STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265398	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare and Rehab-Wellsville	250 E Locust Wellsville, MO 63384

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 43327 Based on record review and interview, facility staff failed to maintain an accurate accounting system that assured the resident fund bank statement matched the reconciliation for the same month for February 2023, March 2023, and May 2023. This had the potential to affect all residents that had funds entrusted to the facility on the residents' behalf. The facility census was 38. 1. Review of the facility's policies showed staff did not provide a policy for resident funds, reconciliation of resident funds, or surety bond. Review of the facility's accounting records, dated 02/2023 showed the record did not contain a bank statement for February 2023. Review of the facility's accounting records, dated 03/2023 showed the record did not contain a bank statement for March 2023. Review of the facility's Bank Statement, dated 05/31/2023 showed: -A beginning balance of $41,771.92; -An ending balance of $41,598.39. Review of the facility's Reconciliation, dated 05/23, showed the bank statement with an ending balance of $41,598.39. Review showed the reconciliation did not contain a final total that showed outstanding deposits and withdraws. (continued on next page)

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

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 8:47 A.M., the Business Office Manager (BOM) said he/she had tried to obtain the bank statements from the prior company but did not have access to the bank records. He/She told the administrator of the issue and left it at that. He/She said the administrator is no longer at the facility and did not follow up any further. The BOM said he/she completed monthly reconciliation with the bank statements then sent the information to the corporate office and never heard any more after that. He/She was not aware the calculations were not completed on the May 2023 reconciliation. He/She said calculations for the bond is usually done by the administrator and when the prior administrator left, he/she put the bond information on the BOM desk and said as long as the fund account does not go over $50,000 the bond should cover it. He/She said no one has reviewed the bond or if the bond covered the patient funds since the prior administrator left. He/She did not know how to use reconciled amounts to calculate the bond. During an interview on 04/04/24 at 2:12 P.M., the administrator said he/she is new to the facility and has been trusting his/her current employee to manage the resident trust. He/She said that employee is leaving so he/she will be training a new staff member and will be assisting him/her in the transition. He/She said he/she will be providing oversight regarding the monthly reconciliation's and will be responsible to ensure the bond is sufficient to cover the resident fund account.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Base on observations, interviews and record review, facility staff failed to close the computer screens from view which showed resident information when left unattended. The facility census was 38. 1. Review of the facility's policies showed staff did not provide a policy for privacy or resident rights. 2. Observation on 04/02/24 at 11:21 A.M., showed a computer kiosk on the wall next to the dining room open with resident information exposed. Observation showed staff and residents passed by the screen. Observation on 04/03/24 at 09:15 A.M., showed a computer screen open on top of a unattended medication cart outside of room [ROOM NUMBER]. Observation showed the computer contained private information visible to staff and residents. Observation on 04/04/24 at 8:50 A.M., showed a computer screen open on top of a unattended medication cart with residents private information visible to staff and residents. During an interview on 04/04/24 at 8:54 A.M., Certified Medication Technician (CMT) I said he/she should have closed the screen to protect the resident's privacy because other people could see it. He/She said they forgot to close the screen. During an interview on 04/04/24 at 10:24 A.M., CNA E said staff are supposed to close the computer screens when they step away from them. He/She is not sure why it would have been left open, but would expect if staff seen it open, they should close it. He/She said resident information is stored in the computers and someone could read it. During an interview on 04/04/24 at 01:34 P.M., the Director of Nursing (DON) said staff are expected to close the screens of the computers to prevent health information private from others.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview and record review, facility staff failed to provide a sanitary, comfortable and homelike environment on the 200 hallway spa/shower room, when staff failed to replace missing and/or loose baseboard on two walls and failed to keep the bathtub free from fall mats, wheelchair cushions and wheelchair leg pedals. Facility staff failed to provide a comfortable and homelike environment for residents, when staff failed to maintain walls, floors, doors, in good repair in the 100 hall. The facility census was 38. 1. Review of the facility's policies showed staff did not provide a policy for environmental repairs, facility cleaning or homelike environment. 2. Observation on 04/01/24 at 08:39 P.M., showed the shower/spa room on the 200 hallway with a brown dried substance on the toilet, a bathtub full of various items including fall mats, wheelchair cushions, wheelchair pedals, and loose/missing baseboard on two walls. Observation on 04/04/24 at 08:19 A.M., showed the shower/spa room on the 200 hallway with a bathtub full of various items including fall mats, wheelchair cushions, wheelchair pedals and loose/missing baseboard on two walls. 3. Observation on 04/01/24 at 7:00 P.M., showed occupied room [ROOM NUMBER] did not have a transition strip between the hall and room flooring. The floor surrounding the residents bed had crumbs and food wrappers covering the floor. Was it cleaned up later? Observation on 04/01/24 at 7:30 P.M., showed occupied room [ROOM NUMBER] had a strong odor of urine coming from the beds. Observation on 04/01/24 at 7:35 P.M., showed occupied room [ROOM NUMBER] had a strong odor of urine. Observation on 04/03/24 at 10:43 A.M., showed occupied room [ROOM NUMBER] with damaged sheet rock and wall corners by the sink area contained multiple areas of brown stains on the bathroom floor. Observation showed the bathroom wall trim damaged. Observation on 04/03/23 at 10:50 A.M., showed occupied room [ROOM NUMBER] with multiple stained areas on the floor tile in both the bedroom and bathroom areas. The floor had crumbs of food on it. Observation on 04/03/24 at 11:05 A.M., showed occupied room [ROOM NUMBER] with a strong odor, floor tiles with multiple cracks and stains, and the wall trim by the window missing. Observation on 04/03/24 at 1:00 P.M., showed occupied room [ROOM NUMBER] with multiple floor tiles raised and the bathroom door with sharp edges. