STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265354	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryville Living Center	524 North Laura Maryville, MO 64468

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46987 Based on observation, interview, and record review the facility failed to respect resident rights of six residents out of the 15 sampled residents, when the facility failed to provide grooming for three residents (#312, #36, #44) and failed to respect the privacy of three residents (#25, #40, #43). The facility census was 59. Facility did not provide a dignity policy. Review of facility policy, shaving the resident, undated, showed: To remove facial hair and improve the resident's appearance and morale. Review of facility policy, resident rights, undated, showed: -Residents will be provided the highest level of care and service; -Each resident shall be treated with consideration, respect a full recognition of his/her dignity, and individuality. -Right to dignified existence 1. Review of Resident #312's Admission face sheet showed: Resident was admitted on [DATE] -Bipolar disorder (mental health disorder that alternates between depression and mania); -Macular degeneration (progressive loss of vision); -Hypertension; -Irritable bowel syndrome with diarrhea; and -Urinary incontinence. Cognition intact, can make all needs known. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/9/24 at 2:53 P.M., the resident said: -That recently he/she had to wait longer than 30 minutes for assistance in the bathroom; -Resident said he/she had incontinent episode and asked for assistance from a staff member and was told somebody would get him/her help since resident was on a different hall than the staff member was assigned; -Resident stated he/she transferred self to the toilet and waited 30 minutes for someone to bring him/her an incontinent brief; -Resident stated he/she felt embarrassed about requiring help and that their care was unimportant to the staff; -Resident stated when help was provided, the staff member did not speak to him/her during cares. During an interview on 6/11/24 at 8:15 A.M.; Nursing Assistant (NA B) said: If a resident asked him/her for aid from another hall and he/she was short of staff he/she would help if possible, contact staff for help, explain any delays to the resident, and do everything he/she could do to help. During an interview on 6/11/24 at 8:25 A.M.; ADON said: If a resident asked her for aid from another hall and she was short of staff she would make sure her hall was safe and help the resident, otherwise she would page someone for help on the staff. During an interview on 6/12/24 at 2:34 P.M.; the Administrator said: She would not expect a staff member to say to a resident that they are not on their assigned hall and could not help them. During an interview on 6/12/24 at 2:34 P.M.; the DON said: She would not expect a resident to wait for 30 minutes for transfer help to the bathroom and hygiene aid. 47195 2. Review of Resident #36's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 5/24/24, showed: -He/She was severely cognitively impaired; -He/She had no physical, verbal, or other behavioral symptoms; -He/She did not exhibit wandering behavior; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was dependent for personal hygiene; -He/She required partial to moderate assistance with bathing; -He/She had no documented preference for customary routines or activities; -Diagnoses included dementia (condition characterized by impairment of at least two brain functions such as memory loss and judgement), bipolar disorder (condition characterized with episodes of mood swings ranging from depressive lows to manic highs), insomnia (problems falling and staying asleep), Alzheimer's disease with late onset (type of dementia that affects memory, thinking, and behavior), psychotic disorder (a condition characterized by a disconnection from reality). Review of care plan, dated 5/28/24, showed: -Resident is limited in ability to dress/undress due to needing assist with activities of daily living (ADL's). Needs limited to partial assist with ADL's. Resident is expected to have decline in all ADL's as dementia progresses; -Do not rush resident. Allow extra time to complete the ADL's; -Allow resident to do as much of ADL's as possible; -Assist with personal cares when resident has been incontinent of bowel and bladder. Observation on 6/10/24 at 8:43 A.M. showed resident was observed facial hair on chin, quarter of inch in length. Review of shower logs from 4/16/24 to 6/11/24 showed: -Resident was provided shaving 4 out of 11 shower opportunities. -4/16/24 shaving was not offered; -4/23/24 shaving provided; -4/26/24 his/her chin was shaved; -4/30/24 his/her chin was shaved; -5/3/24 shaving was not offered; -5/10/24 shaving was not offered; -5/14/24 shaving was not offered; -5/17/24 shaving was not needed; -5/21/24 shaving was not offered; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/24/24 shaving was not offered; -5/29/24 shaving provided. 3. Review of Resident #44's MDS, dated [DATE], showed: -He/She was severely cognitively impaired; -He/She was dependent on a walker; -He/She was independent with eating, oral hygiene, toileting, dressing, and mobility; -He/She required partial moderate assistance with bathing; -He/She had highly impaired vision; -No preferences for customary routines and activities documented; -He/She was independent with personal hygiene; -He/She had clear speech, was able to make self understood and understand others; -He/She required partial to moderate assistance with bathing; -Diagnoses included dementia, anxiety, osteoarthritis (a degenerative disease that worsens over time), osteoporosis (condition in which the bones become weak and brittle), macular degeneration (eye disease that causes vision loss), hearing loss, urinary tract infection Review of care plan, dated 6/4/24, showed: -He/She was at risk for deterioration in self care due to disease processes including osteoarthritis and dementia; -Do not rush resident. Allow extra time to complete ADL's. Encourage independence or set up and cueing to complete ADL's; -Resident had impaired vision related to macular degeneration. Observation on 6/09/24 at 10:15 A.M. showed resident had quarter inch facial hair on chin. During an interview on 6/9/24 at 10:15 A.M., resident said: -The facial hair bothered him/her; -He/She used to try to pull it themselves but now cannot see; -He/She would like his/her chin shaved by staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/12/24 at 8:03 A.M. showed resident still had facial hair growth of quarter inch and had not been shaved. Review of shower log from 3/11/24 to 6/11/24 showed: -Shaving was offered 8 of 18 opportunities; -3/1/24 shaving provided; -3/5/24 shaving not offered; -3/23/24 shaving not offered; -3/26/24, shaving not offered; -3/29/24, shaving of chin was offered; -4/2/24, shaving not offered; -4/5/24, shaving not offered; -4/9/24, shaving offered but refused; -4/12/24, shaving offered; -4/16/24, no shaving offered; -4/26/24, chin was shaved; -4/30/24, chin was shaved; -5/3/24, no shaving offered; -5/10/24 no shaving offered; -5/14/24, no shaving offered; -5/17/24, no shaving offered; -5/21/24, chin was shaved; -5/29/24, chin was shaved. During an interview on 6/12/24, at 2:34 P.M., Assistant Director of Nursing said: -He/She expected residents to be shaved and maintained regularly; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents who were not alert and orientated he/she would expect resident to also be shaved and maintained. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing said: -He/She expected all residents to be shaved and maintained. 31102 4. Review of Resident #25's Quarterly MDS, dated [DATE] showed: - Cognitive skills intact; - Independent with eating and transfers; - Diagnoses included diabetes mellitus and dementia; - Had seven insulin injections in the last seven days. Review of the resident's physician order sheet (POS) showed: - Start date: 12/3/19 - Accucheck (a glucose monitoring machine that tests the blood sugar level of residents which may determine a dose of insulin). Observation on 6/11/24 at 6:55 A.M., showed: - The Director of Nursing (DON) obtained the resident's blood sugar in the hallway. During an interview on 6/12/24 at 2:34 P.M., the Assistant Director of Nursing (ADON) said blood sugars should not be obtained in the hallways. 5. Review of Resident # 40's Significant change in status MDS, dated [DATE], showed: - Cognitive skills intact; - Required partial to moderate assistance with toilet use; - Always incontinent of bowel and bladder; - Diagnoses included cirrhosis (a condition in which the liver is scarred and permanently damaged) and anxiety. Review of the resident's care plan, revised 4/23/24 showed: - The resident experiences bowel and bladder incontinence. Declines to use the bedpan, bathroom or commode. Requests brief changes as needed; - Encourage to use bedpan instead of being incontinent in brief; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Provide incontinence care after each incontinent episode. Encourage the resident to do as much hygiene care as possible. Observation on 6/10/24 at 8:38 A.M., showed: - A sign on the bathroom door in a clear plastic sleeve describing how peri care was to be completed for the resident and included the resident's name; - The sign was in plain view of any staff, visitor or family member who entered the resident's room. 6. Review of Resident #43's Quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI), Review of the resident's care plan, revised 5/1/24 showed: - The resident had a deep tissue pressure injury to the left heel; - Heel protectors when in bed and chair. Use offloading shoe with any weight bearing on left foot; - The resident had an indwelling supra pubic urinary catheter related to obstructive uropathy. Monitor placement of the catheter tubing. Avoid obstructions in the tubing. Observation on 6/9/24 at 10:52 A.M., showed: - A sign on bright yellow paper above the resident's recliner said, Heel protectors on at all times; - A sign on blue paper above that said, 2/14/24 until further notice please only use overnight bag - no more leg bag! Thanks! (leg bag- a small drainage bag attached tot he catheter and secured to either thigh to collect urine); - A sign on green paper above the resident's bed said, Top of head board must be level with green tape on wall when resident is in bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said;- Should not have signs visible that discuss the resident's care. During an interview on 6/12/24 at 10:32 A.M., Certified Nurse Aide (CNA) B said: - The signs should be in a closet and not out in the open. During an interview on 6/12/24 at 2:34 P. M., the DON and the ADON said the signs in the resident's rooms should not be visible to other residents or family members; - The Administrator said Resident #40 has a sign but it is at his/her request and the resident will not allow it be placed anywhere else. 50980

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on interview and record review, the facility failed to ensure that residents were offered a choice of when they would like to get up in the morning. This affected two of the 15 sampled residents (Residents #30, and #43). The facility census was 59. Review of the facility's Resident Rights Policy, dated 6/12/24 showed in part: -Each resident shall be treated with consideration, respect, and full recognition of his/her individuality; -Each resident shall not have the right to self determination which includes the right to a choice of schedules and accommodations for preferences. 1. Review of Resident #30's Quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 4/13/24 showed: -Moderate cognitive impairment; -Partial assistance with showers and personal hygiene; -Substantial assistance with dressing and transfers; -Dependent on staff for bed mobility; -Diagnosis included traumatic brain injury (TBI, injury to the brain from a violent blow or jolt to the head), dementia and asthma. Review of the Resident's care plan, revised 4/16/24 showed: - The resident requires the assistance of two staff for transfers; - The resident's wishes will be honored; - The care plan did not address what time the resident would want up in the morning. Observation and interview on 6/11/24 at 05:20 A.M., showed: - The resident was sitting in his/her wheel chair at the nurse's station; - The resident was dressed; - The resident said he/she was waiting for someone to take him/her to his/room because he/she wanted to lay down; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident yelled is anyone going to come get me; - No staff came to get to take take the resident back to his/her room; - No staff responded to the resident's yelling. Observation on 6/11/24 from 07:43 A.M., to 8:10 A.M., showed: - The resident setting in the dining room eating breakfast; - The resident was still setting in his/her wheelchair. Observation and interview on 6/11/24 at 08:12 A. AM., showed: -The resident was setting in his/her wheel chair in his/her room; -The resident said he/she wanted to lay down right now; - The resident said he/she did not like to get up early in the morning; - The resident said the staff make him/her get when he does not want to get up; - The MDS coordinator and the Director of Nursing (DON) transferred the resident to bed. During an interview on 06/12/24 08:46 A.M., Certified Nurses Aide (CNA) C said: -He/she did not know what the resident preferred when getting up in the morning; -The resident is already up when he/she arrives to work at 6:00 A.M.; - Resident's should have the right to choose what time they get up in the morning; - He/she had not laid the resident down yet because he/she was a two person assist and he/she was waiting for help; - He/she said there are so many two person assists on this hall and it is hard to get someone to help you transfer people - Resident's should have the right to choose what time they get up in the morning and when they want to lay back down. During an interview on 06/12/24 at 09:07 A.M., the Assistant Director of Nursing (ADON) said: -The resident gets up when they want to; -The resident was up at 5:15 A.M. this morning because he/she was yelling that he/she wanted to get up; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident is at risk for pressure injury and should have been laid repositioned or laid back down within two hours; -The resident should be allowed to get up and lay back down when he/she wants to; - It is their choice. During an interview on 06/12/24 at 09:10 A.M., the Director of Nursing (DON) said: -The resident should not have to get up if they do not want to; -The resident should get to choose the time of day they get up and the time of day they go to bed; -The resident has a history of pressure ulcers and should be repositioned at least ever two hours; -He/she would expect the staff to honor the resident's wishes. 31102 2. Review of Resident #43's Quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI), Review of the resident's care plan, revised 5/1/24 showed: - The resident had a deep tissue pressure injury to the left heel; - Heel protectors when in bed and chair. Use offloading shoe with any weight bearing on left foot; - The resident had an indwelling supra pubic urinary catheter related to obstructive uropathy. Monitor placement of the catheter tubing. Avoid obstructions in the tubing; - The resident has been deemed incapacitated (lacks the physical or mental abilities to manage his/her own personal care, property or finances) to make his/her own decisions. The resident's Durable Power of Attorney (DPOA, a legal document that gives someone the authority to make decisions for you if you are incapacitated). All decisions, questions, updates should be made through the DPOA; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The care plan did not address what time the resident would want up in the morning or what time he/she wanted to go to bed at night. Observation and interview on 6/11/24 at 5:15 A.M., showed: - The resident was dressed for the day and was sitting in his/her wheelchair at the nurse's station. The resident had heel protectors on both feet and his/her wound vac (a medical device that uses negative pressure to help wounds heal) in place and the drainage bag (a container that collects urine from the he body by attaching to a catheter inside the body) under the wheelchair in a dignity bag; - The Assistant Director of Nursing (ADON) said the staff start getting the residents who want to get up at 4:45 A.M. Observation on 6/11/24 at 9:50 A.M., showed: - After the resident finished breakfast the staff returned the resident to his/her room; - The staff used the sit to stand lift (a lift that allows a resident who can bear weight to transfer from a sitting position to a standing position) and transferred the resident from his/her wheelchair to the bed. During an interview on 6/11/24 at 3:38 P.M., the MDS/Care Plan Coordinator said: - The staff generally ask the resident on admission what time they want to get up in the morning; - Some of the residents do not have a preference; - Some residents will verbally tell the staff what time they want to get up in the morning; - It is not care planned what time the residents want to get up in the morning, but it should be care planned; - If the resident is incapacitated, he/she did not have a good answer as to when the staff should get the resident up. The staff could ask the responsible party or family member what time the resident would like to get up in the morning. During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said: - It should be care planned on what time to get the resident up or put them to bed at night; - If it was not care planned, they should ask the resident; - If the resident was incapacitated, the staff try to get the residents up by 7:00 A.M., for breakfast. During an interview on 6/12/24 at 12:39 P.M., Family Member A said: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No one had asked him/her what time the resident would like to get up in the morning or what time the resident would like to go to bed at night; - He/she thought the staff should get the resident up around 6:00 A.M., or 6:30 A.M.; - He/she thought it was too long for the resident to have already been up and dressed 5:15 A.M., and not laid down until almost 10:00 A.M., especially since the resident had a pressure ulcer. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said: - It should be the resident's preference on what time they want to get up in the morning; - If the resident was incapacitated, should ask the DPOA; - The Social Services Designee completes an assessment so it should be care planned. During an interview on 6/12/24 at 2:34 P.M., the Administrator said: - If it is out of the norm, then it should be care planned.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47195 Based on interviews and record review, the facility failed to consider the views of resident council and act promptly upon grievances and recommendations made by the group concerning issues of resident care and life in the facility when the facility failed to demonstrate their response and rationale for such responses when they did not maintain documentation of resident concerns, facility's attempt to resolve concerns, or the facility's follow up actions. This affected all the residents serving on the resident counsel and potentially other residents of the facility. The facility census was 59. Review of facility policy, resident rights, undated, showed: -Each resident shall be encouraged and assisted throughout his/her stay to exercise their rights as Resident and citizen, and may voice grievances and recommend changes in policies and services to facility staff or outside representatives of his/her choice. A staff person shall designated to receive grievances and Residents may voice their complaints and recommendations to staff designee, an ombudsman, or any person outside facility. Residents shall be informed of and provided a viable format for recommending changes in policy and services. Facility shall also assist residents in exercising their rights to vote. Review of nursing home residents' rights showed: -Present grievances without discrimination or retaliation, or the fear of it; -Prompt efforts by the facility to resolve grievances, and provide a written decision upon request. -To file a complaint with the long-term care ombudsman program or the state survey agency. 