on 04/30/24 (eight days since previous shower). During an interview on 05/07/24, at 10:48 A.M., the resident said he/she had not had a shower or bed bath for the last two weeks and felt like he/she needed one badly. During an interview on 05/08/24, at 9:39 A.M., the resident said he/she did not know his/her shower schedule, but again said he/she had not had a bath or shower for two weeks and wanted one. 41787 7. Review of Resident #8's face sheet showed the following information: -admitted [DATE]; -Diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and anxiety disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Required staff supervision or touching assistance for showers. Review of the resident's care plan, reviewed 05/04/24, showed the following: -Resident required minimal to moderate assistance with ADLs; -Staff should support daily routines and preferences; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident had limited ability to perform self-care; -Resident will have clean, neat appearance daily and/or will be able to participate in self-care as able. Review of the facility shower list showed resident scheduled for showers on Tuesday and Fridays. Review of the resident's April 2024 shower sheets showed staff documented showers provided on the following dates: -On 04/05/24; -On 04/09/24; -On 04/22/24 (13 days after the previous shower). Review of the resident shower sheets, dated 05/01/24 through 05/07/24, showed staff had not provided the resident a shower. During an interview on 05/07/24, at 9:38 A.M., the resident said he/she would like to receive showers more often. He/she was not sure when the last shower was provided. 8. Review of Resident #15's face sheet showed the following: -admitted [DATE]; -Diagnoses included epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), chronic kidney disease, chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), and chronic pain. Review of the resident's care plan, last updated 04/15/24, showed the following: -Resident requires minimal assistance with activities related to general aging; -Staff should honor resident preferences; -Staff should assist with ADLs per patient's needs and preferences; -Staff should support daily routines and preference. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Required staff supervision or touching for showers. Review of the facility shower list showed resident scheduled for showers on Tuesday and Fridays. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's April 2024 shower sheets showed staff provided showers on the following dates: -On 04/02/24; -On 04/05/24; -On 04/09/24; -On 04/12/24; -On 04/16/24; -On 04/23/24 (seven days after the previous shower); -On 04/30/24 (seven days after the previous shower). During an interview on 05/07/24, at 2:31 P.M., the resident said his/her shower days were schedule on Tuesday and Fridays. He/she said that he/she had only been receiving showers on Tuesdays as the Friday shower aide was often not available. He/she had missed three Friday showers in a row. He/she felt dirty and would prefer at least the two showers per week. 9. Review of Resident #11's face sheet showed the following: -admitted [DATE]; -Diagnoses included heart failure and major depressive disorder. Review of the resident's April 2024 and May 2024 shower records showed staff provided showers on the following dates: -On 04/04/24; -On 04/09/24; -On 04/18/24 (nine days after the previous shower); -On 04/23/24; -On 04/30/24 (seven after the previous shower). During an interview on 05/07/24, at approximately 4:25 P.M., the resident said the following: -He/she was supposed to have had a shower today (05/07/24), but did not receive one; -He/she should get showers twice a week, -His/her shower days are every Tuesday and Thursday; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident said he/she feels dirty and is embarrassed to come out of his/her room because of how he/she may smell to others; -He/she could not say when he/she had a shower last, but said it has been quite a while and staff makes him/her wait sometimes for days or even longer than a week, without getting one. 9. During an interview on 05/08/24, at 10:21 A.M., Certified Nurse Aide (CNA) A said the following: -There used to be two staff doing showers, but one is no longer employed; -Some staff are pulled from the floor to help with showers; -When there were two shower aides one would do halls A and B and the other aide would do halls B and C; -Residents usually get one or two showers per week; -Registered Nurse (RN) D makes up the shower schedule. 10. During an interview on 05/08/24, at 10:27 A.M., CNA B said the following: -When there were two shower aides, one would do halls A and B and the other would do halls B and C; -There are also aides that fill in to help; -There are a couple of residents who don't think they get enough showers. 11. During an interview on 05/09/24, at 9:43 A.M., CNA X said the previous bath aide recently rewrote the current shower schedule. All residents should get two showers per week; either on Mondays/Thursdays or Tuesdays/Fridays. Staff should document the showers or refusals on the shower sheets. Wednesdays and Saturdays are shower make-up days for any missed/refused showers. The nurses do not tell the bath aides when there is a new resident on their hall or when someone transfers over from rehab; they just notice the new person and add them to the schedule. 12. During an interview on 05/08/24, at 10:35 A.M., Licensed Practical Nurse (LPN) C said the following: -He/she doesn't know which staff are giving showers as it has changed; -The residents receive showers at least one time per week; -If they have staff, one aide will do A and B hall and the other C and D hall; -If the residents have wounds they would get them more often. 13. During an interview on 05/08/24, at 10:40 A.M., and on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility tries to provide showers twice per week to each resident, but a minimum of one per week; -There are three staff designated to do showers, one for rehabilitation hall, one for Halls A and B, and one for Halls C and D; -The shower aides have there own method of tracking which resident receives showers on which day; -He/she just fired one shower aide as the aide was not giving showers when he/she said he/she was giving showers; -The facility tries to honor resident's preferences on showers; -Staff should document showers and refusals on the shower sheet and give the sheets to the charge nurse for review. 14. During an interview on 05/08/24, at 10:50 A.M., and 05/10/24, at 1:05 P.M., the Administrator said the following: -Staff try to give residents showers twice per week, if they want more and staff have time, they get more; -They have a bath aide for rehab, and two for long term care unit; -They did have residents complain about not getting showers and they found the one bath aide was not giving showers and they fired the staff; -Staff should document showers and refusals on the shower sheets.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on record review and interview, the facility failed to notify the resident and the resident's representative in writing of a transfer or discharge to a hospital that included the reason for the transfer, date of transfer, and destination of transfer for three residents (Resident #100, Resident #5 and Resident #8) out of 29 sampled residents. The facility census was 115. Review of the facility provided copy of Hospital Transfer Checklist, showed the following: -Fill out Interact Nursing Home to Hospital Transfer under observation, print and send with the resident. 1. Review of Resident #100's progress note, dated 01/23/24, showed the following: -The resident was reported to be combative, agitated, yelling, and cursing at staff and refusing cares; -Order received to send resident to hospital for evaluation and treatment; -Staff called daughter and informed of nurse practitioner's (NP) order; -Resident was transferred to the hospital. (Staff did not document staff provided the resident or representative with a hospital transfer notice.) Review of the resident's medical record showed staff did not have a copy of a letter provided to the resident or representative stating the date of transfer, destination of transfer, or the reason for transfer on 01/23/24. Review of the resident's progress note, dated 05/08/24, showed the following: -On 05/08/24 staff went into resident's room to give resident a stat breathing treatment due to oxygen saturation dropping to 82% on routine vital check. Oxygen kept dropping so order was given to send resident to the emergency room if resident became unstable; -Called emergency medical services at 4:05 A.M., to send resident to the hospital; -Emergency Medical Service (EMS) arrived and resident sent to the hospital at 4:20 A.M. (Staff did not document staff provided the resident or representative with a hospital transfer notice.) (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed staff did not have a copy of a letter provided to the resident or representative stating the date of transfer, destination of transfer, or the reason for transfer on 05/08/24. 2. Review of Resident #5's February 2024 progress notes showed the following: -On 02/14/24, at 6:30 A.M., resident transferred to emergency room due to increased temperature, pale color and poor intake; -Resident returned to facility on 02/14/24, at 5:55 P.M.; -Family contacted regarding resident transfer to the hospital; (Staff did not document staff provided the resident or representative with a hospital transfer notice.) Review of the resident's medical record did not show the facility provided the resident or representative with a letter stating the date of transport, destination of transport or the reason for transport. 3. Review of Resident #8's face sheet showed an admitted [DATE]. Review of the resident's electronic medical record progress notes showed the following: -On 02/29/24, at 11:11 A.M., staff documented that the resident was getting ready for the day, with two CNAs present. The resident was standing and leaned to the right. The resident hit his/her head on the roommate's bed and landed hard on right shoulder. The resident did not remember the fall. Staff notified the physician and received an order to send to the emergency room for evaluation and treatment. The resident left via ambulance at 11:03 A.M. The nurse notified the resident's family; -On 02/29/24, at 5:06 P.M., staff documented the resident returned from the emergency room at 5:03 P.M., two-person transfer from stretcher to wheelchair. (Staff did not document staff provided the resident or representative with a hospital transfer notice.) Review of the resident's medical record did not show the facility provided the resident or representative with a letter stating the date of transport, destination of transport or the reason for transport. 4. During an interview on 05/10/24, at 8:56 A.M., the Social Service Director, Long Term Care Social Worker, and Rehabilitation Social Worker said the following: -Nursing does the hospital transfer notices; -The hospital transfer notices are done when the resident is being prepared to transfer to the hospital; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The hospital transfers are sent with the resident at that time. Two copies are give one for emergency medical services and other for the emergency room staff; -The hospital staff should be giving the resident their part of the paperwork; -The staff doesn't give the residents a hospital transfer notice; -The facility provides a letter to the resident or representative if they're admitted . 5. During an interview on 05/10/24, at 9:55 A.M., Licensed Practical Nurse (LPN) E said the following: -The nurses complete the observation that includes hospital transfer information; -He/she sends the observation form with the resident. It is sometimes sent later. 6. During an interview on 05/10/24, at 10:35 A.M., LPN C said the following: -He/she sends the information on the checklist; -He/she sends the observation sheet with the resident unless the ambulance arrives before he/she gets it's completed and then it's send later. 7. During an interview on 05/10/24, at 10:40 A.M., the Director of Nursing (DON) said the following: -When a resident is transferred to the hospital, emergency medical services receives the hospital transfer along with other identifying paperwork; -He/she is not sure who else receives a hospital transfer. Social services takes care of it. 8. During an interview on 05/10/24, at 10: 50 A.M., the Administrator he/she believes nursing sends the hospital transfer with the resident at time of transport 41787

