STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265205	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedargate Healthcare	2350 Kanell Blvd Poplar Bluff, MO 63901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving one resident (Resident #6) out of nine sampled residents and one resident (Resident #19) outside the sample, exposed during care. The facility census was 49. Review of the facility's policy titled, Dignity, dated August 2009, showed: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality; - Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1. Review of Resident #6's medical record showed: - admitted [DATE]; - Diagnoses of diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), atrial fibrillation (irregular heart rate), chronic diastolic heart failure (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), anxiety disorder (persistent worry and fear about everyday situations), major depressive disorder long-term loss of pleasure or interest in life), and insomnia (difficulty sleeping). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/19/24, showed: - Cognition intact; - Always incontinent of bladder and bowel; - Impairment to one side of upper limbs and both lower limbs; - Dependent for toileting, hygiene, and mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident on 05/08/24 at 9:20 A.M., showed: - The resident lay in bed closest to the window; - Nurse Aide (NA) E and Certified Nurse Aide (CNA) F entered the resident's room to perform incontinent care; - NA E and CNA F did not close the blinds on the window; - The back yard could be seen from the resident's window. 2. Review of Resident #19's medical record showed: - admitted [DATE]; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), contracture (damage to muscle tissue or joint that prevents normal mobility) of the hand muscle, anxiety disorder, convulsions (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), Parkinsonism (a motor syndrome that manifests as rigidity, tremors, and slowness of movement and speed), aphasia (loss of ability to understand or express speech caused by brain damage), and a history of transient cerebral ischemic attack (a neurologic deficit that produces stroke symptoms that resolve within 24 hours). Review of the resident's quarterly MDS, dated [DATE], showed: - Cognition severely impaired; - Always incontinent of bladder and bowel; - Impairment to both upper and lower limbs; - Dependent for toileting, hygiene, and mobility. Observation of the resident on 05/08/24 at 9:42 A.M., of incontinent care showed: - The resident sat in a wheelchair in his/her room; - NA E and CNA F entered the room to perform incontinent care; - NA E and CNA F did not close the blinds on the window; - NA E and CNA F transferred the resident via hoyer lift (a mechanical lift) to the bed closest to the window and provided incontinent care; - The courtyard could be seen from the resident's window. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 3:30 P.M., the Director of Nursing (DON) said the window blinds should always be closed prior to any resident care being provided. During an interview on 05/10/24 at 10:05 A.M., NA E said the door, curtain, and window blinds should always be closed prior to any care being provided for a resident. During an interview on 05/10/24 at 11:00 A.M., the Administrator said all measures of privacy should be provided prior to performing any resident care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 49. The facility did not provide a policy regarding the environment. Observations on 05/07/24 at 8:21 A.M., 05/08/24 at 11:18 A.M., and 05/09/24 at 08:32 A.M., showed water dripped on the floor beside a yellow caution cone beneath a heating ventilation and air conditioning (HVAC) ceiling vent near room [ROOM NUMBER] and the west wing nursing station. Observations on 05/09/24 at 9:12 A.M., 9:33 A.M. and 9:47 A.M., showed: -The east wing men's handicap shower room [ROOM NUMBER] with two 6 inch (in.) diameter piles of fecal material about 1/4 in. above the floor surface below the shower chair outside of the shower stall, the toilet with separated caulk seal and a black substance along the entire toilet base along the floor and 6 white 1 in. x 1 in. ceramic tile surfaces with a black substance; -The east wing women's shower room [ROOM NUMBER] stall floor with a thin, round, metal drain cover in the center raised one in. above the floor and the side exposed a sharp edge hazard, the toilet with separated caulk seal and a black substance along the entire toilet base along the floor; - room [ROOM NUMBER] toilet seat with an 1 in. diameter of fecal material smeared on the rim and a separated caulk seal along the toilet base near the floor with a black substance. During an interview on 05/09/24 at 9:47 A.M., the resident in room [ROOM NUMBER] said there had been a problem with fecal material smeared around the bathroom yesterday. Observations on 05/10/24 at 8:31 A.M., showed: - A 6 in. x 6 in. brown area on the ceiling tile in the corner by the exit door on the memory care hall; - A 1 in. wide stripe with a 1 foot (ft.) brown area beside the vent closest to the memory care dining room door; - A 3 in. x 6 in. brown area on the ceiling tile outside of room [ROOM NUMBER]; - A 1 ft. x 3 ft. brown area down the tile wall between the high and low ceilings in the dining room; - Eight ceiling tiles with brown areas on the lower ceiling in the dining room; - A 1 ft. x 2 ft. brown area on the ceiling tile beside the window in room [ROOM NUMBER]; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A 6 in. x 4 in. brown area on the ceiling tile outside the medical record storage on the 100 Hall; - A 6 in. x 8 in. brown area on the ceiling tile between room [ROOM NUMBER] and room [ROOM NUMBER]; - The men's shower room on the 100 Hall with the white caulk around the toilet with a black substance, 36 white tiles around the toilet with a black substance, and the separation wall between the shower and the bath with a brown substance beside the wall with a 2 ft. section of missing caulk; - Five ceiling tiles around the vent across the hall outside the janitor closet with brown areas; - A 2 in. x 6 in. brown area on the ceiling tile across the hall closest to the fire panel; - A 6 in. x 4 in. brown area and a 2 in. x 6 in. brown area on the ceiling tile beside a vent across the hall outside of room [ROOM NUMBER]; - The women's shower on the 100 Hall with caulking around the toilet with a black substance. Review of the facility's Maintenance Log showed no completed work orders since December 2023. During an interview on 05/10/24 at 11:26 A.M., the Maintenance Supervisor said he/she had received work orders on the plumbing and the electrical since starting this job three weeks ago. Work orders should be provided and he/she then completed them. During an interview on 05/10/24 at 11:30 A.M., the Administrator said staff should complete work orders for the maintenance supervisor to complete.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37575 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a facility-initiated transfer when two residents (Residents #11 and #45) out of five sampled residents transferred to the hospital. The facility census was 49. Review of the facility's policy titled, Emergency Transfer or Discharge, revised August 2018, showed: - Emergency transfers or discharges may be necessary for the resident's welfare and the resident's needs cannot be met in the facility; - Did not address written notification to the resident or resident's representative. 