1. During a group interview on 6/10/24 at 9:25 A.M., four of four residents stated: -They did not know how to complete a grievance; -Did not have access to grievance forms -Did not know who the grievance officer was in the facility; -Did not know where they would submit a grievance form to; -They had concerns regarding showers not being given; -That the meat is tough to eat; -The food is cold; -They often have to wait for call light to be answered resulting in incontinence which made them feel humliated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident council minutes, dated April 2024-June 2024, showed: -On 4/16/24: Old Business showed: chunky cream of wheat, clothing protectors, wash clothes, resident appearance. New business showed: Residents voiced concerns regarding cold food, chunky cream of wheat, meat being too tough, trash not being taken out, meal trays not being picked up, and lack of space in the dining room. -No documentation on how or if concerns were addressed; -On 5/7/24: Old business showed no resolution documented on concerns addressed at April resident council meeting. New Business showed: Meat was too tough, menus were not posted daily, food was cold, meal tickets were not followed, not supplying trash bags in trash cans in resident rooms, tables being too close together in dining room, ice not being passed, call lights, baths, and no velcro closures on clothing protectors. -No documentation on how or if concerns were addressed; -On 6/6/24: Old business showed: no resolution regarding food temperatures still being cold, meat being tough, call lights not being answered, and length of time between baths. New business showed: Call lights, too long between baths, and ice pitchers not being filled. -No documentation on how or if concerns were addressed; During an interview on 6/11/24 at 3:54 P.M., the Social Services Designee said: - When a resident voiced a grievance and wanted to fill out a grievance, they could do so; - The grievances were located by the front door; - If a resident verbally voiced a concern, he/she would ask the resident if they wanted a grievance filled out and if they did, he/she would fill it out for them; - Once a grievance was filled out, he/she would give it to the department head which the the concern related to; - The Administrator goes over the grievances in the morning meeting; - The policy and goal is to have the issue resolved within five days and the resident is happy with the results; - The department head would discuss it with the resident and would follow up with them to let them know if it had been resolved. He/she would follow up with the resident in two weeks to see if there were any other issues; - He/she would document it in the referral log; - The department head and the Administrator sign the grievance. The resident does not sign the grievance; (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a family member had a grievance, they would follow up with the family member. The family member would not sign the grievance; - He/she did not think they go over grievances in the resident council; - He/she goes over the grievances at the time of admission. During an interview on 6/12/24 at 10:09 A.M., Certified Nurse Aide C said: -He/She did not know what the facility grievance process was; -If a resident had a grievance he/she would tell one of the nurses or go to Administrator, Director of Nursing, or Assistant Director of Nursing. During an interview on 6/12/24 at 2:34 P.M., the Administrator said: - The grievance forms are in the hallway by the front door if a family member or a resident wanted to make an anonymous complaint; - It's on the bottom of the form for follow - up. The resident nor the family member sign the grievance form that they are satisfied with the resolution; - Social Services monitors it and follows up with the family in 30 days. -Grievances should not be gone over at resident council. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said: - The Grievances should be discussed at the resident council meetings as a topic to be covered.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation the facility failed to protect the resident's right to personal privacy when a nurse left the medication cart computer screen unattended, unlocked, and visible with resident personal information accessible to anyone near the computer screen. The facility census was 59. Review of facility policy, electronic medical records, undated, showed: -Only authorized persons who have been issued a password and a user identification (ID) code will be permitted access to the electronic medical records system. -The facility electronic medical records system has: -safeguards to prevent unauthorized access; -individual password and user ID codes and permission is established to ensure only authorized persons enter appropriate data; -will not permit a change on the record once it had been locked without the approval of the person that completed the assessment. Review of facility policy, resident rights, undated, showed: -All information contained in resident's medical, personal, or financial record and information concerning source of payment shall be held confidential. Review of patient bill of rights, dated 6/12/24, showed: -All information related to medical, personal, social, or financial affairs shall be kept confidential and privileged information. Observation on 6/11/24 at 6:18 P.M. showed Licensed Practical Nurse (LPN) C left the computer screen on the medication cart open to resident confidential information when he/she left the medication cart unattended from 6:18 A.M. to 6:20 A.M. Observation on 6/11/24 at 6:23 A.M. showed LPN C left the computer screen on the medication cart opened, unlocked, and visible to resident confidential information when he/she left the medication cart and entered room [ROOM NUMBER] from 6:23 A.M. to 6:28 A.M. Observation on 6/11/24 at 6:31 A.M. showed the computer screen on the medication cart was left open and visible to resident confidential information from 6:31 A.M. to 6:35 A.M. Observation on 6/11/24 at 6:37 A.M. showed LPN C entered room [ROOM NUMBER] and left computer screen open and visible to resident confidential information from 6:37 A.M. to 6:39 A.M. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/11/24 at 6:43 A.M. showed LPN C left medication cart computer screen open with resident confidential information visible when he/she left medication cart and entered dining room. Computer screen was unattended and visible from 6:43 A.M. until 6:46 A.M. Observation on 6/11/24 at 6:50 A.M. showed computer screen was left open and visible to resident specific information when LPN C left medication cart to enter the dining room. Medication cart was located in the dinette in the middle of the hall and LPN C entered dining room at the other end of the hall. The computer screen was left unattended and visible until 6:53 A.M. During an interview on 6/11/24 at 9:31 A.M., LPN C said: -He/She should put computer screen down or lock the screen when he/she left the medication cart to protect residents privacy. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) said: -He/She expected the computer screen to be locked and not visible when staff left the medication cart unattended. During an interview on 6/12/24 at 2:34 P.M., the Assistant DON said: -He/She expected the lock screen to be used or the computer screen to be shut when medication cart was left unattended during medication passes.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47195 Based on observations, interviews, and record review, the facility failed to inform residents how to file a grievance or complaint, take prompt efforts to resolve resident grievances voiced in resident council meetings when the same problems were voiced multiple months with no resolutions and failed to follow up with one resident's family member (Resident #43) with resolution regarding a grievance made to the facility. The facility census was 59. Review of nursing home resident right's, undated, showed: -Right to raise grievances: -Present grievances without discrimination or retaliation, or fear of it; -Prompt efforts by the facility to resolve grievances, and provide a written decision upon request. Review of facility policy, resident grievances, undated, showed: -Resident has the right to exercise his or her rights as a resident of the facility; -A complaint must be in writing and contain the name and address of the person filing it; -The grievance coordinator (or designee) shall conduct an investigation of the complaint to determine its validity; -The grievance coordinator will issue a written decision on the grievance no later than 30 days after its filing; -The grievance may appeal the decision of the grievance coordinator by filing an appeal in writing to the administrator within 15 days of receiving the grievance coordinator's decision; -The administrator shall issue a written decision in response to the appeal no later than 30 days after its filing; 1. During a group interview on 6/10/24 at 9:25 A.M., four of four residents stated: -They did not know how to complete a grievance; -Did not have access to grievance forms; -Did not know who the grievance officer was in the facility; -Did not know where they would submit a grievance form; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Concerns regarding showers not being given; -Meat was tough to eat; -Food was cold; -Having to wait for call light to be answered resulting in incontinence which made them feel humiliated. Review of resident council minutes, dated April 2024-June 2024, showed: -On 4/16/24: Old Business showed: chunky cream of wheat, clothing protectors, wash clothes, resident appearance. New business showed: Residents voiced concerns regarding cold food, chunky cream of wheat, meat being too tough, trash not being taken out, meal trays not being picked up, and space in dining room. -On 5/7/24: Old business showed no resolution documented on concerns addressed at April resident council meeting. New Business showed: Meat was too tough, menus were not posted daily, food was cold, meal tickets were not followed, not supplying trash bags in trash cans, tables being too close together in dining room, ice not being passed, call lights, baths, and no velcros on clothing protectors. -On 6/6/24: Old business showed: no resolution to food temperatures still being cold, meat being tough, call lights not being answered, and time between baths. New business showed: Call lights, too long between baths, and ice pitchers not being passed. -No educated provided on grievance process at resident council meetings. During an interview on 6/11/24 at 3:54 P.M., Social Service Designee said: -He/She did not think they went over grievances in resident council; -Residents are told at admission about the grievances. During an interview on 6/12/24 at 10:09 A.M., Certified Nurse Aide C said: -He/She did not know what facility grievance process was; -If resident had a grievance he/she would tell one of the nurses or go to Administrator, Director of Nursing, or Assistant Director of Nursing. 31102 2. Review of Resident #43's concern/grievance report, dated 2/16/24 showed: - The resident's spouse and daughter initiated the complaint; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI), Review of the resident's care plan, revised 5/1/24 showed: - The resident had a deep tissue pressure injury to the left heel; - Heel protectors when in bed and chair. Use offloading shoe with any weight bearing on left foot; - The resident had an indwelling supra pubic urinary catheter related to obstructive uropathy. Monitor placement of the catheter tubing. Avoid obstructions in the tubing. 3. During an interview on 6/10/24 at 4:09 P.M., Family Member B said: - He/she has filled out grievances before and no one has followed up with him/her on them; - He/she has not filed one in quite some time because it does not do any good, there's no follow - up and nothing gets done. 4. During an interview on 6/11/24 at 3:54 P.M., the Social Services Designee said: - When a resident voiced a grievance and wanted to fill out a grievance, they could do so; - The grievances were located by the front door; - If a resident verbally voiced a concern, he/she would ask the resident if they wanted a grievance filled out and if they did, he/she would fill it out for them; - Once a grievance was filled out, he/she would give it to the department head which the the concern related to; - The Administrator goes over the grievances in the morning meeting; - The policy and goal is to have the issue resolved within five days and the resident is happy with the results; - The department head would discuss it with the resident and would follow up with them to let them know if it had been resolved. He/she would follow up with the resident in two weeks to see if there were any other issues; - He/she would document it in the referral log; - The department head and the Administrator sign the grievance. The resident does not sign the grievance; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a family member had a grievance, they would follow up with the family member. The family member would not sign the grievance; - He/she did not think they go over grievances in the resident council; - He/she goes over the grievances at the time of admission. During an interview on 6/12/24 at 2:34 P.M., the Administrator said: - The grievance forms are in the hallway by the front door if a family member or a resident wanted to make an anonymous complaint; - It's on the bottom of the form for follow - up. The resident nor the family member sign the grievance form that they are satisfied with the resolution; - Social Services monitors it and follows up with the family in 30 days. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said: - The Grievances should be discussed at the resident council meetings as a topic to be covered.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview, and record review, the facility failed to develop individualized person centered comprehensive care plans for two residents (Resident #15 and #44) to address dehydration and falls (resident #15) and code status (Resident #44). The facility census was 59. Review of facility policy, care plan comprehensive, undated, showed: -An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. -Assessment of each resident is ongoing process and the care plan will be revised as changes occur in the resident's condition. 1. Review of Resident #15's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/22/24, showed: -He/She was severely cognitively impaired; -He/She was dependent on a walker for mobility; -He/She had fall history prior to admission, but no falls the last 2-6 months; -He/She required substantial or maximal assistance with dressing , bathing, personal hygiene, toileting, chair to bed transfers, sit to stand transfers, and toilet transfers; -He/She had problem conditions of dehydration; -Diagnoses included high blood pressure, dementia (a condition characterized by impairment of at least two brain functions such as memory loss and judgement), stroke, personal history of urinary tract infections, spondylosis (arthritis of the spine), and syncope and collapse (fainting or passing out). Review of MDS record showed: -Entry tracking record showed on 1/8/24 entered from home/community; -discharged [DATE] for short term general hospital; -Re-entered facility on 3/15/24 from short term general hospital stay; -discharged [DATE] for short term general hospital stay; -Re-entered facility 4/18/24 from short-term general hospital stay. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care plan, dated 4/29/24, showed: -He/She had nothing regarding falls in care plan; -He/She had nothing regarding dehydration and hospitalization . -Encourage resident to drink fluids and have a snack during activities. -He/She had a history of stroke and history of pulmonary hypertension. Review of electronic medical record showed: -4/14/24 at 5:50 A.M., Registered Nurse (RN) C wrote resident was sitting on the bathroom floor by the toilet when he/she entered the room. Resident stated he/she became unsteady while and sat down. He/She denied hitting head. He/She denied complaints of pain or discomfort but stated he/she felt weak. -4/14/24 at 2:19 P.M., Licensed Practical Nurse (LPN) D wrote the resident finished antibiotic therapy for urinary tract infection today. At approximately 9:00 A.M., he/she walked the resident's room and found the door shut. He/She heard a knocking sound coming from the resident's room. He/She was unable to open the door and observed the resident's foot when able to slightly open. He/She helped the residnet to his/her feet and the resident walked from the bathroom. -4/15/24 11:01 A.M., Assistant Director of Nursing (ADON) wrote resident was transferred to the hospital. ADON was called to the resident for a condition change. The resident was taken to the shower room for his/her shower, after entering the shower room the resident became unresponsive momentarily, unable to respond to verbal stimuli or hold his/her head up. -4/15/24 2:26 P.M., MDS Coordinator wrote the resident was admitted to the hospital for acute kidney injury and dehydration. -4/19/2024 12:02 P.M., Social Service Director/Activities Director wrote resident with fall on 4/14/24. The resident was observed sitting on the bathroom floor when staff entered room. Resident stated he/she became unsteady on his/her feet and sat down. -4/25/2024 2:08 PM, LPN C wrote resident was sitting on the floor by his/her wheelchair, stated he/she just slid to floor on bottom, didn't hurt self, did not hit head. During an interview on 6/12/24 at 12:05 P.M., MDS Coordinator said: -He/She expected falls to be care planned; -He/She expected a resident who had been hospitalized for dehydration to have it care planned. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing (DON) said: -He/She expected resident with history of falls to have it care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected resident hospitalized for dehydration to have it care planned and interventions in place. During an interview on 6/12/24 at 2:34 P.M., Assistant DON said: -He/She expected resident with history of falls to have it care planned. -He/She expected resident hospitalized for dehydration to have it care planned and interventions in place. 2. Review of Resident #44's annual MDS, dated [DATE], showed: -He/She was severely cognitively impaired with a BIMS score of 3; -He/She was dependent on a walker; -He/She was independent with eating, oral hygiene, toileting, dressing, and mobility; -He/She required partial moderate assistance with bathing; -No preferences for customary routines and activities documented; -Diagnoses included dementia (loss of memory, language, problem-solving and other thinking abilities to interfere with daily life), anxiety, osteoarthritis (a degenerative disease that worsens over time), osteoporosis (condition in which the bones become weak and brittle), macular degeneration (eye disease that causes vision loss), hearing loss, urinary tract infection Review of physician's orders, dated 6/10/24, showed: -He/She had do not resuscitate orders (DNR). Review of electronic medical record, showed: -DNR was signed 8/23/22. Review of care plan, dated 6/4/24, showed: -Care plan did not address code status. During an interview on 6/12/24 at 12:05 P.M., MDS Coordinator said: -Care plans should be updated daily with any changes; -He/She reviewed care plans quarterly and with any significant changes; -He/She expected code status to be care planned. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing (DON) said: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected code status to be care planned; During an interview on 6/12/24 at 2:34 P.M., Assistant DON said: -He/She expected code status to be care planned;

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 31102 Based on observations, interviews and record review, the facility failed to ensure staff followed professional standards when staff failed to administer medications within the appropriate time frame, which affected three of the 15 sampled residents, (Resident #21, #28 and #29). The facility census was 59. Review of the facility's undated policy for the medication administration guidelines showed: - It is the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose tot he proper resident, and promptly recording the information; - Medications may not be prepared in advance and must be administered within one hour of preparation. 1. Review of Resident #28's physician order sheet (POS), dated June 2024 showed:- Start date: 3/3/23 - Levothyroxine 50 micrograms (mcg.) daily at 5:00 A.M. for hypothyroidism (condition that occurs when the thyroid gland doesn't not produce enough thyroid hormones to meet the body's needs). Review of the resident's medication administration record (MAR), dated June 2024 showed: - Levothyroxine 50 mcg. daily at 5:00 A.M. for hypothyroidism; - Documented as late administration at 7:33 A.M. Observation and interview on 6/11/24 at 7:00 A.M., showed: - The Levothyroxine was due at 5:00 A.M.; - The Director of Nursing (DON) was passing the medication and went to the resident's room and staff were cleaning the resident and the DON said she would be back; - At 7:32 A.M., the DON administered the medication to the resident in the dining room. 2. Review of Resident #21's POS, dated June 2024 showed: - Start date: 2/1/24 - Levothyroxine 25 mcg. daily at 5:00 A.M. for hypothyroidism; - Start date: 5/10/24 - Ropinole 0.5 milligrams (mg.) three times daily before meals (5:30 A.M., 11:00 A.M., and 4:00 P.M. for Parkinson's disease (a brain disorder that causes unintended or un controllable movements, such as shaking, stiffness, and difficulty with balance and coordination); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Start date: 6/3/24 - Entacapone 200 mg. before meals at 5:00 A.M., 11:30 A.M., and 4:30 P.M. for Parkinson's disease. Review of the resident's MAR, dated June 2024 showed: - Entacapone 200 mg. before meals at 5:00 A.M., 11:30 A.M., and 4:30 P.M. for Parkinson's disease; - Levothyroxine 25 mcg. daily at 5:00 A.M. for hypothyroidism; - Ropinole 0.5 mg. three times daily before meals 5:30 A.M., 11:00 A.M., and 4:00 P.M. for Parkinson's disease; - Documented as late administration at 7:45 A.M. Observation and interview on 6/11/24 at 7:35 A.M., showed: - The DON administered the medications to the resident; - The DON said the medications are late, they are the early morning medications; - The medications were due at 5:00 A.M. 3. Review of Resident #29's POS, dated June 2024 showed: - Start date: 2/22/23 - Gabapentin capsule 300 mg. four times a day at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. for postherpetic polyneuropathy (a chronic pain syndrome that can occur after a shingles outbreak and is caused by damage to nerve fibers). Review of the resident's MAR, dated June 2024 showed: - Gabapentin capsule 300 mg. four times a day at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. for postherpetic polyneuropathy; - Documented as late administration at 7:47 A.M. Observation on 6/11/24 at 7:45 A.M., showed: - The DON administered the medication at 7:47 A.M. During an interview on 6/12/24 at 2:34 P.M., the DON said medications should be passed one hour before or an hour after they were due.