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to notify and coordinate with the State-designated authority when one resident (Resident #100), a previously identified by the Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disability are not inappropriately placed in nursing homes for long-term care. The PASARR requires that all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability and be offered the most appropriate integrated setting for their needs (in the community, a nursing facility, or acute care setting) and receive the services they need in those settings) as having a mental disorder, experienced a significant change. The facility census was 115. Review of the facility's policy titled Pre-Admission Screening and Resident Review (PASARR), dated 11/2016, showed the center should refer any patient for Level II resident review upon a significant change in status/condition such as newly evident or possible serious mental disorder, intellectual disability, or a related condition. 1. Review of Resident #100's face sheet (gives basic profile information at a glance) showed the following information: -admitted [DATE]; -Admission diagnoses included major depressive disorder (persistent feelings of sadness), generalized anxiety disorder (persistent worry or anxiety), and unspecified dementia with other behavioral disturbances. Review of the resident's Level 1 Nursing Facility Pre-Admission Screening for Mental Illness/Mental Retardation or Related Condition, dated 08/11/2023, showed the following information: -Identified mental illness of major depression disorder; -Primary reason for nursing facility placement not due to dementia; -Had not had serious problems in levels of functioning in the last six months; -Had not received intensive psychiatric treatment in the past two years; -Not known or suspected to have mental retardation that originated prior to age 18; -Not known or suspected to have a related condition. Review of the resident's progress notes showed the following: -On 01/23/24, resident had been telling the staff to go f--- themselves and calling everyone a bunch of thieves and accusing staff of not caring about him/her; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/23/24, resident refusing all cares and not allowing staff to change his/her soiled clothing; -On 01/23/24, staff told the resident if he/she changed his/her mind about being changed the staff would help. The resident kicked at the staff in the air and told them he/she would not change his/her mind and just leave him/her the f--- alone; -On 01/23/24, resident threatened another resident and was throwing things in his/her room destroying things and cussing staff. Resident was reported to be combative, agitated, yelling, cursing staff, and refusing cares. Staff could hear resident threatening to kill him/herself, kill the housekeeper, and kill his/her roommate. The resident attempted to throw his/her television; -On 01/23/24, staff updated the nurse practitioner and staff was told to send the resident out to the hospital. Staff called 911 and police officers showed up first and approached the resident. Resident yelled and cursed at the police officers. Emergency medical technicians were able to get the resident on the stretcher and out of the facility; -On 01/24/24, family called and informed facility that the resident was transferred to a geriatric psychiatric facility and will remain there for at least five days; -On 01/30/24, social services spoke with resident's family requesting records from the resident's hospitalization to determine if the facility could still meet the resident's needs. Review of the resident's medical record showed staff did not refer the resident after a significant change in status, for a Level II PASARR review. During interview on 05/10/24, at 8:56 A. M., the Social Service Director, Long Term Care Social Worker, and Rehabilitation Social Worker said the following: -Level I screenings are completed prior to facility admission on all residents; -Level II screenings are completed when the level I indicates the need for a level II; -The resident had a level one screening completed in 2023 with a diagnosis of major depression and anxiety disorder, there was no level II recommended; -The resident had a hospitalization in January 2023 for threatening to harm him/herself and others, and a level II was not completed and probably should have been done; -Social Services received information from COMRU that indicated a level II could be done after a significant change. During an interview on 05/10/24, at 10:40 A.M., the Director of Nursing (DON) said the following: -He/she doesn't handle PASARR's and doesn't know about a level I screening; -He/she knows there is a level II screening done on mentally incapacitated residents and social services takes care of those. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 05/10/24, at 10: 50 A.M., the Administrator said the following: -Level I screening for PASARR's are done per regulation at the hospital; -Level II is done with there is a positive level I screening; -Would need to check when a level II screening needs to be completed a second time; -He/she doesn't know if one would need to be completed for the resident after being hospitalized at a geriatric psych unit; -Social services takes care of the level II screenings and he/she would need to check with them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37358 Based on observation, interview, and record review, the facility failed to ensure residents who required assistance with showers received the necessary assistance with showers when the facility failed to ensure one resident (Residents #2), dependent on staff for grooming, received regular showers and appropriate grooming. The facility census was 115. Review of the facility's policy titled Bath, Shower/Tub, revised February 2018, showed the purpose of the procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. Review showed the facility did not provide a policy pertaining to the scheduling of showers/bathing. 1. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included heart failure and Stage IV (full thickness skin loss with extensive tissue destruction, tissue death or damage to muscle, bone, or supporting structures) pressure ulcer of the sacral region (the triangular-shaped bone at the base of the spine). Review of the resident's care plan, revised 03/13/24, showed the following: -Extensive assistance required for activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting); -Offer and encourage two showers a week. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/15/24, showed the following: -Moderately impaired cognition; -Dependent on staff for showers to be completed; -Unable to assist in his/her own bathing needs. Review of the resident's April 2024 and May 2024 shower records showed staff provided showers on the following days: -On 04/01/24; -On 04/04/24; -On 04/08/24; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/22/24 (14 days after the previous shower; -On 04/25/24; -On 04/29/24; -On 05/02/24; -On 05/07/24. Observation and interview on 05/08/24, at approximately 1:10 P.M., showed the following: -The resident lay in his/her bed; -The resident's hair was unkempt and greasy; -The resident had a dirty face and crust buildup in the corner of his/her eyes; -The resident said he/she had not been getting any showers; -The resident could not remember when he/she last received a shower; -The resident felt it had been a long time since he/she received a shower. Observation on 05/10/24, at approximately 7:55 A.M., showed the following: -The resident sat in his/her wheelchair close to the nurses' desk; -The resident wore pajamas; -The resident's hair was very unkempt and sticking up in many different directions; -There dried crust around/on the area of the resident's eyes. During an interview on 05/09/24, at 9:43 A.M., Certified Nurse Aide (CNA) X and Certified Medication Technician (CMT) Y said all residents are given two showers per week. During interviews on 05/09/24, at 12:10 P.M., and on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said there was not a set shower schedule. The staff try their best to get each resident two showers per week, but sometimes they only get one per week. There is one shower aide scheduled for the A/B halls, one shower aide for the C/D halls, and one shower aide for the rehab hall. Generally, showers are given Mondays and Thursdays or Tuesdays and Fridays. Staff try to keep Wednesday for a catch-up day. During an interview on 05/10/24, at approximately 1:00 P.M., the Administrator said the following: -Residents usually get one to two showers each week, depending on what they wish; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff always try to accommodate residents when they want showers. 50185

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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** 50185 Based on interview, record review, and observation, the facility failed to ensure staff followed physician orders and accurately documented the implementation of physician orders when staff failed to apply tubi grips (an elasticated tubular bandage designed to provide support for sprains, strains, and swelling) as ordered for one resident (Resident #59). A sample of 29 residents was selected for review. The facility census was 115. Review of the facility's policy titled, Physician Orders Policy, undated, showed the following information: -Orders will be received by licensed nursing staff; -Orders will be reviewed and if there are questions, clarification will be obtained from the physician; -If no questions or questions are clarified, orders will be implemented. 1. Review of Resident #59's face sheet showed the following information: -Readmitted [DATE]; -Diagnoses included chronic respiratory failure with hypoxia (the body doesn't have enough oxygen in your blood), high blood pressure. Review of the resident's care plan, last revised on 03/27/24, showed the following information: -Administer medications per orders; -Monitor for increased edema, increased shortness of breath, and observe for signs and symptoms of hypoxia (pallor, bluish color of the skin, fast pulse, and increased confusion). Review of the resident's significant change MDS, dated [DATE], showed the resident cognitively intact. Review of the resident's current physician order sheet showed the following information: -An order, dated 04/26/24, to apply single layer tubi grips to bilateral lower extremities (BLE- both legs) in the morning and remove in the evening. Review of the resident's care plan showed staff did not revise the care plan to reflect the new treatment order for tubi grips. Review of the resident's treatment administration record (TAR), dated 05/01/24 through 05/09/24, showed the following information: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 05/06/24 through 05/08/24, day shift staff documented application of tubi grips and night shift documented the removal of tubi grips completed. Observation on 05/06/24, at 1:53 P.M. and 4:01 P.M., showed the resident laid on his/her back in bed without tubi grips on. During an observation and interview on 05/07/24, at 9:04 A.M., the resident laid in bed without tubi grips on. The resident said he/she does not have tubi grips on. He/she woke up at 5:00 A.M. and did not ask the staff to put them on at that time. The staff does not put them on him/her unless he/she asks. Sometimes, the tubi grips cause him/her pain due to his/her neuropathy (a group of conditions that result from nerve damage in the peripheral nervous system). That may be why the staff don't offer, and he/she must instruct them. Observation on 05/07/24, at 1:34 P.M., showed the resident laid on his/her back in bed without tubi grips on. During an observation and interview on 05/08/24, at 10:15 A.M., the resident lay in bed on his/her back with BLE noticeably swollen. The resident said staff has not put the tubi grips on him/her yet. During an interview on 05/09/24, at 10:23 A.M., Certified Nursing Assistant (CNA) J said nurses or CNAs put on the tubi grips, but typically it is the aides, as they are the ones who get the residents up in the morning. The nurses are the ones who document the application after they have asked the aides if the tubi grips are on. He/she is aware the resident did have tubi grips, at one point. However, he/she has not seen any tubi grips in the resident's room lately and didn't believe the resident had any swelling or need for the tubi grips to be applied. The nurses have not informed him/her to put them on the resident. During an interview on 05/09/24, at 1:02 P.M., CNA K said if a resident has an order for tubi grips, the staff should be applying them. If the resident were to refuse, he/she would let the nurse know, so the nurse could then make a second attempt and if that was unsuccessful, document a refusal. During an interview on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said if a resident has an order for something, that order should be followed. If the resident refuses or staff are unable to complete the task, the nurses would document the refusal and why. The resident does have an order for tubi grips and he/she wears them sometimes. The resident will put them on his/her self most of the time or will ask staff for help. Nurses don't typically document a refusal for the day, unless there has been multiple attempts and refusals. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said if a resident has an order for something, staff should be following those orders. If the staff is unable to follow the order, the nurses need to document a refusal on the TAR. If the refusals are repetitive, the nurse needs to notify the physician. She is not aware of any issues with the resident, regarding the use of tubi grips. If the resident does not have the tubi grips on, it is ultimately the nurse's responsibility. During an interview on 05/10/24, at 12:00 P.M., the Administrator said all staff should be following physician's orders, If they are unable to do so, they need to document that and let the physician know. He is not aware of anything specific going on with the resident and his/her tubi grips. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41787 31464