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/04/24 at 8:55 A.M., Housekeeper J said he/she cleaned resident rooms continuously all day. There should not be any debris on the floor or stains. He/She said damaged items are brought to the attention of the maintenance department, but we currently do not have a full time maintenance department. During an interview on 04/04/24 at 10:24 A.M., Certified Nurse Aide (CNA) E said the spa room is the collect all for extra fall mats and cushions for the wheelchairs. He/She said those things should not be stored in there but staff keep putting those items back in there. CNA E said residents do not use the bathtub and probably cannot see it from the shower area. He/She said the prior maintenance worker knew about the loose/missing baseboards but is no longer an employee at the facility and does not know if there is a new one yet to fix it. He/She said there used to be forms to fill out for repairs and they would be set on the desk of the maintenance man to fix but doesn't know who is doing it now. During an interview on 04/04/24 at 2:12 P.M., the administrator said there currently is no process to ensure facility repairs are being reported and currently is without a full time maintenance supervisor. He/She said he/she is building a process to include communication of the issue. The administrator expects staff to report issues or needed repairs to him/her or write it down and give the issue to him/her. He/She said he/she has ordered a large roll of baseboard to repair most of the building but would expect the facility to be free of stained floors, dirty caulking, missing/broken tiles and debris on the floor. He/She said there should be nothing stored in the bathtubs in the resident spa rooms, there is a different place for that. 43327

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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. 42484 43327 Based on interview and record review, facility staff failed to meet professional standards of quality when staff failed to prime a insulin pen prior to insulin administration for three (Resident #6, #15, and #17) of three sampled residents and failed to ensure one resident (Resident #16) out of eight sampled residents Prothrombin and International Normalized Ratio ((PT/INR) blood test shows how long it takes to form a blood clot) and digoxin level (blood test to monitor for drug toxicity) were obtained as ordered. The facility census was 38. 1. Review of the facility's policies showed the facility did not provide a policy for insulin pens or insulin administration. Review of https://www.lillyinsulinlispro.com, Lispro Kwikpen Instructions for use, dated 09/2023, showed: -Prime the pen before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin; -To prime, turn the dose knob to select 2 units, hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. -Once primed, dial the correct dose. Review of https://www.lillyinsulinlispro.com, Humalog Kwikpen Instructions for use, dated 08/2023, showed: -Prime the pen before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin; -To prime, turn the dose knob to select 2 units, hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. -Once primed, dial the correct dose. Review of https://www.lantus.com/how-to-use/using-solostar-insulin-pen, how to use your solostar insulin pen, dated 08/2022, showed: -Dial a test dose of 2 Units. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle.This will help you get the most accurate dose; -Press the injection button all the way in and check to see that insulin comes out of the needle.The dial will automatically go back to zero after you perform the test; -If no insulin comes out, repeat the test 2 more times; -If there is still no insulin coming out, use a new needle and do the safety test again; -Always perform the safety test before each injection; -Never use the pen if no insulin comes out after using a second needle. Review of https://www.novo-pi.com/novolog.pdf, Novolog Flexpen instructions for use, dated 2/2023 showed: -Before each injections small amounts of air may collect in the cartridge during normal use; -To avoid injecting air and to ensure proper dosing, turn the dose selector to select 2 units; -Hold the flexpen with the needle pointing up and tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards, press the push-button all they way in. The dose selector returns to 0; -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times; -If you do not see a drop of insulin after 6 times, do not use the flexpen. 2. Observation on 04/01/24 at 8:46 P.M., showed Licensed Practical Nurse (LPN) A applied a needle to a Lantus insulin pen and a Lispro insulin pen, dialed to the dose ordered and injected the insulin using each insulin pen to Resident #6. He/She did not prime either pen with two units prior to administration. Observation on 04/01/24 at 8:53 P.M., showed LPN A applied a needle to a Lispro insulin pen, dailed to the ordered dose and injected the insulin using the insulin pen to Resident #15. He/She did not prime the pen with two units prior to administration. During an interview at 11:37 A.M., LPN A said he/she was not aware to prime an insulin pen. He/She said he/she had not had training on insulin pens at the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 04/02/24 at 11:32 A.M., showed Registered Nurse (RN) B applied a needle to a Novolog insulin pen, dialed to the ordered dose and injected the insulin using the insulin pen to Resident #17. He/She did not prime the pen with two units prior to administration. Observation on 04/02/24 at 11:47 A.M., showed RN B applied a needle to two Humalog insulin pens, dialed to one unit in one pen and seven units to another and injected the insulin using the insulin pens to Resident #6. He/She did not prime either pen with two units prior to administration. During an interview at 11:37 A.M., RN B said he/she has been a nurse a long time and has never heard to prime an insulin pen. He/She said he/she had not had training on insulin pens at the facility. 