1. Review of Resident #11's medical record showed: - admitted [DATE]; - The resident transferred to the hospital for medical evaluation on 01/11/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 02/04/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital for medical evaluation on 04/18/24, and readmitted to the facility on [DATE]; - No documentation of the written notifications provided to the resident and/or the resident's representative for the resident's transfers to the hospital on 01/11/24, 02/04/24, and 04/18/24. 2. Review of Resident #45's medical record showed: - admitted [DATE]; - The resident transferred to the hospital for medical evaluation on 05/06/24, and readmitted to the facility on [DATE]; - No documentation of the written notification provided to the resident and/or the resident's representative for the resident's transfer to the hospital on 05/06/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 1:45 P.M., Registered Nurse (RN) A said when a resident was transferred or discharged to the hospital, the nurse filled out the hospital transfer packet. It contained the Nursing Home to Hospital Transfer form, the hospitalization s Worksheet and the Notice of Transfer or Discharge form. The Nursing Home to hospital Transfer form went with the resident upon the transfer. The hospitalization s Worksheet and the Notice of Transfer went into the basket for the front office. The nurse was to notify the responsible party, if it was someone other than the resident. If the responsible party was not the resident or in the facility, the nurse would leave a message for the responsible party if there was no answer, and document everything in the nurses note. During an interview on 05/09/24 at 1:55 P.M., the Administrator said the transfer/discharge packet was done by the nurse, then it went to the business office, where it was matched with the census, then it went to medical records to be filed in the chart. She said the white copy was mailed to the resident's responsible party, and the pink copy went to medical records. During an interview on 05/09/24 at 2:00 P.M., the Social Services Designee (SSD) said he/she received the yellow copy of the Notice of Transfer or Discharge document. He/She looked in the resident's medical record to verify the family was notified, and then filed it. If there was no note stating the family was notified, he/she sometimes checked with the nurse to see if they notified the family, have them update resident's medical record, and if not, he/she would notify the family. During an interview on 05/09/24 at 3:36 P.M., the DON said the Transfer/Discharge forms were completed by the nurse and were supposed to be provided in writing to the resident, the guardian, or the legal representative. During an interview on 05/10/24 at 9:50 A.M., the Business Office Manager (BOM) said the Notice of Transfer or Discharge was a three-part form and the nurses completed it. The one page went with the resident upon the transfer. The white copy was supposed to be mailed by the nurse to the family or representative. The yellow copy went to the SSD. The pink copy went to the BOM. The nurses had envelopes and the facility used a postage machine. The nurses usually brought the envelope to him/her to run through the postage machine and for them to be sent out. 47445

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to provide written notification of the bed-hold policy to residents and/or their representatives at the time of transfer for two residents (Resident #11 and #45) out of five sampled residents. The facility census was 49. Review of the facility's policy titled, Bed Holds and Returns, revised 03/2020, showed prior to transfers, written information will be given to the residents and the resident representatives that explain in detail: the rights and limitations of the resident regarding bed holds; the reserve bed payment policy as indicated by the state plan (Medicaid residents); the facility per diem rate required to hold a bed (non Medicaid residents), or to hold a bed beyond the state bed hold period (Medicaid residents); and the details of the transfer (per the Notice of Transfer). 1. Review of Resident #11's medical record showed: - admitted [DATE]; - The resident transferred to the hospital on 01/11/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 02/04/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/18/24, and readmitted to the facility on [DATE]; - No written documentation of the notification for the bed hold policy provided to the resident and/or the resident's responsible party. 2. Review of Resident #45's medical record showed: - admitted [DATE] ; - The resident transferred to the hospital on 05/06/24, and readmitted to the facility on [DATE]; - No written documentation of the notification for the bed hold policy provided to the resident and/or the resident's responsible party. During an interview on 05/09/24 at 1:55 P.M., the Administrator said the transfer/discharge packet was done by the nurse, then it went to the business office where it was matched with the census, and then it went to medical records to be filed in the chart. The white copy was mailed to the resident's responsible party and the pink copy went to medical records. She said the facility did not charge to hold a bed. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 2:00 P.M., the Social Services Designee (SSD) said he/she received the yellow copy of the Notice of Transfer or Discharge document. He/She looked in the resident's medical record to verify the family was notified, and then filed it. If there was no note stating the family was notified, he/she sometimes checked with the nurse to see if they notified the family, had them update the resident's medical record, and if not, he/she would notify the family. During an interview on 05/09/24 at 3:36 P.M., the Director of Nursing (DON) said the Transfer/Discharge forms were completed by the nurse and were supposed to be provided in writing to the resident, the guardian, or the legal representative. The bed hold was part of the Notice of Transfer or Discharge. During an interview on 05/10/24 at 9:50 A.M., the Business Office Manager (BOM) said the Notice of Transfer or Discharge was a three-part form and the nurses completed it. The one page went with the resident upon the transfer. The white copy was supposed to be mailed by the nurse to the family or representative. The yellow copy went to the SSD. The pink copy went to the BOM. The nurses had envelopes and the facility used a postage machine. The nurses usually brought the envelope to him/her to run through the postage machine and for them to be sent out. 47445