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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** 50185 Based on observation, interview, and record review, the facility failed to maintain an environment as free of accident hazards as possible when staff transferred one resident (Resident #61) without the use of the gait belt. The facility census was 115. Review of the facility's policy titled, Safe Lifting and Movement of Residents, dated 07/17, showed the following information: -In order to protect the safety and well-being of staff and residents, and promote quality care, this facility uses appropriate techniques and devices to lift and move residents; -Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents; -Manual lifting of residents shall be eliminated when feasible; -Staff will document resident transferring and lifting needs in the care plan; -Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices; -Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding the use of equipment and safe lifting techniques. Review of the facility's policy titled, Gait Belts for Transfer, undated, showed the following information: -Gait belts are provided to assist staff to safely transfer or ambulate residents; -Procedure included the following: explain the procedure to the resident, apply the gait belt around the resident's waist, stand as close to the resident as possible, maintain a broad base for support, assist the resident to a standing position by grasping the belt at the waist from underneath, and pivot the resident to the chair or bed; -When the transfer is complete, remove the belt and return it to the storage area. 1. Review of Resident #61's face sheet (resident's information at a quick glance) showed the following information: -admitted [DATE]; -Diagnoses included senile degeneration of the brain (loss of intellectual ability) and irregular heartbeat. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 01/14/24, showed the following information: -Moderate to maximal assistance from staff for activities of daily living (ADL- bathing, dressing, transfers, toileting); -Assist with ADL's as needed; -Assist of one to two staff for ADL's; -Encourage independence as much as possible; -Support daily routines. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 01/21/24, showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, dressing, mobility, and transfers; -Wheelchair for mobility. Review of the certified nurse a's A-hall cheat sheet, undated, showed the following information for the resident: -Alert and oriented times three; -Two staff assist for transfers. Observation on 05/08/24, at 11:41 A.M., showed CNA K and CNA T prepared for bed to chair transfer for the resident. CNA T lowered the resident's bed and both aides moved the resident to a seated position on the side of the bed. The aides did not apply a gait belt to the resident. Both aides stood on each side of the resident and placed their arms underneath the resident's arm and held the resident. Both aides assisted the resident to a standing position. CNA T and CNA K grabbed a hold of each side of the resident's pants to assist with holding the resident up in a standing position. Both aides assisted the resident to pivot into the wheelchair and assisted the resident to sit down into the wheelchair. During an interview on 05/09/24, at 10:23 A.M., CNA J said if the aides are unsure of how to transfer a resident, they should ask the nurse. If the resident is a two-person transfer, the process would be to get an additional staff member to assist with the transfer. The two staff would put a gait belt on the resident. Typically, he/she has one arm under his/her side of the resident's arm and holds onto the gait belt with his/her other arm. Both aides then pivot the resident to the chair and help them sit down. Staff should not be lifting on the resident's pants to help with the transfer. The nurse has told him/her that the was a two-person transfer and a gait belt should be used for the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said all staff are aware of how a resident transfers by looking at that hall's cheat sheet, which are located at the nurses' station. Staff is also able to come and ask the nurses. If a resident is a two-person transfer, staff should be using a gait belt with the transfer. Staff should never lift on the resident's arms or their pants. The resident is a one person assist most of the time. It depends on his/her mood and capabilities on that day. If the resident is going to require two staff for the transfer, they should be using a gait belt. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said staff should be aware of how to transfer a resident by looking at that hall's cheat sheet, which is located at the nurses' station. If the staff is still unsure, they should be asking the nurses. She expects staff to use gait belts for transfers, however the facility does not have a strict policy on that. Staff should never lift a resident by their arms or the pants. During an interview on 05/10/24, at 12:00 P.M., the Administrator said the CNAs should be aware of how to transfer resident's appropriately from their classes, as well as the education provided during in-services. They are expected to use a gait belt and should never pull on a resident's arms or pants. 31464

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41787 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services to prevent possible urinary tract infection (UTI - infection in any part of the urinary system, the kidneys, bladder) when staff failed to ensure the catheter drainage bag (bag that collects urine from the tube that attaches to a catheter (tube) that is inside the bladder) of three residents (Resident #29, #2, and #61) did not sit or drag on the floor. The facility had a census of 115. Review of the facility's policy titled, Urinary Catheter Care, undated, showed the following information: -Use standard precautions when handling or manipulating the drainage system; -Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag; -If breaks in aseptic technique, discontinuation, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. Review of the Centers for Disease Control and Prevention (CDC), Infection Control, Catheter-Associated Urinary Tract Infections (CAUTI), updated in 2017, showed do not rest the collection bag on the floor. 1. Review of Resident #29's face sheet showed the following information: -admitted [DATE]; -Diagnoses included dementia chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should). Review of the resident's care plan, dated 04/10/24, showed the following: -The resident had an indwelling catheter (A sterile tube inserted into the bladder to drain urine); -Staff should position and anchor catheter tubing and bag below the level of the bladder. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility), dated 04/17/24, showed the following: -Severe cognitive deficit; -Resident had an indwelling catheter. Observation showed the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/07/24, at 2:00 P.M., the resident was in bed with eyes closed. The catheter bag was hanging on the lower bed rail facing the doorway. The bag was not covered by or inside of a dignity bag. The bed was in the lowest position and the catheter bag was touching the floor; -On 05/10/24, at 10:30 A.M., the resident was in bed facing away from the door, the catheter bag was on the lower bed rail inside of a catheter bag and touching the floor. 37358 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included personal history of frequent urinary tract infections (UTI's), neuromuscular dysfunction of bladder (when the brain does not communicate with the bladder), and retention of urine (when one is unable to completely empty the bladder). Review of the resident's care plan, dated 06/11/22, showed the following: -Resident does use an indwelling catheter; -Staff are expected to maintain, clean, and position catheter tubing and bag below level of bladder and provide daily care. Review of the resident's annual MDS, dated [DATE], showed the following: -Resident required an indwelling catheter; -Toileting hygiene showed resident as totally dependent on staff for toileting needs. Observation on 05/09/24, at approximately 4:05 P.M., showed the following: -The resident lay in his/her bed and the catheter was hooked to the side of the bed; -The catheter touched the floor. 50185 3. Review of Resident #61's face sheet showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease (disease of the kidneys leading to failure) and benign prostatic hyperplasia (age associated prostate gland enlargement that can cause urination difficulty) with lower urinary tract symptoms. Review of the resident's care plan, revised 01/14/24, showed the following information: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Needs related to catheter use will be addressed and risks of complications will be minimized; -Change urinary catheter as needed; -Maintain urinary catheter for diagnosis of obstructive uropathy (a urinary tract disorder that occurs when urine cannot drain through the urinary tract); -Position and anchor tubing and bag below level of the bladder; -Provide urinary catheter care daily and as needed; -Provide changes in output, color, and odor. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, dressing, mobility, and transfers; -Indwelling urinary catheter. Observations on 05/07/24, at 8:36 A.M. and 1:32 P.M., showed the resident's room door open. The resident lay on his/ her back in bed with eyes closed and bed in lowest position. The urinary catheter collection bag hanging from the side of the bed and touched the floor. 4. During an interview on 05/09/24, at 1:02 P.M., Certified Nurse Aide (CNA) K said no part of the catheter system should touch the floor and the bag should be placed below the level of the bladder. 5. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said the catheter collection bag should be below the level of the bladder and should never touch the floor. 6. During interview on 05/10/24, at 12:00 P.M. and 1:00 P.M., the Administrator said he expects staff to follow the policy and procedure for catheter care. Catheter drainage bags should never touch the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to provide tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe (trachea) where then a tube is placed into the hole to keep it open for breathing) care following professional standards of practice for one resident (Resident #59). The facility census was 115. Review of the facility's policy titled Tracheostomy Care Procedure, undated, showed the following information: -The purpose of the procedure was to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas; -Aseptic technique (method used to prevent contamination in procedures where a sterile field is required) must be used; -Gloves must be used on both hands during any or all manipulation of the tracheostomy; -Sterile gloves must be used during aseptic procedures, a mask and eyewear must be worn; -Tracheostomy tubes should be changed as ordered and as needed; -A replacement tracheostomy tube, a suction machine, supply for suction catheters, exam and sterile gloves, and flush solution must be available at the bedside; -Staff to complete tracheostomy care in the order that follows; -Check the physician order; -Explain the procedure to the resident; -Wash hands and put exam gloves on both hands; -Remove supplemental oxygen mask from tracheostomy; -Inspect skin and stoma (an opening in the body) site for signs or symptoms of infection; -Assess resident for respiratory distress; -Remove old dressings, pull soiled glove over dressing and discard into appropriate receptacle, and wash hands; -Changing the disposable inner cannula (tube within the outer tube of the tracheostomy that can be removed) included open the cannula kit, apply gloves, remove disposable inner cannula and discard in appropriate receptacle, insert new cannula, and lock into place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Stoma care included apply clean gloves, use gauze moistened with wound wash, peroxide, or saline to gently wipe stoma, pat dry, apply clean split sponge. 