4. During an interview on 04/04/24 at 10:37 A.M., the Medical Director said failing to prime an insulin pen could result in the resident failing to recieve enough insulin. During an interview on 04/04/24 at 11:38 A.M., the pharmacist said to ensure the correct dosing and to prevent air pockets in the needle it is important to prime all insulin pens. He/She said this is especially true for those residents who require a low dose of insulin to ensure they receive the ordered amounts of insulin. During an interview on 04/04/24 at 01:34 P.M., the Director of Nursing (DON) said staff should prime the insulin pens with two units prior to administration of the ordered dose to ensure there is no air in the needle and receiving the correct dose. 5. Review of the facility's policies showed staff did not provide a policy for physician orders. 6. Review of Resident #16's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/23/24 showed the resident with a diagnosis of atrial fibrillation (irregular heartbeat). Review of the resident's Physician Order Sheet (POS), dated 04/01/24 through 04/30/24, showed: -On 09/20/23, an order for digoxin 125 milligrams (mg) daily for atrial fibrillation; -On 03/30/24, an order for warfarin 5 mg daily for atrial fibrillation; -The POS did not contain orders for a warfarin level or digoxin level. During an interview on 04/04/24 at 10:37 A.M., the Medical Director said the medical record should contain lab orders for warfarin and digoxin when a resident is prescribed those medications. He/She would expect the nursing staff to transcribe the orders in the medical record as given via fax, telephone order or verbal order. If the labs are missed, the resident could potentially have a negative outcome. During an interview on 04/04/24 at 10:46 A.M., RN B said the nurses are responsible to ensure physician orders are transcribed in the medical record including orders for any blood work. He/She said he/she did not know why this resident's orders did not get put onto the physician orders but would look into it. He/She said most of the time, the orders for warfarin changes with each blood draw because those levels set the dosing of the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/04/24 at 01:34 P.M., the Director of Nursing (DON) said warfarin blood work and digoxin blood work should be entered into the physician order sheets so that the levels are drawn appropriately. He/She said if the levels are not drawn correctly, there is the potential to incorrectly dose the resident. He/She said the DON is responsible to periodically check the physician orders but he/she is new to the role and has not done it yet.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on observation, interview and record review, facility staff failed to provide interventions to relieve one resident (Resident #192) pain out of one sampled resident. The facility census was 38. 1. Review of the policies provided by the facility showed the staff did not provide a policy for pain management or baseline care plans. 2. Review of Resident #192's medical record showed: -The resident admitted to the facility on [DATE]; -Diagnosis of leg wound; -Did not contain a documented, initiated, completed baseline care plan to include pain interventions. Review of the resident's hospital discharge records, dated 04/01/2024, showed the records did not contain orders for pain managment. Review of the Pain assessment dated [DATE] showed: -Currently complains of pain; -History of pain; -Used prescribed pain medications in the past; -Rated pain a four on a 1-10 scale (ten the worst pain imaginable). Review of the nurse notes, dated 04/01/24 through 04/04/24, showed: -On 4/3/24 at 02:07 P.M., tolerated left leg dressing well, did state the right leg hurt when touched. The nurses notes did not contain documentation staff provided intervention for pain management. -On 4/4/23 at 03:02 P.M., new orders for Tramadol (a pain medication) 50 milligrams every eight hours as needed for wound pain. During an interview on 04/02/24 at 11:13 A.M., the resident said he/she needed a pain pill for leg pain. During an interview on 04/02/24 at 01:11 P.M., the resident said it had been over an hour and no one has brought him/her anything for pain. Observation at this time, showed the resident rubbed his/her leg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/24 at 10:45 A.M., the medical director said he/she would expect staff to call the office if a resident is complaining of pain for further orders. Observation on 04/04/24 at 10:45 A.M., showed the resident asked the physician for pain medication. During an interview on 04/04/24 at 11:16 A.M., CMT I said if a resident complains of pain, he/she tells the charge nurse and gives a pain medication if there is an order. He/She said there is an emergency kit (e-kit) of medications to pull from. During an interview on 04/04/24 at 01:46 P.M., RN B said if a resident is newly admitted standing orders for pain control such as Tylenol should be cleared with the physician so pain control would be available to the resident. If a resident complains of pain and there is no order for pain medication, the doctor should be called and orders obtained. During an interview on 04/05/24 at 01:47 P.M., the Director of Nursing (DON) said standing orders for over the counter pain medications should be approved by the physician upon admission.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on observation, interview, and record review, facility staff failed to complete the inspection of bed frames, mattresses, and bed rails as part of a regular maintenance program to ensure bed rails/grab bars were properly secured. Facility staff failed to obtain consents for the use of bed rails for three (Resident #6, #12, and #33) residents of 17 sampled residents and failed to obtain a physician's order for the use of bed rails for one of 17 sampled residents (Resident #12), and failed to complete bed rail use assessments for two of 17 sampled residents (Resident #6 and #12). The facility cenus was 38. 1. Review of the Facility's Side Rails policy, dated 01/23/23, showed staff are instructed as follows: -Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with a mobility and transfer of residents; -An assessment will be made to determine the resident's symptoms or reason for using side rails and will be reviewed quarterly, to include but not limited to entrapment and risk assessments; -The Maintenance Director or Designee will complete an entrapment assessment prior to installation of any side rail; -The use of side rails be addressed in the resident care plan; -Less restrictive interventions that will be incorporated in care planning; -Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails; -Review of the risks and benefits of side rails will be considered for each resident or the resident's representative will be completed with an informed consent prior to installation; -Consent for side rail, whether used as a restraint or not, will be obtained from the resident or representative, after presenting potential benefits and risks. While the resident or representative may request a restraint, the facility is responsible of evaluation the appropriateness of that request; -An Entrapment Assessment and Risk Assessment must be completed prior to installation of any siderail. 