STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265321	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	700 Garden Path O Fallon, MO 63366

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 0623 Level of Harm - Potential for minimal 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** 32530 Based on interview and record review, the facility failed to provide a written notice of transfer to the resident and/or the resident's representative when six residents (Residents #11, #12, #16, #29, #35, and #251), in a review of 14 sampled residents, were transferred to the hospital. The facility census was 48. Review of the facility's Transfer or Discharge Notice policy, last revised December 2024, showed the following: -Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge when an immediate transfer or discharge is required by the resident's urgent medical needs; -The resident and/or representative will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; d. A statement of the resident's rights to appeal the transfer or discharge, including: -The name, address, email and telephone number of the entity which receives such requests; -Information about how to obtain, complete and submit an appeal form; -How to get assistance completing the appeal process; -The facility bed-hold policy; -The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; -The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); -The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices; -A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman; -The reasons for the transfer or discharge will be documented in the resident's medical record; -If the information in the notice changes prior to the transfer or discharge, the recipients of the notice will be updated as soon as practicable. 1. Review of Resident #29's Face Sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 10/09/24 at 1:08 P.M., showed the following: -The resident complained of not feeling well and wanted to be transferred to the hospital; -Physician notified of the resident's complaint and request; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident transferred to the hospital on 10/09/24. Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident transferred to the hospital on 10/09/24. Review of the resident's Nurses Notes, dated 10/25/24 at 1:08 P.M., showed the following: -The resident complained of increased respiratory effort and not feeling well and wanted to be transferred to the hospital; -Physician notified of the resident's complaint and request; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident transferred to the hospital on 10/25/24 Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident transferred to the hospital on 10/25/24. 2. Review of Resident #16's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 12/07/24 at 4:04 P.M., showed the following: (continued on next page)

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-The resident had elevated fever, decreased oxygen saturation, and increased respiratory effort; -Physician notified of the resident's symptoms and nursing assessment; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident transferred to the hospital on 12/07/24. Review of the resident's Nurse's Notes, dated 12/07/24, showed the resident was admitted to the hospital with a pulmonary embolism (blood clot in the lung). Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident transferred to the hospital on 12/07/24. 3. Review of Resident #11's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 11/19/24 at 7:02 P.M., showed the following: -The resident fell and was found lying on the floor on his/her right side; -The resident could not move his/her right shoulder due to the increased pain; -Physician notified of the resident's symptoms and nursing assessment; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident transferred to the hospital on 11/19/24. Review of the resident's Nurse's Notes, dated 11/19/24 at 7:49 P.M., showed the resident was admitted to the hospital with a right shoulder fracture (break in bone). Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident transferred to the hospital on 11/19/24. Review of the resident's nurse's notes, dated 11/21/24, showed the resident returned to the facility on [DATE]. 4. Review of Resident #35's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 08/26/24 at 9:20 A.M., showed the following: -The resident had moderate periorbital edema (swelling around the eyes) and moderate swelling in upper and lower extremities, confusion, wheezing, and shortness of breath; -The physician gave an order to send the resident to the emergency room ; (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-An ambulance transported the resident to the hospital; -Staff notified the resident's family member by telephone. Review of the resident's Nurse's Notes, dated 08/26/24 at 1:37 P.M., showed the resident was admitted to the hospital. Review of the resident's medical record showed no evidence staff provided the resident's representative with a written notice of transfer when the resident transferred to the hospital on 08/26/24. Review of the resident's nurse's notes, dated 09/05/24, showed the resident returned to the facility on [DATE]. 5. Review of Resident #251's face sheet showed he/she was his/her own responsible person. Review of the resident's progress notes dated 1/15/25 showed the resident complained of having a hard time breathing and suspected he/she had gained weight. Lung sounds revealed crackles in the left lower lobe. Resident transferred to hospital per emergency medical services. During an interview on 1/16/25 at 9:07 A.M., Licensed Practical Nurse (LPN) A said the resident was sent to the hospital last evening due to weight gain and shortness of breath related to his/her congestive heart failure (CHF; heart does not pump blood sufficiently). Review of the resident's census sheet showed he/she was discharged on [DATE] and readmitted on [DATE]. Review of the resident's medical record showed no evidence the facility provided the resident or his/her representative with a written notice of transfer when the resident transferred to the hospital on 1/15/25. 6. Review of Resident #12's face sheet showed he/she had a responsible party. Review of the resident's progress notes, dated 1/11/25 at 11:20 A.M., showed the resident returned from the hospital. Continues on observation for rolling out of bed. (Review of the resident's medical record showed no documentation when the resident went to the hospital.) Review of the resident's medical record showed no evidence the facility provided the resident's representative with a written notice of transfer to the hospital on 1/11/25. 7. During an interview on 01/16/25 at 12:30 P.M., the Administrator said the nurses should send transfer notices with the resident and/or provide the notice to the resident's representative upon transfer to the hospital. After he visited with the nurses, he identified this was not being done. 32899 47008

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 32530 Based on interview and record review, the facility failed to provide a written notice of the bed hold policy with required information to the resident and/or resident representative within 24 hours of transfer to the hospital for four residents (Residents #11, #16, #35, and #251), in a review of 14 sampled residents. The facility census was 48. Review of the facility's undated policy, Bed Hold, showed the following: -If the resident is discharged to the hospital, the bed is considered empty. The facility can do one of two things: -1. Hold the bed for the resident who is in the hospital or on leave from the facility for any reason; -2. Release the bed, allowing the facility to admit a new resident; -During the absence of resident for any reason, the regular charge herein shall apply until the room is released and all belongings are removed. Resident and/or responsible party shall notify the facility's social services department regarding whether resident's bed should be held, or whether resident shall be discharged . If notice is nor received, the resident's bed will automatically be held and charges will continue to accrue; -When the bed is held, the responsible party agrees to pay the current room rate as a bed hold fee. The bed hold fee is a private chare, no matter what the resident's pay source is. The plan specified in this record will immediately go into effect when hospitalization is warranted. The responsible party should contact admissions or social services within 24 hours following hospitalization or on a weekend or holiday the next business day if the family wishes to make changes in the plan for bed hold. The facility must issue notification within 24 hours of transfer to hospital details of bed hold policy. 1. Review of Resident #16's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 12/07/24 at 4:04 P.M., showed the following: -The resident had elevated fever, decreased oxygen saturation, and increased respiratory effort; -Physician notified of the resident's symptoms and nursing assessment; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident transferred to the hospital on 12/07/24. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's Nurse's Notes, dated 12/07/24, showed the resident was admitted to the hospital with a pulmonary embolism (blood clot in the lung). Review of the resident's medical record showed no evidence staff provided a copy of the facility's bed hold policy to the resident's representative when the resident was transferred to the hospital on 12/07/24. Review of the resident's nurse's notes, dated 12/10/24, showed the resident returned to the facility on [DATE]. 2. Review of Resident #11's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 11/19/24 at 7:02 P.M., showed the following: -The resident fell and was found lying on the floor on his/her right side; -The resident could not move his/her right shoulder due to the increased pain; -Physician notified of the resident's symptoms and nursing assessment; -Orders received to send the resident to the emergency room for evaluation via ambulance. Review of the resident's census sheet showed the resident was transferred to the hospital on 11/19/24. Review of the resident's Nurse's Notes, dated 11/19/24 at 7:49 P.M., showed the resident was admitted to the hospital with a right shoulder fracture (break in bone). Review of the resident's medical record showed no evidence staff provided a copy of the facility's bed hold policy to the resident's representative when the resident was transferred to the hospital on 11/19/24. Review of the resident's nurse's notes, dated 11/21/24, showed the resident returned to the facility on [DATE]. 