1. Review of Resident #51's face sheet (brief resident profile sheet) showed the following information: -Readmitted [DATE]; -Diagnoses included chronic respiratory failure with hypoxia (the body doesn't have enough oxygen in your blood), high blood pressure, heart failure, dependence on supplemental oxygen, and surgical aftercare following new tracheostomy. Review of the resident's care plan, revised 03/27/24, showed the following information: -Permanent tracheostomy in place; -Observe for decreased pulse ox (blood oxygen level) and respiratory distress; -Suction as needed and maintain HAG (humidification and hydration for tracheostomy and mechanical ventilation) at settings; -Respiratory function is at risk for compromise related to shortness of breath and chronic obstructive pulmonary disease (blocked airflow causing breathing to be difficult); -Maintain tracheostomy with HAG per orders; -Administer medications per orders; -Monitor for increased edema (swelling) , increased shortness of breath, and observe for signs and symptoms of hypoxia (pallor, bluish color of the skin, fast pulse, and increased confusion); -Oxygen as ordered: five liters by tracheostomy. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/01/24, showed the following information: -Cognitively intact; -Special treatments included tracheostomy care, suctioning, and mechanical ventilator. Review of the resident's current physician order sheet,showed the following: -An order, dated 03/25/24, to change tracheostomy sponge (highly absorbent woven or non-woven gauze dressing) every shift; -An order, dated 03/25/24, to change trach ties (bands that go around the neck and stabilize cannula) weekly, on Mondays; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 03/25/24, to change disposable inner cannula every day; -An order, dated 03/27/24, to suction after each duo-neb (breathing treatment) four times a day; -An order, dated 04/17/24, to check drain bag for condensation and empty as needed every shift; -An order, dated 04/17/24, to make sure balloon is deflated on trach cuff (directs airflow through the tracheostomy tube) every six hours; -An order, dated 04/17/24, to check water level every shift; -An order, dated 04/24/24, to check settings every shift: HAG-60, FiO2 35%, Heater 3, 4 liters oxygen. Observation on 05/07/24, at 9:04 A.M., showed the following: -Licensed Practical Nurse (LPN) C entered the resident's room with gown and gloves donned (put on); -The LPN gathered tracheostomy supplies from a bedside organizer; -The LPN opened the suction catheter and attached the suction catheter to suction machine tubing; -LPN removed gloves; -The suction catheter fell on to the floor of the resident's room. The LPN picked up the catheter and removed it from the tubing and threw it into the trash; -Without performing hand hygiene, the LPN obtained a new suction catheter set; -The LPN opened the set and donned gloves found in the new set. While donning gloves, the right glove broke at the palm of the LPN's hand. The LPN did not change the broken glove; -The LPN touched the suction catheter with both gloved hands. He/she removed the inner cannula's cap and began suctioning with the catheter in his/her right hand, left thumb used for the suction port. When he/she pulled the suction catheter out of the inner cannula, on the second attempt, the catheter touched the resident's shirt; -The LPN realized he/she had no sterile water to flush the catheter. The LPN removed the suction catheter from the tubing and threw it into the trash; -The LPN went into the resident's bathroom, removed gloves, put water from the bathroom sink into a graduate cylinder; -Without completing hand hygiene, the LPN donned new gloves and carried the graduate of water over to resident's bedside table; -The LPN removed the inner cannula and threw it in the trash, inserted the new cannula, and put on the cap; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The LPN removed the pad around the stoma; -Without changing gloves or completing hand hygiene, the LPN placed a new pad around the tracheostomy site. He/she hooked the oxygen back up to the resident and sat up a nebulizer treatment for the resident; -The LPN placed the nebulizer in front of the resident's tracheostomy and asked the resident to press his/her call light when the treatment finished; -The LPN obtained the tracheostomy suction canister and disposed of it's contents in the toilet and rinsed and dried the canister. While doing so, he/she dropped some of the contents onto the resident's bathroom floor. He/she wiped it up with a paper towel; -The LPN then removed gloves and donned new gloves without completing hand hygiene; -The LPN returned the canister to the resident, organized the resident's tracheostomy supplies, and got the trash; -The LPN removed his/her gown and gloves and put them into the trash bag. The LPN used the hand sanitizer located inside the resident's room and exited the room. During an interview on 05/09/24, at 1:52 P.M., LPN C said he/she did the process out of order, that he/she is supposed to suction after giving the resident a nebulizer treatment. The resident prefers to be suctioned first, then replace the inner cannula daily, and change the tracheostomy ties weekly. He/she is aware of this because it populates on the resident's medication administration record. It takes two nurses to change the tracheostomy ties. The HAG machine gets set on 60, that's where the resident likes it. Everything that populates on the medication administration record comes from the physician's orders. He/she believes the only part of tracheostomy care that is sterile, would be the suctioning. After staff put on sterile gloves, staff should not touch anything else. If the gloves become contaminated, staff should remove them, wash hands, and don new sterile gloves. If something becomes contaminated, such as the suction catheter, staff should disconnect it and throw it away. He/she would then remove gloves, wash hands, don new gloves, and start the process over. The nurse assigned to the resident's hall is who performs the care. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said suctioning of a tracheostomy should be a sterile procedure, with sterile gloves. The care depends on the type of tracheostomy. If the resident has a disposable inner cannula, that should be changed daily. The split sponge is changed twice a day and the trach ties are changed once a week. All tracheostomy orders are in the computer. The nurses are responsible for performing this care and documenting it. While doing trach care, if something falls onto the floor, gloves should be removed, hands should be washed, and the process should be started over. She expects the nurses to wash their hands before performing the care, when going from a dirty to a clean surface, and after performing the care. During an interview on 05/10/24, at 12:00 P.M., the Administrator said his expectation for tracheostomy care would be for the nurses to follow the policy and procedure regarding that care. If something were to become contaminated during the care, he expects the nurse to pick it up, throw it away, remove gloves, wash their hands, and don new gloves. All staff are expected to wash their hands before and after care, before donning gloves, or after removing gloves.

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	265157	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41787 Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services with accurate documentation and storage for the emergency kit (E-Kit - kits containing commonly prescribed medications for emergency use) when medication lock tags failed to match the form titled All E-Kit Lock Registration for three of five E-Kit boxes. The facility census was 115. Review of the facility policy titled Medication Storage in the Facility, dated 01/01/19, showed the following: -Medications and biologics are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -The provider pharmacy dispenses medications in containers that meet regulatory requirements, including requirements of good manufacturing practices. Medications are kept in these containers; -Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications; -Medication storage conditions are monitored on a quarterly basis by the consultant pharmacy or pharmacy designee and corrective action taken if problems are identified; Review showed the facility did not provide a policy related to emergency kit boxes and logs. 1. Observation on 05/10/24, at 9:53 A.M., showed the following: -The A/B medication room had four locked plastic boxes. Each labeled with A, B, C, or narcotic kit on the outside of the box. There was a three-ring binder with forms labeled All E-Kit lock register that had an area for the date, two nurse signatures, the box letter and lock 1 and lock 2 information; -The A kit box tag locks showed numbers 909 and 908, with a white pharmacy tag dated 05/01/24 and signed by the pharmacy; -The C kit box tag locks showed number 953 and 954, with a white pharmacy tag dated 05/01/24 and signed by the pharmacy. Review on 05/10/24, at 9:55 A.M., of the All E-Kit lock register showed the following: -On 03/28/24, staff documented the C kit box tag numbers 431 and 432 on the box received from the pharmacy; -On 04/29/24, staff documented for the A box the tag number 522 removed and 098 put on; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/01/24, there was no documentation on the register form related to A kit box or the C kit box; -On 05/04/24, staff documented tag number 035 removed and 036 put on the A kit box; -There was no documentation matching the numbers currently on the A and C kit box. 2. Observation on 05/10/24, at 10:49 A.M., of the rehab hall medication room, showed the following: -Two emergency medication kits observed in the rehab hall medication room, labeled A box and B box; -The A kit box showed lock tag numbers 247 and 248, with a pharmacy tag dated 04/22/24 and signed by the pharmacy. Review of the E-kit Lock Register on 05/10/24, at 10:50 A.M., showed the following: -On 04/23/24, staff documented that lock 579 and 580 were removed and lock 565 and 566 were put on for the A kit box; -On 04/26/24, staff signed the lock register form that lock 512 and 511 were removed and lock 451 and 452 were put on for the A kit box; -No information on the log matched the lock tags currently on the A kit box. 3. During an interview on 05/10/24, at 10:00 A.M., Licensed Practical Nurse (LPN) F said that the nurses and certified medication technicians (CMT) were able to access the non-narcotic E-Kit boxes, but only the nurses can access the narcotic E-Kit. Each box had two numbered lock tags. The E-Kits are kept in the A/B hall medication room and the rehab therapy hall medication room. He/she did not know who was responsible for monitoring accuracy of the tag numbers and register documentation. 4. During an interview on 05/10/24, at 10:35 A.M., Registered Nurse (RN) D said on Wednesday the pharmacy drops off boxes. they do not put the numbers into the book. The night nurses should be putting the tags on the register form. He/she did not know why the forms did not currently match the boxes. There was not any facility staff that were responsible for reconciliation of the register books. The contents of the emergency kits included commonly prescribed antibiotics, respiratory medications, cardiac medications, intravenous (IV) fluids, and medications. The pharmacy prints the inventory list on the top of each box. 5. During an interview on 05/10/24, at 12:00 P.M., LPN G said when the night nurse received medications, he/she was to check in the medications. The staff should ensure the emergency kit registers and lock tags are correctly documented when accessed. The boxes included common medications such as blood pressure medication, cholesterol medication, muscle relaxants, antibiotics, and non-narcotics medications that would be needed before the pharmacy could deliver a new mediation order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said that the pharmacy delivers the emergency box kits every four weeks. The boxes are locked with tags from the pharmacy and then the first staff that access the box should ensure they change the tag and enter the information accurately on the register book. The kits should be accessed by two staff and the narcotic box should be accessed by two nurses. No staff at the facility audits the emergency kit locks and register. The pharmacy likely audits when they are here. There is no policy for the facility for emergency medication kits. 7. During an interview on 05/10/24, at 1:32 P.M., the Administrator said the facility received emergency medication kits from the pharmacy, so that commonly ordered medications can be obtained in a timely manner. The pharmacy delivers to the facility six days per week, and they deliver the emergency kits when needed. The emergency medication kit tag locks should match the information on paper register. If the nursing staff enter the emergency kit, they should switch the tag and document on the book accurately. The pharmacist should ensure the information matches.