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to implement a care plan with specific interventions to meet individual needs for three residents (Resident #5, #7 and #18) out of 13 sampled residents. The facility census was 49. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated March 2020, showed: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; - The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The care planning process will include an assessment of the resident's strengths and needs; - The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Review of Resident #5's medical record showed: - An admitted [DATE]; - A diagnosis of Alzheimer's (a progressive disease that destroys memory and other important mental functions) disease. Review of the resident's care plan, revised on 09/12/23, showed the care plan did not address specific interventions related to Alzheimer's disease. 2. Review of Resident #7's medical record showed: - admitted [DATE]; - Diagnoses of anxiety disorder (persistent worry and fear about everyday situations) and major depressive disorder (long-term loss of pleasure or interest in life). Review of the resident's care plan, last revised 3/13/24, showed: - Did not address anxiety disorder with specific interventions; - Did not address major depressive disorder with specific interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/10/24 at 9:45 A.M., Resident #7 said anxiety and depression medicines were helping mostly to deal with his/her concerns. Depression had been a problem for many years. 3. Review of Resident #18's medical record showed: - admitted [DATE]; - Diagnosis of dementia (a group of thinking and social symptoms that interferes with daily functioning). Review of the resident's care plan, dated 04/18/24, showed the care plan did not address specific interventions related to dementia. During an interview on 05/10/24 at 12:20 P.M., the Social Services Designee (SSD) said it was expected that anxiety, depression, and dementia were addressed in a resident's comprehensive care plan. During an interview on 05/10/24 at 12:16 P.M., the Minimum Data Set (MDS) (a federally mandated assessment instrument completed by the facility staff) Coordinator said anxiety, depression, Alzheimer's disease and dementia should be included in a comprehensive care plan. There should be pharmacological and non-pharmacological interventions addressed. Correcting and updating the care plans had been an on-going concern. During an interview on 05/10/24 at 12:25 P.M., the Administrator said issues like dementia, anxiety, and depression should be included in the comprehensive care plan and should include pharmacological and non-pharmacological interventions. 46521

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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** 45693 Based on interview and record review, the facility failed to ensure one resident (Resident #4) out of three sampled residents receiving hospice (palliative care for the terminally ill with a life expectancy of six months or less) services had a complete hospice coordinated plan of care. The facility failed to provide needed care and services in accordance with professional standards of practice for one resident (Resident #23) out two sampled resident who required positioning due to an impairment. The facility census was 49. The facility did not provide a hospice policy. 1. Review of Resident #4's medical record showed: - admitted to hospice on 02/27/24; - No facility staff signatures for the hospice coordinated plan of care, dated 02/09/24; - The facility failed to provide a complete hospice coordinated plan of care for the resident. Review of the facility's policy titled, Repositioning, revised 05/2013, showed: - The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents; - Review the resident's care plan to evaluate for any special needs of the resident; - Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning; - A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated; - Residents who are in bed should be on at least an every two hour repositioning schedule. - For residents with a Stage I (intact skin with non-blanchable redness) or above pressure ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin), an every two hour repositioning schedule is inadequate; - Notify the supervisor if the resident refuses the procedure; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated. During an interview on 05/09/24 at 3:30 P.M., the Director of Nursing (DON) said hospice coordinated plans of care should be signed by both hospice and the facility staff. 2. Review of Resident #23 medical record showed: - An admitted [DATE]; - Diagnoses of cerebral ischemia (an acute brain injury resulting from an impaired blood flow to the brain), hemiplegia (paralysis of one side of the body) from a stroke affecting the left non-dominant side, muscle weakness, lack of coordination, Type 1 diabetes mellitus (a lifelong condition where the pancreas makes little or no insulin which leads to high blood sugar levels) with diabetic chronic kidney disease (a decrease in kidney function from diabetes), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities), morbid obesity, and left hand contracture (a shortening and hardening of muscles, tendons and other tissue); - Maximum assist of staff with mobility. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated process for clinical assessment of all residents in certified nursing homes), dated 03/27/24, showed: - Upper and lower extremity, impairment to one side; - Substantial/maximal assistance to roll to left and right from the back; - Always incontinent of bladder; - Diabetic foot ulcer; - At risk for pressure ulcers; - Moisture associated skin damage (MASD); - Turing/repositioning program. Review of the resident's care plan, updated on 04/11/24, showed: - Bowel and bladder incontinence; - An Activity's of Daily Living (ADL's) performance deficit and required assistance with all ADL's; - Impaired skin integrity and at risk for further impaired skin related to impaired mobility and incontinence; (continued on next page)

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Cedargate Healthcare	2350 Kanell Blvd Poplar Bluff, MO 63901

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Interventions of check the resident every two hours and as required for incontinence, resident required extensive assist of two staff to reposition and turn in the bed, turn and reposition every two hours and as needed, heel lift boots while in bed, and provide incontinence care after any incontinent episode followed by barrier cream. Observations of the resident showed: - On 05/07/24 at 8:57 A.M., 10:55 A.M., 12:09 P.M., 12:55 P.M., 2:00 P.M., and 3:15 P.M., the resident lay in bed on his/her back with a wedge under the left upper arm; - The resident lay in same position in the bed on his/her back for four hours and 20 minutes on 05/07/24; - On 05/08/24 at 8:15 A.M., 9:25 A.M., 10:38 A.M., 11:10 A.M., 12:15 P.M., 1:35 P.M., and 2:45 P.M., the resident lay in bed on his/her back and leaned to the left; - The resident lay in the same position in the bed on his/her and leaned to the left for six hours and 30 minutes. During an interview on 05/08/24 at 9:25 A.M., Resident #23 said staff must have two people to assist him/her to move or turn because he/she cannot move the left side since having a stroke. The staff would place a wedge under his/her left arm, but they didn't turn him/her off his/her back and bottom. He/She had wounds on his/her bottom before, and they put cream on him/her sometimes, but not always. During an interview on 05/09/24 at 2:15 P.M., Certified Nursing Assistant (CNA) I said Resident #23 was to be checked and changed every two hours since he/she was incontinent of bowel and bladder. The resident's plan of care did not show the resident on a two hour turn schedule. During an interview on 05/09/24 at 3:36 P.M., the DON said residents that can't turn themselves should be turned or repositioned every two hours. 47445