3. Review of Resident #35's face sheet showed the resident's family member was his/her responsible party. Review of the resident's Nurses Notes, dated 08/26/24 at 9:20 A.M., showed the following: -The resident had moderate periorbital edema (swelling around the eyes) and moderate swelling in upper and lower extremities, confusion, wheezing, and shortness of breath; -The physician gave an order to send the resident to the emergency room ; -An ambulance transported the resident to the hospital. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the resident's medical record showed no evidence staff provided a copy of the facility's bed hold policy to the resident's representative when the resident was transferred to the hospital on 08/26/24. Review of the resident's Nurse's Notes, dated 08/26/24 at 1:37 P.M., showed the resident was admitted to the hospital. Review of the resident's nurse's notes, dated 09/05/24, showed the resident returned to the facility (from the hospital) on 09/05/24. 4. Review of Resident #251's face sheet showed he/she was his/her own responsible party. Review of the resident's progress notes, dated 1/15/25, showed the resident complained of having a hard time breathing and suspected he/she had gained weight. Lung sounds revealed crackles in the left lower lobe. Resident transferred to hospital per emergency medical services. Review of the resident's census sheet showed he/she was discharged from the facility on 1/15/25 and readmitted to the facility on [DATE]. Review of the resident's medical record on 1/16/25 showed no evidence the facility provided the resident with a copy of the facility's bed hold policy when the resident was transferred to the hospital on 1/15/25. 5. During an interview on 01/16/25 at 9:05 A.M., the Admission Director said she contacted the residents and/or the residents' representatives to go over the bed hold policy via phone but did not document the discussion. She was unaware of a paper trail for this. During an interview on 01/16/25 at 12:30 P.M., the Administrator said the nurses were to send the bed hold policy with the resident and/or provide the policy to the resident's representative upon transfer to the hospital. After visiting with the nurses, he identified this was not being done. 32899 47008

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32530 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for incontinence care for one resident (Resident #1) and failed to provide oral care for one resident (Resident #29), in a review of 14 sampled residents, who required assistance to perform activities of daily living. The facility census was 48. Review of the facility's policy, Oral Care, dated October 2024, showed the purpose of the procedure was to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth. (The policy did not include documentation to show when staff were to assist with oral care.) Review of the facility's policy, Perineal Care, dated November 2024, showed the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. (The policy did not include documentation to show when staff were to assist residents with perineal care.) 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/20/24, showed the following: -His/Her cognition was severely impaired; -Dependent on staff for oral hygiene, toilet hygiene, and bathing; -Always incontinent of bowel and bladder. Review of the resident's Care Plan, last updated on 11/21/24, showed the following: -He/She had an activities of daily living (ADL) self-care performance deficit related to dementia; -He/She was totally dependent on staff for personal hygiene and oral care, but would often refuse to have his/her teeth cleaned; -Totally dependent on one to two staff for toilet use; -Incontinent of bladder and bowel related to dementia; -Staff were to check for incontinence every two hours and provide peri-care after each incontinent episode. Observation on 01/14/25 at 11:46 A.M., showed the following: -The resident sat in the dining room waiting for lunch service; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She became agitated as evidenced by facial expressions and cursing, increased fidgeting in his/her chair, and banging hands on the chair arm rests. Observation on 01/14/25 at 1:25 P.M. showed the following: -The resident sat in his/her broda chair (a specialized positioning chair) in his/her room with his/her eyes closed; -There was a strong urine odor noted in room. Observation on 01/14/25 at 2:40 P.M. showed the following: -The resident sat in his/her broda chair in his/her room with his/her eyes closed; -There was a strong urine odor noted in room. Observation on 01/14/25 at 4:48 P.M. showed the following: -The resident sat in his/her broda chair in his/her room with his/her eyes closed; -There was a strong urine odor noted in room; -No evidence staff checked the resident for incontinence. Observation of the resident on 01/14/25 at 5:07 P.M. showed the following: -The resident had a strong odor of urine and feces; -Without first checking for incontinence and/or providing perineal care, CNA D assisted the resident from his/her room to the dining room for supper. Observation on 01/15/25 at 6:06 A.M. showed the resident lay in his/her bed. A stale urine odor was present in the resident's room. Observation on 01/15/25 at 6:45 A.M. showed the following: -The resident was incontinent of bowel and bladder; -The resident had debris noted around his/her mouth; -Certified Nurse Aide (CNA) E and CNA F provided incontinence care for the resident, dressed the resident and transferred him/her to the broda chair; -Staff took the resident to the dining room without offering to provide oral care for the resident. During an interview on 01/15/25 at 7:05 A.M., CNA E said the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was too pressed for time to complete oral care on any of the residents, but would if he/she had more time; -More often than not, he/she did not have time to perform oral care as part of morning care; -He/She hoped the day shift staff would provide the care, but didn't know if they did or not; -Staff should check the resident for incontinence every two hours and as needed when staff noted odors. Observation on 01/15/25 at 11:23 A.M. showed the resident sat in his/her room in the broda chair and had a strong urine odor. During an interview on 01/15/24 at 11:44 A.M., CNA G said the following: -The resident was usually incontinent; -Staff were supposed to check the resident for incontinence and change the resident every two hours. -He/She did not notice the resident had urine/fecal odors. Observation on 01/15/25 at 11:55 A.M. showed the following: -The resident sat in his/her broda chair in his/her room with strong urine and fecal odors; -His/Her pants were visibly soiled; -CNA G transported the resident with soiled pants and strong urine/fecal odors from his/her room to the dining room for lunch. Observation on 01/15/25 at 12:42 P.M., showed the following: -CNA H assisted the resident from the dining room to his/her room; -The resident yelled, was agitated and hit the chair rail; -His/Her pants were soiled; -CNA H prepared to take the resident to the shower. Observation on 01/15/25 at 12:50 A.M., showed the following: -The resident yelled out and had facial grimacing; -CNA H took the resident to the shower room; -The resident's pants and incontinence brief were heavily soiled with urine and feces; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA H cleaned the resident in the shower room and transported him/her back to his/her room; -CNA H did not attempt to provide oral hygiene for the resident. During an interview on 01/15/25 at 1:37 P.M., CNA H said the following: -This was not the resident's normal shower day. The Director of Nurses (DON) told him/her the resident needed a shower so he/she showered the resident; -The resident had continuous diarrhea, which was usual for the resident; -Staff should check the resident for incontinence every two hours and as needed, and should provide incontinence care after each incontinence episode; -He/She tried to complete oral care for the residents after meals when he/she had time and when the residents cooperated. 2. Review of Resident #29's significant change MDS, dated [DATE], showed the following: -His/Her cognition was moderately impaired; -He/She required substantial/maximum assistance with oral hygiene; -He/She had no abnormalities with dental assessment. Review of the resident's Care Plan, last reviewed on 10/31/24, showed the resident required extensive/total assistance with oral care. During an interview on 01/15/25 at 8:15 A.M., the resident said he/she did not have any top teeth, but had a few teeth on the bottom. Staff did not assist him/her with oral care. Observation on 01/15/25 at 8:15 A.M. showed there were no oral care supplies in the resident's room. The resident had no upper teeth, but had a few teeth on the bottom. The resident's mouth was dry and he/she had debris on his/her teeth. Review of the resident's electronic health record on 01/16/25 showed there was no documentation staff provided oral hygiene as it was not part of the resident's activity of daily living (ADL) tasks documentation. During an interview, on 01/16/25 at 3:15 P.M., the DON said the following: -She noted Resident #1 had strong urine/fecal odors on 01/15/25 and instructed the CNA to bathe the resident; -Staff should ensure the residents were clean and odor free at all times; -Staff should not have taken the resident to the dining room with soiled clothing; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNAs, who assists residents out of bed, were expected to provide/assist with oral care; -Staff should also provide oral care at bedtime and as needed.