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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** 31464 Based on observation, record review and interview the facility failed to ensure that the medication error rate was not 5 percent or greater, when staff failed to prime insulin pens (removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; failure to do so may result in administering too much or too little insulin) for three residents (Residents #220, #215, and #10) of 29 opportunities observed during medication pass (10% error rate). The facility census was 115. Review of the Instructions for Using Insulin Lispro (rapid acting insulin) KwikPen, revised 07/2023, showed the pen needs to primed before each use. The pen should be primed by the following steps: -Turn dose knob to two units; -Hold pen with needle pointing up; -Tap the cartridge holder gently to collect air bubbles at the top; -Continue holding the pen with needle pointing up and push dose knob until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. Insulin should be visible at the tip of the needle; -Repeat, no more than four times, until insulin is visible. If insulin is still not visible, change the needle and repeat priming process. Review of the Instructions for Using NovoLog (rapid acting insulin) FlexPen, revised 01/2019, showed to perform an air shot prior to injection. For each injection: -Select a dose of two units; -Take off the outer needle cap (save it) and inner needle cap (throw away); -With the pen pointing up, tap the insulin to move the air bubbles to the top; -Press the button all the way in and make sure insulin comes out of the needle; -Repeat up to two more times with the same needle if needed; -If insulin does not come out after three times, change needle and try again. If insulin still does not come out after changing the needle, the pen may be broken. Review of a facility policy entitled Specific Medication Administration Procedures, (revision date 1/01/2019), showed the following information: -Policy was to administer medications in a safe and effective manner; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review medication for accuracy; -If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. Review of facility guidelines entitled Insulin Administration, undated, showed the following: -Types of insulin/brand names include rapid-acting insulin lispro (Humalog) and insulin aspart (NovoLog), and long-acting insulin glargine (Lantus); -Priming the pen: Dial up two units and hold the pen with the needle pointing upwards. Tap the pen gently to remove air bubbles, and then push the injection button until a drop of insulin appears at the tip of the needle. 1. Review of Resident #220's face sheet (gives basic profile information) showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve pain) and diabetic chronic kidney disease and long term (current) use of insulin. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/07/24, showed the following information: -Cognition intact; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 05/03/24, showed the resident was prescribed insulin to help manage his/her diabetes. Staff to administer insulin as ordered. Review of the resident's Physician Order Sheet (POS), dated 05/10/24, showed the following: -An order, dated 04/30/24, to administer insulin lispro, insulin pen 100 units (u)/milliliter (ml) per sliding scale; -If blood sugar is less than 40 milligrams (mg)/deciliter (dL), call physician; -If blood sugar is 120 mg/dL - 160 mg/dL, give 2 units; -If blood sugar is 161 mg/dL - 200 mg/dL, give 4 units; -If blood sugar is 201 mg/dL - 240 mg/dL, give 6 units; -If blood sugar is 241 mg/dL - 280 mg/dL, give 8 units; -If blood sugar is 281 mg/dL - 320 mg/dL, give 11 units; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, give 15 units; -If blood sugar is greater than 320 mg/dL, call physician; -Administer insulin subcutaneously (under the skin) before meals. Observation on 05/09/24, at 11:54 A.M., showed Registered Nurse (RN) M performed an accucheck (finger stick blood test to determine level of sugar) with a result of 183 mg/dL. The RN said the resident required four units of insulin lispro per the sliding scale order. He/she wiped the insulin pen tip with alcohol and attached the needle. Without first priming the insulin pen, RN M set the dial to 4 and administered the insulin to the resident. 2. Review of Resident #215's face sheet showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus and long term (current) use of insulin. Review of the resident's admission MDS, dated [DATE], showed the following information: -Cognition intact; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 05/08/24, showed the resident prescribed insulin to help manage his/her diabetes. Staff to administer insulin as ordered. Review of the resident's POS, dated 05/10/24, showed the following: -An order, dated 05/01/24, for insulin lispro insulin pen, 100 unit/ml, 20 units subcutaneous with meals; -An order, dated 05/01/24, for insulin lispro insulin pen, 100 units/ml, per sliding scale: -If blood sugar is less than 40 mg/dL, call physician; -If blood sugar is 120 mg/dL - 160 mg/dL, give 2 units; -If blood sugar is 161 mg/dL - 200 mg/dL, give 4 units; -If blood sugar is 201 mg/dL - 240 mg/dL, give 6 units; -If blood sugar is 241 mg/dL - 280 mg/dL, give 8 units; -If blood sugar is 281 mg/dL - 320 mg/dL, give 11 units; -If blood sugar is greater than 320 mg/dL, give 15 units; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, call physician; -Insulin administered subcutaneously before meals. Observation on 05/09/24, at 11:33 A.M., showed RN M performed an accucheck for the resident with a result of 94 mg/dL. RN M asked the resident to calculate the required amount of insulin to be given based on the sliding scale (copy provided to the resident). The resident said he/she would not require additional insulin. RN M agreed, stating he/she would wait until the resident ate lunch before administering the ordered base amount of insulin of 20 units. Observation on 05/09/24, at 12:27 P.M., showed RN M retrieved the insulin lispro pen for the resident from the nurses' treatment/medication cart drawer. Without priming the pen, the RN turned the dial to 20, went to the resident's room, showed the pen setting to the resident, and administered the insulin to the resident. 3. Review of Resident #10's face sheet showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus and long term (current) use of insulin. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognition moderately impaired; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 03/15/24, showed the resident prescribed insulin and oral medication to help manage his/her diabetes. Review of the resident's POS, dated 05/10/24, showed the following: -An order, dated 11/24/23, for NovoLog U-100 insulin aspart solution, 100 unit/ml, per sliding scale; -If blood sugar is less than 40 mg/dL, call physician; -If blood sugar is 120 mg/dL to 160 mg/dL, give 3 units; -If blood sugar is 161 mg/dL to 200 mg/dL, give 5 units; -If blood sugar is 201 mg/dL to 240 mg/dL, give 8 units; -If blood sugar is 241 mg/dL to 280 mg/dL, give 12 units; -If blood sugar is 281 mg/dL to 320 mg/dL, give 16 units; -If blood sugar is greater than 320 mg/dL, give 20 units; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, call physician; -Insulin administered subcutaneously before meals. Observation on 05/09/24, at 11:39 A.M., showed RN M performed an Accucheck for the resident, with a result of 242 mg/dL. The RN said he/she would need to retrieve a new insulin pen from the e-kit (emergency use medications to be used when resident specific medication hasn't yet been delivered) however, the resident went to the dining room and began eating before administration of the insulin. Observation on 05/09/24, at 12:02 P.M., showed RN M retrieved a NovoLog insulin pen from the medication room e-kit for the resident. The resident was still eating lunch in the dining room. Observation on 09/05/24, at 12:45 P.M., showed RN M checked the resident's sliding scale to confirm a required dose of 12 units of NovoLog insulin. Without priming the pen, RN M set the dial to 12 and administered the insulin to the resident. 4. During an interview on 05/09/24, at 12:48 P.M., RN M said he/she would usually prime an insulin pen, but forgot to do so prior to the pen injections that day. 5. During an interview on 05/10/24, at 11:00 A.M., Licensed Practical Nurse (LPN) G said the facility was in the process of switching from insulin vials to injectable pens and there had not been a facility in-service yet. LPN G said to use an insulin pen staff should remove the cap, clean the tip with an alcohol wipe, attach the needle, set the dial to the number of units required to give, and administer the insulin. LPN G was not aware of the need to prime an insulin pen. 6. During an interview on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said the facility was in the process of switching from insulin vials to injectable pens. An in-service training was planned for 05/13/24 and would probably be done by the Assistant Director of Nursing (ADON), who was currently on vacation. Staff should check the pharmacy tag to verify the resident's name, type of insulin, and that dates were marked showing when the pen was opened and the last day to use after opening. Staff should use an alcohol wipe to clean the tip of the pen, apply the needle, dial in two units to prime the pen, then dial in the required number of units of insulin to give. 7. During an interview on 05/10/24, at 1:05 P.M., the Administrator said the facility is switching from vials to the use of insulin pens. There was an in-service training scheduled for 05/13/24. The Administrator was not aware of the need to prime the pens. Staff should follow the manufacturer's guidelines for the use of the pens.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, interview, and record review, the facility staff failed ensure all residents were free from significant medication errors when staff failed to to prime (removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; failure to do so may result in administering too much or too little insulin) the insulin pens before administering insulin to three residents (Residents #220 #215, and #10) of four residents observed during insulin administration. The facility census was 115. Review of the Instructions for Using Insulin Lispro (rapid acting insulin) KwikPen, revised 07/2023, showed the pen needs to primed before each use. The pen should be primed by the following steps: -Turn dose knob to two units; -Hold pen with needle pointing up; -Tap the cartridge holder gently to collect air bubbles at the top; -Continue holding the pen with needle pointing up and push dose knob until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. Insulin should be visible at the tip of the needle; -Repeat, no more than four times, until insulin is visible. If insulin is still not visible, change the needle and repeat priming process. Review of the Instructions for Using NovoLog (rapid acting insulin) FlexPen, revised 01/2019, showed to perform an air shot prior to injection. For each injection: -Select a dose of two units; -Take off the outer needle cap (save it) and inner needle cap (throw away); -With the pen pointing up, tap the insulin to move the air bubbles to the top; -Press the button all the way in and make sure insulin comes out of the needle; -Repeat up to two more times with the same needle if needed; -If insulin does not come out after three times, change needle and try again. If insulin still does not come out after changing the needle, the pen may be broken. Review of a facility policy entitled Specific Medication Administration Procedures, (revision date 1/01/2019), showed the following information: -Policy was to administer medications in a safe and effective manner; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review medication for accuracy; -If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information. Review of facility guidelines entitled Insulin Administration, undated, showed the following: -Types of insulin/brand names include rapid-acting insulin lispro (Humalog) and insulin aspart (NovoLog), and long-acting insulin glargine (Lantus); -Priming the pen: Dial up two units and hold the pen with the needle pointing upwards. Tap the pen gently to remove air bubbles, and then push the injection button until a drop of insulin appears at the tip of the needle. 1. Review of Resident #220's face sheet (gives basic profile information) showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (nerve pain) and diabetic chronic kidney disease and long term (current) use of insulin. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/07/24, showed the following information: -Cognition intact; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 05/03/24, showed the resident was prescribed insulin to help manage his/her diabetes. Staff to administer insulin as ordered. Review of the resident's Physician Order Sheet (POS), dated 05/10/24, showed the following: -An order, dated 04/30/24, to administer insulin lispro, insulin pen 100 units (u)/milliliter (ml) per sliding scale; -If blood sugar is less than 40 milligrams (mg)/deciliter (dL), call physician; -If blood sugar is 120 mg/dL - 160 mg/dL, give 2 units; -If blood sugar is 161 mg/dL - 200 mg/dL, give 4 units; -If blood sugar is 201 mg/dL - 240 mg/dL, give 6 units; -If blood sugar is 241 mg/dL - 280 mg/dL, give 8 units; -If blood sugar is 281 mg/dL - 320 mg/dL, give 11 units; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, give 15 units; -If blood sugar is greater than 320 mg/dL, call physician; -Administer insulin subcutaneously (under the skin) before meals. Observation on 05/09/24, at 11:54 A.M., showed Registered Nurse (RN) M performed an accucheck (finger stick blood test to determine level of sugar) with a result of 183 mg/dL. The RN said the resident required four units of insulin lispro per the sliding scale order. He/she wiped the insulin pen tip with alcohol and attached the needle. Without first priming the insulin pen, RN M set the dial to 4 and administered the insulin to the resident. 2. Review of Resident #215's face sheet showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus and long term (current) use of insulin. Review of the resident's admission MDS, dated [DATE], showed the following information: -Cognition intact; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 05/08/24, showed the resident prescribed insulin to help manage his/her diabetes. Staff to administer insulin as ordered. Review of the resident's POS, dated 05/10/24, showed the following: -An order, dated 05/01/24, for insulin lispro insulin pen, 100 unit/ml, 20 units subcutaneous with meals; -An order, dated 05/01/24, for insulin lispro insulin pen, 100 units/ml, per sliding scale: -If blood sugar is less than 40 mg/dL, call physician; -If blood sugar is 120 mg/dL - 160 mg/dL, give 2 units; -If blood sugar is 161 mg/dL - 200 mg/dL, give 4 units; -If blood sugar is 201 mg/dL - 240 mg/dL, give 6 units; -If blood sugar is 241 mg/dL - 280 mg/dL, give 8 units; -If blood sugar is 281 mg/dL - 320 mg/dL, give 11 units; -If blood sugar is greater than 320 mg/dL, give 15 units; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, call physician; -Insulin administered subcutaneously before meals. Observation on 05/09/24, at 11:33 A.M., showed RN M performed an accucheck for the resident with a result of 94 mg/dL. RN M asked the resident to calculate the required amount of insulin to be given based on the sliding scale (copy provided to the resident). The resident said he/she would not require additional insulin. RN M agreed, stating he/she would wait until the resident ate lunch before administering the ordered base amount of insulin of 20 units. Observation on 05/09/24, at 12:27 P.M., showed RN M retrieved the insulin lispro pen for the resident from the nurses' treatment/medication cart drawer. Without priming the pen, the RN turned the dial to 20, went to the resident's room, showed the pen setting to the resident, and administered the insulin to the resident. 