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accident hazards by not maintaining water temperatures between 105 degrees Fahrenheit (F) to 120 degrees F in five occupied resident room sinks and a community shower, which put residents at an increased risk of injuries from exposure to the hot water. This practice had the potential to affect all the residents at the facility. The facility census was 49. Review of the facility's policy titled, Safety of Water Temperature, revised 12/2009, showed: - Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees F; - Maintenance staff will be responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log; - Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. Review of the Burn Foundation website showed hot water caused third degree burns (full thickness burns which go through the skin and affect deeper tissue resulting in white or blackened, charred skin) at the following temperatures and time parameters: - In one second at 156 degrees F; - In two seconds at 149 degrees F; - In five seconds at 140 degrees F; - In 15 seconds at 133 degrees F; - In one minute at 127 degrees F. 1. Observation and interview on 05/09/24 at 10:40 A.M., showed: - Nursing Aide (NA) E turned the water on at the resident' sink in room [ROOM NUMBER]; - NA E said the water got really hot. Observation on 05/09/24 at 10:40 A.M., through 11:05 A.M., of water temperatures taken at 30 and 60 seconds which ran for two minutes, with a digital thermometer showed: - room [ROOM NUMBER] water temperature recorded at 130.1 degrees F at the resident sink; - room [ROOM NUMBER] water temperature recorded at 131.5 degrees F at the resident sink; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER] water temperature recorded at 131.7 degrees F at the resident sink; - room [ROOM NUMBER] water temperature recorded at 129.2 degrees F at the resident sink; - room [ROOM NUMBER] water temperature recorded at 131.2 degrees F at the resident sink; - room [ROOM NUMBER] water temperature recorded at 130.1 degrees F at the resident sink; - room [ROOM NUMBER] water temperature recorded at 134.5 degrees F at the resident sink and 132.4 degrees F at the resident shower. Observation on 05/09/24 at 11:07 A.M., of the electrical room showed: - One digital hot water heater with a reading of 131 degrees F and an operational set point of 135 degrees F; - An error message that read alert occurred 11 hours and 40 minutes ago with no current detected in one or more heating circuits, will continue to heat water in this container; - Another non-digital hot water heater. Review of the facility's Weekly Temperature Check Logs showed: - Eleven rooms on the 100 Hall with a temperature range of 59 to 62 degrees F, dated 03/14/24; - Eleven rooms on the Memory Care Hall with a temperature range of 110 to 111 degrees F, dated 03/21/24; - Eleven rooms on the 200 Hall with a temperature range of 122 to 127 degrees F, dated 04/08/24; - Eleven rooms on the 200 Hall with a temperature range of 99 to 116 degrees F, dated 04/15/24; - Eleven rooms on the 200 Hall with a temperature range of 101 to 116 degrees F, dated 04/22/24; - Three rooms with a temperature range of 68.3 to 118.2 degrees F, dated 04/29/24; Review of the facility's plumbing invoices, dated 01/09/24 to 05/10/24, showed a new water heater ordered and installed on 04/03/24. During an interview on 05/09/24 at 11:30 A.M., the Administrator said the facility had water temperature issues for months. The problem had been low temperatures but never hot. They had a plumber in multiple times and even had a new water heater installed last month. During an interview on 05/09/24 at 3:46 P.M., the Maintenance Supervisor said he/she checked the water temps weekly. There were checks completed since 04/29/24. The hot water heater had been turned up to compensate because they only had one heater instead of two for a period of time. Now they were back to two hot water heaters, the temperature didn't need to be up as high.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on observation, interview and record review, the facility failed to ensure placement of the Foley catheter (a tube inserted into the bladder to drain urine) tubing and drainage bags for two residents (Resident #4 and #7) and failed to consistently use a dignity bag for one (Resident #7) out of 2 sampled residents. The facility census was 49. Review of the facility's policy titled, Catheter Care, Urinary, revised September 2014 showed: - The purpose of this procedure is to prevent catheter-associated urinary tract infections; -If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered; - Infection Control, use standard precautions when handling or manipulating the drainage system, be sure the catheter tubing and drainage bag are kept off the floor. The facility did not provide a policy in regards to Foley catheter placement. 1. Review of Resident #4's medical record showed: - admitted [DATE]; - Diagnosis of unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black)) sacral (the bottom area of the spine) wound; - The resident's Physician Order Sheet (POS), dated May 2024, showed an order to change the catheter monthly on the 28th and as needed with an 18 French catheter for Foley catheter maintenance care, dated, 03/04/24. Observation on 05/08/24 at 11:20 A.M., showed: - Registered Nurse (RN) A used his/her foot to push the resident's bedside table away from the bed and RN A's shoe touched the catheter tubing. 2. Review of Resident #7's medical record showed: - admitted [DATE]; - Diagnosis of benign prostatic hyperplasia (BPH - an enlargement of the prostate causing difficulty in urination); (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident's POS, dated May 2024, showed an order to change the resident's suprapubic (a catheter inserted into the bladder through a surgical incision) monthly on the 15th with a 16 French catheter every night shift, dated 03/31/24. Observations of the resident showed: - On 05/09/24 at 9:24 A.M., the resident lay in bed and the uncovered catheter drainage bag hung from the bed frame and the bottom of the drainage bag touched the floor; - On 05/09/24 at 1:46 P.M., and on 05/10/24 at 8:36 A.M., the resident sat in a wheelchair in his/her room and the catheter tubing touched the floor; - On 05/10/24 at 9:45 A.M., the resident lay in bed and the uncovered catheter drainage bag hung from the bed frame During an interview on 05/10/24 at 9:45 A.M., Resident #7 said the catheter drainage bag was changed on the weekends and it got placed under the bed or wheelchair. It was hard to see if the bag or tubing touched the floor since it was placed below his/her bed and wheelchair. During an interview on 05/09/24 at 3:40 P.M., the Director of Nursing (DON) said catheter bags and tubing should not touch the floor, be touched by a shoe or anything else. The catheter bags should be always in a privacy bag. During an interview on 05/10/24 at 1:00 P.M., Registered Nurse (RN) A said catheter drainage bags should be changed weekly and should be kept in dignity bags and not touching the floor. During an interview on 05/10/24 at 1:05 P.M., Licensed Practical Nurse (LPN) G said catheter drainage bags should be changed weekly and should be kept in dignity bags and not touching the floor. During an interview on 05/10/24 at 1:20 P.M., the Administrator said she would expect the catheter drainage bag to be off the floor and tubing should not be on the floor. They should be kept in dignity bags and not touching 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** 45693 Based on observation, interview and record review, the facility failed to ensure proper storage of nasal cannulas when not in use for two residents (Resident #27 and #42) and failed to follow oxygen orders for