2. Review of Resident #6's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/22/24 showed staff assessed the resident as: -Cognitively intact; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required substantial/maximum assistance to roll from left to right and lying to sitting on the side of the bed; -Dependent on staff for sit to stand and bed to chair transfers. Review of the resident's care plan, dated 10/03/23, showed side rail assist bars to help with turning and repositioning and transfers. Review of the resident's physician order sheet (POS), dated 4/3/24, showed an order on 09/22/23 for turn and reposition bars to assist with bed mobility. Review of the resident's medical record showed the record did not contain a completed side rail assessment, consent or entrapment assessment for the use of side rails. During an interview on 04/01/24 at 7:28 P.M., the resident said he/she uses the rails to move in bed. 3. Review of Resident #12's Annual MDS, dated [DATE], showed the staff assessed the resident as follows: -Moderately Cognitively Impaired; -Required substantial/maximal assistance to roll; -Dependent for sitting to lying. lying to sitting, and transfers between the bed to wheelchair. Review of the resident's medical record showed the record did not contain a completed side rail assessment, a physican order, consent or entrapment assessment for the use of side rails. Observation on 04/01/24 at 7:19 P.M., showed the resident in bed with the left U-Bar (a side rail on the bed that provides a hand-hold for getting into or out of bed) in the upright position. 4. Review of Resident #33's Quarterly MDS dated [DATE] showed staff assessed the resident as: -Cognitively intact; -Required supervision for sit to stand and bed to chair transfers. Review of the resident's care plan, dated 10/3/23, showed side rail assist bars to help with turning and repositioning and transfers. Review of the resident's POS dated 04/03/24 showed an order on 07/27/23 for turn and reposition bars to assist with repositioning and slide board transfers. Review of the resident's medical record showed the record did not contain a signed consent or entrapement assessment for the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/24 at 08:24 A.M., the resident said he/she uses the rails to move in bed and to help with getting out of bed. 5. During an interview on 04/04/24 at 10:46 A.M., Registered Nurse (RN) B said side rail assessments should be done on admission by the charge nurse. He/She said there should be physician orders, a consult with therapy to make sure they are appropriate and maintenance to ensure they are safe to use. He/She said he/she does not know what the new company policy will be on how often the assessments should be completed. During an interview on 04/04/24 at 1:34 P.M., the Director of Nursing (DON) said side rail assessments should be completed when there is a possibility a resident will need a rail. He/She said a therapy consult should also be completed. He/She does not know who is completing entrapment assessments, but feels those should be completed to keep the residents safe. During an interview on 04/04/24 at 2:12 P.M., the administrator said there is currently no staff assigned to complete entrapment assessments.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42484 Based on interview and record review, facility staff failed to ensure nursing staff had the appropriate skills and competencies to meet the care needs for the residents by not providing in-services, re-evaluating and documenting skills and competencies on a regular basis for each employee received the required 12 hours in-service education annually. The facility census was 38. 1. Review of the facility policies provided did not contain a policy on staff annual education or in-service requirements. Review of the facilities in-service annual training did not contain documentation skills and competencies to meet the care needs for the residents. During an interview on 04/04/24 at 01:34 P.M., the Director of Nursing (DON) said he/she is new to the position, but the prior DON kept a an inservice binder in the administrator's office The DON said the binder is no longer there and did not know where it went. He/She said since the prior DON is not there anymore, he/she is not sure who is ensuring education is completed. During an interview on 04/04/24 at 02:12 P.M., the administrator said the person responsible for completing the training no longer works at the facility and has not identified someone to replace them. 43327

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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 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. 42484 Based on interview and record review, facility staff failed to assist two residents (Resident #33 and #35) of two sampled residents assistance with transportation arrangements to and from their source of service. The facility census was 38. 1. Review of the policies provided by the facility showed the facility did not have a policy on transportation and resident appointments. 