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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** 46706 Based on observation, interview, and record review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADL) received the necessary assistance with bathing, incontinent care. This affected four out of the 17 sampled residents, when the facility staff failed to ensure two residents (Resident #4 and #43) received regular showers, failed to provide complete incontinence care for two residents (Resident #33 and #40) The facility census was 59. Review of the facility's undated Perineal Care policy showed: -Wash hands and apply clean gloves; -Using a clean wipe separate and cleanse all skin folds that have came in contact with urine or feces; -Wash from front to back. Review of the facilty's undated Resident Rights policy showed; -Residents have the right to dignified existence; -Residents have the right to be treated with consideration, respect and dignity, recognizing each residents individuality; -Residents have the right to a quality of life that is maintained or improved. The facility did not provide the requested policy on showers. 1. Review of Resident #4's Quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 5/16/24 showed: -No cognitive impairment; -Partial assistance with showers and personal hygiene; -Partial assistance with lower body dressing; -Dependent on staff for toileting; -Dependent on staff for bed mobility; -Diagnosis included heart failure, high blood pressure, diabetes (disease that results in too much sugar in the blood) and renal insufficiency (poor kidney function). Review of the resident's care plan, revised 5/30/24 showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Limited in the ability to completed ADL's due to weakness; - Has the potential for skin conditions including reddened buttocks, yeast infections of the skin folds and redness to abdominal redness related to obesity. Observation on 6/10/14 at 2:48 P.M. showed: -The resident was setting in his/her room in a wheel chair; -The resident was wearing a purple dress; -The resident's hair was greasy and uncombed. Observation and interview on 6/11/24 at 2:16 P.M. showed: -The resident was setting in his/her room in a wheel chair; -The resident was wearing the same purple dress he/she was wearing yesterday; -The resident's hair was greasy and uncombed; -The resident said he/she does not receive showers on a regularly basis; -The resident said it has been over a week since he/she received a shower and had his/her hair washed; -The resident said it makes him/her feel dirty and uncomfortable when he/she does not receive regularly showers. Review of the resident's shower sheets showed the resident received a shower on the following dates: - April 2024 - 4/16; - May 2024 - 5/8 and 5/21; - June 2024 - 6/11; - No other shower sheets were provided. During an interview on 6/12/24 at 08:46 A.M., Certified Nurses Aide (CNA) C said: -He/she is not sure if their is a dedicated shower aide or not; -Usually one CNA is assigned to each hall and the a nurse is our second person assigned to help with care on the hall; -The the nurses are busy passing pills and doing nursing duties and it's hard for them to help us; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There is not enough staff to get showers done like it should be done. -The residents should have at least a shower per week. During an interview on 6/12/24 at 08:18 A.M., Registered Nurse (RN)A said: -Residents should have at least one shower per week; - Residents should not be wearing the same clothes as the day before; -Residents should be clean and hair combed. 31102 2. Review of Resident #43's Quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Frequently incontinent of bowel; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI. Review of the resident's care plan, revised 5/1/24 showed: - The resident required substantial to dependent assistance with most activities of daily living (ADL's) related to impaired mobility. Allow the resident to participate with dressing as much as possible to his/her ability; - The resident is at risk for decreased independence in bed as evidenced by poor strength and decreased ability to move self effectively. Encourage use of the the grab bar while performing care to maintain strength and encourage independent movement side to side while in bed. Review of the resident's shower sheets showed the resident received a shower on the following dates: - January 2024 - 1/24 and 1/31; - February 2024 - 2/8, 2/10, 2/16 (bed bath), 2/18 and 2/28; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- March 2024 - 3/6, 3/9, 3/13, and 3/20; - April 2024 - 4/2, 4/10, and 4/17; - May 2024 - 5/2, 5/15 and 5/27; - June 2024 - no shower sheets were provided. During an interview on 6/10/24 at 4:09 P.M., Family Member B said: - The resident gets a shower maybe once a week; - We usually ask for the resident to have a shower after it has been two weeks. During an interview on 6/11/24 at 3:09 P.M., the Assistant Director of Nursing (ADON) said: - The do not have a dedicated shower aide; - They assign showers to the aides on the halls. During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said: - On the day shift there's usually a Certified Nurse Aide (CNA) and a charge nurse on A and D hall and a shower aide floats between the two halls. During an interview on 6/12/24 at 9:15 A.M., Licensed Practical Nurse (LPN) A said: - On B hall there's usually a have a charge nurse and a CNA; - The CNA gives the residents their showers. During an interview on 6/12/24 at 10:32 A.M., CNA B said: - They do not have a designated shower aide; - They usually have one charge nurse on each hall and one CNA and the shower aide floats between the two halls. 3. Review of Resident #33's quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Dependent on staff assistance for toilet use and dressing; - Requires partial to moderate staff assistance with transfers; - Always incontinent of bowel and bladder; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included Alzheimer's disease (a type of dementia that affects memory, thinking and behaviors), urinary tract infection (UTI, an infection in any part of the urinary system) in the last 30 days and anxiety. Review of the resident's care plan, revised 6/9/24 showed: - The resident is limited in ability to dress/undress self related to being totally dependent with activities of daily living (ADL's). Provide total dependent assistance for dressing and all ADL functions; - The resident experiences bladder incontinence related to has frequent bowel/bladder incontinence related to impaired mobility and request assistance secondary to dementia. Provide the resident with assistance for toileting. Take the resident to the the bathroom before every meal, at bedtime and when awake during the night. Peri care and clothing changes as needed. Observation on 6/11/24 at 7:04 A.M., showed: - CMT A and Nurse Aide (NA) A uncovered the resident; - CMT A used the same area of the wipe and cleaned the front perineal folds and did not separate and clean all the skin folds; - CMT A and NA A turned the resident on his/her side; - CMT A wiped from front to back twice with a different wipe each time; - CMT A did not clean all areas of the skin where urine had touched. During an interview on 6/20/24 at 3:30 P.M., CMT A said: - He/she should not use the same area of the wipe to clean different areas of the skin. It should be one wipe, one swipe; - He/she should have separated and cleaned all the skin folds where urine or feces had touched. 4. Review of Resident #40's Significant Change in Status MDS, dated [DATE] showed: - Cognitive skills intact; - Required partial to moderate assistance with toilet use; - Always incontinent of bowel and bladder; - Diagnoses included cirrhosis (a condition in which the liver is scarred and permanently damaged) and anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, revised 4/23/24 showed;- The resident experiences bowel and bladder incontinence. Declines to use the bedpan, bathroom or commode. Requests brief changes as needed; - Encourage to use bedpan instead of being incontinent in brief; - Provide incontinence care after each incontinent episode. Encourage the resident to do as much hygiene care as possible. Observation on 6/11/24 at 5:42 A.M., showed: - The resident unfastened his/her incontinent brief; - LPN B used a wet wash cloth and wiped down one side of the groin, folded the wash cloth and wiped down the other side of the groin and with the same area of the wash cloth, wiped back up the groin, folded the wash cloth, wiped once down the middle and with the same area of the wash cloth, wiped across the pubic area, folded the wash cloth and with the same area of the wash cloth, wiped down one side of the groin and back up the groin; - Turned the resident on his/her side, and LPN B removed the saturated incontinent brief. He/she used a new wash cloth and with the same area of the wash cloth, wiped back and forth across both sides of the buttocks; - LPN B placed a clean incontinent brief under the resident and the resident fastened it. During an interview on 6/20/24 at 6:46 A.M., LPN B said: - He/she should wiped across the pubic area with one wash cloth, wiped down each side of the groin with a different wash cloth each time and use a new wash cloth and wipe once down the middle; - He/she should have wiped down each side of the buttocks with a different wash cloth each time and use a new wash cloth and wipe up from the rectal area; - Should not use the same area of the wipe to clean different areas of the skin; - He/she should have separated and cleaned all areas of the skin where urine or feces had touched; - Should wipe from front to back. During an interview on 6/12/24 at 2:34 P.M., the DON and ADON said: - Staff should not use the same area of the wipe or wash cloth to clean different areas of the skin; - Staff should wipe from front to back; - Staff should separate and clean all the skin folds.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observations, interviews and record review, the facility failed to identify, assess and document a pressure ulcer (an area of localized damage to skin and underlying tissue caused by pressure, shear, friction and/or a combination of these) for one of the 15 sampled residents, (Resident #43). The facility census was 59. Review of the facility's undated policy for wound care and treatment showed, in part: - The purpose of the facility is to prevent and treat all wounds; - There must be a specific order for the treatment; - Prevention strategies - On - going skin assessment with weekly documentation of status. Minimize dry skin. Apply house moisturizer to areas of dry skin, after and as needed. Avoid massage over bony prominence's. Minimize friction and sheer through proper positioning transferring and turning. Develop and implement method of communicating position changing; - Incontinence management - Minimize skin exposure to incontinence, perspiration and /or wound drainage. Use cloth clothing protector and cloth pads on the bed. Following each incontinent episode, use tissue to remove excess soiling. Clean perineal area with house peri wash. Protect perineal area with house moisturizer; - Positioning and pressure reduction - Foot cradle for pressure - reduction and positioning. The foot should not have contact with the he mattress surface; - Consultations - Dietician - obtain suggestions on needed dietary modifications and protein/caloric supplementation. Assess need for house vitamin supplement if: wound is present; resident is losing weight. Quality Assurance (QA) Nurse - obtain consultation when the following exists: multiple (three or more) Stage II (a partial thickness loss of skin layers that presents clinically as an abrasion, blister or a shallow crater) wounds; Stage III (a full thickness of skin is lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue) or greater wound; - Treatment guidelines - Universal precautions and strict hand washing procedure for all wound care and/or resident contact; remove existing dressing and dispose of old dressing properly; Cleanse wound with: standard cleanser or antimicrobial (for use on infected dermal wounds) or other wound cleanser, as ordered by physician. Wound cleaning guidelines: cleanse all wounds with chosen solution; dry around wound without touching wound bed; If ordered, apply dressing. Never occlude infected wounds; use protective barrier wipe to peri wound and tape area of intact skin. 1. Review of Resident #43's medical record showed: - admitted : 1/17/24; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Admitting diagnoses included status post (s/p) left hip fracture and dementia (inability to think). Review of the resident's clinical admission assessment, dated 1/17/24 showed: - Skin integrity upon admission - surgical wound; - Foot problems and care - none. Review of the resident's progress notes dated 1/17/24, showed: - The resident admitted to facility for skilled services following hospital stay. Resident diagnosed with dementia three to four years ago according to spouse. Review of the resident's progress notes dated 1/26/24 at 4:48 P.M., showed: - The writer was notified that the resident had skin breakdown on left heel; - Open Stage II pressure area noted to left heel. Measured 5 centimeters (cm.) x 4 cm. reddened area noted. 1 cm. x 1 cm. black center. Serous drainage (a clear to yellow fluid that leaks from a wound and is a normal part of the body's healing process) noted to dressing. Area cleansed, dressing applied. Message sent to primary care physician. Heel protectors placed at this time. Staff educated to have resident wear heel protectors while in bed. Review of the resident's skin assessment dated [DATE] showed: - The writer was notified that the resident had skin breakdown on left heel; - Open Stage II pressure area noted to left heel. Measured 5 centimeters (cm.) x 4 cm. reddened area noted. 1 cm. x 1 cm. black center. Serous drainage noted to dressing. Area cleansed, dressing applied. Message sent to primary care physician. Heel protectors placed at this time. Staff educated to have resident wear heel protectors while in bed. Review of the resident's wound progress notes, dated 1/30/24, showed: - The resident was admitted to the facility after a left hip fracture repair; - Since arriving, the resident has primarily been laying in bed and requires the sit to stand (a lift that allows residents who can bear weight to transfer from a sitting position to a standing position) for moving to his/her recliner; - Staff noticed discoloration on the resident's left heel and began protecting it with foam dressings and consulted wound care; - Left heel measured - 3.6 cm. x 5.6 cm., moderate amount of serosanguinous drainage (a thin, red discharge composed of serum and blood); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wound care orders - do not get your wound wet in the shower/bath. Clean wound with wound cleanser during dressing changes. Apply skin prep (a protective interface to prepare intact skin for attachment sites, tapes, films and adhesive dressings) to the dry/stable eschar (dead skin that is usually dry, tough, leathery, and black in color, tightly attached to a wound bed) and surrounding intact skin. Cover the entire wound with adaptic (non-adhering dressing indicated for dry to highly exuding wounds where adherence of dressing and exudate is to be prevented) and Aquacel AG (a sterile, soft, hydrofiber wound dressing that contains ionic silver and non-woven sodium carboxymethylcellulose fibers) foam as instructed, secure with kerlix (a white gauze dressing). Change the dressing every day and for dressing contamination. Review of the resident's weekly wound report, dated 2/8/24 at 10:08 A.M., showed; - Resident seen by wound clinic. The left heel has declined since last week. Staff to ensure left heel is offloaded at all times. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/12/24 showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Occasionally incontinent of bowel; - Had a Stage II pressure ulcer; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI), Review of the resident's care plan, revised 5/1/24 showed: - The resident had a deep tissue pressure injury to left heel; - Heel protectors when in bed and chair. Use offloading shoe with any weight bearing on left foot; - Protein as ordered for wound healing; - Wound vac, (a wound dressing system that uses sub-atmospheric pressure to help wounds heal),ensure wound vac is in place and working every shift - set to 125 negative pressure every shift; - Heel protectors on at all times, except when transferring or working with therapy; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Treatment to the resident's left heel as per the physician's order; - Weekly skin assessment. Report to the Director of Nursing (DON) with any skin changes; - Wound clinic to follow weekly until area is healed. Review of the resident's physician order sheet (POS) dated June 2024, showed: - Start date: 6/4/24 - Vitamin C 500 milligram (mg.) tablet daily for pressure induced deep tissue damage of left heel); - Start date: 6/4/24 - Zinc Sulfate 50 mg. daily for wound healing; - Start date: 5/2/24 - Left heel wound treatment (tx.)- monitor for signs and symptoms (S/S) and follow up immediately for any concerns for infection related to pressure induced deep tissue damage of left heel; - Start date: 3/6/24 - Heel protectors at all times. On while in bed and in recliner. Off load shoe while ambulating every shift; - Start date - 4/22/24 - Change dressing if soiled, integrity compromised, presence of blood or moisture as needed. Order did not indicate location of dressing; - Start date - 4/22/24 - Change transparent dressing using sterile technique daily every seven days for ankle and foot; - Start date: 4/30/24 - Wound vac - change dressing set and tubing to wound vac daily twice a week on Monday and Thursday. Wound Clinic will change on Thursdays. Canister to be changed when full for pressure induced deep tissue damage of left heel; - Start date: 5/2/24 - Treatment to left heel - keep the wound out of the shower; cover and do not allow left heel to be in the shower daily on Wednesday and Saturdays for pressure induced deep tissue damage of left heel; - Start date: 5/18/24 - Left heel wound tx orders - change wound vac twice weekly - wound team will change on Thursdays, staff to change on Mondays. Clean wound with [NAME] wound cleanser (intended for cleansing, irrigating, moistening and debriding acute and chronic dermal lesions); apply Prisma (maintains an optimal wound healing environment) on the wound bed; apply black foam as instructed, tracking the number of foam pieces used; continue suction at 150 mmHg; charge device as instructed in manual; follow the manual for alarms and change canister as directed; if wound vac is nonfunctioning for two hours or more remove vac and dressings and apply sterile slightly moistened gauze and contact wound clinic. During an interview on 6/12/24 at 8:26 A.M., the Director of Nursing (DON said: - The resident's family member found the wound on the resident's left heel; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There was no documentation on admission that the resident had any skin issues except the surgical wound on his/her left hip; - The nurses should have found the wound on the left heel before the family found it; - After it happened, they updated the skin assessments to ensure everyone had one, anyone at risk had heel protectors, turning and repositioning residents and had a low air loss mattress (medical mattress designed to help prevent and treat pressure ulcers by reducing pressure on the skin). During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said; - He/she did the resident's admission and the resident did not have any wounds or breakdown on his/her heels; - The resident only had a surgical wound from the left hip fracture and his/her Suprapubic catheter. During an interview on 6/12/24 at 2:34 P.M., the DON and Assistant Director of Nursing (ADON) said: - Weekly skin assessments should have been completed and documented - The resident was not admitted with a pressure ulcer to his/her left heel. 46706