3. Review of Resident #10's face sheet showed the following: -admitted [DATE]; -Diagnoses included type 2 diabetes mellitus and long term (current) use of insulin. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognition moderately impaired; -Insulin given seven of seven days during look back period. Review of the resident's care plan, updated 03/15/24, showed the resident prescribed insulin and oral medication to help manage his/her diabetes. Review of the resident's POS, dated 05/10/24, showed the following: -An order, dated 11/24/23, for NovoLog U-100 insulin aspart solution, 100 unit/ml, per sliding scale; -If blood sugar is less than 40 mg/dL, call physician; -If blood sugar is 120 mg/dL to 160 mg/dL, give 3 units; -If blood sugar is 161 mg/dL to 200 mg/dL, give 5 units; -If blood sugar is 201 mg/dL to 240 mg/dL, give 8 units; -If blood sugar is 241 mg/dL to 280 mg/dL, give 12 units; -If blood sugar is 281 mg/dL to 320 mg/dL, give 16 units; -If blood sugar is greater than 320 mg/dL, give 20 units; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If blood sugar is greater than 320 mg/dL, call physician; -Insulin administered subcutaneously before meals. Observation on 05/09/24, at 11:39 A.M., showed RN M performed an Accucheck for the resident, with a result of 242 mg/dL. The RN said he/she would need to retrieve a new insulin pen from the e-kit (emergency use medications to be used when resident specific medication hasn't yet been delivered) however, the resident went to the dining room and began eating before administration of the insulin. Observation on 05/09/24, at 12:02 P.M., showed RN M retrieved a NovoLog insulin pen from the medication room e-kit for the resident. The resident was still eating lunch in the dining room. Observation on 09/05/24, at 12:45 P.M., showed RN M checked the resident's sliding scale to confirm a required dose of 12 units of NovoLog insulin. Without priming the pen, RN M set the dial to 12 and administered the insulin to the resident. 4. During an interview on 05/09/24, at 12:48 P.M., RN M said he/she would usually prime an insulin pen, but forgot to do so prior to the pen injections that day. 5. During an interview on 05/10/24, at 11:00 A.M., Licensed Practical Nurse (LPN) G said the facility was in the process of switching from insulin vials to injectable pens and there had not been a facility in-service yet. LPN G said to use an insulin pen staff should remove the cap, clean the tip with an alcohol wipe, attach the needle, set the dial to the number of units required to give, and administer the insulin. LPN G was not aware of the need to prime an insulin pen. 6. During an interview on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said the facility was in the process of switching from insulin vials to injectable pens. An in-service training was planned for 05/13/24 and would probably be done by the Assistant Director of Nursing (ADON), who was currently on vacation. Staff should check the pharmacy tag to verify the resident's name, type of insulin, and that dates were marked showing when the pen was opened and the last day to use after opening. Staff should use an alcohol wipe to clean the tip of the pen, apply the needle, dial in two units to prime the pen, then dial in the required number of units of insulin to give. 7. During an interview on 05/10/24, at 1:05 P.M., the Administrator said the facility is switching from vials to the use of insulin pens. There was an in-service training scheduled for 05/13/24. The Administrator was not aware of the need to prime the pens. Staff should follow the manufacturer's guidelines for the use of the pens.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 31464 Based on observation, interview, and record review, the facility failed to ensure medications were stored safely and securely when staff failed to lock medication and treatment carts when unattended by authorized personnel. The facility had a census of 115. Review of the facility policy titled Medication Storage in the Facility, revised 01/01/19, showed the following information: -Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications; -Medication rooms, carts, and medication supplies are to be locked when not attended by persons with authorized access. Review of the facility policy titled Specific Medication Administration Procedures, revised 01/01/19, showed the following information: -All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/tech. 1. Observation on 05/08/24, at 10:48 A.M., showed C hall medication cart, unlocked and accessible with no certified medication technician (CMT) or nurse present with the cart or in sight of the cart. CMT returned to the cart at 10:51 A.M. 2. Observations on 05/09/24 showed the following: -At 9:58 A.M., the rehab hall nurses' treatment cart was backed up against the nurses' desk. The cart was unlocked. The cart contained insulin, glucometers individually bagged/named, prescription creams and ointments, and two sets of keys. No staff were present at the desk or in the area of the cart; -At 10:11 A.M., Registered Nurse (RN) M walked to the unlocked cart and leaned on the cart while speaking on a cell phone regarding a resident's supplies. RN M ended the phone conversation and walked away. The cart remained unlocked; -At 10:24 A.M., the treatment cart remained unlocked. RN M approached the cart and moved it down the hallway, backing the cart up to the doorway of a resident's room. -At 12:02 P.M., RN M stood in front of the rehab hall nurses' treatment cart, which was backed up against the nurses' desk area, facing the open resident dining area. Leaving the cart unlocked, RN M walked away from the cart for several minutes while retrieving a medication from the unit medication room. Six residents, one visitor, and several staff were present in the dining area; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:09 P.M., RN M stood in front of the rehab hall nurses' treatment cart, which was backed up against the nurses' desk area, facing the open resident dining area. The RN drew up insulin from a vial and placed the vial on top of the cart. Leaving the cart unlocked with the insulin vial on top, RN M walked away from the cart for several minutes to a resident's room to administer the insulin. Six residents, one visitor, and several staff were present in the dining area. 50185 3. During an interview on 05/10/24, at 12:00 P.M., Licensed Practical Nurse (LP:N) G said staff should lock the medication and treatment carts when they walk away. 4. During an interview on 05/10/24, at 12:32 P.M., the Director of Nursing (DON) said all medication carts and treatment carts should be locked when unattended by staff, securing the medications and treatments. 5. During an interview on 05/10/24, at 3:05 P.M., the Administrator said all medication and treatment carts should be locked when the staff walks away from the cart. 41787

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to have an effective system in place to ensure accommodation of residents' meal preferences when staff served one resident (Resident #84) meals that did not reflect the resident's requested food preferences. The facility census was 115. Review showed the facility did not provide a policy regarding resident food preferences. 1. Review of the Resident #84's face sheet (a document showing the resident's information at a quick glance) showed the following information: -Readmitted [DATE]; -Diagnoses included congestive heart failure (a condition in which the heart doesn't pump blood as it should), respiratory failure with hypoxia (a condition where one does not have enough oxygen in the tissues of the body), type two diabetes, and dysphagia (difficulty swallowing). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 01/12/24, showed the following information: -Cognitively intact; -Can eat independently. Review of the resident's care plan, revised 04/27/24, showed the following information: -The resident or a resident assistant (RA) will circle preferences provided at the base of each meal ticket when desired; -Honor preferences and provide snacks; -Prefers meals in main dining room; -Regular diet, 1800 cubic centimeter (cc) fluid restriction. Observation on 05/06/24, at 12:01 P.M., showed the lunch menu as: -Beef pot roast; -Mashed potatoes and gravy; -Green beans; -Carrot cake cupcakes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/06/24, at 12:46 P.M., the resident received beef pot roast, mashed potatoes, green beans, a roll, and a cupcake. The resident did not receive any gravy. The resident said he/she wanted gravy and ordered gravy, but didn't want to wait the time for staff to get it, as the other food would be cold by that time. Observation and interview on 05/07/24, at 8:51 A.M., showed Certified Nursing Assistant (CNA) H in the resident's room offering to warm up the resident's breakfast tray. At 9:02 A.M., the resident said his/her tray was missing the oatmeal he/she requested. The resident showed his/her meal ticket which had oatmeal circled and handwriting which requested brown sugar with the oatmeal. The resident received brown sugar, but no oatmeal. The resident said yesterday, 05/06/24, he/she received the oatmeal, but no brown sugar. During an interview on 05/09/24, at 10:34 A.M., CNA J said staff knows what a resident wants to eat by the RA's going around and asking them. The RA's will bring around tickets the day before, typically there are two main options for the residents to choose from. If they don't like those options, staff offer the alternate menu. Once the tickets are filled out, the residents are still able to change their minds. If the resident has something marked, that is what they should get. For the residents who get a hall tray, the CNAs are the ones who serve those out. CNAs try to look at the ticket and the food to ensure nothing is missing. If something is missing, he/she tries to fix it prior to serving it to the resident. During an interview on 05/09/24, at 1:02 P.M., CNA K said there are meal tickets given to the residents every morning that tells the mealtime offerings. If the resident doesn't like what they are having, the aide will recite all the available substitutes. Staff always ask the residents what they want and will write it on the meal ticket. Sometimes the residents get served what they want, sometimes they don't. If he/she notices a resident isn't being served what they asked for, he/she will return it to the kitchen and have them fix it. During an interview on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said the residents let staff know what they want to eat by the RA's going around with the meal tickets every morning. The residents get to choose. When the tray is served, everything on the tray should be correct. He/she has had complaints that the residents are not getting what they requested. He/she is aware that this has been a problem and is not sure if it's a miscommunication. The staff needs to look at the meal tickets, or the residents should let them know of the error in the meal and they will try to make it right when they can. During an interview on 05/09/24, at 3:16 P.M., RA L said his/her job duties included food service in the dining room, taking down hall trays and going to resident's rooms after breakfast and asking the residents what they would like to eat for the following day. After the RAs get the meal tickets filled out, they leave those tickets in the dietician's office. The kitchen staff will then use those meal tickets to dish up the meals, then the tickets are thrown away. They all check to make sure the residents are getting what they want. Typically, the cook will go through the tickets prior to cooking so they can prepare enough of the meal, then they serve the dish. He/she said they have had trouble with people getting things that they did not want. Sometimes they can make the accommodation, sometimes they cannot. As far as hall trays, the aides will help the RAs pass them out, but everyone should be checking to make sure it is correct. If an order is incorrect, staff should be going back to the kitchen to make it right. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/10/24, at 9:47 A.M., the Clinical Dietician/Dietary Manager said the menus are created at the corporate home office. The residents are provided with two entree options for lunch and dinner. Breakfast is usually a special item and then the standard breakfast items. They also have the always available menu. RAs are employed by the nursing department and they are who asks the residents their preferences the day prior. After that is collected, they will leave the tickets in the mailbox for the dietician. RAs have access to the kitchen just like dietary staff. When the kitchen is serving the two entrees, they have two cooks for each meal, one of them being the helper. The helpers are responsible for cooking the always available menu items. Recently they have went down to one entree and the always available menu, due to limited staffing. The first thing the cook should do is look at the ticket, they count how many items of what meal is needed, so they cook the correct amount. Primarily the CNAs pass the hall trays, and the RAs pass trays in the dining room. Both of them should be looking at the tickets and the trays to ensure they are correct. Three people should be looking and checking for accuracy. Those three people are the cook, the helper, and the person serving the dish. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said residents make their wishes known for how they want their meal served. There are two choices for the main dish and they also have an alternate menu. RAs go around and fill out everyone's tickets, with their preferences the day prior. RAs then turn the tickets into the kitchen. Double checking should be happening to ensure what's on the tray matches the ticket. Kitchen staff should do that, not the aides. During an interview on 05/10/24, at 12:00 P.M., the Administrator said the facility has staff go around every day with the menus for the next day. Those staff members are to tell the residents what the meal options are, as well as what the alternate options are. The staff should fill those out and then collect them and turn them into the dietary folder. The cook is to use those tickets to determine how much of what meal to cook. There are three people that should be checking to make sure the residents are getting what they request, those people are the cook, the drink preparer, and the server.