2. Review of Resident #33's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/29/24 showed the resident as cognitively intact with diagnosis of migraine headache. Review of the resident's Physician Order Sheet (POS), dated 04/03/24, showed an order for a neurology consult dated 08/09/23 and 12/19/23 Review of the residents nurse notes, dated 07/13/23 through 04/04/24, showed staff documented: -On 08/09/23, resident seen by the physician, consult neurology; -On 11/14/23, new orders received to consult neurology and transportation made aware. During an interview on 04/02/24 at 08:42 A.M., the resident said he/she has needed to see a neurologist since last fall but the facility has not had a transportation van or assist to ensure he/she had transportation to/from his/her appointment. During an interview on 04/04/24 at 08:03 A.M., the transportation technician said he/she has only been doing the tranportation position for seven weeks but knows the facility was without a transportation van for three or four months but could not remember the months for sure. He/She said he/she is working on getting an appointment set up for the resident but it takes a little time to get the authorization from his primay care provider. He/She said he/she cannot answer for prior to when he/she took over the position. During an interview on 04/04/24 at 10:20 A.M., the prior transporation technician said he/she was aware of the resident's need for a neurology consult but the transportation van was broke down for six to eight months. He/she said he/she informed the administrator at that time of the transportation need. 3. Review of Resident #35's Quarterly MDS, a federally mandated assessment tool, dated 01/19/24/24 showed the resident as cognitively intact with a diagnosis of medically complex conditions. Review of the resident's medical record showed the resident had a new diagnosis of a malignant neoplasm of the connective and soft tissue (cancer not in the bone or an organ) with a follow up appointment scheduled to begin cancer treatment on 02/29/24. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/24 at 08:12 P.M., the resident said the facility had cancelled two appointments for the doctor who would be treating his/her cancer. The resident was upset he/she had cancer and could not get it taken care of. The resident said he/she was very concerned the disease could progress if cancer treatment was not started as soon as possible. During an interview on 04/03/24 at 01:59 P.M., the scheduling assistant for the resident's oncologist said the resident had appointments that were cancelled by the facility: -An appointment on 02/29/24 for which the resident did not show up for the appointment and the facility did not call to cancel; -An appointment on 03/13/24, and the transportation aide called on that day to cancel the appointment and stated there were no more transportation slots for the rest of the month; -An appointment on 04/03/24, and the facility called at 12:30 P.M. that day and said the transportation bus was held up in St. Louis and could not transport the resident to his/her appointment. During an interview on 04/03/24 at 02:15P.M., the oncologist nurse said the resident had missed several appointments and needed to be scheduled with the doctor as soon as possible. He/She said this is a significant concern because if treatment is delayed, the cancer could spread and/or the resident may have considerable increased pain. During an interview on 04/04/24 at 08:03 A.M., the transportation technician said there were issues initially with the coordination of appointments and some were missed. He/She said the appointments had to be cancelled because there were more than one appointment in the same day and they could not all be coordinated. During an interview on 04/05/24 at 01:47 P.M., the Director of Nursing (DON) said he/she was not sure why the resident's appointments were cancelled. The DON said it was up to the administrator to decide transportation priorities. During an interview on 04/04/24 at 02:12 P.M., the administrator said the transportation issue had been a difficult one, and unexpected issues had prevented the planned transportation to the appointments. 43327

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45564 Based on interview and record review, facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. The census was 38. 1. Review of facility provided policies showed staff did not provide a policy related to the qualifications of kitchen staff. Review of the Dietary Manager's (DM) personnel record showed the DM hire date as a part time cook in February 2023. Review showed the record did not contain documentation of when the DM assumed the DM role. The record did not contain documentation of previous food service experience or food service management certification. During an interview on 04/02/24 at 9:22 AM , the DM said he/she started as a part time cook in February of 2023 and became the DM in March of 2024. The DM said he/she worked as a DM for a couple of years in another facility. The DM said he/she was not a Certified Dietary Manager and never completed any type of food service training. The DM said he/she did not receive assistance or consultation from any other facility staff. During an interview on 04/03/24 at 9:40 A.M. the Business Office Manager (BOM) said the administrator was responsible for ensuring staff had qualifications for positions. The BOM said he/she was not familiar with the DM completing any food service related training. During an interview on 04/03/24 at 10:15 A.M., the administrator said the DM should be certified. The administrator said he/she told the DM to look into classes toward certification. The administrator said he/she did not know if the DM had identified any certification courses. The administrator said he/she was not aware of any other qualified staff in the facility. The administrator said he/she just started at the facility on 03/01/24 so he/she hasn't had time to fix everything.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45564 Based on observation, interview and record review, facility staff failed to serve food in accordance with the nutritionally calculated recipes and menus. Facility staff failed to ensure meal substitutions were reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy. The census was 38. 1. Review of facility provided policies showed they did not contain a policy related to food service. 2. Observation on 04/02/24 at 9:00 A.M., showed an always available menu posted in the resident dining room. The menu showed: -Hamburger or cheeseburger; -Grilled cheese special (sandwich with a side of cottage cheese); -Peanut butter and jelly special (sandwich with a side of cottage cheese); -Deli meat and cheese sandwich; -Side dishes included vegetable of the day, cottage cheese and salad of the day. Review of the facility's Week At a Glance menu showed on 04/02/24, staff were to serve spaghetti with meat sauce, parmesan baked zucchini, [NAME] fruit crisp, breadstick and a beverage for the lunch meal. Observation on 04/02/24 at 12:41 P.M., showed two residents on pureed diets received pureed spaghetti and green beans. Observation showed the residents did not receive fruit or bread. Observation showed residents on regular diets received spaghetti, green beans and baked apples. Observation showed the residents on regular diets did not receive bread. During an interview on 04/02/24 at 12:44 P.M., Cook F said he/she was in a hurry and forgot about pureed fruit. Cook F said staff were not serving bread sticks because