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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** 47195 Based on observation, interviews, and record review, the staff failed to ensure residents remained free from accident hazards and failed to provide adequate supervision to prevent accidents. Staff failed to ensure one resident was served the accurate therapeutic ordered diet (Resident #27) and staff failed to ensure medication was administered when a controlled medication was left on a resident's card table for two days (Resident #49). This affected two of fifteen sampled residents. Additionally, the facility failed to ensure staff used proper techniques to reduce the possibility of injuries during the use of sit to stand (a lift that allows residents who can bear weight to transfer from a sitting position to a standing position) transfer, which affected Resident #43. The facility census was 59. Facility did not provide a policy regarding prevention of accidents. Review of facility policy, diet orders, undated, showed: -Diet orders prescribed by the attending physician shall be reviewed monthly by the dietary manager to assure that diet orders in the resident's chart and the dietary meal cards are accurate; -The food and nutritional needs of residents are met in accordance with the physician's orders. Review of facility policy, medication administration, undated, showed: -Medications are given to benefit a resident's health as ordered by the physician. -Remain in the room while the resident takes the medication. -Record the medication on the medication sheet. 1. Review of Resident #27's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/27/24, showed: -He/She was independent with eating; -He/She had a therapeutic diet; -Diagnosis included dementia (condition characterized by impairment of at least two brain functions such as memory loss and judgement), mild protein-calorie malnutrition (a nutritional disorder caused by inadequate quantities of protein and energy in diet), gastro-esophageal reflux disease without esophagitis (a condition in which stomach contents move up into the esophagus) Review of care plan, dated 5/1/24, showed: -Resident was at risk for weight loss due to dementia, he/she had a history of gradual weight loss. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had strong food preferences; -Diet regular with moist and minced meats; -Monitor for signs of malnutrition. Review of physician's orders, dated 5/11/24 to 6/11/24, showed: -Ordered 5/31/24, Diet: Level 7 Minced and Moist meat. Review of Speech Therapy Evaluation, dated 5/18/24, showed: -Diagnosis: dementia, dysphagia (difficulty swallowing), pharyngeal phase (step in swallowing categorized by a rapid phase of muscle contraction to propel the bolus through the upper esophageal sphincter and into the esophagus); -Treatment approaches may include: Treatment of swallowing dysfunction and/or oral function of feeding. Review of treatment encounter notes from Speech Language Pathologist (SLP), showed: -5/31/24: The resident was seen with meal. The resident continues to exhibit poor by intake with ground meat and ground meat with gravy. He/She reported that regular meat is too difficult to chew. The resident was served regular meat by kitchen and diet ticket stated ground meat. Spoke with Director of Rehabilitation (DOR), Director of Nursing (DON) regarding diet not being served correctly. Recommend minced meat to see if he/she exhibits increased by mouth intake. -6/2/24: The resident was seen with his/her meal. He/She continued to exhibit poor by mouth intake with meat only taking a couple bites of meats. The resident was without dentures when SLP initially saw him/her. -6/5/24: The resident was seen with meal. The resident tolerated solids and liquids without signs or symptoms of aspiration. -6/10/24: The resident was seen with his/her meal and was served regular bacon and did not touch bacon. Observation on 6/11/24 at 7:36 A.M. showed that minced and moist food not served as ordered for resident. Observation showed the SLP noted resident was served wrong food when he/she arrived to unit and he/she went to CNA B to advise he/she served resident wrong diet order. The plate was observed with two strips of regular bacon and scrambled eggs. SLP went to the kitchen and got the resident minced and moist eggs and bacon and returned to unit with new plate. During an interview on 6/11/24 at 8:03 A.M., SLP said: -Resident was served improper diet at breakfast; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It was responsibility of person serving the food to ensure the proper diet was served to each resident; -He/She had notified his/her supervisor of the issue and has had several conversations with administration regarding concerns with diets not being served as ordered; -Diets had been discussed at morning meeting; -Diets not being followed has been an ongoing issue in the facility; -When he/she writes an order the order gets put into the computer by a nurse, then diet slip is taken to the dietary manager; -Problem has been with person who has served the food incorrectly; -Inservices have occurred by the facility and staff have been educated; -Resident's diet was usually not followed at breakfast; -If he/she would not have been at breakfast today he/she did not think the error would have been caught or corrected by staff working. Observation on 6/11/24 at 12:59 P.M. showed resident's plate was in the refrigerator. The resident's meal ticket showed minced and moist meat. Plate was observed to be served with pureed meats, not minced and moist as ordered. During an interview on 6/11/24 at 12:59 P.M., SLP said: -Resident was again served wrong dietary menu from kitchen; -He/She was going back to kitchen to correct tray and get proper minced and moist foods. During an interview on 6/12/24 at 8:49 A.M., [NAME] A said: -He/She knew resident specific diets based on meal tickets; -When the resident had new diet order a paper is received and placed on bulletin board inside kitchen. During an interview on 6/12/24 at 9:07 A.M., Dietary Manager said: -He/She expected staff to follow resident's diet orders; -Following diet orders was difference between resident choking or not; -He/She was aware of resident #27 being served the wrong diet this week; -Resident #27 was served wrong breakfast on 6/11 and wrong lunch on 6/11; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cook B got really scared after serving resident wrong breakfast on 6/11 and so go over zealous and served pureed at lunch on 6/11. During an interview on 6/12/24 at 10:09 A.M., CNA C said: -He/She looked at resident meal tickets to ensure their diet was served correctly; -If tray was wrong he/she would take it back to kitchen to have them make it correctly. During an interview on 6/12/24 at 10:32 A.M., [NAME] B said: -He/She reads meal tickets to know resident's specific diets; -He/She had issues with serving residents the wrong diets; -Some diets are hard to understand as the ticket would have ground and then also have minced and moist; -SLP showed him/her how to prepare minced and moist foods, he/she had only been preparing meat pureed or ground prior to education received from SLP; -He/She served Resident #27 wrong diet, his/her diet had just been changed; -He/She had served wrong resident diets every once in awhile; -The unit staff, nurse, or SLP brings it to his/her attention when diet is wrong. During an interview on 6/12/24 at 10:56 A.M., Dietician said: -He/She expected staff to follow diet orders for residents. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing (DON) said: -He/She expected resident to be served correct diet order. During an interview on 6/12/24 at 2:34 P.M., Assistant DON said: -He/She expected resident to be served physician ordered diet. 2. Review of Resident'#49's annual MDS, dated [DATE], showed: -He/She was severely cognitively impaired; -He/She was dependent on a walker for mobility; -He/She is taking antipsychotic, antianxiety, and an antidepressant. -He/She displayed physical behavioral symptoms 1-3 days; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She displayed wandering behaviors 1 to 3 days; -Diagnoses included dementia (a condition characterized by impairment of at least two brain functions such as memory loss and judgement), glaucoma (eye condition that can cause blindness), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), depression, and anxiety. Review of care plan, dated 6/1/24, showed: -He/She had anxiety disorder and had physical and verbal altercations with other residents; -Administer medications as ordered per medical provider to include clonazepam; -Monitor for signs and symptoms of anxiety. Review of physician's orders, dated 6/11/24, showed: -Orders started 4/15/21, clonazepam tablet 0.5 mg, amount 1 tablet oral, twice a day from 6:00 A.M.-9:00 A. M. and 7:00 P.M. to 8:00 P.M. -No orders to self-administer medications. Review of medication administration record, dated 5/1/24 to 5/31/24, showed: -No missed doses of clonazepam documented. Review of medication administration record, dated 6/1/24 to 6/11/24, showed: -On 6/2/24, at 7:00 P.M.-8:00 P.M., cloazepam tablet 0.5 mg was blank with no entry, the notes below indicated it was charted late by Certified Medication Technician (CMT) C. Review of electronic medical record showed: -Resident has no assessments to self-administer his/her own medications. Observation on 6/9/24 at 11:28 A.M. showed in Resident #49's room he/she had a card table with a round orange pill sitting on the table with 99 v and an etched line in the pill. Observation on 6/11/24 at 8:01 A.M. showed resident had an orange pill sitting on center basket on top of card table in his/her bedroom. Observation on 6/11/24 at 9:10 A.M. showed LPN C located a bubble pack medication of the resident's to include a round orange pill found on resident's card table identified as clonazepam tablet 0.5 mg. Review of facility monthly inservices held from June 2023-May 2024, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/25/24, medications cannot be left in resident rooms or at dining table. Staff must watch resident take their medication before leaving resident's view. During an interview on 6/11/24 at 9:10 A.M., LPN C said: -Pill found on resident's card table in room was resident's clonazapam; -He/She received medication twice daily; -He/She gets scheduled dose between 7:00 P.M.-8:00 P.M. and 6:00 A.M.-9:00 A.M. each day. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) said: -He/She would not expect a medication to be sitting on resident's table in their room for two days. During an interview on 6/12/24 at 2:34 P.M., the Assistant DON said: -He/She did not expect a medication to be left sitting on a resident's table in his/her room for two days. 31102 3. Review of the facility's undated policy for transfer activities, showed, in part: - The purpose is to transfer the resident from the bed to the chair safely; - The brakes on the wheelchair should be locked; - The policy did not address the use of a mechanical lift or a sit to stand lift (a lift that allows residents who can bear weight to transfer from a sitting position to a standing position). Review of the manufacturer's guidelines for the Maxi Move lift, dated July, 2008, showed in part: - Transport the Maxi Move with he chassis legs in parallel (closed) position only; - Do not apply the [NAME] brakes as the position of the resident will adjust to his/her own center of gravity when lifted. Review of the manufacturer's guidelines for the [NAME] 3000, dated 10/2019 showed, in part: - The resident shall be transferred with the chassis legs closed, as this will be easier to maneuver through doorways; - The chassis rear castors have brakes which can be foot operated if required; - When raising the resident with a standing sling, the resident's body posture shall go from seated to standing position; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN B said he/she would normally let the family help move the resident up in the bed; - Nurse Aide (NA) C entered the room and assisted CNA B to move the resident up in the bed. During an interview on 6/12/24 at 10:32 A.M., CNA B said: - With the sit to stand lift, the brakes should be locked when lowering or raising the resident and the legs of the lift should be closed when moving with the resident in the lift; - The lift pad should not have slid up on the resident, he/she felt like it was a safe transfer until the resident started falling out of the lift; - The resident does not bear much weight. In the beginning when he/he was getting therapy, he/she was stronger. He/she felt like the resident has declined a little. During an interview on 6/21/24 at 6:46 A.M., LPN B said: - The lift pad should not slide up on the resident; - The legs of the sit to stand lift should be open when moving with the resident in the lift to make it more stable; - The brakes on the sit to stand lift should be locked when lowering or raising the resident; - The resident is able to stand a little on his/her own with the sit to stand lift. Observation on 6/11/24 at 1:23 P.M., showed: - Certified Medication Technician (CMT) A and NA B used the sit to stand lift and transferred the resident from his/her wheelchair to the bed with the legs of the lift closed; - During the transfer the resident had his/her legs bent and was not standing well; - The lift pad was sliding up on the resident and he/she said, You are hurting my back!, God Dammit it hurts!; - CMT A moved to the side of the bed and lowered the resident onto the bed and CMT A and NA B removed the lift pad and assisted the resident to lay down. During an interview on 6/20/24 at 3:30 P.M., CMT A said: - Typically the resident does not stand well in the sit to stand lift; - The legs of the sit to stand lift should be open when moving with the resident in the lift; - The brakes of the Hoyer and the sit to stand lift should be locked when raising or lowering the resident; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The lift pad should not slide up on the resident; - The resident should not holler out during a transfer with the sit to stand lift. During an interview on 6/21/24 at 8:31 A.M., NA B said: - He/she only used the sit to stand lift with a CNA; - The residents legs are usually bent when they are transferring the resident; - The staff encourage the resident to stand up straight; - The resident should not holler out in pain during the transfers; - The lift pad should not slide up on the resident. During an interview on 1/12/24 at 2:324 P.M., the DON and ADON said:- If a staff member is not strong enough to lift a resident, staff should get another staff member to assist. Should not expect the family to help lift the resident; - The legs of the sit to stand lift should be opened when moving with the resident in the lift; - The brakes on the sit to stand lift should be locked when raising or lowering a resident to the bed or wheelchair; - The lift pad should not slide up and would not expect the resident to holler out in pain.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observations, interviews, and record review, the facility failed to ensure sufficient staffing to provide services to residents to maintain highest practicable physical, mental, and psychosocial well-being when residents did not receive showers which affected one of the 15 sampled residents, (Resident #43), meal service was late which affected all the residents, activities were not offered due to activity director being pulled to cover the floor, and medications were late which affected Resident # 21, #28 and #29. The facility census was 59. The facility did not provide a policy for staffing. The facility did not provide a policy for showers. 1. Review of Resident #43's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 4/12/24 showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Frequently incontinent of bowel; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI. Review of the resident's care plan, revised 5/1/24 showed:- The resident required substantial to dependent assistance with most activities of daily living (ADL's) related to impaired mobility. Allow the resident to participate with dressing as much as possible to his/her ability; - The resident is at risk for decreased independence in bed as evidenced by poor strength and decreased ability to move self effectively. Encourage use of the the grab bar while performing care to maintain strength and encourage independent movement side to side while in bed. Review of the resident's shower sheets showed the resident received a shower on the following dates: - January 2024 - 1/24 and 1/31; - February 2024 - 2/8, 2/10, 2/16 (bed bath), 2/18 and 2/28; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- March 2024 - 3/6, 3/9, 3/13, and 3/20; - April 2024 - 4/2, 4/10, and 4/17; - May 2024 - 5/2, 5/15 and 5/27; - June 2024 - no shower sheets were provided. During an interview on 6/10/24 at 4:09 P.M., Family Member B said: - The resident gets a shower maybe once a week; - We usually ask for the resident to have a shower after it has been two weeks. During an interview on 6/11/24 at 3:09 P.M., the Assistant Director of Nursing (ADON) said: - The do not have a dedicated shower aide; - They assign showers to the aides on the halls. During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said: - On the day shift there's usually a Certified Nurse Aide (CNA) and a charge nurse on A and D hall and a shower aide floats between the two halls. During an interview on 6/12/24 at 9:15 A.M., Licensed Practical Nurse (LPN) A said: - On B hall there's usually a have a charge nurse and a CNA; - The CNA gives the residents their showers. During an interview on 6/12/24 at 10:32 A.M., CNA B said: - They do not have a designated shower aide; - They usually have one charge nurse on each hall and one CNA and the shower aide floats between the two halls; - They do not have enough help. They always run late for meals and activities, it takes longer for the call lights to get answered, to get the residents up for meals or to lay residents down after meals, have a hard time getting the showers done. If someone calls in then the resident does not get their shower and would have to wait until who knows when; - The charge nurses don't usually help out on the floor; - At meal times, we normally do not have the Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Coordinator, Social Services (SS) or the Business Office Manager (BOM) helping to pass trays or assist the residents to eat; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- We actually had extra aides this week and it has been nice. 2. Review of the facility's undated policy for the medication administration guidelines showed: - It is the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person, in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose tot he proper resident, and promptly recording the information; - Medications may not be prepared in advance and must be administered within one hour of preparation. 3. Review of Resident #28's physician order sheet (POS), dated June 2024 showed: - Start date: 3/3/23 - Levothyroxine 50 micrograms (mcg.) daily at 5:00 A.M. for hypothyroidism (condition that occurs when the thyroid gland doesn ' t ' not produce enough thyroid hormones to meet the body's needs). Review of the resident's medication administration record (MAR), dated June 2024 showed: - Levothyroxine 50 mcg. daily at 5:00 A.M. for hypothyroidism; - Documented as late administration at 7:33 A.M. Observation and interview on 6/11/24 at 7:00 A.M., showed: - The Levothyroxine was due at 5:00 A.M.; - The DON was passing the medication and went to the resident's room and staff were cleaning the resident and the DON said she would be back; - At 7:32 A.M., the DON administered the medication to the resident in the dining room. 4. Review of Resident #21's POS, dated June 2024 showed: - Start date: 2/1/24 - Levothyroxine 25 mcg. daily at 5:00 A.M. for hypothyroidism; - Start date: 5/10/24 - Ropinole 0.5 milligrams (mg.) three times daily before meals (5:30 A.M., 11:00 A.M., and 4:00 P.M. for Parkinson's disease (a brain disorder that causes unintended or un controllable movements, such as shaking, stiffness, and difficulty with balance and coordination); - Start date: 6/3/24 - Entacapone 200 mg. before meals at 5:00 A.M., 11:30 A.M., and 4:30 P.M. for Parkinson's disease. Review of the resident's MAR, dated June 2024 showed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Entacapone 200 mg. before meals at 5:00 A.M., 11:30 A.M., and 4:30 P.M. for Parkinson's disease; - Levothyroxine 25 mcg. daily at 5:00 A.M. for hypothyroidism; - Ropinole 0.5 mg. three times daily before meals 5:30 A.M., 11:00 A.M., and 4:00 P.M. for Parkinson's disease; - Documented as late administration at 7:45 A.M. Observation and interview on 6/11/24 at 7:35 A.M., showed: - The DON administered the medications to the resident; - The DON said the medications are late, they are the early morning medications; - The medications were due at 5:00 A.M. 5. Review of Resident #29's POS, dated June 2024 showed: - Start date: 2/22/23 - Gabapentin capsule 300 mg. four times a day at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. for postherpetic polyneuropathy (a chronic pain syndrome that can occur after a shingles outbreak and is caused by damage to nerve fibers). Review of the resident's MAR, dated June 2024 showed: - Gabapentin capsule 300 mg. four times a day at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. for postherpetic polyneuropathy; - Documented as late administration at 7:47 A.M. Observation on 6/11/24 at 7:45 A.M., showed: - The DON administered the medication at 7:47 A.M. During an interview on 6/12/24 at 2:34 P.M., the DON said medications should be passed one hour before or an hour after they were due. 46706 47195 6. Review of facility activity attendance logs dated 2/1/24 to 4/30/24, showed: -2/28/24, Activity Director did not do activity of making flowers due to working floor; -2/29/24, Activity Director did not do stretching activity due to working the floor; -3/28/24, Activity Director did not do second activity due to working the floor; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/4/24, Activity Director could not lead bingo due to working the floor; -4/25/24, Activity Director did not have float social due to working the floor; -4/30/24, Activity Director did not have bingo or manicures due to working on the floor. During an interview on 6/12/24 at 8:34 A.M., Activity Director said: -He/She got pulled to cover the floor quite a bit; -He/She just started in Activity Director role at beginning of June; -He/She had to continue to work in previous role as business office receptionist until new staff could be hired and orientated; 7. Observation of posted meal service times showed lunch was scheduled to be served at 12:00 P.M.; Review of facility meal time policy showed: -lunch: -Memory care 7:00 A.M. -Dining room [ROOM NUMBER]:30 P.M. -Room trays 1:00 P.M. Observation on 6/9/24 on memory care unit showed: -12:30 P.M., lunch trays delivered to unit, 30 minutes after posted lunch start time; -12:32 P.M., first tray served in dining room; -12:43 P.M., last tray served, 43 minutes after posted meal time. Continuous observation on 6/10/24 from 11:11 A.M.