one resident (Resident #42) out of four sampled residents. The facility census was 49. Review of the facility's policy titled, Oxygen Administration, revised, July 2010, showed: - Verify there is a physician's order for this procedure; - Review the physician's orders or facility protocol for oxygen administration; - Review the resident's care plan to assess for any special needs of the resident; - Assemble the equipment and supplies as needed; - The nasal cannula (plastic tubing placed in the nostrils to provide supplemental oxygen) is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head; - Check the tubing connected to the oxygen cylinder to assure that it is free of kinks; - Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter); - Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 1. Review of Resident #27's medical record showed: - admitted [DATE]; - Diagnosis of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of the resident's Physician Order Sheet (POS), dated May 2024, showed; - An order to change the oxygen tubing on Saturdays, dated 02/26/24; - An order for oxygen at 2 liters per minute (L/min) per nasal cannula continuously, dated 02/26/24. Observation of the resident on 05/08/24 at 9:30 A.M., showed: - The resident's nasal cannula lay on the floor and the prongs touched the floor; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Nurse Assistant (CNA) C pushed the resident into the room in a wheelchair, picked up the nasal cannula from the floor, and put it in the resident's nostrils. 2. Review of Resident #42's medical record showed: - admitted [DATE]; - Diagnoses of congestive heart failure (CHF - an inability of the heart to pump sufficient blood flow to meet the body's needs) and atherosclerotic heart disease (a buildup of cholesterol plaque in the walls of the arteries causing obstruction of blood flow). Review of the resident's POS, dated May 2024, showed; - An order to change the oxygen tubing weekly on Saturdays, dated 03/30/24; - An order for oxygen at 2 L/min per nasal cannula continuously, dated 03/30/24. Observation of the resident on 05/07/24 at 11:19 A.M., showed: - The resident lay in bed not wearing a nasal cannula and the oxygen concentrator set at 2.5 L/min at the bedside; - The nasal cannula attached to the oxygen concentrator, undated, lay in the floor without a sealed container; - The nasal cannula for the portable oxygen tank, undated, lay in the wheelchair seat without a sealed container. Observation of the resident on 05/09/24 at 1:34 P.M., showed: - The resident lay in bed and the oxygen concentrator set at 3 L/min at the bedside; - The nasal cannula, dated 05/04/24, held by the resident in bed while he/she attempted to untangle the coiled tubing and the nasal cannula hung from the resident's left ear; - The nasal cannula for the portable oxygen tank, undated, lay in the wheelchair seat without a sealed container. Observation of the resident on 05/10/24 at 8:39 A.M., showed: - The resident lay in bed and the oxygen concentrator set at 3 L/min at the bedside; - The nasal cannula, dated 05/04/24, lay under the resident's pillow near the resident's feet; - The nasal cannula for the portable oxygen tank, undated, lay in the wheelchair seat without a sealed container. During an interview on 05/09/24 at 1:35 P.M., the resident said staff changed the tubing, but he/she wasn't sure how often. The oxygen was used and was helpful, but the tubing got tangled sometimes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 3:40 P.M., the Director of Nursing (DON) said oxygen cannulas shouldn't touch the floor ever. If it did touch the floor, it should be replaced. During an interview on 05/10/24 at 1:00 P.M., Registered Nurse (RN) A said nasal cannulas should never be left in the floor, under a pillow, or hanging from a resident's ear. The concentrator should be set according to the physician's orders. Nasal cannulas for portable oxygen tanks on the resident wheelchair should be in a sealed container when not in use by the resident. During an interview on 05/10/24 at 1:05 P.M., Licensed Practical Nurse (LPN) G said nasal cannulas should never be left in the floor, under a pillow, or hanging from a resident's ear. When they were not in use, the tubing and parts should be in a sealed container. The concentrator should be set according to the physician's orders. Nasal cannulas for portable oxygen tanks should be in a sealed container. During an interview on 05/10/24 at 1:20 P.M., the Administrator said she would expect nasal cannulas to be placed in bags for storage if not in use and the nasal cannula should be placed properly on the resident when in use. The cannula should not be in the floor, under a resident's pillow, or hanging loosely from a resident's ear. Portable tubing and accessories should also be stored in a sealed container when not in use. Concentrators should be set according to the physician's order. 46521

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on interview, and record review, the facility failed to identify, assess and provide supportive interventions for one resident (Resident #43) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of two sampled residents. The facility's census was 49. Review of the facility's policy titled, Trauma-Informed and Culturally Competent Care (TIC), dated 2019, showed: - Trauma informed activities of the facility include, but are not limited to care planning person centered approaches and interventions in response to the universal screening and/or periodic assessment of resident survivor needs including but not limited to honoring individual preferences and routines and responding to the emotional and psychosocial needs of resident survivors; - Collaborate with the treatment team to advocate for residents and reduce barriers to recovery; - Link resident survivors with community resources as needed; - Fostering a peer support environment and culture through the code of conduct, competency processes, continuing education, and multi-level support; - Staff development activities focused on (TIC), elder abuse prevention and reporting, cultural competence, communication and behavioral health; - Implementation of monitoring the staff implementation of interventions and performing quality improvement measures in response to identified needs and/or as problems are identified. 1. Review of Resident #43's medical record showed: - admitted [DATE]; - Diagnoses of PTSD, bipolar disorder (a mental disorder that causes unusual shifts in mood), essential tremor (a nervous system disorder that causes rhythmic shaking), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) without behavioral disturbance. Review of the resident's PTSD assessment, dated 03/11/24, showed other unwanted or uncomfortable sexual experience as stressful for the resident. Review of the resident's Physician Order Sheet (POS), dated May 2024, showed: - An order for benztropine (an anti-tremor medication) 0.5 milligram (mg) by mouth once a day at bedtime for dementia, unspecified without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, dated 02/23/23; (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for divalproex sodium (a seizure medication) delayed release 250 mg by mouth once daily in the morning for bipolar disorder, dated 04/23/24; - An order for divalproex sodium delayed release 500 mg by mouth once daily at bedtime for bipolar disorder, dated 04/23/24; - An order for memantine (a dementia medication) 10 mg twice daily for dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, dated 02/23/23; - An order for olanzapine (an antipsychotic medication) 7.5 mg once daily in the morning for bipolar disorder, dated 10/11/23; - An order for olanzapine 10 mg once daily at bedtime for bipolar disorder, dated 10/11/23; - An order for primidone (a seizure medication) 50 mg, give 0.5 tablet by mouth at bedtime for essential tremor, dated 07/20/23. Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 02/21/23, showed: - Dysthymic disorder (low mood occurring for at least two years, along with at least two other symptoms of depression), anxiety disorder, major depressive disorder (MDD- long-term loss of pleasure or interest in life), personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), bipolar disorder and PTSD; - No behaviors documented. Review of the resident's care plan, revised 03/12/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 05/09/24 at 10:05 A.M., Resident #43 said he/she didn't understand much about PTSD and said he/she wasn't sure about the diagnosis. The facility staff didn't speak with him/her about PTSD. During an interview on 05/10/24 at 12:20 P.M., the Social Services Designee said it was expected that PTSD was addressed in a resident's comprehensive care plan. During an interview on 05/10/24 at 12:16 P.M., the the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said PTSD should be included in the resident's comprehensive care plan. There should be pharmacological and non-pharmacological interventions. Correcting and updating care plans had been an ongoing concern. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/10/24 at 12:25 P.M., the Administrator said an issue like PTSD should be included in the comprehensive care plan and include pharmacological and non-pharmacological interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50260 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) when medications were administered. There were 32 opportunities with two errors made, for an error rate of 6.25%. This practice affected two residents (Resident #17 and #19) outside of the seven sampled residents. The facility census was 49. Review of facility's policy titled, Insulin Administration, revised ,d+[DATE], showed staff to check the expiration date if drawing from a multi-dose vial. Review of facility's policy titled, Storage of Medications, revised ,d+[DATE] showed nursing staff is responsible for maintaining the medication storage. Review of Novolog (type of insulin) manufacturer's instructions, revised ,d+[DATE], showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. 1. Review of Resident #17 medical record showed: - admitted on [DATE]; - Diagnosis of diabetes mellitus (DM - the body has trouble controlling blood sugar); - An order for Novolog per sliding scale if blood sugar ,d+[DATE] = 2 units, ,d+[DATE] = 6 units, ,d+[DATE] = 8 units, ,d+[DATE] = 10 units, greater than 400 = call the physician, subcutaneously (inject under the skin) before meals for DM, discard remainder after 28 days, dated [DATE]. Observation on [DATE] at 11:31 A.M., of the resident showed: - Certified Medication Technician (CMT) D administered 2 units of Novolog from a multi-dose vial with an opened date of [DATE], to the resident; - CMT D administered expired insulin to the resident. During an interview on [DATE] at 11:33 A.M., CMT D said he/she was aware the insulin was expired but the pharmacy had not sent any new insulin yet. He/she said insulin should be discarded after 27 days of being opened. Review of the facility's policy titled, Insulin Administration, revised ,d+[DATE] showed: - Check the order for the amount of insulin; - Double check the order for the amount of insulin; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Re-check the amount of insulin drawn into the syringe matches the amount of insulin ordered. 2. Review of Resident #19's medical record showed: - admitted on [DATE]; - Diagnosis of DM; - An order for Novolog per sliding scale if blood sugar ,d+[DATE] = 2 units, ,d+[DATE] = 3 units, ,d+[DATE] = 6 units, ,d+[DATE] = 12 units, ,d+[DATE] = 18 units, ,d+[DATE] = call the physician, subcutaneously before meals and at bedtime for DM, dated [DATE]. Observation on [DATE] at 11:47 A.M. of the resident showed: - CMT D checked the resident's blood sugar ; - The resident with a blood sugar of 194; - Per the resident's Novolog insulin order, the resident should receive 2 units of Novolog and CMT D said he/she would give the resident 2 units of Novolog; - CMT D drew up 4 units of Novolog from the multi dose vial; - CMT D verified 4 units of Novolog in the syringe; - CMT D stopped before administration of the 4 units of Novolog. During an interview on [DATE] at 11:51 A.M., CMT D said he/she must have forgotten what the blood sugar was and the amount of insulin due per the physician's orders. During an interview on [DATE] at 10:35 A.M., the Director of Nursing (DON) said she would expect CMTs and nurses to double check the expiration dates on the insulin before administration. It was the responsibility of the CMTs and nurses who use the medication cart to check the dates and made sure the expiration dates were being followed. If insulin was expired, she would expect the CMTs and nurses to hold the insulin, and call the doctor or pharmacy to figure out an alternative as soon as possible. Insulin expired after 28 days of opening. She expected the CMTs and nurses to check the insulin dose order more than once before administration. During an interview on [DATE] at 11:31 A.M., the Administrator said she would expect the CMTs and nurses to follow expiration dates.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50260 Based on observation and interview, the facility failed to ensure opened, multi-use vials were discarded after the opened expiration date. The facility census was 49. Review of the facility's policy titled, Storage of Medications, revised ,d+[DATE] showed the nursing staff is responsible for maintaining the medication storage. Review of Novolog (type of insulin) manufacturer's instructions, revised ,d+[DATE], showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. Review of insulin aspart (type of insulin) manufacturer's instructions, revised ,d+[DATE], showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. Review of Fiasp (type of insulin) manufacturer's instructions, revised ,d+[DATE], showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. Review of lispro (type of insulin) manufacturer's instructions, revised ,d+[DATE], showed: - Throw away opened vials after 28 days, even if they still have insulin left in them; - Do not use insulin past 28 days after opened. 1. Observation of the Certified Medication Technician (CMT) medication cart on [DATE] at 9:19 A.M., showed: - One Novolog multi-dose vial, opened and dated [DATE]; - One insulin aspart multi-dose vial, opened and dated [DATE]; - One Fiasp multi-dose vial, opened and dated [DATE]; - One lispro multi-dose vial, opened and dated [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:20 P.M., CMT D said he/she was responsible for checking the expiration dates on the cart along with other nursing staff. He/She said insulin would expire 27 days after the opened by date. During an interview on [DATE] at 10:35 A.M. , the Director of Nursing (DON) said insulin should not be used after 28 days after the opened by date. The CMT and nurses should be checking the expiration dates before administering. She expected staff to hold the insulin if expired and call for a replacement.