they did not have any. Cook F said there was not enough bread to serve all residents but if a resident asked, they could have a slice of bread. During an interview on 04/02/24 at 12:45 P.M., the DM said he/she was responsible for ordering foods. The DM said the facility vendor had been out of some items, so staff were making substitutions. The DM said he/she never spoke with the dietician about meal substitutions. Review of the facility's Week At a Glance Menu, showed on 04/02/24 staff were to serve deluxe potato ham bake, mixed vegetables, frosted cake, dinner roll and a beverage for the supper meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the menu substitution form showed on 04/02/24 staff served a hot dog on a bun, cheesy fries and creamy cole slaw for the supper meal. Review showed the DM signed off on the meal in the column designated for the Registered Dietician review signature. Review of the facility's Week At a Glance Menu, showed on 04/03/24 staff were to serve two ounces of protein, one grain, 2 vegetables, one fruit and a beverage as a Resident's Choice supper meal. Review of the menu substitution form showed the form did not contain documentation of the meal provided on 04/03/24 and did not contain documentation the meal was reviewed by a registered dietician. During an interview on 04/04/24 at 9:55 A.M., the DM said the resident's choice meal consisted of a can and a frozen bag of chicken and dumplings. The DM said he/she could not remember what vegetables and sides were served. The DM said the dietician did not review the meal. Review of the facility's Week At a Glance Menu, showed on 04/04/24, staff were to serve roast pork, cornbread stuffing, buttered corn, glazed applesauce cake, dinner roll and a beverage for the lunch meal. Observation on 04/04/24 during the lunch meal, showed staff served the residents a cheeseburger on a bun, french fries, baked beans, cookies and a beverage. During an interview on 04/04/24 at 12:25 P.M., Cook F said the menu was switched yesterday. He/She said the residents were to receive the fried chicken meal today, but the food delivery did not come. Cook F said the residents were being served cheeseburgers and fries instead. During an interview on 04/04/24 at 9:35 A.M., RN B said some residents expressed concerns about food portions and the kitchen running out of food or milk. RN B said he/she did not pass these concerns to anyone. During an interview on 04/02/24 at 2:34 P.M., The DM said he/she was responsible for meal substitutions, and he/she kept a substitutions log. The DM said he/she had not been able to keep up with the log. The DM said he/she did not know the last time the dietician was in the building or if the dietician reviewed meal substitutions. The DM said staff had not been able to provide planned meals quite a few times since he/she started as the DM in March of 2024. The DM said staff used food from the emergency food supply a couple of weeks ago because there was not enough food. The DM said there was no lettuce in the kitchen but they were expecting a delivery the next day. The DM said residents had never missed a meal because of food shortages. The DM said he/she was still trying to figure things out since there were no historical records or documents in the dietary office when he/she started. During an interview on 04/03/24 at 10:15 A.M., the administrator said he/she would expect kitchen staff to follow prepared menus. The administrator said he/she would expect the dietician to review any meals that were not on approved menus. The administrator said he/she had not seen a dietician in the facility since he started on 03/01/24. The administrator said the dietician should come in monthly to review diets and perform kitchen inspections and staff education. The administrator said he/she reviewed the new resident's admission paperwork and he/she did not see any documentation stating the resident was on a gluten free diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/03/24 at 11:40 A.M., the administrator said he/she was informed by staff a short time ago, food had not been delivered due to the vendor not being paid. The administrator said he/she resolved the issue and the food delivery should arrive on 04/04/24.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43327 45564 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #13) out of two sampled residents received food in the proper form in accordance with their physician's orders. The facility census was 38. 1. Review of facility provided policies showed staff did not provide a policy related to pureed diets. Review of Resident #13's Significant Change of Status Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/02/24 showed staff assessed the resident as cognitively impaired with a diagnosis of dementia. Review of the Physician Order Sheet (POS) showed an order, dated 03/19/24, for a puree texture, regular/thin consistency diet. Review of the resident's care plan, dated 02/26/24, showed the care plan did not contain direction for diet consistency. Review of the resident diet roster, dated 03/29/24, showed the resident's diet type listed as regular diet and regular texture. Observation on 04/02/24 at 12:30 P.M., showed the resident at the dining room table with a plate of regular consistency, not pureed, spaghetti and green beans. Observation showed next to the plate a slip of paper with the resident's first name hand written on one side and a typed diet order on the opposite side which said regular diet and regular consistency which was crossed over with a pen. Observation showed Certified Nurse Aide (CNA) D encouraged and assisted to feed the resident. During an interview on 04/04/24 at 09:55 A.M. CNA D said he/she was not aware the resident was on a puree diet until 04/03/24. He/She said if there was a change in what is normally served to a resident, he/she would ask the nurse about the change before feeding or serving the resident. During an interview on 04/02/24 at 1:19 P.M., Cook F said he/she followed the ticket that was given for the resident's meal. Cook F said he/she did not know why the residents name was written on a scratched out ticket. During an interview on 04/02/24 at 2:34 P.M., the Dietary Manger (DM) said the cook was responsible for ensuring residents received meals that were the ordered texture. The DM said a resident with an order for pureed meals should not receive regular texture meals. The DM said he/she was still trying to figure out the diet orders process since he/she just got access to the dining software. The DM said he/she tries to print a diet roster a couple of times a week to review diets.