-1:12 P.M., showed: -12:12 P.M., first meal plated for memory care unit; -12:25 P.M., hot box left dining room and wheeled to memory cart unit, 25 minutes after posted meal time; -12:25 P.M., first meal plated for dining room residents; -12:49 P.M., [NAME] B started plating room trays, -1:12 P.M., last room tray served, 12 minutes past posted meal time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in dining room at lunch on 6/10/24 showed: -12:22 P.M., staff still bringing residents to dining room for lunch; -12:29 P.M., first tray passed in dining room; -12:49 P.M., last tray was passed in dining room, 19 minutes after posted meal time. Observation on 6/11/24 on memory care unit showed: -12:21 P.M., food cart delivered to unit, 21 minutes after posted meal time; During an interview on 6/12/24 at 8:49 A.M., [NAME] A said: -Delay in meal service was sometimes related to nurse aides were not in dining room to serve; -Sometimes meal trays sit too long and he/she had to go out to dining room to take food to residents. During an interview on 6/12/24 at 10:09 A.M., Certified Nurse Aide (CNA) C said: -Meals are usually late due to staffing; -There is only two staff working the floor and trying to get all the residents to the dining room; -It is usually not until 12:15 P.M. until kitchen staff is loading the special care unit food trays and dining room did not start serving meals until 12:30, thirty minutes after posted meal time; -Staffing shortages sometimes results in residents not getting laid down on time, sometimes ice water and snacks did not get passed, and he/she would transfer two assist residents by him/her self. During an interview on 6/12/24 at 10:32 A.M., [NAME] B said: -Meal service was sometimes late due to nurse aides not having all residents up and in dining room; -He/She had to go out on unit to serve residents their meals.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46706 Based on observations, interviews and record review, the facility failed to ensure staff administered medications with a medication rate of less than five percent (5%). Facility staff made nine medication errors out of 28 opportunities for error, resulting in a medication error rate of 32.14%. This affected five of 15 sampled residents, (Resident #3, #4, #12, #48 and #53). The facility census was 59. Review of the manufactures guidelines for Novolog insulin FlexPen dated July 2023 showed: -Clean the area with an alcohol swab and let dry; -Hold the needle in the skin for at least 6 seconds before removing the needle. Review of the manufactures guidelines for Levimir FlexTouch insulin pen dated March 2024 showed in part: -Clean the area with an alcohol swab and let dry; -Hold the needle in the skin for at least 6 seconds before removing the needle. The facilty did no provide the requested policy on insulin administration. 1. Review of Resident #3's Physician's Order Sheet (POS), dated June 2024 showed: -Start date: 3/2/20 - Novolog insulin FlexPen (fast-acting) 100 units/millilliter (ml), give per sliding scale before meals and at bed time, sliding scale as follows: o Blood sugar 120 to 150 give 2 units; o Blood sugar 151 to 200 give 4 units; o Blood sugar 201 to 250 give 8 units; o Blood sugar 251 to 300 give 10 units; o Blood sugar greater than 300 give 15 units; o Blood sugar less than 60 or greater than 500 notify physician; -Start date: 3/10/20 - Levimir FlexTouch insulin pen (a long-acting insulin that starts to work several hours after injection) 100 units /ml, give 54 units once a day for diabetes mellitus (a chronic disease that when the pancreas does not produce enough insulin); -Start date: 11/19/20 - Novolog insulin FlexPen 100 units/ml, give 7 units before meals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Medication Administration Record (MAR), dated June 2024 showed: -Novolog insulin FlexPen 100 units/ml, give per sliding scale before meals and at bed time; -Levimir FlexTouch insulin 100 units/ml, give 54 units once a day; -Novolog insulin FlexPen 100 units/ml, give 7 units before meals. Observation on 06/11/24, at 06:38 A.M.,, showed:-The Assistant Director of Nursing (ADON) wiped the resident's finger with an alcohol pad and let dry; - He/she obtained the resident's blood sugar; -The resident's blood sugar was 90; - The ADON cleaned the resident's arm with the an alcohol pad and let dry; - The ADON dialed 7 units on the Novolog insulin FlexPen and inserted it in the resident's skin and removed it after 3 seconds; -The ADON failed to hold the needled in the resident's skin for 6 seconds as per the manufacturers instructions. 2. Review of Resident #4's POS dated June 2024 showed: -Start date: 10/12/22 - Novolog insulin FlexPen 70/30, 100 units/ml, give per sliding scale before meals and at bed time, sliding scale as follows: o Blood sugar 120 to 150 give 5 units; o Blood sugar 151 to 200 give 7 units; o Blood sugar 201 to 250 give 10 units; o Blood sugar 251 to 300 give 12 units; o Blood sugar 301 to 350 give 15 units; o Blood sugar greater than 350 give 20 units; -Start date: 3/21/23 - Novolog insulin FlexPen 70/30, 100 units/ml, give 18 units twice a day. Review of the resident's MAR, dated June 2024 showed: -Novolog insulin FlexPen 100 units/ml, give per sliding scale before meals and at bed time; -Novolog insulin FlexPen 70/30, 100 units/ml, give 18 units twice a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/11/24, at 06:56 A.M.,, showed: -The ADON wiped the resident's finger with an alcohol pad and let dry; -The ADON obtained the resident's blood sugar; -The resident's blood sugar was 195; - The ADON cleaned the resident's right abdomen with the an alcohol pad and let dry; - The ADON dialed 7 units on the Novolog insulin FlexPen and inserted it in the resident's skin and removed it after 3 seconds; - The ADON cleaned the resident's left abdomen with the an alcohol pad and let dry; - The ADON dialed 18 units on the Novolog insulin FlexPen and inserted it in the resident's skin and removed it after 3 seconds; -The ADON failed to hold the needled in the resident's skin for 6 seconds as per the manufacturers instructions after giving the 7 units of Novolog insulin and after giving the 18 units of Novolog 70/30 insulin. During an interview on 06/12/24, at 09:07 A.M., the ADON said: -He/she holds the insulin injections in the resident's skin and starts counting roughly three or four seconds; -Insulin should be given per the manufacturer instructions. During an interview on 06/12/24, at 09:10 A.M., the DON said: -Insulin pen should be held 10 seconds after the insulin is injected. 3. Review of the manufactures guidelines for the Salonpas Lidocaine Patch 4% dated 6/15/21, showed: -Clean and dry the area the patch is to be applied; -Apply the patch on the area; -Remove the patch between 8 and 12 hours; -Don not leave the patch on for more than 12 hours. The facilty did not provide the requested policy on transdermal patches. Review of Resident #48's POS, dated June 2024 showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Start date: 1/10/24 - Lidocaine medicated patch 4%, apply patch to left hip area daily at 5:00 A.M. and remove in 12 hours at 5:00 P.M. daily. Review of the resident's MAR, dated June 2024 showed: - Lidocaine medicated patch 4%, apply patch to left hip area daily at 5:00 A.M. and remove in 12 hours at 5:00 P.M. daily. Observation and interview on 06/11/24, at 05:36 A.M.,, showed: -Licensed Practical Nurse (LPN) B entered the resident's room with a Lidocaine patch; -LPN B dated, timed and initialed the patch; -LPN B removed a Lidocaine patch from the resident's left hip; -The patch had no date, time or initials; -The nurse working last night did not take the patch off and it is supposed to be removed in the evening; -LPN B applied the new patch to the resident; -LPN B said the patch is supposed to be applied in the morning and taken off at 5:00 P.M. in the evening. During an interview on 06/12/24, at 09:10 A.M., the DON said: -He/she expects the physicians orders to be followed; -If the order said remove the resident's patch at 5:00 P.M. he/she expects that to be followed. 31102 4. Review of the facility's undated policy for medication administration showed: - Medications are given to benefit a resident's health as ordered by the physician; - For administration of tablets: do not crush any medication if a liquid form is available. Certain medications should never be crushed. Review of the facility's undated policy for crushing medications, showed: - Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders; - The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug when the manufacturer has stated that it should not be crushed; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The attending physician or consultant pharmacist must identify an alternative. Review of the website https://www.webmd.com for multivitamin with minerals showed: - Swallow the tablets whole. Do not crush or chew the tablets. Review of the website https://www.mayoclinic.org for Metformin ER (used to treat diabetes mellitus). showed: - Swallow tablet whole with a full glass of water. Do not crush, break or chew it. Review of the website https://www.stlukes-stl.com for Vitamin C showed: - Swallow the tablet or capsule whole, do not chew or crush. Review of the website https://my.clevelandclinic.org for zinc showed: - Do not cut, crush or chew this medication. 5. Review of Resident #53's POS, dated June 2024 showed: - Start date: 5/21/24 - Multivitamin with minerals, one tablet daily for wound healing; - Start date: 6/4/24 - Vitamin C tablet, 500 milligrams (mg.) daily for wound healing; - Start date: 6/4/24 - Zinc sulfate, 50 mg. daily for wound healing; - Start date: 9/3/23 - Metformin extended release (ER) 750 mg. tab twice daily for diabetes mellitus; - Start date: 10/8/23 - Vitamin B 12 chewable 1000 micrograms (mcg.) one daily for anemia (a condition in which the body does not have enough healthy red blood cells). Review of the resident's MAR, dated June 2024 showed: - Multivitamin with minerals, one tablet daily for wound healing; - Vitamin C tablet, 500 mg. daily for wound healing; - Zinc sulfate, 50 mg. daily for wound healing; - Metformin ER 750 mg. tab twice daily for diabetes mellitus; - Vitamin B 12 chewable 1000 mcg. one daily for anemia. Observation and Interview on 6/11/24 at 9:33 A.M., showed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- CMT A place the Multivitamin with minerals tablet, Vitamin C tablet, Zinc tablet, and the Metformin ER tablet in a plastic bag and crushed them; - CMT A placed Vitamin B 12 500 mg. two tabs in a medication cup; - CMT A asked the DON if he/she could use plain Vitamin B 12 instead of the Vitamin B 12 chewable which was ordered. The DON read the label on the bottle and said it did not say he/she could not use it; - CMT A crushed the Vitamin B 12 tabs and placed all the crushed medication in a medication cup with pudding and administered it to the resident. During an interview on 6/12/24 at 2:34 P.M., the DON and ADON said: - Staff should not crush Metformin ER or Multivitamin with minerals; - They were not for sure if staff should crush Vitamin C or Zinc; - If the order said Vitamin B 12 chewable, then staff should have administered the chewable. During an interview on 6/20/24 at 3:30 P.M., CMT A said: - He/she should not have crushed the Multivitamin with minerals, the Vitamin C, the Zinc, or the Metformin ER; - He/she should have administered the Vitamin B 12 1000 mg. chewable and not used the plain Vitamin B 12. 6. Review of the facility's undated policy for instillation of eye medication, showed: - The purpose is to introduce medication into the eye for treatment or for examination purposes; - Tilt the resident's head backward, draw down lower lid. Have resident look up; - To prevent dropper tip form touching eye or lids, the nurse should support hand on the resident's forehead or bridge of nose. Introduce drop on center of lower lid; - Instruct the resident to close eye; - Gently press tissue against lacrimal duct (short tube in the inner corner of the eyelid through which tears drain into the nose). Press the tear duct for one minute after eye drop administration or by gentle eye closing for approximately three minutes after the administration. Review of the webpage https://webmd.com for Refresh Tears showed: - Tilt your head back and pull down the lower eyelid to make a pouch; - Place the dropper directly over the eye and squeeze out the correct amount; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Look down and gently close your eye and place your finger at the corner of the eye near the nose and apply gentle pressure for one to two minutes. Review of Resident #12's POS dated June 2024 showed: - Start date - 8/27/22 - Refresh Tears 0.5 %, instill one drop three times daily for dry eye syndrome. The order did not indicate if it was to be administered in one eye or both eyes. Review of the resident's MAR dated June 2024 showed: - Refresh Tears 0.5 %, instill one drop three times daily for dry eye syndrome. The order did not indicate if it was to be administered in one eye or both eyes. Observation on 6/11/24 at 10:10 A.M., showed: - CMT A placed one drop of Refresh Tears in the right eye and wiped the right eye with a tissue; - CMT A placed one drop of Refresh Tears in the left eye and wiped the right eye with a tissue; - CMT A did not apply lacrimal pressure. During an interview on 6/12/24 at 2:34 P.M., the DON and ADON said: - Staff should apply lacrimal pressure but were not for sure for how long. During an interview on 6/20/24 at 3:30 P.M., CMT A said:- Lacrimal pressure should be administered for ten seconds.

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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** 47195 Based on observation, interview and record review, the facility failed to store medications in a locked storage area to ensure medications were inaccessible to unauthorized staff and residents, when the medication cart was left unlocked and unattended. Additionally, the staff failed to discard a vial of the Influenza Vaccine after it had expired and failed to ensure medication had had a pharmacy label on it. The facility census was 59. Review of facility policy, storage of medications, undated, showed: -All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile medicaiton carts. -All mobile medication carts must be under visual control of the staff at all times when not stored safetly and securely. Carts must be either in a locked room or otherwise made immobile. -All controlled substances must be stored under double lock and key. -An unattended medication cart must remain locked at all times. In the event the nurse is distracted from the task of passing medications by some unforseen occurrence, the cart must be locked before leaving it, or secured in a locked medication room. 1. Observation on 6/10/24 at 3:37 P.M., showed Registered Nurse (RN) left medication cart unlocked in dinette area. RN A is at the end of the hall in the television room talking with residents. No staff in visual site of medication cart. Observation on 6/11/24 at 6:06 A.M. showed Licensed Practical Nurse (LPN) C left medication cart unlocked in dinette area at middle of hallway. LPN C walked down towards dining room and left cart with lock popped out and left special care unit. CNA B is in dining room passing drinks. LPN C returned to special care at 6:08 A.M. Observation showed on 6/11/24 at 6:18 A.M., LPN C left medication cart unlocked and walked to end of hall to pas medications. LPN C returned to cart at 6:20 A.M. Observation on 6/11/24 at 6:23 A.M. showed LPN C left medication cart unlocked and unattended, went into resident room [ROOM NUMBER]. LPN C exited room [ROOM NUMBER] at 6:26 A.M. walked passed medication cart that remained unlocked and down to dining room at other end of ahllway. LPN C returned to medication cart at 6:28 A.M. Observation on 6/11/24 at 6:31 A.M. showed LPN C left medication cart unlocked and unattended with five bubble packs with medications sitting on top of cart. LPN C took medication cup with pills to dining room. LPN C returned to medication cart at 6:35 A.M. and put bubble packs back inside medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/11/24 at 6:37 A.M. showed medication cart was left unlocked and unattended by LPN C as he/she entered resident room [ROOM NUMBER]. At 6:39 A.M. LPN C returned to medication cart. Observation on 6/11/24 at 6:43 A.M. showed LPN C left medication cart unlocked and went into dining room out of site of medication cart. LPN C returned to medication cart at 6:46 A.M. Observation on 6/11/24 at 6:50 A.M. showed medication cart left unattended and unlocked in dinette by LPN C. LPN C returned to medication cart at 6:53 A.M. Observation on 6/12/24 at 7:46 A.M. showed LPN A left medication cart unlocked and unattended when he/she went into dining room and sat next to resident. Observation on 6/12/24 at 8:11 A.M. showed LPN A left medication cart unlocked and unattended with open pill bottles sitting on top of the medication cart at dining room door when he/she responded into Resident #44's room. Observation on 6/12/24 at 8:17 A.M. showed LPN A left medication cart unattended and unlocked with open pill bottles on top of cart while passing medication at dining room door. He/She walked into the dining room to pass medication, looked in cabinet in dining room, and did not have visual contact of his/her medication cart. Residents passed by medication cart with open pill bottles as exiting dining room. Review of facility monthly inservices held from June 2023-May 2024, showed: -7/25/23, ensure all medicaitons and storage are secured in carts for safety. Carts are to be kept locked when not in use or not in visual contact. -12/12/23, storage of drugs and biologicals. All nursing staff that are assigned to medicaiton treatments carts will keep carts locked when not in use and present at the cart. When medication cart is unattended it must remain locked at all times. -3/25/24, locked medication carts; During an interview on 6/11/24 at 9:10 A.M., LPN C said: -He/She should leave medication cart locked when he/she leaves it unattended; -He/She did forget to lock the cart this morning while passing medications. 2.Review of Resident'#49's annual minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/15/24, showed: -He/She was severely cognitively impaired; -He/She was dependent on a walker for mobility; -He/She is taking antipsychotic, antianxiety, and an antidepressant. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She displayed physical behavioral symptoms 1-3 days; -He/She displayed wandering behaviors 1 to 3 days; -Diagnoses included dementia (a condition characterized by impairment of at least two brain functions such as memory loss and judgement), glaucoma (eye condition that can cause blindness), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), depression, and anxiety. Review of care plan, dated 6/1/24, showed: -He/She had anxiety disorder and had physical and verbal altercations with other residents; -Administer medications as ordered per medical provider to include clonazepam; -Monitor for signs and symptoms of anxiety. Redirect as needed. Review of physician's orders, dated 6/11/24, showed: -Orders started 4/15/21, clonazepam tablet .5mg, amount 1 tablet oral, twice a day from 6:00 A.M.-9:00 A.M. and 7:00 P.M. to 8:00 P.M. -No orders to self-administer medications. Review of medication administration record, dated 5/1/24 to 5/31/24, showed: -No missed doses of clonazepam documented. Review of medication administration record, dated 6/1/24 to 6/11/24, showed: -On 6/2/24, at 7:00 P.M.-8:00 P.M., cloazepam tablet .5mg was blank with no entry, the notes below indicated it was charted late by Certified Medication Technician (CMT) C. Review of electronic medical record showed: -Resident has no assessments to self-administer his/her own medications. Observation on 6/9/24 at 11:28 A.M. showed in Resident #49's room he/she had a card table with a round orange pill sitting on the table with 99 v and an etched line in the pill. Observation on 6/11/24 at 8:01 A.M. showed resident had an orange pill sitting on center basket on top of card table in his/her bedroom. Observation on 6/11/24 at 9:10 A.M. showed LPN C located a bubble pack medication of resident #49 to include a round orange pill found on resident's card table identified as clonazepam tablet .5mg. Review of facility monthly inservices held from June 2023-May 2024, showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/25/24, medications cannot be left in resident rooms or at dining table. Staff must watch resident take their medication before leaving resident's view. If staff dropped pill on the floor make sure to throw medicaiton away and then offer the resident another pill. During an interview on 6/11/24 at 9:10 A.M., LPN C said: -Pill found on resident's card table in room was resident's clonazapam; -He/She received medication twice daily; -He/She gets scheduled dose between 7:00 P.M.-8:00 P.M. and 6:00 A.M.-9:00 A.M. each day During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) said: -He/She expected the medication cart to be locked when it was unattended. During an interview on 6/12/24 at 2:34 P.M., the Assistant DON said: -He/She expected to lock the medication cart when they left the medication cart unattended. 31102 3. Observation and interview on 6/11/24 at 12:48 P.M., of the front medication room showed: - An opened vial of Influenza Vaccine, dated 3/19/24. The label on the box showed to discard after 28 days from opening; - An opened bottle of Lactulose Solution (used to treat constipation) did not have a pharmacy label on it to indicate which resident it belonged to; - The DON said the flu vaccine should not be used, it should have been discarded. The Lactulose should have a pharmacy label on it with the resident's name; - The nurses and the DON check the medication rooms and the medication carts daily for expired medications.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, interview and record review, the facility failed to adequately staff the kitchen with enough dietary staff to ensure the cleanliness of the kitchen, and meals were served to residents in a timely manner. This has the potential to affect all residents of the facility. The facility census was 59. Facility did not provide a policy regarding dietary staffing. 