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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. 46521 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices had the potential to affect all residents. The facility census was 49. The facility did not provide a kitchen policy. Review of the facility's policy titled, Food Preparation and Service, revised 07/2014, showed: - Only pasteurized shell eggs will be cooked and served when residents request undercooked, soft-served or sunny side up eggs and preparing foods that will not be thoroughly cooked example (e.g.) hollandaise sauce, French toast, ice cream, et cetera (etc); - Unpasteurized eggs will be cooked until all parts of the egg (yolk and whites) are completely firm. 1. Observation on 05/07/24 at 8:38 A.M., of the walk-in refrigerator showed: - One partially full, 15 dozen case box of non-pasteurized shell eggs, received 05/06/24; - Interior surface of the door with a 3 foot (ft.) diameter (dia.) section with a brown substance. During an interview on 05/07/24 at 8:45 A.M., Dietary Aide J said eleven residents had been served eggs today that were fried over easy using the non-pasteurized shell eggs in the walk-in refrigerator. The facility did not have pasteurized eggs available to cook. Review of the resident dietary service cards, dated 05/02/24, showed eleven resident dietary service cards with an egg of choice to be fried over easy for today. During an interview on 05/07/24 at 8:50 A.M., the Dietary Manager (DM) said dietary staff cooked eggs to order using the fresh shell eggs that were non-pasteurized. The menu showed egg of choice. Several of the residents wanted fried eggs and liked them medium or over easy, so they were not always cooked well done. There were eleven residents who requested eggs fried today and they were served the non-pasteurized fried eggs with runny or medium yolks. Pasteurized eggs had not been ordered recently. During an interview on 05/07/24 at 9:56 A.M., the Administrator said she would expect eggs to be served according to the menu and the resident's choice. The menu showed egg of choice for breakfast today and some of the residents requested their eggs fried over easy. The cooks should be using only pasteurized shell eggs if they were going to serve the eggs under cooked. The eleven residents that were served non-pasteurized under cooked eggs this morning will be monitored for issues with food poisoning. The non- (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 05/07/24 at 8:38 A.M., and 05/10/24 at 11:08 A.M., of the dry food storage room showed: - The ice machine interior horizontal plastic surface with a black substance above the ice, a 4 ft. by 6 inch (in.) vertical white substance on the entire right side of the machine and a black substance covered the entire 6 in. exposed exterior surface of the 1 in. plastic drain; - Separated floor tiles with a damp black substance below the ice machine; - Three 10-pound hamburger sticks in the upright deep freezer with 1 in. frost build up, 1/4 in. ice formation on all interior shelving and lower shelf of the freezer; - The floor with a sticky film; - A 1 ft. cabinet baseboard peeled away and exposed a black substance; - Three dented 3 quart (qt.) metal cans of chocolate pudding; - Two dented 3 qt. metal cans of mandarin oranges; - Two 50 ounce (oz.) metal cans dented of cream of mushroom soup. 3. Observation on 05/07/24 at 8:45 A.M., and 05/10/24 11:18 A.M., of the kitchen showed: - The can opener with a sticky film and black substance on the worn knife blade, base portions with black build up; - The dishwasher with white and brown build up on the exterior surfaces near the base about 1/4 in. thick; - Three 12 cup muffin pans with a brown build up on the interior surface of the cups; - Two 18 in. x 24 in. cookie sheets with brown build up; - Four 12 in. x 18 in. baking pans with brown build up; - Twelve trays of approximately 10 oz. plastic drinking cups with white build up; - Six cardboard case boxes with 6 gallon bottles of bleach liquid stacked outside the DM's office. 4. Observation on 05/10/24 at 11:24 A.M., of the walk-in refrigerator showed: - One partially full, 15 dozen case box of non-pasteurized shell eggs, received 05/06/24; - One 18 in. x 24 in. metal cookie sheet filled with round sausage patties partially covered with parchment paper; - Door interior surface with a 3 ft. dia. section with a brown substance. (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 11:27 A.M., the DM said the maintenance director was supposed to keep the ice machine cleaned. The floor should be clean and in good repair, freezers should be cleaned and defrosted and were done as needed. Dented cans should be placed to the side and sent back to the supplier. The cans should be checked for dents before they were placed on the shelf. Lime scale shouldn't be on the drinking cups, weekly cleaning and brushing should be done to prevent the build up. The bleach should not be stored in the kitchen near the office door. During an interview and kitchen tour on 05/10/24 at 11:54 A.M., the Administrator said the refrigerated foods should not be stored with ice build up and refrigerators should appear defrosted. Sausage patties should not be stored in the walk in without a covered storage container. There should not be brown substance or rust in the refrigerator. There should not be canned foods on the shelves that were dented. The can opener should not have sticky film build up or brown substance along the base and the knife should appear clean. The baking pans should not have brown carbon build up. The dishwasher should appear clean and not have any build up on the exterior. The pasteurized eggs should not have been served undercooked. The ice machine should appear clean and not have a black substance on the interior. The drain should not have a black substance. During an interview on 05/10/24 at 12:19 P.M., the Maintenance Director said the ice machine should be checked for cleanliness and well maintained. This was a maintenance responsibility and inspection but it had not been checked since he/she started here three weeks ago.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37575 Based on observation, interview, and record review the facility failed to maintain proper infection control practices during incontinent care for four residents (Resident #4, #5, #6 and #43) out of six sampled residents, catheter care for one resident (#4) out of two sampled residents, and wound care for two residents (Resident #4 and #303) out of three sampled residents. The facility census was 49. The facility did not provide a policy regarding infection control. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised 08/2019, showed: - The facility considers hand hygiene the primary means to prevent the spread of infections; - All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; - Use an alcohol-based hand rub or soap and water for: before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, after contact with a resident's intact skin, after handling used dressing or contaminated equipment, after contact with objects, and after removing gloves. - The use of gloves does not replace hand washing/hand hygiene. Review of the facility's policy titled, Wound Care, revised 10/2010, showed: - Use disposable cloth to establish clean field on resident's overbed table; - Wash and dry your hands thoroughly; - Position resident, put on exam glove, loosen tape and remove dressing; - Pull glove over the dressing and discard, wash and dry hands; - Put on gloves; - Use no-touch technique for ointments and creams; - Wear exam gloves for folding gauze to catch irrigation solution; - Wear sterile gloves when physically touching the wound or holding moist surface over the wound; - Dress wound; - Remove disposable cloth next to the resident and discard; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wipe reusable supplies with alcohol as indicated (scissor blades); - Wash and dry hands thoroughly. Record review of the facility's policy titled, Enhanced Barrier Precautions, revised 04/2024 showed Gloves and gowns are required for wound care and any skin opening requiring a dressing. 