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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** 32899 Based on observation, interview and record review, the facility failed to ensure resident safety by failure to transfer one resident (Resident #1) as directed in his/her plan of care and failed to follow facility fall policy and procedure following one resident's fall (Resident #12) or implement interventions in the resident's plan of care to prevent further falls in a review of 15 sampled residents. The facility census was 48. Review of the facility's policy, Gait Belt Use/Transfers, dated November 2024, showed the following: -The facility will take all measures to ensure resident safety; -Transfers are performed based upon resident transfer status and the facility's policy; -Gait belts should be placed around the resident's waist, above the pelvic bone and below the rib cage over top of clothing; -A gait belt should be adjusted so that it is snug, without being uncomfortable for the resident; -Verify proper closure of buckle before use; -Grasp/transfer belt from underneath; -Remove/loosen gait belt when not in use; -No direction to show when a gait belt should be used. Review of the facility policy Fall Risk Assessment and Management dated 11/2024 showed the following: -Based on previous evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. -Assessment data should be used to identify underlying medical conditions that may increase the risk of injury from falls (such as osteoporosis) (a condition in which the bones become weak and brittle); -Staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence and cognition; -Identify environmental factors that may contribute to falling, such as lighting and room layout; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff and attending physician would collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable; -Staff, with the input of the attending physician would identify appropriate interventions to reduce the risk of falls; -If underlying causes cannot be readily identified or corrected, staff should try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of falling was identified as unavoidable; -In conjunction with the attending physician, staff should identify and implement relevant interventions to try to minimize serious consequences of falling; Staff should monitor and document each resident's response to interventions intended to reduce falling or risks of falling. Review of an undated facility document/policy titled, Falls, showed the following: -Must complete RISK (risk management), including pain and signing last page, progress note, 72 hour charting started, Certified Nurse Assistant (CNA) post fall summary tool; -Assessments that need to be completed: Fall risk, pain, skin, neuro focused evaluation, neuro checks started if unwitnessed; -Progress note needs to include time of fall, location, activity prior to fall (walking, transfer, bed, chair, etc.), injury description, treatment if needed, put in order for treatment, notification of physician, family and Director of Nursing (DON), neuro checks started, send to hospital. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by the facility, dated 11/20/24, showed the following: -His/Her cognition was severely impaired; -He/She was dependent on staff for bathing; -He/She was dependent on staff for assistance with tub/shower transfers. Review of the resident's Care Plan, last updated on 11/21/24, showed the following: -He/She was a high risk for falls related to confusion, poor communication/comprehension, unaware of safety needs, jerky movements, and unpredictable with transfers and ambulation; -He/She required extensive assistance from two staff to move between surfaces; -Staff were to make sure he/she was properly positioned in the shower chair and to get help if he/she started to slide down; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/11/24, the resident fell out of the shower chair and was taken to the emergency room with a head laceration; -If he/she becomes agitated, return him/her to his/her to room, assist him/her back to bed, and play music; -The resident was a two-person transfer; he/she no longer transferred to the bathroom. Observation on 01/15/25 at 12:42 P.M., showed CNA H assisted the resident from the dining room to his/her room in his/her broda chair (tilt in space chair) as the resident yelled and hit the arm rest. Observation on 01/15/25 at 12:50 P.M. showed the following: -CNA H took the resident to the shower room in his/her broda chair; -Without using a gait belt, CNA H instructed the resident to grab the assist bar next to the shower; -The resident grabbed the assist bar and stood from the broda chair. The resident was unsteady with jerky movements; -The resident transferred to the shower chair for the shower; -The resident was agitated, yelled and attempted to stand from the shower chair during the entire shower; -Once the shower was completed, CNA H assisted the resident with dressing, but did not put socks on the resident's feet; -CNA H placed a bath blanket on the floor, and instructed the resident to grab the assist bar and stand; -The resident began to lean backwards; -CNA H placed his/her left leg behind the resident, the resident leaned on CNA H's leg for support and to prevent the resident from falling backwards as the resident continued to hold onto the assist bar; - As the resident continued to lean on the CNA's leg, CNA H pivoted the resident and assisted him/her to sit in the broda chair. During an interview on 01/15/25 at 1:37 P.M., CNA H said the following: -He/She did not use a gait belt because he/she did not want to harm the resident's skin and make him/her more agitated; -He/She normally did not have any problems transferring the resident by himself/herself; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident could stand and grip onto the assist rail and wouldn't let go; -He/She should have had a second person for increased safety because of the resident's increased agitation, but no other staff was available to assist him/her; -The resident did not have socks in his/her room because they were in the laundry, but he/she should have obtained grip socks from the supply room prior to the shower and made sure he/she had all supplies available before she started the shower. Review of resident's undated care card located in the resident's closet on 01/15/25 at 1:37 P.M. showed the resident required two person assist with a stand/pivot transfer. 2. Review of Resident #12's fall risk assessment, dated 04/11/24, showed the resident was at risk for falls. Review of the resident's significant change MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Dependent for transfers; -Substantial to maximum assist for bed mobility; -No falls since admission or last assessment. Review of the resident's care plan, last revised 11/12/24, showed the following: -At risk for falls related to gait/balance problems/ dependent on a mechanical lift device for transfers; -History of falls; -Follow facility fall protocol (fall policy); -Provide safe environment, low bed at night (06/23/23). Review of the resident's Physician Order Sheet (POS), dated 01/2025, showed the following: -Diagnoses included age related osteoporosis, abnormal gait and mobility, and dementia; -Low air loss (LAL) mattress (a specialized mattress designed to prevent and treat pressure wounds composed of multiple inflatable air tubes that alternately inflate and deflate); -Mechanical lift for transfers. Review of the resident's progress notes showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff documented on 01/11/25 at 11:20 A.M., the resident returned from hospital with no new orders. X-rays negative for fractures. Tramadol (narcotic pain medication) for pain, hematoma (bruise) to right shin area. Continues on observation for rolling out of bed; -There was no documentation in the progress notes regarding the time of the resident's fall, location, activity prior to the fall, injury description, treatment needed if any, notifications of the physician, family or DON or that neuro checks had been started, all of which was directed by the facility policy to documented in the progress notes. Review of the resident's 72 hour neuro checklist paper document showed the following: -Fall: 01/11/25; -Time: 4:00 A.M.; -RISK completed and signed by nurse; -Neuros started: yes; -Assessments completed: fall risk, pain and neuro focused assessment; -Notification: medical director (MD), family and DON; -72 hour charting, each shift and nurse initial when completed: started 01/11/25 (unable to read time) and last entry 01/14/25 at 7:00 A.M. Review of the resident's medical record showed no documentation of the location of the resident's fall, the activity prior to the fall, injury description and treatment or that the facility had completed a root cause of the fall, all of which was directed by the facility policies. Observation on 01/13/25 at 12:10 P.M. showed the resident lay in his/her bed on a LAL mattress with partial bolstered sides (air-filled sides that are meant to prevent residents from falling out of bed). The bed was at waist height and not in a low position. During an interview on 01/13/25 at 12:10 P.M., the resident said he/she rolled out of bed recently, maybe Saturday the 11th, and was transferred to the hospital for x-rays. Review of the resident's undated care plan, posted in the resident's closet, on 01/15/25 at 3:40 P.M., showed the following: -Resident at risk for falls; -Lock bed and chair; -No documentation to show the resident was supposed to have his/her bed in the lowest position. Observation on 01/16/25 at 8:16 A.M. showed the resident lay in his/her bed. The bed was not in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/25 at 9:33 A.M., CNA G said he/she was aware of the resident's fall. He/She had not been informed of any new interventions put in place to prevent falls for the resident. During an interview on 01/15/25 at 3:45 P.M., Licensed Practical Nurse (LPN) A said the following: -He/She knew the resident fell out of bed recently; -He/She was not informed of