1. Review of Resident # 40's Significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 4/7/24, showed: - Cognitive skills intact; - He/She was independent with eating - Diagnoses included high blood pressure, gastroesophageal reflux disease (GERD) (A digestive disease in which stomach acid or bile irritates the food pipe lining), and anxiety. Review of the resident's care plan, revised 4/25/24 showed: -Resident was at nutritional risk for having strong food preferences and personal choices on not leaving his/her room for meals; -Regular diet; -Dietary to provide resident with quarterly menu in his/her room for him/her to be able to plan out his/her food choices for meals. During an interview on 6/10/24 at 8:10 A.M., the resident said meal is usually at least 30 minutes late. 2. Review of Resident #43's Quarterly MDS, dated [DATE], showed: -Cognitive skills severely impaired; -Lower extremity impaired on one side; -He/She required set up or clean up assistance with eating; - Diagnoses included high blood pressure. Review of the resident's care plan, revised 5/1/24 showed: (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident required substantial to dependent assistance with most activities of daily living (ADL's) related to impaired mobility. -Resident needed adequate intake of food to help with wound healing; -Offer resident substitutes if he/she had problems with food being served; -Dining room for all meals; During an interview on 6/9/24 at 3:23 P.M. resident said lunch and dinner was always a minimum of thirty minutes late. 3. Observation of posted meal service times showed lunch was served at 12:00 P.M. Review of facility provided open dining policy showed: -Lunch served: -Memory care 7:00 A.M. -Dining room [ROOM NUMBER]:30 A.M. -Room trays 1:00 P.M. Observation on 6/9/24 on memory care unit showed: -12:30 P.M., lunch trays delivered to unit, 30 minutes after posted lunch start time; -12:32 P.M., first tray served; -12:43 P.M., last tray served, 43 minutes after posted meal time. Observation on 6/9/24 in dining room showed: -12:30 P.M. first tray passed, Continuous observation on 6/10/24 from 11:11 A.M.-1:12 P.M., showed: -12:12 P.M., first meal plated for memory care unit; -12:25 P.M., hot box left dining room and wheeled to memory cart unit, 25 minutes after posted meal time; -12:25 P.M., first meal plated for dining room residents; -12:49 P.M., [NAME] B started plating room trays; -1:12 P.M., last room tray served; 12 minutes past posted meal time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in dining room at lunch on 6/10/24 showed: -12:22 P.M., staff bringing residents to dining room for lunch; -12:29 P.M., first tray passed in dining room; -12:49 P.M., last tray was passed in dining room, 19 minutes after posted meal time. Observation on 6/11/24 on memory care unit showed: -12:21 P.M., food cart delivered to unit, 21 minutes after posted meal time; 4. Review of facility policy, using the food safety and sanitation checklist, showed: -Monitor and correct deficient safety and sanitation practices in dietary department. Review of facility policy, cleaning schedules, dated May 2015, showed: -It was responsibility of dining services manager to enforce cleaning schedules and to monitor the completion of assigned cleaning tasks. Observation of the kitchen on 6/9/24 at 9:28 A.M. showed: -Tables had not been cleaned from breakfast, carts of dishes were stacked at doorway to dish room; -Trash can lid next to food preparation table had chunks of food stuck and liquid substances coated to lid; -Stove top had burnt on food residue caked to the burners and stove top including a black egg noodle; -Grease trap on stop top griddle had food residue in it; -Back and sides of stove top were black from grease and cooking residue; -Handles of stove were sticky, caked in grease and grime, and food crumbs sitting on edges of handle; -Outside of stove had streaks of spilled food items running down front of stove; -Steam table was observed with kernels of corn sitting in the steam table water and a cream colored sticky substance was stuck to inside of one of the steam table vats; -Plate warmer had food residue and crumbs all around top of unit; -Microwave was not clean and had spilt food inside and stuck to walls of unit; -Dish drying rack next to three compartment sink had dust caked to the metal shelves of unit; (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A snack cart had a bowl of crackers with a sandwich in a bag that was dated 6/7/24 and a container of luke warm water with five containers of yogurt and two mozzarella sticks sitting in it, tea on snack cart had no ice in it and no label or date on the pitcher; -A bowl of 3/4 eaten oatmeal was sitting on cart with clean adaptive silverware in dish room; -Dry storage room showed 3 tiered metal cart had brown sticky substance spilled on bottom tier, second tier had spilled cereal crumbs and the container of rice Krispies did not have the lid secured to top, the top tier of the cart had cheerios and corn flakes spilled and crumbs of powder residue laying on top of cart. -Walk in cooler had a box of pasteurized eggs sitting directly on floor and 3-4 individualized butter containers were scattered about walk in cooler floor. -Floors of kitchen had food particles and crumbs all over; -Empty boxes laying on the ground by back door; -No paper towels were available at hand washing sink as the paper towel dispenser was empty; -Paint was peeling and chipping off of the ceiling; -Ceiling vent at entry of kitchen was covered with dust; Observation of cleaning logs on 6/9/24 at 10:01 A.M. showed: -Daily cleaning logs had no entries on Thursday, Friday, Saturday, or Sunday; -Weekly cleaning schedule log had no dates entered as to when schedule was started and what dates were week 1, 2, 3 or 4; -Week 1 had no entry for cleaning of stove, mixer, refrigerators, freezers, food storage bins, utility carts, tray carts, vent hood screens, delime of dish machine, walls, fans, kitchen vents, ice machine, dish storage units, janitor closet, back door areas, doors, and dietary manager office, and no entries at all on the log for week 2, week, 3, week 4; -Monthly cleaning schedule log had no entries. 5. During an interview on 6/12/24 at 8:49 A.M., [NAME] A said: -Dietary aide position was hard to keep filled due to the work load being too much to do; -There had been six or seven dietary aides who have attempted to do the job and quit because of the work load. During an interview on 6/12/24 at 9:07 A.M., the Dietary Manager said: -He/She did not have sufficient staff in the kitchen; (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She could not get to all management duties, cleaning, complete dietary staff training, complete assessments, order food due to having to cover as dietary aide or cook; -He/She experienced high turn over of staff in dietary department due to lack of training and work load, often having new employees walk out after three hours; -He/She was supposed to have one dietary aide and one cook, but he/she felt too much work for one dietary aide; -He/She had asked to get additional help from 9:00 A.M. to 1:00 P.M.; -Most dietary staff had no food service experience and training; -He/She did not feel like he/she had all the training or tools needed to effectively do his/her position as dietary manager; -He/She had no prior food service experience before becoming dietary manager; -He/She had minimal training from previous dietary manager due to prior dietary manager getting pulled to work as a dietary aide or cook and him/her getting pulled from training to participate in management and care plan meetings; -He/She expected the floors to be swept, mopped, and stove top burners to be cleaned right after a meal; -He/She expected the dish room to be clean and sanitary; -Surfaces in the kitchen should be cleaned as they go about meal preparation. During an interview on 6/12/24 at 10:32 A.M., [NAME] B said: -Cleaning list was hanging on bulletin board to back of kitchen; -He/She did not always following cleaning list; -He/She typically just worked with one dietary aide and him/herself at meal service times, sometimes dietary manager was available to help; -Sometimes meals were served late and behind schedule due to work load; -Sometimes he/she had to go into dining room to help serve food to resident due to staffing; During an interview on 6/12/24 at 10:56 A.M., Dietician said: -He/She expected kitchen to be clean and sanitary; -He/She had not done formal inservices with dietary staff; (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She observed an influx of new staff in and out of kitchen; -He/She tried to complete hands on training when he/she observed specific staff having issues; -He/She expected meal service to take forty five minutes from start of memory care to end of room trays; -He/She expected meal service to start at posted meal time. During an interview on 6/12/24 at 2:34 P.M., Administrator said: -He/She expected kitchen to be sanitary; -He/She expected whole meal service from memory care unit to room tray to take one hour from start to finish.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47195 Based on observation, interview, and record review, the facility failed to ensure meals were served to meet the needs of the residents when staff failed to serve food items for each diet type when staff failed to prepare food according to the menu and failed to serve the correct portion sizes per the menu. This had the ability to affect all residents. The facility census was 59. Review of facility policy, menus, dated May 2015, showed: -Menus shall meet the nutritional needs of the resident in accordance with the attending physician's orders and the recommended dietary allowances; -Any unusual or complex diet not printed on the menu or listed in the Manual shall be written by the consulting dietician based on physicians orders. Review of facility menus, day 16 lunch, showed: -Regular baked chicken: portion size 3 ounces (oz); -Pureed baked chicken: portion size/serving utensil #8 scoop; 5 servings recipe showed : -3 oz chicken,1/2 cup + 2 tablespoons stock chicken soup based,1 Tablespoon + 3/4 teaspoon food thickener; -Minced and moist chicken: portion size #8 scoop, 5 serving recipe showed: 15 oz diced chicken, 1 and 7/8 teaspoon margarine melted, 1/8 teaspoon salt, 1/8 teaspoon black pepper. Sauce of choice: 1 and 1/4 cup of sauce, combine meat with 2 oz sauce per portion. -Regular baby carrots, serving utensil 4 oz spoodle, portion size 1/2 cup -Pureed baby carrots, serving scoop- #16 scoop, recipe for 5 servings: 5 and 1/2 cups baby carrots cooked according to recipe, food thickener bulk 2 Tablespoons + 1 and 1/2 teaspoons; -Minced and moist baby carrots: serving spoon 4 oz spoodle; recipe showed 5 servings - 1 pound baby carrots steam or boil until well cooked and extremely soft, 1/8 teaspoon salt, 1 Tablespoon and 1/4 teaspoon margarine bulk, dash of black pepper to taste. Continuous observation in the kitchen on 6/10/24 from 11:11 A.M. to 1:12 P.M., showed: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11:18 A.M., [NAME] B prepared minced and moist meat in robot coupe did not follow recipe by adding margarine, black pepper, and salt. [NAME] B added gravy that was warmed in microwave, did not measure, he/she told the Dietary Manager he/she used seven pieces of meat to prepare the minced and moist; -11:29 A.M., [NAME] B added more gravy to robot coupe container; -11:31 A.M., [NAME] B added more gravy to robot coupe directly from the refrigerator; -11:38 A.M., [NAME] B did not following any recipe during food preparation, no menu books open for regular, pureed, or minced and moist food preparations; -12:05 P.M., [NAME] B added carrots to robot coupe for pureed, did not use chicken stock or thickener according to recipe; -12:17 P.M., [NAME] B added cut up chicken to plate using blue 2 oz scoop, portion did not look sufficient (wrong scoop size used); -12:17 P.M., [NAME] B added small meat portions to plate using blue 2 oz scoop (wrong scoop size used). -12:18 P.M., [NAME] B scooped up carrot portions, did not get full 4 oz scoop and did not ensure carrots were drained before adding to plate. 12:19 P.M., [NAME] B used blue scoop 2 oz for minced and moist meat, portion looked small and not appropriate size (incorrectly scoop size); -12:21 P.M., [NAME] B scooped another minced and moist plate, small portions were given using blue 2 oz scoop (incorrect scoop size); -12:37 P.M., [NAME] B had not been providing consistent meat on all plates, some residents served three pieces of chicken, some 4 pieces, some 5 pieces, and even some received 6 pieces of meat (menu showed 3 oz portions); During an interview on 6/12/24 at 8:49 A.M., [NAME] A said: -When he/she prepped puree diets he/she just added gravy to all meats, when she prepared scrambled eggs he/she just added half and half; -He/She did not look at menu book to prepare puree foods; -He/She just learned from the speech language pathologist that minced and moist and ground was not the same consistency for diets; -He/She learned that with minced and moist diets he/she just used less gravy than when he/she prepared puree diets; -He/She did not want minced and moist foods to be as thin as the puree food consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 9:07 A.M., the Dietary manager said: -He/She expected staff to follow recipe when preparing menu items; -Prior to him/her becoming dietary manager the dietary staff did not know where the recipe book was located; -Staff should use recipes in menu book when they prepared pureed diets and minced and moist diets; -Recipes in menu book help staff ensure they follow steps to ensure making foods at right consistency; During an interview on 6/12/24 at 10:32 A.M., [NAME] B said: -Recipes for the menus are located in a book in kitchen; -He/She did not use menu book to prepare meals; -He/She knew what spoons or spoodle's to use during meal service by looking at menu book which tells to use a 6 oz or 8 oz or blue or green spoon; -Previous dietary manager told him/her which spoons to use, vegetables is always a 3 oz spoodle with holes in it, mashed potatoes and scrambled eggs are always a green spoons, he/she always used a small ladle for the gravy, cream of wheat was a big ladle, and for oatmeal she used the white ladle; -When he/she served the chicken pieces he/she was trying to serve residents four or five pieces because that is what the menu called for, however he/she knew what residents hardly eat their food so she served them smaller portions. Towards end of meal service he/she served only three pieces because he/she was not sure he/she had enough food; -He/She served men bigger portions because men eat more, but he/she had to make sure he/she had enough food for meal service; During an interview on 6/12/24 at 10:56 A.M., Dietician said: -He/She expected staff to follow menus; -He/She expected staff to follow recipe when making puree and minced and moist foods; -He/She expected staff to serve residents portions listed in menus with proper serving scoops. During an interview on 6/12/24 at 2:34 P.M., Administrator said: -He/She expected staff to follow recipes; -He/She expected staff to follow the menu indicated portions during meal services; -He/She expected staff to follow the menu for proper use of serving spoons during meal service.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation and interviews, the facility failed to ensure staff served food to the residents that was palatable, attractive, and served at a safe and appetizing temperature to the residents when hot food was not served at an appetizing temperature to three (resident #40, #43, and #312) of fifteen sampled residents. The facility census was 59. Review of facility policy, food temperatures, dated April 2015, showed: -Hot foods should be at least 120 degrees Fahrenheit when served to the resident. 1. Review of Resident # 40's Significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 4/7/24, showed: - Cognitive skills intact; - He/She was independent with eating - Diagnoses included high blood pressure, gastroesophageal reflux disease (GERD) (A digestive disease in which stomach acid or bile irritates the food pipe lining), and anxiety. Review of the resident's care plan, revised 4/25/24 showed: -Resident was at nutritional risk for having strong food preferences and personal choices on not leaving his/her room for meals; -Monitor meal intake every day; -Regular diet; -Dietary to provide resident with quarterly menu in his/her room for him/her to be able to plan out his/her food choices for meals. Review of physician's orders, dated 5/10/24 to 6/10/24 showed: -He/She was on a regular diet. During an interview on 6/10/24 at 8:10 A.M., Resident said: -Food was usually on the cold side; -Hot food was typically cold; -Cold food was way too warm; -Meat was tough. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #43's Quarterly MDS, dated [DATE], showed: -Cognitive skills severely impaired; -Lower extremity impaired on one side; -He/She required set up or clean up assistance with eating; - Diagnoses included high blood pressure. Review of the resident's care plan, revised 5/1/24 showed: - The resident required substantial to dependent assistance with most activities of daily living (ADL's) related to impaired mobility. -Resident was at nutritional risk and weight loss due to dementia; -Resident needed adequate intake of food to help with wound healing; -Offer resident substitutes if he/she had problems with food being served; -House supplement at noon with meal; -Dining room for all meals; -Weighted silverware at all meals. Review of physician's orders, dated 5/10/24-6/10/24, showed: -Resident was on regular diet with special instructions of fortified foods at breakfast, milk or chocolate milk with all meals; -Curved silverware at all meals. During an interview on 6/9/24 at 3:23 P.M., Resident said his/her food was cold. 3. Observation on 6/10/24 at 1:12 P.M. of a meal test tray showed: -Fish temperature was 99.2 degrees, below serving temperature; -Carrots temperature was 111.9 degrees, below safe serving temperature; -Chicken tenders temperature was 140.0 degrees; -Mashed Potatoes temperature was 120.2 degrees; -Baked beans temperature was 104.6, below safe serving temperature; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pureed chicken temperature was 126.6 degrees; -Minced and moist chicken temperature was 114.1 degrees; -Cut up chicken temperature was 106.3 degrees; -Macaroni and cheese temperature was 105.3 degrees; -Pureed spiced peaches temperature was 81.5 degrees; -Spiced peaches temperature was 82.4 degrees. 31102 Review of Resident #312's admission face sheet showed: -Diagnoses included: Bipolar disorder (mental health disorder that alternates between depression and mania), Irritable bowel syndrome with diarrhea and urinary incontinence. -Cognition intact, can make all needs known. During an observation and test tray testing on 6/10/24 1:15 P.M., the meal's appearance was unappetizing, and the temperature was lukewarm. The texture of the vegetables was soft and overcooked. The chicken nuggets were soggy and the breading on them was breaking down. During an interview on 6/9/24 3:07 P.M., Resident (312) said that the meat was tough and sometimes the meal temperatures are cold in the dining room. During an interview on 6/12/24 at 9:07 A.M., the Dietary manager said: -Food should not be served below temperature; -He/She expected staff to bring the food back to appropriate temperature by reheating food items in the oven. During an interview on 6/12/24 at 10:56 A.M., Dietician said: -He/She expected staff to temperature check food as soon as it came out of oven, before it was placed on steam table, and before serving food; -He/She expected staff to check food temperatures after meal service to ensure temperature was maintained throughout the meal service; -When temperature checked food was not to temperature, he/she expected staff to cover food and put back into the oven, steamer, or stove top to be brought back to proper holding temperature; -He/She expected food cooked in microwave to be temperature checked; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She would not expect staff to serve food without hitting correct temperature points. During an interview on 6/12/24 at 2:34 P.M., Administrator said: -He/She did not expect staff to serve food that was not at proper serving temperature. -He/She expected staff to reheat foods per the facility reheating policy; -He/She expected hot food to be served hot. 50980