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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. 37358 Based on observation, interview, and record review, the facility failed to keep food safe from potential contamination when staff stacked clean dishware inside one another instead of air drying, which could potentially contaminate food served from those items, and failed to keep dented cans separate from other canned goods. The facility census was 115. 1. Review of the 2022 Food Code, issued by the Food and Drug Administration (FDA), showed the following information: -After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food; -Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Review of the facility's policy titled Warewashing Machines Operation, by Safety and Sanitation Best Practice Guidelines, revised November 2017, showed the following information: -Air-dry all items; -Make sure all items are completely dry before stacking to prevent wet-nesting. Observation on 05/06/24, beginning at 9:05 A.M., showed the following items left wet and stacked on top of one another trapping water between the items: -Three metal pans for the steam table; -Seventy-eight plastic soup/cereal bowls. Observation on 05/10/24, at 11:44 P.M., showed the following items left wet and stacked on top of one another trapping water between the items: -Thirty-eight plastic bowls stacked together and sitting in a large plastic tub; -Nine plastic coffee cups; -Five plastic divided plates. During an interview on 05/10/24, at 11:58 A.M., Dietary Aide AA said the following: -The few that have worked in the kitchen for some time, know to let dishes air dry before putting them away; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There are a few new employees, that are not doing a good job of air drying dishes. During an interview on 05/10/24, at 12:15 P.M., Dietary Aide DD said dishes should always be air dried and never stacked while still wet. During an interview on 05/10/24, at 12:20 P.M., Regional Dietary Manager, said the following: -He/she is aware that some dishes have not been air dried; -He/she has tried to redirect this current dishwasher. 2. Review of the 2022 Food Code showed the following information: -Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard; -Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food; -If the integrity of the packaging has been compromised, contaminants may find their way into the food. Review of the facility's policy titled Review Cans Using Following Guidelines, by Safety and Sanitation Best Practice Guidelines, revised November 2017, showed the following information: -A can is unacceptable if a dent is on side seam, top, or bottom rim or if severely dented or buckled, resulting in bulged lids; -Before discarding unacceptable cans, review with manager for appropriate credit. Observation on 05/06/24, beginning at 9:05 A.M., showed the following cans were dented and not separated from the cans that were appropriate to use: -One 6.93 pound (lb) can of tomato paste; -One 6.12 lb can of mixed sweet peas; -One 6.14 lb can of navy beans; -On 6.9 lb can of grapefruit sections. During an interview on 05/10/24, at 11:58 A.M., Dietary Aide AA, said the following: -He/she was not aware of any dented cans on the shelf; -Dented cans should be put to the side; -The manager will send pictures to the food provider to get credit. (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 interview on 05/10/24, at 12:20 P.M., the Regional Dietary Manager said staff had already noticed that there were dented cans and have put them in the correct place. 3. During an interview on 05/10/24, at approximately 1:00 P.M., the Administrator said he/she was already aware of the issues in the kitchen from the Regional Dietary Manager.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program to prevent the risk of contamination and spread of infection when staff failed to complete proper hand hygiene during incontinent care for one resident (Resident #81) and during urinary catheter (bag that collects urine from the tube that attaches to a catheter (tube) that is inside the bladder) care for one resident (Resident #61). The facility also failed to protect clean laundry from possible contamination. The facility census was 115. Review of the facility's policy titled Handwashing/Hand Hygiene, revised August 2015, showed the following information: -Hand hygiene is the primary means to prevent the spread of infections; -All personnel should be trained and inserviced on the importance of hand hygiene and shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections; -Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies; -Wash hands with soap (antimicrobial or non-antimicrobial) and water when hands are visibly soiled and after contact with a resident with infectious diarrhea; -Perform hand hygiene before and after coming on duty, before and after direct care with residents, before and after handling an invasive device, before donning (putting on) sterile gloves, before handling clean or soiled dressings, before moving from contaminated body sites to clean body sites, after contact with residents' skin or any bodily fluids, after handling used dressings or equipment, and after removing gloves. 1. Review of Resident #81's face sheet (brief resident profile sheet) showed the following information: -admitted [DATE]; -Diagnoses included Alzheimer's disease, dementia, history of falling, high blood pressure, urine retention, and insomnia. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 02/14/24, showed the following information: -Severely cognitively impaired; -Dependent on staff for toileting, bathing, dressing, and mobility; -Frequently incontinent of bowel and bladder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue Springfield, MO 65807

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, revised 02/12/24, showed the following information; -Incontinence care per needs; -Incontinence pads or briefs as needed; -Protective barrier cream as needed; -Requires moderate to maximum assist with all cares; -Assist with toileting and incontinence care as needed. Observation on 05/07/24, at 8:52 A.M., showed the following: -Certified Nursing Assistant (CNA) H and Nursing Assistant (NA) I entered the resident's room. CNA H and NA I donned gloves without performing hand hygiene and shut the resident's room door; -CNA H and NA I transferred the resident from the wheelchair to the bed with a mechanical lift; -CNA H entered the resident's bathroom, removed his/her gloves, and donned new gloves without performing hand hygiene; -CNA H explained to the resident he/she would be changing the resident and providing incontinent care to the resident; -CNA H and NA I undressed the resident. NA I handed CNA H wipes. CNA H wiped the resident's bottom several times. Bowel movement observed on the wipe being used; -CNA H placed the dirty brief and wipes into the trash. CNA H removed his/her gloves and donned new gloves without performing hand hygiene. NA I continued with the same gloves; -A new brief was placed under the resident and CNA H cleansed the resident's front genital area; -NA I removed gloves and donned new gloves without performing hand hygiene; -The resident rolled toward NA I for clothing adjustments and brief latch; -NA I removed the gloves and threw the gloves in the trash; -CNA H continued adjusting the resident's clothing with the contaminated gloves, covered the resident with a blanket, laid the fall mat down on the right side of the bed, and placed the resident's call light on his/her chest. NA I lowered the resident's bed; -CNA H removed his/her gloves. CNA H and NA I removed the trash bags and left the room; -CNA H and NA I applied hand sanitizer in the hallway outside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident # 61's face sheet (brief resident profile sheet), showed the following information: -admitted [DATE]; -Diagnoses included senile degeneration of the brain (loss of intellectual ability), type two diabetes, chronic kidney disease (disease of the kidneys leading to failure), benign prostatic hyperplasia (age associated prostate gland enlargement that can cause urination difficulty) with lower urinary tract symptoms, and irregular heartbeat. Review of the resident's care plan, revised 01/14/24, showed the following information: -Change catheter as needed; -Provide catheter care daily and as needed. Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -Dependent on staff for toileting, dressing, mobility, and transfers; -Indwelling catheter. Observations on 05/08/24, at 11:41 A.M., showed the following: -CNA K entered the resident's room and donned gloves without performing hand hygiene; -The CNA closed the door, turned on the lights, raised the bed to his/her waist level, uncovered the resident, and prepared the brief and wipes; -The CNA removed the resident's brief and pants. Without performing hand hygiene or changing gloves, the CNA performed pericare the resident's genitals and catheter. The CNA completed multiple wipes of the catheter with the same wipe; -The CNA threw the dirty wipe into the trash. Without completing any hand hygiene or glove change, he/she placed a clean brief under the resident; -The CNA wiped the resident's buttocks with a new wipe. Without completing any hand hygiene or glove change, the CNA pulled up the resident's brief in the front and fastened it; -The CNA pulled up the resident's pants, removed his/her gloves, and collected the trash. During an interview on 05/09/24, at 10:23 A.M., CNA J said the aides or the nurses can complete catheter care. Hand hygiene should be performed before starting care and staff should don gloves. Staff should wipe the catheter tubing in a downward motion. Staff should change the position of the cloth with each cleansing stroke. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24, at 1:02 P.M., CNA K said staff should wash their hands prior to donning gloves. Staff should change the position of the cloth with each cleansing stroke of the catheter tubing or use a new wipe with each stroke. During an interview on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said the nurses are the ones generally responsible for catheter care. When providing catheter care, staff should change the position of the cloth with each cleansing stroke or use a new wipe with each stroke. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said staff should clean the catheter tubing in a downward motion. Staff should change to a new cloth with each cleansing stroke. 3. During an interview on 05/09/24, at 10:34 A.M., CNA J said that staff should wash their hands before providing incontinent care. Once you've done all the cleaning, staff should remove those gloves, wash their hands again before touching anything else in the room. Staff should don new gloves before putting a fresh brief onto the resident, and then again before pulling up the resident's clothing. 4. During an interview on 05/09/24, at 1:02 P.M., CNA K said that staff should wash their hands prior to performing incontinence care. After hand washing, they should don gloves. After all cleansing is done, staff should remove gloves and wash hands. After providing care, staff should not touch anything in the room until they wash their hands. 5. During an interview on 05/09/24, at 1:52 P.M., LPN C said staff should wash their hands before, in-between, and after providing care. If the gloves become contaminated, staff should remove them, wash hands, and don new gloves. 6. During an interview on 05/10/24, at 11:00 A.M., the DON said staff should wash their hands prior to starting incontinence care, when going from dirty to clean, and after providing care. Once their hands are washed, they should not touch anything else in the room before providing care. 7. During an interview on 05/10/24, at 12:00 P.M., the Administrator said all staff are expected to wash their hands before and after care and before donning or doffing gloves. If something were to become contaminated during the care, he expects staff to wash their hands, and don new gloves. 31464 8. Review showed the facility did not provide a policy related to infection control related to clean laundry. During an observation and interview on 05/08/24, at 11:50 A.M., Laundry Staff P carried three to four garments on hangers down the full length of the A hall to a resident's room on the Rehab hall. The garments were not covered. The staff said they usually deliver the clean laundry on a rolling rack with an attached basket and the carts do not have a cover. The load he/she already delivered was too large, so he/she just hand carried the extra few items to a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/08/24, at 1:20 P.M., showed an uncovered wire rolling cart was positioned along the A hall wall. Clean clothing hung on the rack or lay folded in the attached basket underneath. Housekeeping Staff Q delivered the articles into residents' rooms. The staff said the clothing cart did not have a cover. They usually delivered clean laundry from one of the same type carts. Sometimes they just picked up a few articles at a time and carried them to the correct room. During an interview on 05/08/24, at 2:49 P.M., the Housekeeping/Laundry Supervisor said the facility used rolling carts with attached baskets (not covered) to deliver clean laundry to residents. If there were only a few garments on hangers, staff would just hand carry them to the resident's room. During an interview on 05/08/24, at 2:53 P.M., the Director of Nursing (DON) said for delivering clean laundry, the facility used rolling carts with a hang-up rack and attached wire basket below. The carts did not have covers. Linens are taken on a covered cart to transfer to storage shelves on halls. During an interview on 05/08/24, at 3:01 P.M., the Administrator said the staff used rolling metal carts with clothing hung on the upper rod or folded in the wire basket below. Those carts were not covered. Linens are taken out on rolling plastic carts, covered, and transferred to wire shelving on the halls.