any new interventions to prevent falls for the resident following his/her recent fall. During an interview on 01/29/25 at 10:58 A.M., LPN P said the following: -He/She was working the night/morning the resident fell out of bed; -The resident said he/she rolled out of bed and landed between the bed and the bedside table with his/her leg lying on the wheels of the table; -A resident's fall should be documented in the progress notes, on the paper incident report and under the risk management section of assessments in the electronic record; -He/She had only completed the paper neuro check list with cover sheet but failed to document in the resident's progress notes; -When a resident falls, the nurse should assess and care for the resident, interview the resident and any witnesses, notify the physician and family and document in the necessary areas which would include the date, time, incident, resident interview, assessment, treatment and notifications. All should be completed prior to the end of staff's shift; -He/She believed the resident's bed had been in the medium to low height at the time of the fall; -The resident could use his/her remote to move the bed him/herself; -He/She had not added any new interventions after the resident's fall and was not made aware of any new interventions being added after the resident fell out of bed; -He/She had not investigated further how the resident fell out of bed. During an interview on 01/16/25 at 1:50 P.M. and 3:15 P.M., the DON said the following: -She could not find a fall report or documentation for Resident #12's fall in the progress notes, which occurred on 01/11/25, in the electronic health record; -Resident #12 was on the LAL mattress and was a mechanical lift transfer prior to the fall; -She had spoken with the nurse when notified of Resident #12's fall and instructed him/her to make sure he/she completed the fall protocol; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected staff to follow resident's care plan guidance for all transfers; -Resident #1 required assistance of two staff for transfers; -Staff should use gait belts for transfers unless directed otherwise with mechanical lift transfers; -CNA H should not have attempted to complete the shower alone when Resident #1 was agitated; -It was not appropriate for the CNA to place his/her leg behind Resident #1 for support; he/she should have had assistance; -Staff should be prepared and have all supplies available before starting the shower; -She would expect staff to follow the facility fall protocol/policy following a resident fall; -She would expect the charge nurse (who worked when the fall occurred), to document the incident in the progress notes, investigate to find the root cause, fill out the fall report and implement new interventions when possible.; -No new interventions had been put in place after Resident #12's fall; she did not feel they needed to add any as the resident had not fallen before.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 32899 Based on observation, interview and record review, the facility failed to properly store, change and date respiratory equipment (oxygen tubing) for two residents (Residents #4 and #39), in a review of 14 sampled residents. The facility census was 48. During an interview on 01/23/25 at 10:59 A.M., the administrator said the facility did not have a policy for changing and dating oxygen (O2) tubing. 1. Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 10/10/24, showed the following: -Cognitively intact; -Used oxygen. Review of the resident's care plan, dated 10/17/24 showed the following: -Oxygen for for chronic obstructive pulmonary disease (COPD) (lung disorder that blocks airflow), history of pneumonia and respiratory failure; -Oxygen via nasal prongs (nasal cannula (NC) (prongs that are inserted into the nares to deliver oxygen) at one-two liters (L) as needed (PRN); -The care plan did not direct staff to change or date the O2 tubing. Review of the resident progress notes dated 11/10/24, showed the resident admitted to the hospital with pneumonia (lung infection). Review of the resident's Physician Order Sheet (POS), dated 01/2025 showed the following: -Diagnoses included COPD, respiratory failure and history of pneumonia; -Oxygen at 1-2 L per NC as needed for shortness of breath (SOB); order date of 10/04/24; -No order indicating when to change O2 tubing. Review of the resident's Treatment Administration Record (TAR) dated 01/2025, showed O2 at 1-2 L per NC as needed for shortness of breath (SOB); order date of 10/04/24. The TAR did not address when to change the O2 tubing. Observation on 01/13/25 at 3:00 P.M., 01/14/25 9:00 A.M., and 01/15/25 at 6:50 A.M. and 11:21 A.M., showed the resident lay in his/her bed and wore O2 per NC that was attached to a concentrator. There was no date or initials on the oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/15/25 at 11:45 A.M. the resident said he/she could not recall the last time staff changed his/her oxygen tubing. 2. Review of Resident #39's care plan, dated 11/07/24, showed the following: -Diagnoses included COPD; -Resident will be free of signs/symptoms of respiratory infections through review date; -O2 via NC 2-3 L continuous. Review of the resident's progress notes, dated 11/21/24 showed resident chest x-ray results show mild left lower lobe pneumonia. Review of the resident's POS, dated 01/2025, showed the following: -O2 at 2-3 L per NC every shift; order date of 10/29/24; -No order indicating when to change O2 tubing. Observation on 01/13/25 at 11:45 A.M. showed the resident propelled him/herself in the hallway and wore O2 per NC attached to an O2 cylinder strapped to the back of the chair. There was no date or initials on the oxygen tubing. Observation on 01/14/25 at 8:45 A.M. showed the resident sat in his/her wheelchair in his/her room and wore O2 per NC attached to the cylinder on the back of the chair. There was no date or initials on the oxygen tubing. Observation on 01/15/25 at 6:10 A.M. showed the resident lay in his/her bed and wore O2 per NC attached to an O2 concentrator. There was no date or initials on the oxygen tubing. During an interview on 01/28/25 at 10:27 A.M., Licensed Practical Nurse (LPN) M said the following: -It was the licensed nurses responsibility to change O2 tubing; -Tubing should be changed weekly on night shift; -Tubing should be initialed and dated; -Staff should document changing the oxygen tubing on the TAR. During an interview on 01/29/25 at 10:58 P.M. LPN P said the following: -He/She worked night shift at the facility; -If a task (changing O2 tubing) showed up on the night shift TAR, then night shift would be responsible for that task; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was not aware that it was a night shift duty to change the O2 tubing; -Oxygen tubing should be tagged with a piece of tape with the initials of who changed it and the date. During an interview on 01/16/25 at 3:10 P.M., the Director of Nursing (DON) said the following: -Nursing (not specific as to what nursing or what shift) was responsible for changing the O2 tubing weekly; -Tubing should be initialed an dated when it is changed weekly; -Staff should document on the TAR when the tubing is changed. During an interview on 01/23/25 at 10:59 A.M., the administrator said he expected oxygen tubing be changed and dated weekly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 32899 Based on observation, interview, and record review, the facility failed to assess residents for risk of entrapment prior to placement of bed rails, document alternatives attempted prior to bed rail placement, complete entrapment zone measurements, or obtain written consent from the residents and/or their guardians prior to use for one resident (Residents #11), who used side rails, in a review of 14 sampled residents. The census was 48. Review of the facility's Bed Safety /Bed Rails policy, last revised in July 2024, showed the following: -The facility shall strive to provide a safe sleeping environment for the resident and after evaluation, if need be, appropriate bed rails will be used for bed mobility as necessary: -The resident's sleeping environment should be assessed by the Nursing Supervisor/ Administrator/ DON (interdisciplinary team), considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; -The facility will attempt to utilize appropriate alternatives to bed rails prior to initiating the use of a bed rail; -The facility will identify specific medical reasons to justify the use of a bed rail such as functional ability, bed mobility, etc. and will provide rationale for why the use of bed rail is necessary and why the alternatives to bed rails did not meet the resident's needs; -To try to prevent injuries from the use of bed rails and related equipment, the facility should promote the following approaches: -Assess resident for risk of entrapment from bed rails prior to installation of a bed rail; -Consult with attending physician and resident/resident representative regarding the risks and benefits of the use of a bed rail and why other alternatives attempted failed to meet resident's needs; -Obtain informed consent from resident and/or resident representative for the install and use of bed rail prior to installing; -Ensure the beds dimensions are appropriate for the resident's size and weight; -Ensure that bed rails are properly installed and used following the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility's education and training activities would include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. -Ongoing evaluation of resident and bed rails will occur to assess the ongoing need for use of bed rails and resident's safety. Review of the facility's Proper Use of Side Rails policy, last revised in November 2023 showed the following: -The purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints and prevent entrapment; -Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents; -An assessment will be made to determine the residents symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: -Bed mobility; -Ability to change positions, transfer to and from bed or chair, and to stand and toilet; -Risk of entrapment from the use of side rails; and -The bed's dimensions are appropriate for the resident's size and weight; -If the use of a side rail is as an assistive device this will be addressed in the resident care plan; -Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol; -Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails; -The risks and benefits of side rails will be considered for each resident; -Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks; -Manufacturer instructions for the operation of side rails will be adhered to; -The resident will be checked periodically for safety relative to side rail use; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used); -Facility staff, in conjunction with the attending physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. 