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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. 45564 Based on observation, interview and record review, facility staff failed to maintain kitchen cleanliness in a manner to prevent potential food contamination. Facility staff failed to sanitize kitchen wares in a manner to prevent contamination. Facility staff failed to maintain and serve food at temperatures adequate to prevent food borne illness. The facility staff failed to ensure the ice machine, used to supply ice to residents, drained through an air gap to prevent cross-contamination. The facility census was 38. 1. Review of facility provided policies showed staff did not provide a policy related to kitchen cleaning. Review of the End of Shift Cleaning checklists for aide and cook , dated March (no year indicated), showed the checklist included clean work station for both aides and cooks. Review showed the checklists did not specify stand mixer, microwave or cleaning of any specific equipment items. Observation on 04/2/24 from 9:20 A.M., through 1:15 P.M., showed: -The stand mixer uncovered and an accumulation of dried food debris on the mixer and the table around the base of the mixer; -The window exhaust filters contained an accumulation of dust and grease; -The ceiling vent in the dry storage room contained an accumulation of dust and grease; -The microwave oven contained an accumulation of dried food debris inside; -The walk in freezer contained an accumulation of ice on the storage shelves and food boxes inside the door. The freezer door did not close and seal; -The supports to the hanging ceiling lights and the ceiling above the food preparation area contained an accumulation of dust and grease; -The ice machine, located in a room down the hall from the kitchen, contained a drain line connected to the floor drain and did not contain an air gap. 2. Review of facility provided policies showed staff did not provide a policy related to the use of sanitizer solution. Review of the sanitizer directions for use showed: -Thoroughly wash equipment and utensils in hot detergent solution; -Rinse utensils and equipment thoroughly with potable water; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Sanitize equipment and utensils by immersion in a use solution of one ounce of this product per four gallons of water (200-400 parts per million (ppm) active solution) for at least 60 seconds at a temperarure of 75 degrees Fahrenheit (F); -For equipment and utensils too large to sanitize by immersion use a soultion of 200-400 ppm by rinsing, spraying or swabbing until visibly wet. Observation on 04/02/24 at 11:57 A.M., showed Dishwasher G cleaned two large pots in compartment one of the three compartment sink. Dishawasher G then added sanitizer to compartment three and added water. Dishwasher G placed the pots in compartment three and added more water and did not check the sanitizer concentration. Observation showed the pots were not fully submerged in the sanitizer solution. Dishwasher G removed the pots and placed them on the sideboard. Dishwasher G prewashed a large rectangle pan and placed the pan in the sanitizer. Observation showed the rectangle pan not fully submerged in the sanitizer solution. Dishwasher G removed the pan and placed it on the sideboard. Observation showed a chemical test strip indicated a sanitizer solution less than 150 ppm. During an interview on 04/02/24 at 12:15 P.M., Dishwasher G said he/she did not check the sanitizer since he/she was never shown how to use the strips. During an interview on 04/02/24 at 12:20 P.M., the dietary manager (DM) said items should be fully submerged in the sanitizer and the sanitizer concentration should be between 150 and 200. 3. Review of facility provided policies showed staff did not provide a policy related to food temperatures. Observation on 04/02/24 at 12:00 P.M., showed Cook F placed prepared spaghetti in a small food processor and pureed the spaghetti. Cook F placed the pureed spaghetti in a pan and pureed a second portion. Cook F added the second portion to the pan of spaghetti and set the pan on the counter at room temperature. Cook F removed green beans from the steam table and pureed the beans in a small food processor. Cook F placed the spaghetti and green beans on the steam table. Cook F did not check the temperature of the spaghetti or grean beans after he/she pureed the items. Observation at 12:30 P.M., showed the spaghetti and green beans in pans on the steam table during meal service. The temperature of the pureed spaghetti was 112 degrees Fahrenheit (F) and the temperature of the pureed green beans was 114 degrees F. The pureed spaghetti and green beans were served to two residents. During an interview on 04/02/24 at 12:36 P.M., Cook F said he/she did not check the temperatures of the pureed items before serving. Cook F said the temperature should be checked after an item is pureed, but he/she did not know why he/she didn't check. Cook F said food should be served at 165 degrees or above. 4. Review of facility provided policies showed staff did not provide a policy related to the ice machine air gap. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/02/24 at 10:21 A.M., showed the ice machine drain hose was connected to a white piece of plastic which was directly connected to the floor drain. The floor drain contained an accumulation of dust and debris. Observation showed the ice machine did not contain an air gap between the drain hose and the floor drain. During an interview on 04/02/24 at 2:34 P.M., the DM said all staff responsible for cleaning the kitchen but maintenance was responsible for lights/ceilings and high areas. The DM said he/she never discussed kitchen cleaning with maintenance staff. The DM said staff should check the sanitizer concentration before using the sanitizer. The DM said he/she reviewed the sanitizer label and sanitizer concentration should be between 200 and 400. The DM said the cook was responsible for proper food temperatures. The DM said when staff puree foods they puree the items and place them in a steam table pan for heating on steam table. The DM said staff should check the food temperature after the item is pureed and it should be 175-180 degrees F. The DM said the pureed item can then be placed on the steam table where foods should be held at 175-185 degrees F. The DM said he/she was not familiar with an air gap for the ice machine drain. During an interview on 04/04/24 the maintenance director said he/she had only been in the building twice before this survey. The maintenance director said he/she had not looked in depth at the kitchen or the ice machine. During an interview on 04/03/24 at 10:15 A.M., the administrator said the DM and himself/herself were responsible for kitchen cleanliness and staff training. The administrator said maintenance was responsible for high areas and kitchen ceilings as well as the ice machine drain. The administrator said he/she was not aware of the ice machine drain air gap requirement.