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on record review, observation, and interview, the facility failed to ensure all bathroom were adequately equipped with a full call light system when call light pull cords were wrapped around the grab bars or missing in the bathrooms of eight residents (Resident #9, #21, #23, #108, #8, #26, #99, and #107) preventing the pull cord accessibility to call for staff assistance. A sample of 29 residents was reviewed in a facility with a census of 115. Review of the facility's policy titled, Call Lights, dated 04/30/24, showed the following: -The center will provide each resident with a functioning call light; -The call light alerts the staff to respond to a resident's request for assistance; -Be sure the call light is always within in reach of the resident. 1. Review of Resident #9's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses include stroke, hemiplegia (weak or paralysis on one side of the body), seizure disorder, anxiety disorder, and depression. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/03/24, showed the following: -Cognitively intact; -Impairment on one side of the body; -Independent with toileting hygiene and toilet transfer. Review of the resident's care plan, revised 05/08/24, showed the following: -Resident fall risk related to stroke with left side weakness; -Resident to call for assistance post toileting when he/she feels unsteady; -Keep call light and personal items within his/her reach; -Remind to call for transfer assist. Observations on 05/06/24, at 1:40 P.M., and on 05/07/24, at 8:35 A.M., of the resident's shared bathroom showed the call light pull cord wrapped tightly around the grab bar and tied preventing the resident from easily accessing and activating the call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/24, at 8:35 A.M., the resident said he/she uses the toilet and sink in his/her bathroom. 2. Review of Resident #21's face sheet showed the following: -admitted [DATE]; -Diagnoses include Type 2 diabetes (body has problem with regulating and using sugar as fuel), chronic kidney disease stage 3 (kidneys have mild damage and are less able to filter waste), and heart disease. Review of the the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Requires partial to moderate assistance with toileting hygiene and toilet transfer; -Impairment on both sides of the body. Review of the resident's care plan, revised 03/06/24, showed the following: -Resident is at increased risk for falls related to generalized weakness/advanced age; -Call light within reach; -Educate on call light use; -One assist with transfers. Observations on 05/06/24, at 1:40 P.M., and on 05/07/24, at 8:35 A.M., of the resident's shared bathroom showed the call light pull cord wrapped tightly around the grab bar and tied preventing the resident from easily accessing and activating the call light. During an interview on 05/06/24, at 1:40 P.M., the resident said he/she does use the toilet in his/her bathroom and he/she has needed to use the call light. 3. Review of Resident #23's face sheet showed the following: -Re-admitted [DATE]; -Diagnoses included Type 2 diabetes with chronic kidney disease stage, dementia (loss of memory), heart disease, major depression disorder, and generalized anxiety. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Requires partial to moderate assistance with toileting hygiene and supervision with toileting transfer. Review of the resident's care plan, revised 04/17/24, showed the following: -Fall risk related to the disease process and drug regimen; -Encourage resident to call for assistance when feeling tired or weak; -Encourage resident to call for assist with toileting, especially during the night when lighting is reduced. Observations on 05/07/24, at 10:10 A.M. and 2:20 P.M., of the resident's shared bathroom showed the call light pull cord was missing. During an interview on 05/07/24, at 2:20 P.M., the resident said he/she does use the toilet in his/her bathroom. 4. Review of Resident #108's face sheet showed the following: -admitted [DATE]; -Diagnoses included wedge compression fracture of fourth lumbar vertebra (back fracture) and type 2 diabetes. Review the resident's admission assessment MDS, dated [DATE], showed the following: -Cognitively intact; -Requires supervision with toileting hygiene and transfer. Review of the resident's care plan, revised 03/23/24, showed the following: -Resident at increased risk for falls related weakness and limited mobility; -Call light within reach; -Educate on call light use; -Transfer assist, one assist. Observations on 05/07/24, at 10:10 A.M. and 2:20 P.M., of the resident's shared bathroom showed the call light pull cord was missing. During interviews on 05/07/24, at 10:10 A.M. and 2:25 P.M., the resident said he/she does use the sink and toilet in his/her bathroom and he/she told the maintenance person a few days ago that the string is missing to the call light. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41787 5. Review of Resident #8's face sheet showed the following: -admitted [DATE]; -Diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), history of falling, Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and generalized anxiety disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Used walker and/or wheelchair for mobility; -Independent with toileting hygiene; -Independent with upper and lower body dressing; -Supervision with transferring from bed, chair, or toilet. Review of the resident's care plan, reviewed on 05/04/24, showed the following: -Resident at increased risk for falls related to Parkinson's, poor safety awareness, and history off falls; -Staff should re-educate resident to call for assistance when needed; -Staff should keep call light within reach. Observation on 05/07/24, at 10:55 A.M., of the resident's shared bathroom showed the call light cord wrapped around the positioning bar in the bathroom. The cord was wrapped around the bar multiple times and did not extend past the bar and was about four feet from the floor. The cord was not easily accessible for activation by the resident. During an interview on 05/07/24, at 11:00 A.M., the resident said that if he/she was in the bathroom and had a fall on the floor, he/she would not be able to reach the call light because it does not reach past the grab bar or to the floor. 6. Review of Resident #26's face sheet showed the following: -admitted [DATE]; -Diagnoses included cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain), malignant neoplasm (cancer) of large intestine (colon), and insomnia (sleep disorder with trouble falling and/or staying asleep). (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Use of motorized wheelchair for mobility; -Partial to moderate assistance with toileting hygiene; -Partial to moderate assistance with transfers from bed, chair, or toilet. Review of the resident's care plan, reviewed 03/05/24, showed the following: -Resident is at increased risk for falls related to generalized weakness and advanced age; -Staff should keep call light within reach; -Staff should educate on call light use. Observation on 05/07/24, at 10:55 A.M., of the resident's shared bathroom showed the call light cord wrapped around the positioning bar in the bathroom. The cord was wrapped around the bar multiple times and did not extend past the bar and was about four feet from the floor. The cord was not easily accessible for activation by the resident. During an interview on 05/07/24, at 11:10 A.M., the resident said if he/she was on the floor he/she would not be able to reach the call light in the bathroom. When he/she is on the toilet he/she cannot reach the call light if the cord was not pulled forward as the cord is behind him/her when seated on the toilet. 7. Review of Resident #99's face sheet showed the following: -admitted [DATE]; -Diagnoses included post traumatic stress disorder (PTSD - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), major depressive disorder, type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), and autoimmune hepatitis (disease that happens when the body's immune system attacks the liver). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Independent with toileting hygiene; -Independent with transfers from bed, chair, and toilet. Review of the resident's care plan, reviewed 04/03/24, showed the following: -Resident was at risk for increased fall related to generalized weakness and history of falls; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should keep call light within reach; -Staff should educate on call light use; -Staff should provide transfer assist as needed. During an observation and interview on 05/10/24, at 10:45 A.M., the resident said he/she would not be able to reach the call light if he/she fell on the floor in the bathroom. The call light was wrapped around grab bar several times on the left side of the toilet. The call light does not reach past the grab bar. 50185 8. Review of Resident #107's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Required partial/moderate assistance with toileting hygiene and toileting transfer; -Diagnoses included seizure disorder, high blood pressure, and anemia. Observation on 05/06/24, at 4:06 PM., of the resident's shared bathroom showed the call light about 4 feet from the floor. The call light did not have a string hanging down and was not accessible from the toilet or the floor. Observation on 05/10/24, at 9:25 A.M., of the resident's shared bathroom showed the call light without a string hanging down and was not accessible from the toilet or the floor. During an interview on 05/10/24, at 9:26 A.M., the resident said he/she uses the bathroom on a regular basis. He/she uses his/her room call light instead of the bathroom light since it doesn't have a string. During an interview on 05/10/24, at 10:24 A.M., Certified Nurse Aide (CNA) O said the resident used the bathroom and call light in the bathroom. The resident required assistance with walking back and forth. 9. During an interview on 05/09/24, at 1:02 P.M., CNA K said call lights should always be within reach. He/she directly hands the call lights to the residents and/or will clip It to their blankets. Residents should be able to reach the call lights in the bathrooms, they should not be wrapped around anything in the bathroom. He/she has seen call lights not be accessible in some of the resident's bathrooms. He/she has reported this, if it's not fixed in a timely manner, he/she will fix it his/herself. 10. During an interview on 05/08/24, at 10:21 A.M., CNA A said the following: -Call lights should always be accessible, both at the bedside and the bathroom; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she sometimes ties the string around the grab bar so the resident can reach the string since the call light is back pretty far; -Some resident's call lights in the bathroom don't have strings; -Maintenance checks the call lights to see if they work and if they have strings. 11. During an interview on 05/08/24, at 10:27 A.M., CNA B said the following: -Call lights should always be accessible in the room and bathroom; -The call lights should have strings on them. Sometimes the residents aren't able to reach the strings so they wrap them around the grab bar; -All call lights in the bathrooms should have strings; -He/she doesn't tie the strings to the grab bars he/she wraps it around the grab bar if the resident wants them too; -Maintenance checks the strings and to make sure they work, he/she isn't sure how often. 12. During interviews on 05/08/24, at 10:35 A.M., and on 05/09/24, at 1:52 P.M., Licensed Practical Nurse (LPN) C said the following: -Call lights should always be accessible to residents; -Call lights in the bathroom should have a string and it should be hanging down; -It would not be appropriate to tie the string around the grab bar; -If the string is tied to the grab bar the resident couldn't pull it if they were on the floor; -When he/she sees a call light wrapped up, he/she unwraps it. If any staff member sees a call light without a string, they should tell maintenance. 13. During an interview on 05/10/24, at 11:00 A.M., the Director of Nursing (DON) said call lights should be easily accessible from the resident's bed, the bathroom, and the floor. 14. During an interview on 05/10/24, at 12:00 P.M., the Administrator said that call lights are to always be within reach of the resident. Call lights being wrapped up and not accessible to the residents is not acceptable.