1. Review of Resident #11's undated face sheet showed the following: -His/Her family member was his/her responsible party; -Diagnoses included fracture of upper end of the right humerus (bone in the arm), unsteadiness on feet, abnormalities of gait and mobility, history of falling, generalized muscle weakness and repeated falls. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/03/24, showed the following: -Intact cognition; -Limited range of motion on the upper and lower extremities on one side of his/her body; -Substantial/Maximum assistance required for rolling left and right and for lying to sit on side of bed transfers; -The resident was dependent on staff for sit to stand transfers and chair/bed-to-chair transfers. Review of the resident's care plan, revised 12/05/24, showed the following: -The resident returned from the hospital after a fall and fractured shoulder with non-weight bearing and sling requiring more assistance; -The resident used half side rails to maximize independence with turning and repositioning in bed. He/She requires extensive assist at this time; -The resident is at high risk for falls related to gait and balance problems, medication use and incontinence; -The resident needs a safe environment with side rails as ordered; -The resident requires assist with bed mobility; may assist with use of bed rails. Review of the resident's January 2025 Physician's Orders showed no order for bed rails. Observation on 01/15/25 at 7:29 A.M., showed the resident lay in bed. The resident had a half bed rail in the raised position on the left side of his/her bed. The resident used the bed rail to assist himself/herself to sit on the side of the bed. The right side of the resident's bed was up against the wall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center	700 Garden Path O Fallon, MO 63366

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/24 at 8:45 A.M., the resident said he/she used the bed rail to turn in bed and help him/her get out of bed. He/She felt safer in bed with the half bed rail. Review of the resident's medical record showed no bed rail assessment, no bed rail entrapment assessment or informed consent from the resident for the use of the bed rail. During an interview on 01/15/2025 at 3:50 P.M., the Director of Nursing (DON) said the facility had no orders, assessments, consents or entrapment zone measurements for the resident's bed rail. The facility had thought about taking all the bed rails down, but after talking to the resident in question, the resident and the facility thought it was in the best interest of the resident to keep the bed rail. 47008

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on observation, interview, and record review, the facility failed to ensure expired testing supplies and medications not in use by two residents including one current resident Resident #10) and one discharged resident (Residents #100), were destroyed or returned as directed by facility policy. The facility census was 48. Review of the facility's policy, Storage of Medications, last revised [DATE], showed the following: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 1. Review of Resident #100's physician orders, dated [DATE], showed an order for fluticasone-salmeterol (a combination of two medicines that are used to help control the symptoms of asthma and improve breathing) aerosol powder breath activated ,d+[DATE] microgram (mcg)/dose, one inhalation - inhale orally every 12 hours (original order dated [DATE]). Review of the facility clinical census showed the resident discharged from the facility on [DATE]. Observation on [DATE] at 10:37 A.M. of the medication storage room for the 100, 200 and 300 halls showed the following: -Fluticasone propionate/salmeterol metered diskus inhalation powder 250 mcg/50 mcg located in the upper middle cabinet by the door; -The medication was labeled for Resident #100 and was labeled as opened on ,d+[DATE]. (The medication remained in the facility 182 days after the resident was discharged .) 2. Observation on [DATE] at 10:37 A.M. of the medication storage room for 100, 200 and 300 halls, in a cabinet above the sink on the far right side, showed the following: -One BinaNow COVID-19 Ag Self Test, lot number 226882, with an FDA extended expiration date of [DATE]. (The test kits had not been pulled for destruction or destroyed per facility policy and remained in the facility for 132 days after expiration); -Eleven unopened boxes of Access Bio, Inc. CareStart COVID-19 Antigen Home Test and On/Go Antigen Self Test, lot number CP23B10, with an expiration date of [DATE]. (The test kits had not been pulled for destruction or destroyed per facility policy and remained in the facility for 74 days after expiration); (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One unopened box of Access Bio, Inc. CareStart COVID-19 Antigen Home Test and On/Go Antigen Self Test, Lot Number CP23B16, with an expiration date of [DATE]. (The test kits had not been pulled for destruction or destroyed per facility policy and remained in the facility for 71 days after expiration); -Four unopened boxes of Access Bio, Inc. CareStart COVID-19 Antigen Home Test and On/Go Antigen Self Test, Lot Number CP23B36, with an expiration date of [DATE]. (The test kits had not been pulled for destruction or destroyed per facility policy and remained in the facility for 66 days after expiration); -Twenty-on unopened boxes of OHC COVID-19 Antigen Self Test, lot number SHK2901-XL,d+[DATE]AF, with an FDA extended expiration date of [DATE]. (The test kits had not been pulled for destruction or destroyed per facility policy and remained in the facility for 42 days after expiration.) During an interview on [DATE] at 11:08 A.M., Licensed Practical Nurse (LPN) L said the COVID-19 tests were used for employees and residents who had symptoms of COVID-19. 3. Review of Resident #10's face sheet showed the resident admitted to the facility on [DATE]. Observation on [DATE] at 10:37 A.M., of the medication storage room for 100, 200 and 300 halls in the cabinet by the door, showed the following medications labeled for the resident and not in use: -Sixteen atorvastatin (a medication used to treat high cholesterol) 20 mg tablets; -Thirty cyclobenzaprine (a muscle relaxant) 10 mg tablets; -Fourteen digoxin (a medication to treat heart failure) 0.125 mg tablets; -One diltiazem ER (a medication used to treat high blood pressure and chest pain) 180 mg tablet; -Three gabapentin (a medication used to treat seizures and nerve pain)100 mg tablets; -Eleven ropinirol (a medication used to treat symptoms of Parkinson's disease and restless leg syndrome) 1 mg tablets; -Thirty sertraline (an antidepressant/antianxiety medication)100 mg tablets; -Thirteen one-half tablets of spironolactone (a diuretic medication used to treat high blood pressure) 25 mg; -Seventeen montelukast (an anti-inflammatory medication used to treat allergies and prevent asthma attacks) 10 mg tablets. (Review of the resident's physician orders showed no orders for this medication since admission to the facility); -Nineteen prednisone (a steroid medication) 5 mg tablets. (Review of the resident's physician orders showed no orders for this medication since admission to the facility); (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Four quetiapine (an antipsychotic medication) 400 mg tablets. (Review of the resident's physician orders showed no orders for this medication since admission to the facility); -Twenty-two sertraline 200 mg tablets. (Review of the resident's physician orders showed no orders for this medication since admission to the facility.) During an interview on [DATE] at 11:08 A.M., LPN L said the following: -He/She did not know why the medication cards labeled for the resident were in the cabinet; -He/She did not know how long the medications had been in the cabinet; -He/She did not know who put the medications in the cabinet; -Sometimes family brought in medications from home, and the facility cannot use them. The medications were stored in the cabinet because family was supposed to take them home; -If the medications were not narcotics, he/she could destroy them without another staff member present. During an interview on [DATE] at 11:22 A.M., the Director of Nursing (DON) said the following: -She was responsible for checking the medication storage room; -She tried to check it weekly, but the last time she checked the storage room was two weeks ago; -If there were any medications that needed to be destroyed, she destroyed them at that time; -The COVID-19 tests were normally stored in the supply room not in the medication storage room; -She did not know why the COVID-19 tests were in the medication storage room; -The last time she checked the medication storage room, she had not remembered seeing the COVID-19 tests in the cabinet, Resident #10's medication or Resident #100's medication cards in the cabinet; -The night nurse should check the COVID-19 tests and destroy them if they were expired; -Anyone who sees outdated COVID-19 tests could get rid of them; -Medications that needed to be destroyed were to be placed in the destroyed container on the counter with the medication destruction book; -She normally destroyed any medication that should not be in the medication storage room.