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47195 Based on observation, interview, and record review the facility failed to prepare food in a form designed to meet individual needs when residents were served food not consistent with their dietary orders (Resident #27). This affected one of fifteen sampled residents. The facility census was 59. Review of facility policy, menus, dated May 2015, showed: -Menus shall meet the nutritional needs of the resident in accordance with the attending physician's orders and the recommended dietary allowances; -Any unusual or complex diet not printed on the menu or listed in the Diet Manual shall be written by the consulting dietician based on physicians orders. Review of facility policy, diet communication form, dated April 2006, showed: -It is the responsibility of the nursing department to communicate all information associated with the residents diet order to the dietary department via the dietary communication form; -A dietary communication form will be completed when there is a change in diet. 1. Review of Resident #27's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/27/24, showed: -He/She was independent with eating; -He/She had a therapeutic diet; -Diagnosis included dementia (condition characterized by impairment of at least two brain functions such as memory loss and judgement), mild protein-calorie malnutrition (a nutritional disorder caused by inadequate quantities of protein and energy in diet), gastro-esophageal reflux disease without esophagitis (a condition in which stomach contents move up into the esophagus) Review of care plan, dated 5/1/24, showed: -Resident was at risk for weight loss due to dementia, he/she had a history of gradual weight loss; - He/She had strong food preferences; -Diet regular with moist and minced level 5 meats; -Monitor for signs of malnutrition. Review of physician's orders, dated 5/11/24 to 6/11/24, showed: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ordered 5/31/24, Diet: Level 7 Minced and Moist Level 5 (MM5) meat. Observation on 6/11/24 at 7:36 A.M. showed that minced and moist food not served as ordered for resident. Observation showed the speech language pathologist (SLP) noted resident was served wrong food when he/she arrived to unit and he/she told Certified Nurses Aide (CNA) B he/she served the resident the wrong diet order. The plate had two strips of regular bacon and scrambled eggs. SLP went to kitchen and got resident minced and moist eggs and bacon and returned to unit with new plate. During an interview on 6/11/24 at 8:03 A.M., SLP said: -Resident was served improper diet at breakfast; -Diets not being followed has been an ongoing issue in the facility; -When he/she writes an order the order gets put into the computer by a nurse, then diet slip is taken to the dietary manager; -Problem has been with person who has served the food incorrectly; -Inservices have occurred by the facility and staff have been educated. Observation on 6/11/24 at 12:59 P.M. resident was served with pureed meats, not minced and moist as ordered. Review of facility in-service education showed: -On 5/31/24, Dietary Manager educated on dietary tickets, duets must be read thoroughly to ensure correct diets were followed. During an interview on 6/11/24 at 12:59 P.M., SLP said: -Resident was again served wrong dietary menu from kitchen. During an interview on 6/12/24 at 8:49 A.M., [NAME] A said: -He/She knew resident specific diets based on their meal tickets; -When resident had a diet change, he/she would receive a new meal ticket paper and it was placed inside kitchen door or given to dietary manager; -He/She was aware of resident being served wrong diet when his/her dietary ticket showed minced and moist and he/she received regular cereal. Resident had trouble eating and would choke a lot because he was being given stuff he/she was not supposed to have. During an interview on 6/12/24 at 9:07 A.M., the Dietary manager said: -He/She expected staff to follow the physician ordered diet as it was difference between a resident choking or not choking; (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had seen residents choke on regular meat and it was very important that residents received what the physician ordered; -He/She was aware of residents being served the wrong diets that week; -Resident #27 was served wrong diet; -Resident #27 was served wrong breakfast on 6/11/24 when he/she was served regular diet; -Resident #27 was served wrong lunch on 6/11/24 when [NAME] B got really scared and nervous and served everything minced and moist when just the resident's meat should have been served minced and moist; -He/She educated staff on 5/31/24 in-service on ensuring staff read meal tickets and ensured diet orders were being followed. During an interview on 6/12/24 at 10:09 A.M., CNA C said: -He/She looked at resident meal tickets to ensure their diet was served correctly; -If tray was wrong he/she would take it back to kitchen to have them make it correctly. During an interview on 6/12/24 at 10:32 A.M., [NAME] B said: -He/She reads meal tickets to know resident's specific diets; -He/She had served residents the wrong diets; -He/She served the resident the wrong diet; -He/She had served wrong diets to other residents every once in awhile; -The unit staff, nurse, or SLP brings it to his/her attention when diet was served wrong. During an interview on 6/12/24 at 10:56 A.M., Dietician said: -He/She expected staff to follow diet orders for residents. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing (DON) said: -He/She expected physician ordered diet orders to be followed; -He/She expected staff serving resident's plate to correct improper diets before serving meal to residents -He/She expected the cook to ensure resident diets were served correctly. During an interview on 6/12/24 at 2:34 P.M., Assistant DON said: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expected resident to be served physician ordered diet. -He/She expected staff to identify improper served diets and correct diet before serving to a resident. During an interview on 6/12/24 at 2:34 P.M., Administrator said: -He/She expected resident's diet orders to be followed

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47195 Based on observation, record review, and interview the facility failed to prepare and serve food in accordance with professional standards for food service safety when staff failed to maintain a clean and sanitary kitchen, failed to take food temperatures on the steam table before food service and when cooking items, failed to reheat foods to safe temperatures before serving, stored glasses with openings facing up, stored eggs on the floor, did not properly sanitize food preparation surfaces in kitchen, did not have a thermometer in refrigeration unit, did not ensure proper parts per million (PPM) sanitation levels were reached while using a 3 compartment sink, did not wash hands after contamination, did not have paper towels available at hand washing sink, and when dietary staff did not wear hairnets prior to entering kitchen. The facility census was 59. 1. Review of facility policy, Receiving and storage of food, dated [DATE], showed: -Keep storage areas clean and dry. Review of facility policy, storage of dry food and supplies, dated [DATE], showed: -Storeroom must be neat and orderly. Shelving is kept clean and free of rust and chipped paint; -Metal and plastic containers with tight fitting covers, labeled top or side, bust be used for storing opened products; -Food is to be stored a minimum of six inches above the floor. Review of facility policy, using the food safety and sanitation checklist, dated [DATE], showed: -Monitor and correct deficient safety and sanitation practices in dietary department. Review of facility policy, cleaning schedules, dated [DATE], showed: -It is responsibility of dining services manager to enforce the cleaning schedules and to monitor the completion of assigned cleaning tasks; -Daily, weekly, and monthly cleaning schedules prepared by the dining services manager with all cleaning tasks listed will be posted in dietary department. Review of facility policy, developing cleaning schedules, dated [DATE], showed: -To develop detailed cleaning schedules to ensure sanitation is at acceptable standards. -The employee responsible for performing the task is responsible for initialing the cleaning schedule on the day the task was completed; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Daily cleaning schedule showed: counter tops, steam table, 3 compartment sink, stove top, dishwashing area, refrigerator,, garbage cans and lids, hand sink/soap/paper towels, tray carts, floors - sweep and mop, microwave; -Monthly cleaning schedule: oven - clean thoroughly, ceiling, ceiling lights and covers, baseboards; -Weekly cleaning schedule showed: stove, steamer, utility carts - polish/clean, storage room. Review of facility policy, guidelines for cleaning gas stove, dated [DATE], showed: -Remove pot rests from above burners on the cooking surfaces; -Wash, rinse, and dry; -Remove sections of the cooking surface by lifting upward and outward, place sections on newspaper and brush with oven cleaner. -Wipe off dissolved grease with paper towels; -If any grease remains, brush again, and wipe off; -Clean area around and under burners with warm detergent solution and rinse; -Place units in pot sink with hot detergent solution, wash, rinse, and dry or run through dishwasher; -Empty grease pan and wash with hot detergent solution, rinse, dry, and replace. Review of facility policy, guidelines for cleaning gas oven, dated [DATE], showed: -Oven will be cleaned weekly -Wipe off loosened grease with paper towels -Wash and rinse the racks and let air dry Review of facility policy, stoves, ovens and microwaves, dated [DATE], showed: -Each cook is responsible for the use and care of the stove on his or her shift. Review of facility policy, guidelines for cleaning microwave, dated [DATE], showed: -Wash out spills and splatters as they occur, using a detergent solution; -Sanitize with appropriate strength of solution. Review of facility policy, cleaning floors, undated, showed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Kitchen floor maintenance will be done after each meal. Spills need to be mopped up immediately; -Sweep the floor, pushing all debris forwarding, using dustpan to remove debris. Review of facility sanitation checklists completed by facilitation dietician showed: -[DATE]: carts needed deep cleaned, many holes in cleaning tasks, garbage can lid dirty, deep cleaning needed of dish machine, all food was not properly covered, labeled, and dated; -[DATE]: floors were not clean, shelving and carts needed cleaned; corrected dietary manager on getting all hair in hair net, deep cleaning needed of dish machine, garbage can lid was dirty, holes in cleaning list tasks. Observation of the kitchen on [DATE] at 9:28 A.M. showed: -Tables had not been cleaned from breakfast, carts of dishes were stacked at doorway to dish room; -Trash can lid next to food preparation table had chunks of food stuck and liquid substances coated to lid; -Stove top had burnt on food residue caked to burners and stove top including a black egg noodle; -Grease trap on stop top griddle had food residue in it; -Back and sides of stove top were black from grease and cooking residue; -Handles of stove were sticky, caked in grease and grime, and food crumbs sitting on edges of handle; -Outside of stove had streaks of spilled food items running down front of stove; -Steam table was observed with kernels of corn sitting in the steam table water and a cream colored sticky substance was stuck to inside of one of the steam table vats; -Plate warmer has food residue and crumbs all around top of unit; -Microwave was not clean and had spilt food inside and stuck to walls of unit; -Dish drying rack next to three compartment sink had dust caked to the metal shelves of unit; -A bowl of ,d+[DATE] eaten oatmeal was sitting on cart with clean adaptive silverware in dish room; -Dry storage room showed 3 tiered metal cart had brown sticky substance spilled on bottom tier, second tier had spilled cereal crumbs and the container of rice Krispies did not have the lid secured to top, the top tier of the cart had cheerios and corn flakes spilled and crumbs of powder residue laying on top of cart; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Walk in cooler had a box of pasteurized eggs sitting directly on floor and ,d+[DATE] individualized butter containers were scattered about walk in cooler floor; -Floors of kitchen had food particles and crumbs all over; -Empty boxes laying on the ground by back door; -No paper towels were available at hand washing sink as the paper towel dispenser was empty; -Paint was peeling and chipping off of ceiling; -Ceiling vent at entry of kitchen is covered with dust. Observation of cleaning logs on [DATE] at 10:01 A.M. showed: -Daily cleaning logs had no entries on Thursday, Friday, Saturday, or Sunday; -Weekly cleaning schedule log had no dates entered as to when schedule was started and what dates were week 1, 2, 3 or 4; Week 1 had no entry for cleaning of stove, mixer, refrigerators, freezers, food storage bins, utility carts, tray carts, vent hood screens, delime of dish machine, walls, fans, kitchen vents, ice machine, dish storage units, janitor closet, back door areas, doors, and dietary manager office, and no entries at all on the log for week 2, week, 3, week 4. -Monthly cleaning schedule log had no entries. Continuous observation in the kitchen on [DATE] from 11:11 A.M. - 1:12 P.M. showed: -11:30 A.M., Dietary Aide observed adding clean dishes to plate warmer. Plate warmer had crumbs and dirt piled on top of unit. Observation on [DATE] at 11:30 A.M. showed paint chipping off ceiling by the air ventilation units and air ventilation units are caked in layers of dust. During an interview on [DATE] at 8:49 A.M., [NAME] A said: -Clean cups should be stored with the opening down; -Kitchen had a cleaning list to follow; -He/She did not clean items in kitchen that was not used like the griddle; -He/She should sweep, mop, and wipe off everything in kitchen; -When he/she wiped off surfaces in kitchen he/she should use bucket with sanitizer water in it; -When he/she swept he/she needed to sweep under tables and counters; -He/She checked to make sure nothing was expired in fridge; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Night shift emptied water from steam table; -Steam table was not cleaned on [DATE] when their was food found in steam table on morning of ,d+[DATE]. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -He/She expected the floors to be swept, mopped, and stove top burners to be cleaned right after a meal; -He/She expected the dish room to be clean and sanitary; -Surfaces in the kitchen should be cleaned as they go about meal preparation; -Grease trap should be cleaned every time it is used and checked weekly; -Maintenance was responsible for cleaning vents in the kitchen; -Staff know what serving spoons to use during meal service by looking at menu book that shows what spoon or spoodle to be used; -Steam table should be cleaned every night; -There should not be leftover food such as corn or spilled substance on steam table, the unit should be wiped out and refilled every evening; -The trash can lid should be cleaned regularly and should not have food caked to top of it. During an interview on [DATE] at 10:04 A.M., Dietary Aide A said: -He/She did not clean surfaces in the dish room; During an interview on [DATE] at 10:32 A.M., [NAME] B said: -Cleaning list is hanging on bulletin board to back of kitchen; -He/She tried to clean up food surfaces he/she used during meal preparation; -He/She did not always following cleaning list. During an interview on [DATE] at 2:34 P.M., Administrator said: -He/She expected kitchen to be sanitary; -Food should not be stuck to top of stove top; -There should not be grease or grime on stove and refrigerator; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Trash can should not have food stuck to the lid; -Floor should be swept and mopped at end of every shift; -He/She would not expect corn or sticky substance coated to inside of steam table; -He/She expected maintenance to clean air vents in kitchen; -He/She would not expect paint to be peeling off kitchen ceiling; -He/She expected food preparation services to be cleaned using sanitizing spray; -It was not appropriate to use soapy wash cloth to sanitizer kitchen preparation services. 2. Review of facility policy, food temperatures, dated [DATE], showed: -The dietary manager or designee is responsible for seeing that all food is the proper serving temperature before trays are assembled; -Keep the temperature of hot foods no less than 140 degrees during tray assembly; -Hot foods should be at least 120 degrees Fahrenheit when served to the resident; -Keep temperatures of potentially hazardous cold foods no greater than 40 degrees F. Prepare cold items a day in advance when possible. Place items in freezer 45 minutes before serving and use ice baths when needed; -Take and record the temperatures of all items at all meals; -Once weekly a test tray should be sent with the hall trays. Food temperatures should be taken and recorded after all trays have been delivered; -Heat food to the proper temperature by direct heat (using a stove, oven, steamer) and then transfer food to the preheated steam table no more than thirty minutes before meal service; -To ensure adequate temperatures, proper-holding techniques should be used; -Food is not placed on steam table more than 30 minutes before meal service; -Food is not held in warm ovens more than 30 minutes before meal service. It is recommended that food not be held on steam table for longer than two hours; -Only remove up to five plates at a time from the heated plate warmer; -Foods should be reheated to a minimum temperature of 165 degrees for fifteen seconds. Review of facility policy, using the food safety and sanitation checklist, dated [DATE], showed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Monitor and correct deficient safety and sanitation practices in dietary department. -Food safety and Sanitation checklist; -Does hot food leave the kitchen above 140 degrees. Observation on [DATE] at 9:28 A.M. showed: -A snack cart had container of room temperature water with five containers of yogurt and two mozzarella sticks sitting in it, tea on snack cart had no ice in it. Continuous observation in the kitchen on [DATE] from 11:11 A.M. to 1:12 P.M., showed: -11:16 A.M., [NAME] B added chicken fritters to steam table, no temperature taken; -11:17 A.M., [NAME] B used white wash cloth that had not been in sanitizer to wipe off counter of steam table. -11:18 A.M., [NAME] B prepared minced and moist meat. He/She added minced and most to steam table and did not temperature check the meat; -11:20 A.M., [NAME] B removed macaroni from microwave, added to steam table, was not temperature checked; -11:46 A.M., Administrator in dish room rinsing dishes and running dish washer; -11:46 A.M., Baked beans dated ,d+[DATE], use by ,d+[DATE] added to microwave for two minutes; -11:53 A.M., Baked beans still sitting in microwave, have not been touched; -11:59 A.M., Baked beans removed from microwave and added to steam table, 13 minutes after being placed in microwave. Beans were not temperature checked; -12:06 P.M., Dietary Manager added pureed carrots to a container from robot coupe, then temperature checked pureed carrots at 148.6 degrees (below serving temperature), did not document temperature, carrots added to steam table not at appropriate temperature; -12:42 P.M., Dietary Manager brought food temperature log over to clip board; -12:46 P.M., [NAME] B completed food temperatures on some foods on steam table but not all of them were temperature checked, items were not at appropriate holding temperature: -Chicken 159.6 degrees; -Cut up chicken patties - 129.9 degrees; -Carrots 170.6; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Minced carrots 127.9 degrees; -pureed chicken 157.8 degrees; -Mashed potatoes were not temperature checked -Minced and moist chicken 158.7 degrees; -1:06 P.M., Dietary Manager brought cooked hamburger patty to cook B, temperature checked it at 147.7 degrees (not to safe temperature) During an interview on [DATE] at 8:49 A.M., [NAME] A said: -Food should be cooked mostly to 165 degrees, and fish was lower at 145 degrees; -He/She temperature checked foods right when it came out of the oven; -He/She documented food temperatures on a paper in the kitchen; -He/She temperature checked food after it sat in the steam table; -He/She had many people complained that food was cold; -Food is cold because staff let it food sit and do not serve the trays right away; -Food temperatures that are taken on steam table are documented on same paper cooking temperatures are documented where there is a holding temperature row; -He/She had no specific time for doing temperature checks on food on the steam table, he/she usually temperature checked food at some point between serving food and being done with food service; -He/She reheated vegetables in the oven; -He/She reheated hot dogs and items that were already cooked in the microwave. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -Food should be temperature checked when it came out of oven; -Mechanical diets should be temperature checked to ensure food is hot and fresh; -Foods are not temperature checked on steam table; -Food is temperature checked before room trays are served; -When food was not at temperature then he/she expected staff to bring it up to proper temperature by putting food back in stove or oven; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Food should be held on steam table at a minimum of 135 degrees; -Meats are to be held between 145 degrees and 175 degrees; -Most of the time the staff crank the steam table; -He/She had told staff that the steam table was not to be used to cook foods; -Food temperature checks should be documented; -He/She had issues getting staff to document temperatures of foods; -Cold food items should not be sent out on snack cart at night time; -Cold food items should be kept on ice at all times, if cold food items return to kitchen no longer in ice bath the food should be thrown out if not stored at appropriate temperature. During an interview on [DATE] at 10:56 A.M., Dietician said: -He/She expected staff to temperature check food as soon as it came out of oven, before it was placed on steam table, and before serving food; -He/She expected staff to check food temperatures after meal service to ensure temperature was maintained throughout the meal service; -When temperature checked food was not to temperature, he/she expected staff to cover food and put back into the oven, steamer, or stove top to be brought back to proper holding temperature; -He/She expected food cooked in microwave to be temperature checked; -He/She would not expect staff to serve food without hitting correct temperature points; -He/She expected most leftover foods to be reheated in oven or steamer to 165 degrees; -He/She would not expect staff to reheat fish patties in the microwave. During an interview on [DATE] at 2:34 P.M., Administrator said: -He/She was unsure what policy was but before being placed on steam table, during meal time, after food is cooked; -Cooking temperature and serving temperature should be recorded. 3. Review of facility policy, general dish room sanitation, dated [DATE], showed: -All items must be stored inverted, covered, or stacked with top of dish/tray inverted. Observation on [DATE] at 9:28 A.M. showed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Drinking cups were stored upright in storage containers. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -Clean cups should be stored with their openings flipped down. 4. Review of facility policy, storage of food and supplies, dated [DATE], showed: -Food is to be stored a minimum of six inches above the floor. Observation on [DATE] at 9:42 A.M. showed a box of pasteurized eggs was sitting directly on the floor of walk in cooler. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -Eggs should not be stored on floor of cooler, they should be stored six inches off the ground. During an interview on [DATE] at 10:32 A.M., [NAME] B said: -Eggs should not be stored on floor, nothing should be stored on the floor. During an interview on [DATE] at 2:34 P.M., Administrator said: -Eggs should not be stored on floor; -Food should be stored on a shelf. 5. Facility had no policy regarding sanitation bucket use. Review of facility policy, using food safety and sanitation checklist, dated [DATE], showed: -Are cleaning clothes stored in sanitizing solution; -Are food contact surfaces cleaned and sanitized after each use. Observation on [DATE] at 9:49 A.M. showed no sanitizer buckets were prepared or set up in kitchen. Observation on [DATE] at 9:58 A.M. showed there was two sanitizer buckets sitting on shelf under the three compartment sink that were empty and had not been used. During an interview on [DATE] at 10:03 A.M., [NAME] A said: -He/She did not prep sanitizer-buckets; -He/She thought aides are supposed to do that; -He/She does not use sanitizer buckets as he/she cooks to clean to food preparation surfaces in kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continuous observation in the kitchen on [DATE] from 11:11 A.M. - 1:12 P.M. showed: -11:36 A.M., No sanitizer buckets filled anywhere in kitchen; -11:46 A.M., Dietary Manager observed adding sanitizer to green bucket; -11:54 A.M., [NAME] B uses wash cloth from soapy water to wipe off food preparation service; -12:04 P.M., [NAME] B used wash cloth dipped in soapy water to wipe off gravy off surface of preparation table. During an interview on [DATE] at 9:49 A.M., Dietary Aide C said: -He/She had not set up sanitizer buckets yet because he/she just used them to wipe off tables in dining room; During an interview on [DATE] at 8:49 A.M., [NAME] A said: -Sanitizer buckets should be prepared by the dietary aide, he/she prepared the bucket before or after the meal. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -Staff should use a wash cloth dipped in sanitizer to clean food preparation services; -Sanitizer buckets should be set up prior to staff clearing the tables in dining room and silver soak needs to be set up to clean off table; -Detergent went in green buckets, and then sanitizer in red buckets; -Sanitizer buckets should be tested ; -Wash clothes being used should be stored in sanitizer solution. During an interview on [DATE] at 10:04 A.M., Dietary Aide A said: -He/She set up sanitizer buckets for washing dining room tables only; -The sanitizer buckets should be used to wash down the three tiered carts; -Wash clothes should be stored in the sanitizer solution when not in use. During an interview on [DATE] at 10:32 A.M., [NAME] B said: -He/She washed kitchen preparation surfaces with soapy dish water first and then went back over surfaces with sanitizer water; -He/She stores his/her wash rag in the soapy dish water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:56 A.M., Dietician said: -He/She expected food preparation surfaces to be cleaned off first with sanitizer solution. During an interview on [DATE] at 2:34 P.M., Administrator said: -He/She expected food preparation services to be cleaned using sanitizing spray; -Sanitizer buckets should be prepped prior to meal service; -It was not appropriate to use soapy wash cloth to sanitizer kitchen preparation services. 6. Review of facility policy, refrigerator and freezer temperatures, dated [DATE], showed: -There should be a thermometer in all refrigerator and freezers. Thermometers should be located in the front of the unit. Observation on [DATE] at 9:56 A.M. showed no thermometer located in refrigerator unit, outside of the unit had a digital temperature reading of 34 degrees. During an interview on [DATE] at 9:58 A.M., [NAME] A said the refrigerator had no thermometer inside unit, they just used the digital thermometer on the outside of the refrigerator to track temperatures. During an interview on [DATE] at 2:34 P.M., Administrator said: -Thermometers should be located in all refrigerators and freezers. 7. Review of facility policy, sanitizing the three-compartment sink, dated [DATE], showed: -Ensure that the sanitizing water is at the appropriate level, is being monitored, documented, and used correctly, according to the instruction below. -Fill third compartment of 3-compartment sink with water to the line as indicated on the sink. -Add pre-measured sanitizing solution per manufacturer's setting. Solution must be at room temperature. -Test paper must be clean and dry. Remove 1 ,d+[DATE] inches of test paper from container. -Dip test paper into solution and hold for 10 seconds. -Compare color on strip to chart on container (desired reading is 200ppm). -Document test strip completion on log provided. -Dishes should be submerged in sanitizing solution for 1 to 2 minutes and allowed to air dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Sanitizing solution should be tested and logged three times daily prior to the use of the 3 compartment sink. Observation on [DATE] at 9:42 A.M., showed [NAME] A had soap in first compartment of sink, no water or sanitizer in other containers of three compartment sink. Three compartment sink log hanging above sink showed it had no entries for [DATE]. During an interview on [DATE] at 9:42 A.M., [NAME] A said the first compartment of sink had dish soap and water only. Continuous observation in the kitchen on [DATE] from 11:11 A.M.-1:17 P.M. showed: -11:14 A.M. Three compartment sink was filled, steam coming off from hot water; -11:17 A.M., [NAME] B used white wash cloth that had not been in sanitizer to wipe off counter of steam table; -11:21 A.M., [NAME] B took robot coupe container to sink and washed container in first compartment of three compartment sink with soapy water; -11:24 A.M., [NAME] B ran a test strip at request of surveyor in third compartment of sink, test strip did not change colors showing 0 parts per million (PPM) of sanitizing solution. [NAME] B said he/she added sanitizer to third compartment of sink but he/she had not completed a test strip yet today. Observation showed dishes had already been washed and were sitting in clean dish return. Dietary manager advised [NAME] B to run another test strip. [NAME] B put another sanitizer strip in third compartment of sink and strip did not change color showing 0 PPM. Dietary Manager advised [NAME] B to drain third compartment of sink and re-add sanitizer solution. Water begins to drain from third compartment of sink. -11:27 A.M., [NAME] B obtains robot coupe container that had not been ran through sanitizer, and only washed in soapy water, and used a paper towel to dry the robot coupe. -11:29 A.M., Dietary manager ran test strip in third compartment of sink showing 200 PPM. During an interview on [DATE] at 8:49 A.M., [NAME] A said: -The three compartment sink should be tested every morning before he/she did dishes for breakfast and before lunch; -Sanitizer was not coming out at the sink so when he/she tested the three compartment sink it was at 0 parts per million (PPM), showing he/she had no sanitizer in sink; -He/She had done dishes this morning in three compartment sink without having sanitizer in the sink; -The robot coupe was always washed in the sink. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11:36 A.M., [NAME] B applied gloves to cut up meat patties; -11:45 A.M., [NAME] B had not washed hands, gone from washing robot coupe back to food preparation; -11:55 A.M., Dietary Aide A re-entered kitchen from dining room, did not wash hands; -12:09 P.M., [NAME] B moved glasses from top of head down to face, did not wash hands; -12:12 P.M., [NAME] B used bare hands and opened serving window, he/she did not wash hands; 12:35 P.M., Dietary Manager exited and then re-entered kitchen, did not wash hands, obtained clean cups off dish washer clean side and stacked them on clean cup stack in main dining room; -12:38 P.M., Dietary manager re-entered kitchen, did not wash hands, got item out of the refrigerator, and obtained container of broth. During an interview on [DATE] at 11:03 A.M., Dietary Aide A said: -He/She was trained on washing hands before pulling clean items and how to load items into the dishwasher. During an interview on [DATE] at 10:56 A.M., Dietician said: -He/She identified hand hygiene as a concern during his/her on-site visits; -He/She had not done any formal in-services or training with facility staff; -Facility had an influx of staff; -He/She had done some informal training with staff as he/she observed issues while not washing hands when changing from tasks. During an interview on [DATE] at 8:49 A.M., [NAME] A said: -Hand washing should be completed before he/she touched food, before and after touching food, when he/she left kitchen and re-entered kitchen, and if he/she left work station and went to new area of kitchen. During an interview on [DATE] at 9:07 A.M., the Dietary manager said: -He/She expected staff to wash their hands every time they touched food, removed gloves, after doing dishes and going from dirty side to clean side, whenever staff touched their face, nose, glasses, heads, and anything personally on them, after handling food, when going to a different food preparation station, and after remove their gloves; -There should be paper towels available for staff at the hand washing sink; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was no paper towels in the dispenser on [DATE]. During an interview on [DATE] at 10:04 A.M., Dietary Aide A said: -He/She should wash hands after handling food, before he/she touched drinks, after touching residents, before going to clean side of dish washer to put away clean dishes, when going in and out of kitchen, after he/she used restroom, and when he/she returned to his/her work space. During an interview on [DATE] at 10:32 A.M., [NAME] B said: -He/She should wash hands when he/she went from one activity to another; -He/She did not wash hands while cooking food; -He/She would stick his/her hands in wash water and sanitizer; -He/She did not wash hands when he/she went to serve foo

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31102 Based on observations, interviews, and record review, the facility failed to provide care in a manner to prevent infection or the possibility of infection when staff failed to wash hands between dirty and clean tasks which affected one of the 15 sampled residents, (Resident #43). The facility census was 59. Review of the facility's undated policy for handwashing showed: - The purpose is to reduce transmission of organisms form resident to resident, nursing staff to resident and resident to nursing staff; - The policy did not indicate when staff should wash or sanitize their hands. 1. Review of Resident #43's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/12/24 showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Occasionally incontinent of bowel; - Had a Stage II pressure ulcer (a partial thickness loss of skin layers that presents clinically as an abrasion, blister or a shallow crater) - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI). Review of the resident's care plan, revised 5/1/24 showed: - The resident required substantial to dependent assistance with most activities of daily living (ADLs) related to impaired mobility. Allow the resident to participate with dressing as much as possible to his/her ability; - The resident is at risk for decreased independence in bed as evidenced by poor strength and decreased ability to move self effectively. Encourage use of the the grab bar while performing care to maintain strength and encourage independent movement side to side while in bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/9/24 at 2:39 P.M., showed;- The resident was on enhanced barrier precautions (EBP, an infection control strategy that uses personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs) between residents in long term care facilities) due to having a wound and a Suprapubic catheter; - Certified Nurse Aide (CNA) B entered the resident's room with a gown on and gloves; - CNA B brought the sit to stand lift (a lift that allows residents who can bear weight to transfer from a sitting position to a standing position) into the room, uncovered the resident, removed the heel protectors (helps prevent pressure ulcers, (PU, an area of localized damage to skin and underlying tissue caused by pressure, shear, friction and/or a combination of these), unfastened the wound vac (a wound dressing system that uses sub-atmospheric pressure to help wounds heal); - Licensed Practical Nurse (LPN) A entered the resident's room with gloves and a gown on; - CNA B and LPN A hooked the resident up to the sit to stand lift; - CNA B moved across the floor to the bathroom and lowered the resident onto the toilet; - After the resident finished using the bathroom, CNA B cleaned fecal material from the resident's rectum; - CNA B returned the resident to his/her bed and laid him/her down and removed his/her pants; - LPN A sprayed wound cleanser (the process of removing contaminants, bacteria, and remnants of previous dressings from a wound and the surrounding skin) on the resident's coccyx (tailbone), removed his/her gloves, did not wash hands and applied new gloves. LPN A provided peri care and applied miconazole cream (used to treat fungal skin infections) to the resident's groin area, placed the heel protectors back on the resident; - CNA B and LPN A attempted to move the resident up in the bed so they could turn the resident on his/her side; - LPN A removed gloves and left the room; - Nurse Aide (NA) C entered the resident's room with gloves and a gown on and assisted CNA B to move the resident up in the bed and turned the resident on his/her side; - CNA B and NA C removed gown and gloves and left the room. During an interview on 6/12/24 at 9:15 A.M., LPN A said: - Should wash hands when you enter a resident's room, between glove changes and before leaving the room; - If cleaning fecal material, should removed gloves and wash hands. Observation on 6/11/24 at 1:23 P.M., showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Medication Technician (CMT) A entered the resident's room with a gown on, did not wash his/her hands and applied gloved; - NA B washed hands and applied gloves; - CMT A and NA B hooked the resident up to the sit to stand lift; - CMT A removed gloves, did not wash his/her hands and applied new gloves; - CMT A and NA B transferred the resident to the side of the bed and assisted the resident to lay down and removed his/her pants; - CMT A and NA B removed gloves, did not wash their hands and applied new gloves; - CMT A and NA B placed the resident's wound vac at the foot of the bed, placed the resident's heel protectors on him/her, placed the drainage bag (a bag that collects urine from the body when it's attached to a catheter that's inserted into the bladder) in the dignity bag on the side of the bed, covered the resident, pushed the bed against the wall, and placed the fall mat beside the resident's bed; - NA B removed his/her gown and gloves, did not wash his/her hands and took the sit to stand lift out of the room; - CMT A removed the gown and washed his/her hands and left the room. During an interview on 6/12/24 at 2:34 P.M., the Director of Nursing (DON) said: - Staff should wash their hands before cares, when they enter the resident's room, between glove changes, before they leave the resident's room; - If staff are cleaning fecal material, would expect staff to remove gloves and wash hands, not sanitize their hands. During an interview on 6/20/24 at 3:30 P.M., CMT A said: - He/she should wash his/her hands or sanitize if touching the resident, when gloves are visibly dirty, when he/she entered the room, and between glove changes; - When cleaning fecal material, should remove gloves and wash hands. During an interview on 6/21/24 at 8:31 A.M., NA B said: - He/she should wash hands when entering the resident's room, between glove changes and before leaving the room. 46706

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 31102 Based on observations, interviews, and record review, the facility failed to ensure the call light system was accessible for residents in their rooms when call lights were out of reach for two of the 15 sampled residents, (Resident # 43 and #44). The facility census was 59. Review of facility policy, use of call light, undated, showed: -When providing care to residents, be sure to position the call light conveniently for the resident's use. -Tell the resident where the call light is and show him/her how to use the call light. -Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand. 1. Review of Resident #43's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/12/24 showed: - Cognitive skills severely impaired; - Lower extremity impaired on one side; - Required substantial to maximal assistance with toilet use, dressing and transfers; - Had a Suprapubic catheter (a catheter which enters the bladder through the lower abdomen; - Frequently incontinent of bowel; - Diagnoses included pressure induced deep tissue damage of the left heel, obstructive uropathy (a urinary tract disorder that occurs when urine flow is blocked causing urine to back up and potentially injure the kidneys) and urinary tract infection (UTI, presence of bacteria indicative of a possible UTI), Review of the resident's care plan, revised 5/3/24 showed: - The resident was at risk for falls related to a history of alls and impaired mobility due to recent fracture to left hip from a fall at home. Keep call light in reach at all times. Observation on 6/9/24 at 10:48 A.M., showed: - The resident sat in his/her recliner with feet elevated and covered with a blanket; - The resident's call light was was draped over the foot of the resident's bed and not within his/her reach. Observation on 6/11/24 at 2:51 P.M. showed: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff provided incontinent care and moved the resident up in the bed; - When the staff left the room, the resident's call light was at the foot of his/her bed and the family moved it to within the resident's reach. During an interview on 6/12/24 at 8:46 A.M., Registered Nurse (RN) A said the call lights should be in reach of the residents at all times. During an interview on 6/12/24 at 9:15 A.M., Licensed Practical Nurse (LPN) A said the call lights should be within the residents reach. During an interview on 6/12/24 at 10:32 A.M., Certified Nurse Aide (CNA) B said call lights should be in the residents reach. 47195 2. Review of Resident #44's annual minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 3/3/24, showed: -He/She was severely cognitively impaired with a BIMS score of 3; -He/She was dependent on a walker; -He/She was independent with eating, oral hygiene, toileting, dressing, and mobility; -He/She required partial moderate assistance with bathing; -No preferences for customary routines and activities documented; -Diagnoses included dementia (loss of memory, language, problem-solving and other thinking abilities to interfere with daily life), anxiety, osteoarthritis (a degenerative disease that worsens over time), osteoporosis (condition in which the bones become weak and brittle), macular degeneration (eye disease that causes vision loss), hearing loss, and history of urinary tract infections. Review of care plan, dated 6/4/24, showed: -He/She had impaired vision related to macular degeneration; -He/She was at risk for deterioration in self care due to disease processes of dementia and osteoarthritis; -Allow extra time to complete activities of daily living (ADL's). Encourage independence or set up and cueing to complete ADL's. -He/She was at risk for falling due to balance and posture. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/9/24 at 10:39 A.M. showed resident was laying in his/her bed. His/her call light was laying on the floor. Resident got out of bed and went to the door to ask staff for water. CNA C responded to resident room and did not provide resident his/her call light as assisted back to his/her bed. Observation on 6/10/24 at 9:17 A.M. showed resident up in his/her rocking chair while bed was stripped. Resident did not have call light accessible. Call light was hanging on the back of the corner of bed out of reach. Observation on 6/10/24 at 3:15 P.M. showed resident was laying in his/her bed. Call light was inaccessible hanging behind mattress off the corner of bed/under the mattress with the call light touching the floor. Observation on 6/11/24 at 6:04 A.M. showed resident was laying in bed. Call light was not in reach and was hanging off the top of the corner of the bed under mattress and light was resting on floor. Observation on 6/11/24 at 9:16 A.M. showed resident's call light was laying on the floor not in reach of the resident. Review of monthly staff in-services showed: -On 1/25/24, call lights should be answered in timely and appropriate manner; -On 2/24, call lights should be answer in timely manner. Resident's should not wait twenty to thirty minutes. If staff answered call light take care of residents need right away. -On 5/24/24, all staff can answer a call light. A single call light should never go off more than two minutes. A resident should not have to call the facility for a call light going off for more than twenty minutes. During an interview on 6/12/24 at 10:09 A.M., CNA C said: -A resident's call light should be right next to them within reach where resident had access to it. During an interview on 6/12/24 at 12:05 P.M., MDS Coordinator said: -Call lights should be within residents reach. During an interview on 6/12/24 at 2:34 P.M., Director of Nursing (DON) said: -He/She expected call lights to be within resident's reach. During an interview on 6/12/24 at 2:34 P.M., the Assistant DON said: -He/She expected call lights to be within resident's reach. During an interview on 6/12/24 at 2:34 P.M., Administrator said: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected call lights to be within resident's reach.