1. Observation on 05/08/24 at 11:20 A.M., of incontinent care for Resident #4 showed: - Nursing Assistant (NA) E and Certified Nurse Assistant (CNA) F failed to perform hand hygiene and put on gloves; - NA E performed incontinent care and applied barrier cream to the resident's buttocks; - NA E and CNA F removed gloves, failed to perform hand hygiene, and put new gloves on; - NA E removed the urine soaked sheet from the mattress; - NA E and CNA F failed to clean the urine soaked mattress. 2. Observation on 05/08/24 at 11:20 A.M., of wound care for Resident #4 showed: - Licensed Practical Nurse (LPN) H and Registered Nurse (RN) A failed to perform hand hygiene and put on gloves and a gown; - LPN H rolled the resident to the left side, RN A removed the soiled bandage from the sacral (the area below the spine and above the tailbone), and the incontinent pad under the resident saturated with the wound discharge; - RN A cleansed the wound with moistened gauze; - RN A removed the gloves, failed to perform hand hygiene, and put on new gloves; - RN A applied wound cleanser to Hydrofera Blue (antibacterial wound dressing) to moisten it and applied to the wound bed; - RN A applied an ABD pad (absorbent dressing) over the wound and secured with tape; - RN A removed the gloves, did not perform hand hygiene, and put on new gloves; - RN A rolled the resident to the right side and LPN H cleaned the resident's back, buttocks and thighs with peri wash; - With the same gloves, LPN H touched the resident's left hand and touched the resident's clean shirt when LPN H assisted the resident to put on the clean shirt. 3. Observation on 05/09/24 at 9:35 A.M., of catheter (tubing inserted into the bladder to drain urine) care for Resident #4 showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- NA E performed hand hygiene and put on gloves; - NA E held the resident's leg; - NA E removed the gloves, failed to perform hand hygiene, and put on new gloves; - NA E performed peri care, removed the gloves, failed to perform hand hygiene, and put on new gloves; - NA E performed catheter care. 4. Observations on 05/08/24 at 9:50 A.M., of incontinent care for Resident #5 showed: - CNA B failed to perform hand hygiene and put on gloves; - CNA B removed the resident's soiled brief, cleaned the resident's front perineal area, removed the gloves, failed to perform hand hygiene, and put on clean gloves; - CNA B cleaned the resident's buttocks, hips, thighs and rectal area, removed the gloves, failed to perform hand hygiene, and put on clean gloves; - CNA B placed a brief on the resident and a clean incontinent pad on the bed under the resident. 5. Observation on 05/08/24 at 9:20 A.M., of incontinent care for Resident #6 showed: - NA E and CNA F performed hand hygiene and put on gloves; - NA E and CNA F removed the resident's urine soaked brief and sheet; - NA E performed incontinent care for the resident; - NA E and CNA F removed the gloves, failed to perform hand hygiene, and put on clean gloves; - NA E and CNA F failed to clean the urine soaked mattress; - NA E and CNA F put a clean sheet on the urine soaked mattress and a clean brief on the resident. 6. Observation on 05/09/24 at 10:55 A.M., of incontinent care for Resident #43 showed: - NA E and CNA F failed to perform hand hygiene and put on gloves; - CNA F removed the soiled brief with urine and blood on it from the wounds on the resident's buttocks; - CNA F performed incontinent care; - CNA F removed the gloves, failed to perform hand hygiene, put on new glove, and applied barrier cream to the resident's buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Observation on 05/09/24 at 11:14 A.M., of wound care for Resident #303 showed: - LPN K failed to perform hand hygiene and failed to put a gown on before entering the resident's room to perform wound care; - LPN K brought the wound care supplies into the resident's room and lay them on top of the resident's personal belongings without a clean barrier ; - LPN K opened the cotton tipped applicator package with his/her with bare hands, failed to perform hand hygiene, and put on clean gloves; - LPN K removed the gloves, failed to perform hand hygiene, and exited the room to retrieve gauze; - LPN K entered the room, failed to perform hand hygiene and failed to put a gown on, and put on clean gloves; - LPN K removed the dressing and failed to remove the gloves and perform hand hygiene; - LPN K irrigated the wound with normal saline, picked up the clean Iodoform (wound dressing) packing strip off the resident's personal belongings, and used the wooden end of the cotton tip applicator to pack the wound with the Iodoform; - LPN K applied a bordered dressing to the wound. During an interview on 05/09/24 at 3:30 P.M., the Director of Nursing (DON) said hand hygiene should be completed between glove changes and glove changes should be done when moving between tasks, body parts, or going from dirty to clean care. Gowns and gloves should be worn in all rooms with enhanced barrier precautions as well as hand hygiene when entering or exiting a resident's room. A clean barrier should be used to put wound care supplies on. During an interview on 05/10/24 at 11:30 A.M., NA E said hands should be sanitized or washed between glove changes. Gowns and gloves should be worn in all enhanced precaution rooms. During an interview on 05/10/24 at 11:45 A.M., the Administrator said hand hygiene and glove changes should be done when needed. Enhanced barrier precautions should be followed. 45693 46521 47445 50260

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45693 Based on interview and record review, the facility failed to document pertinent education provided to the residents or the resident's representative regarding benefits, side effects or warnings of the influenza (a viral respiratory infection) and/or the pneumococcal (an infectious lung disease) vaccine for four residents (Residents #6, #23, #43, and #44) out of five sampled residents. The facility's census was 49. The facility did not provided policy regarding the influenza and pneumonia immunizations. 1. Review of Resident #6's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 11/20/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine. 2. Review of Resident #23's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 10/20/23; - Pneumococcal vaccine administered on 11/26/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine; - No documentation the facility provided information and education to the resident or the resident's representative of the pneumococcal vaccine. 3. Review of Resident #43's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 11/20/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine. 4. Review of Resident #44's medical record showed: - admitted [DATE]; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Influenza vaccine administered on 11/20/23; - Pneumonia vaccine administered on 11/26/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine; - No documentation the facility provided information and education to the resident or the resident's representative of the pneumococcal vaccine. During an interview on 05/09/24 at 3:30 P.M., the Director of Nursing (DON) said education should be provided prior to any vaccine being administered. The education should be documented when provided.