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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. 32530 Based on observation, interview, and record review, the facility failed to ensure staff maintained areas throughout the kitchen in a clean and sanitary manner, failed to ensure ice machines in the kitchen and nourishment centers were clean and in good repair, failed to ensure staff properly wore hair and beard restraints while in the kitchen, and failed to cover food/drink items when transporting meal trays to residents' rooms. The facility census was 48. 1. Review of the facility policy, Sanitation, dated November 2024, showed the following: -All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair; -Kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime; -The food services manager would be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Review of the facility policy, Food Receiving and Storage, dated July 2024, showed all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Observations on 1/13/25 between 10:38 A.M. and 4:00 P.M., showed the following: -Eight opened, one-gallon containers of salad dressing, mayonnaise and slaw dressing were not marked with an expiration date and did not contain an opened or use by date; -The lids to the bulk flour and sugar bins were heavily soiled with dried debris; -The trash can, located next to the steamer and near the foot preparation counter and range, did not have a lid; -The power controls and the base of the blender were soiled with dried debris; -A one-half gallon bottle of stir fry sauce sat on a lower shelf by the range. The label on the bottle showed to refrigerate after opening; -Two large pans (24 inches by 12 inches) of gelatin were uncovered on a cart in the roll-in refrigerator; -The floors under the freezer and refrigerator in the hallway were soiled with debris; -The floor under the food preparation counter in the kitchen was soiled with food debris; -Black, mold-like debris was on the fan covers in the refrigerator located in the kitchen; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The lids, handles and sides of 14 five-pound spice containers, located on the top shelf above the sink and preparation counter, were soiled with dried debris; -The exterior surfaces of 22 16-ounce spice containers, located on the lower shelf above the sink and preparation counter, were soiled with dried debris. The lids to nine of the containers were open to air; -Splashes of food debris were located on the wall above the sink near the food processors; -The floor directly under the deep fat fryer and beside the range was heavily soiled with grease. 2. Observation on 1/13/24 between 1:15 P.M. and 2:00 P.M., showed the following: -A buildup of dust and debris on two plastic vent covers located in the ceiling above refrigerator in the kitchen; -A buildup of loose dusty debris on the ceiling vent and the ceiling tiles located in the hallway by the dry food storage room; -A buildup of dust and debris on the ceiling tiles, ceiling grid, and ceiling vents throughout the kitchen; Observation on 1/13/25 between 2:29 P.M. and 2:50 P.M. showed Dietary Staff N stood on a step ladder and used a cloth in his/her hand to clean the dust from the ceiling tiles in the kitchen while other dietary staff prepared a brownie mix in the mixer and filled beverage pitchers. Dietary Staff R made sandwiches at the preparation counter by the range. Dietary Staff N used a swinging motion with the cloth to wipe dust from the ceiling. Dust was visible in the air as Dietary Staff N cleaned the ceiling. Gray dust/debris was observed on preparation counters, the bulk flour and sugar bins, on the steamer, on the stack of clean dishes located next to the steamtable and on the steamtable. At 2:50 P.M., Dietary Staff N wiped a light fixture in the kitchen near the food preparation counter where a large bowl of a pudding dessert (staff was preparing to serve for the lunch meal) sat uncovered on the counter. He/She used a swinging motion with the cloth to wipe dust from the light fixture. Dust and debris fell from the ceiling/light fixture in the area of the open bowl. Dust and debris lay on the preparation counter by the bowl. 3. Review of the facility policy, Ice Machines and Ice Storage Chests, dated January 2024, showed the following: -To prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow precaution, including keeping the access door closed when not in use. -The facility policy has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. Observation on 1/13/25 at 12:30 P.M., showed the exterior of the ice machine, located in the kitchen, was soiled. The sides in the interior of the ice machine and the area along the edge where the access door closed were soiled with white debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 1/13/25 at 12:21 P.M. and at 1:45 P.M. of the ice machine, located in the A Wing nourishment center, showed the following: -A heavy buildup of slimy yellow debris and crusty white debris along the ice-making components inside the machine. Water flowed over these areas within the machine; -A buildup of white debris along the sides inside the machine; -A white rubber drain pipe had a heavy buildup of white and yellow crusty debris at the end of the pipe. The end of the drain pipe was in direct contact with the floor funnel drain and was not equipped with an appropriately spaced air gap. During an interview on 1/13/25 at 12:23 P.M., the Maintenance Supervisor said he was unaware that an air gap was required on an ice machine. Observation on 1/13/25 at 4:55 P.M. of the ice machine located in the C Wing nourishment center, showed the following: -A heavy buildup of yellow and white debris along the ice-making components inside the machine. Water flowed over these areas in the machine; -A black, mold-like substance on the water filter, located inside the machine. -The door to the ice machine was completely open and would not close to protect the ice from contamination. Observation on 1/14/25 at 2:34 P.M., the door to the ice machine, located in the C Wing nourishment center, stood open and would not close. During an interview on 1/14/25 at 2:34 P.M., Certified Nurse Assistant (CNA) G said the ice machine door kept breaking for a couple of months. The staff fill out a paper to show it is broken and give to the receptionist who puts it in the computer system for the maintenance staff. Maintenance tried to fix the door and then it would break again. During an interview on 1/14/25 at 2:36 P.M., CNA Q said the door to the ice machine was open all the time. Maintenance staff tried to fix it and then it would break again. It had been like this for awhile. 4. Review of the facility policy, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated October 2024, showed food service employees must wear hair nets or caps and/or beard restraints to keep hair from contacting exposed food, clean equipment, utensils and linens. Observation on 1/13/25 at 12:00 P.M.,showed Dietary Staff O served meals trays from the kitchen to residents in the dining room. He/She entered the kitchen, opened the refrigerator and obtained lettuce for a resident. Dietary Staff O's hair was approximately shoulder length. He/She wore a hat and did not wear a hair restraint that covered all of his/her hair. Dietary Staff O had facial hair and did not wear a beard restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 1/13/25 at 12:09 P.M., Dietary Staff N assisted with serving residents and was in the kitchen. Dietary Staff N had a bear and wore a beard restraint; however, the restraint did not cover all of the facial hair on the sides of his face. Observation on 1/14/25 at 10:09 A.M., showed Dietary Staff O placed apple cobbler into individual bowls for the residents. His/Her hair was approximately shoulder length. He/She wore a hat and did not wear a hair restraint to cover his/her hair that hung down below his/her hat. Dietary Staff O had facial hair and did not wear a beard restraint. A loose hair (the length of Dietary Staff O's hair) was visible on the left sleeve of his/her shirt. 5. Observations on 1/13/25 between 12:15 P.M. and 12:45 P.M., showed CNA staff served meal trays from an insulated cart on the A wing to residents in their rooms. Staff covered the plates on the meal trays with plate covers, however, the cake and the drinks were not covered as staff transported the trays down the hallways to the residents' rooms. Observations on 1/13/25 at 5:28 P.M., showed CNA staff served meal trays from the insulated cart on the A wing to residents in their rooms. Staff covered the plates on the meal trays with a plate cover, however, the dessert and drinks were not covered as staff transported the trays down the hallways to the residents' rooms. An unknown CNA carried two small, uncovered cups of salad dressing (prepared for a resident upon request) from the kitchen down the B wing hall to the A wing nurses station. 6. During interview on 1/15/25 at 10:50 A.M., the Dietary Manager said following: -Housekeeping staff were responsible for cleaning the ice machines in the nourishment centers; -He noticed the door to the ice machine in the C hallway nourishment center did not close and reported this to the Maintenance Supervisor on 1/14/25; -All food items in the refrigerators should be covered; -If there was no expiration date on items in the refrigerator, such as the salad dressing containers, then staff should label with the date they were opened and discard within two weeks of opening; -Staff were to deep clean (scrub) the floors weekly, sweep after each meal, and mop at least twice a day. Staff last deep cleaned the floors on 1/7/25; -Dietary staff were responsible for cleaning the ceilings in the kitchen. The dust builds up quickly on the ceilings. Staff are to clean the ceilings once a month. He expected staff to clean the ceilings after meals and not during meal preparation. He noticed dust particles around the kitchen after Dietary Staff N cleaned the ceilings on 1/13/25. -Staff should cover all items on the residents ' meal trays, including drinks and desserts, when transporting them from the hall cart to the residents ' rooms. -All dietary staff were to wear a hat or hair net. He expected any facial hair over 0.5 inch to be covered with a beard restraint. Dietary Staff O should wear a hair net to cover all of his/her hair and Dietary Staff N should wear a beard restraint that covers all of his facial hair.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to ensure staff washed their hands after each direct resident contact and when indicated by professional standard of practice during personal care for four residents (Residents #1, #4, #6, and #11), in a review of 14 sampled residents. The facility failed to complete Tuberculin Skin Tests (TST) and/or annual evaluations as required to rule out Tuberculosis (TB) (a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) for three of ten new employees reviewed (Registered Nurse I, Laundry Staff J and Dietary Staff K). The facility failed to monitor cold water temperatures as part of their water management program to prevent the growth of water borne pathogens including Legionella. The facility census was 48. Review of the facility policy, Handwashing/Hand Hygiene, last revised in November 2024, showed the following: -The facility considered hand hygiene the primary means to prevent the spread of healthcare associated infections; -All personnel were trained and in-serviced on the importance of hand hygiene to prevent the transmission of healthcare associated infections; -All staff were expected to adhere to hand hygiene policies and practices to help prevent the spread of infections; -Hand hygiene is indicated: -Before and after direct contact with residents; -After contact with blood or bodily fluids, or contaminated surfaces; -After touching a resident; -After touching a resident's environment; -Before moving from work on a soiled body site to a clean body site on the same resident; -After removing gloves; -Use an alcohol-based rub containing at least 60% alcohol for most clinical situations; -Wash hands with soap and water when hands are visibly soiled and after contact with resident with infectious diarrhea; -The use of gloves does not replace hand washing/hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Tuberculosis, Employee Screening policy, last revised in July 2024, showed the following: -All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. The need for annual testing shall be determined by the annual TB risk classifi cation or as per State regulations; -Each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment. -Tuberculin Skin Testing: -The facility's Employee Health Coordinator will administer a TST to all newly hired employees except those who have documented positive TST or BAMT results, and those who provide doc umented verification of having had a negative TST or BAMT within the preceding 12 months; -The initial TB testing will be a two-step TST performed by injecting 0.1 ml (5 tuberculin units) of purified protein derivative (PPD) intradermally; -If the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test. The employee may begin duty assignments after the first skin test (if negative) unless prohibited by state regulations. Review of the facility policy Water Management Program dated 11/2018, showed the facility will establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of communicable diseases and infections. Water management programs identify hazardous conditions and take steps to minimize the growth and spread of Legionella and other waterborne pathogens in building water systems. Seven key activities are routinely performed in a Legionella water management program: In general, the principles of effective water management include maintaining water temperatures outside the ideal range for Legionella growth. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/20/24, showed the following: -His/Her cognition was severely impaired; -He/She was dependent on staff for oral hygiene, toilet hygiene, and bathing; -He/She was always incontinent of bowel and bladder. Review of the resident's Care Plan, last updated on 11/21/24, showed the following: -He/She had an activities of daily living (ADL) self-care performance deficit related to dementia; -He/She was totally dependent on staff for personal hygiene and oral care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She was totally dependent on one to two staff for toilet use; -He/She was incontinent of bladder and bowel related to dementia; -Staff were to check for incontinence every two hours and provide peri-care after each incontinent episode. Observation of the resident on 01/15/25 at 6:45 A.M. showed the following: -The resident was incontinent of bowel and bladder; -While wearing gloves, CNA E cleaned urine from the resident's perineum, assisted the resident onto his/her side and used a perineal wipe to remove feces from the resident's rectal area; -Without removing gloves, CNA E put a clean incontinence brief on the resident, assisted the resident to dress, and transferred the resident to his/her chair. During interview on 1/15/25 at 7:17 A.M., CNA E said staff should wash their hands between glove changes. Staff should change their gloves and wash hands when going from a dirty task to a clean task. Staff should not touch clean supplies/items with soiled gloves. 2. Review of Resident #4's admission MDS, dated [DATE] showed the following: -Cognitively intact; -Partial to moderate assist with bed mobility; -Substantial to maximum assist with personal hygiene; -Dependent with toileting; -Always incontinent of bladder and bowel. Review of the resident's care plan dated 10/17/24, showed the following: -Incontinence related to impaired mobility, use of diuretics and BPH (benign prostatic hyperplasia-gland enlargement making urinating difficult); -Clean peri-area with each incontinent episode. Observation on 1/15/25 at 11:21 A.M. showed the following: -The resident lay in bed on his/her back; -CNA C entered the room to perform morning cares and without washing his/her hands, donned gloves, removed tape fasteners from the urine soiled incontinent brief and using wipes, cleaned the front perineal area; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA C, wearing the same soiled gloves, assisted the resident to his/her left side with the cloth pad located under the resident; -CNA C removed formed feces from the resident's anal area and tucked it in the soiled brief. With the same soiled gloved hands, he/she cleaned the resident's anal area and buttocks. He/She tucked the soiled brief and pad, placed a clean brief under the resident, and assisted the resident to his/her right side; -Wearing the same soiled gloves, CNA C pulled the soiled items and the clean brief through. He/She picked up a tube of barrier cream and without changing gloves, applied barrier cream to the resident's perineal and groin areas; -CNA C degloved and without washing hands, pulled the incontinence brief up, fastened it and covered the resident with a sheet. During an interview on 1/23/25 at 10:17 A.M. CNA C said the following: -Hands should be washed before cares, with glove changes, when soiled and after the completion of cares; -Gloves should be removed and hands washed after perineal care and clean gloves applied, before moving to a clean area or touching clean items. 3. Review of Resident #6's care plan dated 6/13/23 showed the following: -Bladder incontinence related to impaired mobility and lack of bladder control; -Provide peri-care with episodes of incontinence. Review of the resident's annual MDS, dated [DATE] showed the following: -Cognitively intact; -Dependent for toileting hygiene and transfers; -Substantial to maximum assist with bed mobility and dressing; -Always incontinent of bladder and frequently incontinent of bowel. Observation on 1/15/25 at 7:09 A.M. showed the following: -The resident lay on his/her back in bed; -CNA B entered the room and without washing his/her hands, donned gloves; -CNA B cleaned the resident's front perineal area with wipes and tucked the urine soiled pad under the resident. Without washing hands or changing gloves, CNA B touched the resident's back and hip and assisted the resident to roll to his/her right side; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-CNA B cleaned the resident's buttocks and with the same soiled gloves picked up and placed a clean brief under the resident, rolled the resident back to his/her left side, pulled the urine soiled pad out, placed it in a bag, and pulled the clean brief through; -He/She picked up barrier cream with the same soiled gloves, applied the cream to the resident's bilateral inner thighs, pulled up and attached the clean brief and applied the resident's clean pants; -He/She rolled the resident back to his/her right side and placed a mechanical lift sling under the resident, pulled the resident's pants up and placed a cloth pad between the resident and the sling; -He/She rolled the resident back to his/her left side and pulled the sling and pad through, pulled the resident's pants up and assisted the resident to his/her back; -Wearing the same soiled gloves, CNA B removed the resident's gown and applied a clean top; -He/She removed his/her gloves and without washing hands exited the room to get assistance. 4. Review of Resident #11's significant change MDS, dated [DATE], showed the following: -Intact cognition; -Dependent on staff for toileting; -Always incontinent of bladder and occasionally incontinent of bowel. Review of the resident's care plan, revised 12/05/24, showed the following: -The resident had and ADL self-care performance deficit related to impaired balance, advanced age, and episodes of incontinence; -The resident required extensive assist by one staff to dress; -The resident required extensive to total assist by one staff for toileting. Observation on 01/15/25 at 7:36 A.M., showed the following: -The resident lay on his/her back in bed; -CNA B entered the room and without washing hands donned gloves; -CNA B provided peri care cleansing the resident's front perineal area with wipes. Without washing hands and changing gloves, he/she touched the resident's back and hip and assisted the resident to roll to his/her right side; -He/She then cleaned the resident's buttocks with cleansing wipes removing brown fecal matter from the resident's rectal area; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She picked up a container of barrier cream with the same soiled gloves and applied it to the resident's buttocks and pulled up a clean brief; -CNA B then changed gloves without washing his/her hands with soap and water and donned gloves; -He/She dressed the resident and applied a gait belt assisting the resident to stand. He/She then pulled up the resident's shorts; -CNA B then removed his/her gloves and applied hand sanitizer to his/her hands. During an interview on 01/15/25 at 7:49 A.M., CNA B said the following: -He/She should wash his/her hands when entering a resident's room and then apply gloves; -He/She should change gloves after cleaning a resident's peri area; -He/She should have changed gloves and washed his/her hands with soap and water after cleaning fecal matter from the resident's rectal area; -He/She should not have picked up barrier cream with dirty gloves; -He/She thought hand sanitizer was sufficient to use after completing morning cares. During an interview on 01/16/25 at 3:15 P.M., the Director of Nursing (DON) said she expected staff to change their gloves and perform hand hygiene any time they were contaminated. Hands were to be sanitized every time gloves were removed. Staff should not be touching any clean surfaces with contaminated gloves and/or hands. 5. Review of the facility employee list, provided by the facility, showed Registered Nurse (RN) I's date of hire was 02/08/23. Review of RN I's employee file showed the following: -No documentation of a first-step TB test or a second-step TB test completed or provided at the time of hire; -No documentation of a TB test completed at one year of employment in February 2024; -No documentation of an annual evaluation to rule out signs and symptoms of TB. During an interview on 01/15/25 at 11:51 A.M., the DON/Infection Preventionist (IP) said she did not know if RN I had any TB testing completed when he/she was hired. She did not know if RN I had a TB test in February 2024. During a telephone interview on 01/24/25 at 5:37 P.M., RN I said the following: -He/She had worked at the facility for almost two years; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She thought she had a one-step TB test when hired; -He/She did not have a two-step TB test when hired; -He/She thought she had a TB test after one year of employment; -He/She did not have any records of the test. 6. Review of the facility employee list, provided by the facility, showed Laundry Staff J's date of hire was 10/29/24. Review of Laundry Staff J's employee file showed the following: -Documentation of a first-step TB test administered on 10/24/24 with results read on 10/29/24; -No documentation a second-step TB test was administered. 7. Review of the facility employee list, provided by the facility, showed Dietary Staff K's date of hire was 11/05/24. Review of Dietary Staff K's employee file showed the following: -Documentation of a first-step TB test administered on 10/31/24 with results read on 11/04/24; -No documentation a second-step TB test was administered. During an interview on at 01/15/25 at 11:27 A.M. the DON/Infection Preventionist (IP) said all new employees should have a TB test prior to starting employment and a second TB test in three weeks. The employee should have a TB test annually thereafter. She started employment at the facility in August 2024. She had asked the departments to send her the laundry staff and the dietary staff to get their second TB test, but the employees had not come to her for their second TB test. She would have to start both the laundry staff and the dietary staff testing over from the beginning. 8. Review of the facility's Legionella binder on 1/15/24 at 12:00 P.M. showed the following: -Hot water temperatures documented along with room numbers and dates; -No cold water temperatures documented. During an interview on 1/15/25 at 1:00 P.M. the maintenance director said the following: -He had been in his position for three months; -They were working to get the water management program going; -He had not been directed to and had not measured cold water temperatures; -He was vaguely aware of the danger zone of cool water for optimal Legionella growth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/23/25 at 10:32 A.M. the administrator said he did not expect cold water temperatures to be measured as the cold water cames off the main line. The facility would have to have a chiller added to control the cold water temperatures. 47008

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 32899 Based on observation, interview and record review, the facility failed to complete inspections of bed frames, mattresses and bed rails, as part of a regular maintenance program, to identify areas of possible entrapment for one resident (Resident #11), in a review of 14 sampled who used bed rails/assist bars. The facility census was 48. Review of the facility's Bed Safety /Bed Rails policy, last revised in July, 2024, showed the following: -The facility shall strive to provide a safe sleeping environment for the resident and after evaluation, if need be, appropriate bed rails will be used for bed mobility as necessary; -To try to prevent injuries from the use of bed rails and related equipment, the facility should promote the following approaches: -The maintenance department will complete an inspection on bed rail and bed components routinely and should provide a copy of inspections to the Administrator. These inspections will be incorporated into Safety Committee; -Ongoing evaluation of resident and bed rails will occur to assess the ongoing need for use of bed rails and resident's safety. Review of the facility's Proper Use of Side Rails policy, last revised in November, 2023, showed the following: -The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints and prevent entrapment; -An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails; -When used for mobility or transfer, an assessment will include a review of the resident's risk of entrapment from the use of side rails and the bed's dimensions are appropriate for the resident's size and weight; -When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used). 1. Review of Resident #11's undated face sheet showed the following: -His/Her family member was his/her responsible party; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included fracture of upper end of right humerus (long bone in the upper arm that runs from the shoulder to the elbow), unsteadiness on feet, abnormalities of gait and mobility, history of falling, generalized muscle weakness and repeated falls. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/03/24, showed the following: -Intact cognition; -Limited range of motion on the upper and lower extremities on one side of his/her body; -Substantial/ Maximum assistance required for rolling left and right and lying to sitting on side of bed; -The resident was dependent on staff for sit to stand transfers and chair/bed-to-chair transfers; -Used a walker and a wheelchair. Review of the resident's care plan, revised 12/05/24, showed the following: -The resident returned from the hospital after a fall; fractured his/her shoulder; is non-weight bearing and has sling; requiring more assistance; -The resident used half side rails to maximize independence with turning and repositioning in bed; requires extensive assist at this time; -The resident is high risk for falls related to gait and balance problems, medication use and incontinence; -The resident needs a safe environment with side rails as ordered; -The resident requires assist with bed mobility, may assist with use of bed rails. Observation on 01/15/25 at 7:29 A.M., showed the resident lay in bed. The resident had a half bed rail in the raised position on the left side of his/her bed. The resident used the bed rail to assist himself/herself to a sitting position on the side of the bed. The right side of the resident's bed was up against the wall. Review of the resident's Physician Order Summary Report, dated 01/15/25, showed no order for bed rails. During an interview on 01/16/24 at 8:45 A.M., the resident said he/she used the half bed rail to turn in bed and help him/her get out of bed. He/She felt safer in bed with the half bed rail. Review of the resident's medical record showed no bed rail assessment, no bed rail entrapment assessment or informed consent from the resident or the resident's representative for the use of the bed rail. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 01/23/25 at 9:58 A.M. , the Maintenance Director said he did not realized it was his responsibility to measure bed rails for entrapment zones. He had only worked at the facility for three months and in that time he had never installed any bed rails or measured any existing bed rails for entrapment zones. During an interview on 01/15/2025 at 3:50 P.M., the Director of Nursing (DON) said the facility had no orders, assessments, consents or entrapment zone measurements for the resident's bed rails. During a telephone interview on 01/23/25 at 10:32 A.M., the Administrator said the maintenance director was responsible for measuring for bed rail entrapment zones and checking all current bed rails every quarter. The maintenance director had only worked at the facility for one quarter. He did not realize there were so many bed rails in the facility, He did not realize the bed rails were not being measured for entrapment zones or no quarterly checks were being completed for all the current bed rails. 47008

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47008 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure staff responded timely to reports of pests in the building. The facility census was 48. Review of the facility's policy, Pest Control, revised May 2024, showed the following: -The facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents; -Pest control services are provided by the pest control service/vendor; -Maintenance services assist, when appropriate and necessary, in providing pest control services. Review of the facility's policy, Sanitation, revised November 2024, showed all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. 1. Review of the pest control company's service summary report, dated 12/31/24, showed the company treated the exterior of the facility for rodents and ants. Observation on 1/13/25 at 2:30 P.M. showed a light brown insect crawled along the wall by the heated carts, located in the kitchen near the dishwashing area. The insect crawled around the wall into the dishwashing room and went through a gap between the wall and the metal backsplash in the dishwashing area. Three light brown insects crawled on the floor in the dishwashing area near and under the trash can on the dirty side of the dishwashing room. A light brown insect crawled on the floor under the clean side of the dishwashing room under the dishwashing area. Observation on 1/13/25 at 3:41 P.M., showed a light brown insect crawled on the floor in the kitchen by the convection ovens and deep fat fryer. During interview on 1/13/25 at 3:56 P.M. and 1/15/25 at 10:50 A.M., the Dietary Supervisor said a pest control company came to the facility to spray for insects when needed. The pest control company last sprayed at the facility a month or month and a half ago. Staff reported on 1/11/25 they saw a roach in the service hallway where they received deliveries. He didn't think about it since it wasn't located in the kitchen. He called the pest control company on 1/13/25 and was told there was an issue with payment. On 1/15/25, he talked to the Maintenance Supervisor, who said the billing issue had been resolved, so he called the pest control company again this morning and they responded. Observation on 1/14/25 at 10:38 A.M., showed technicians from the pest control company placed insect bait in the dining room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/15/25 at 10:38 A.M., the pest control technician said the insects in the kitchen were roaches. The pest control company came to the facility on ce a month. They conducted an inspection and sprayed/baited inside one month and then treated the exterior of the facility the next month. If the facility sees insects, they are to contact the pest control company. He/She received a call this morning to go to the facility to spray. Health care facilities were a priority, so they get to the facilities as soon as they receive a report of pests. The facility had an ongoing issue with roaches, however, the volume had been down. During an interview on 1/13/25 at 3:52 P.M., the Administrator said the pest control company came to the facility monthly. They haven't needed the pest control company to come since their last visit. If staff see insects, they are supposed to report them to him or to their supervisor. The Dietary Supervisor just told him about the insects in the kitchen. He was not aware of any current issues with insects in the kitchen until now.