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40424 Based on record review and interviews, the facility administration failed to develop or maintain operational policy to guide the day-to-day operation of the facility. This failure had the potential to effect all staff and residents in the facility. The facility census was 38. 1. Review of facility records showed the records did not contain a guide for the day-to day functions of the facility. During an interview on 04/04/24 at 8:59 A.M., the administrator said he/she became aware the facility did not have a policy in the second week of March 2024. The current owners of the facility did not leave a policy and he/she did not develop new policy. During an interview on 04/04/24 at 1:48 P.M., the Director of Nursing (DON) said he/she did not have an answer as to why there were not policy's. The DON said there used to be a policy book kept but it couldn't be found. The DON said the facility should not be operated without a guiding policy in place. 42484

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 40424 Based on record review and interview, facility staff failed to conduct, document, or create a thorough facility-wide assessment to determine what resources are necessary to care for residents during both day-to-day operations and emergencies. The facility census was 38. 1. Review of facility's records showed staff did not provide a policy or guidance to develop a facility assessment. During an interview on 04/03/24 at 9:12 A.M., the administrator said the facility has no facility assessment and the previous administrator did not leave one. I have no explanation for why the assessment is not done and did not know it was required. During an interview on 04/04/24 at 1:48 P.M., the Director of Nursing said I do not know why we there is no facility assessment done. It probably should be done to operate the facility correctly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on observation, interview, and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing, and maintenance of the facility's water system to inhibit the growth of waterborne pathogens and reduce the risk of outbreak of Legionnaire's Disease (a serious type of lung disease caused by Legionella bacteria) (LD). Facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, when staff failed to use appropriate hand hygiene during blood glucose monitoring and insulin administration for two of four residents (Resident #6 and #15), failed to wear gloves during insulin administration for one of four residents (Resident #6), failed to cleanse a glucometer between two of four sampled residents (Resident #6 and #15). The facility census was 38. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17; showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppressive. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of Legionella was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a tool kit to facilitate implementation of this ASHRAE Standard(https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Water Management Program policy, undated, showed it is the policy of the facility to establish water management plans for reducing the risk of legionellosis (lung infection caused by legionella bacteria) and other opportunistic pathogens (disease causing organisms) in the facility's water systems based on nationally accepted standards. During an interview on 04/03/24 at 10:15 A.M., the administrator said he/she was aware of the requirement to have a water management program. The administrator said the facility did not have a water management program. The administrator said he/she started at the facility on 03/01/24 and could not locate the water management plan. 2. Review of the facility policies showed the facility did not provide a policy on hand hygiene, infection control, or blood glucose testing, or insulin administration. 3. Observation on 04/01/24 at 08:46 P.M., showed Licensed Practical Nurse (LPN) A placed a blood glucose meter on the bed of Resident #6, with gloved hands he/she obtained a blood glucose sample, placed the blood glucose meter on top of the medication cart. LPN A and did not place down a barrier on top of the cart and or did not clean the meter. He/She obtained the resident's ordered insulin pen and administered the ordered dose of insulin and did not wear gloves or sanitize hands. LPN A applied new gloves and used the same unclean glucose meter to obtain Resident #15's blood glucose. He/She sat the meter down on the residents overbed table, then placed the meter on top of the medication cart, then into the top drawer of the medication cart. He/She did not cleanse the meter or perform hand hygiene. During an interview on 04/01/24 at 09:05 P.M., LPN A said he/she should have cleansed his/her hands between residents and cleaned the blood glucose meter after every three residents. He/She said gloves should be worn with insulin administration. He/She said he/she was really nervous but knows failing to cleanse the meter or the hands could result in spreading pathogens and disease. During an interview on 04/04/24 at 11:38 A.M., the Director of Nursing (DON) said staff are expected to wash his/her hands before and after performing a blood glucose test, wear gloves when administering insulin, and clean the blood glucose meter between each resident to prevent the spread of bacteria or infection to staff or other residents.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 42484 Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with a system to monitor antibiotic use. The facility census was 38. 1. Review of the policies provided by the facility showed the facility did not provide a policy on antibiotic stewardship. 2. Review of the facility's Infection Control program showed the facility did not have an antibiotic stewardship program and did not contain a previous record of an antibiotic stewardship program. During an interview on 04/03/24 at 09:31 A.M., the Infection Preventionist said he/she was new to the position and the previous Infection Preventionist left suddenly. The Infection Preventionist said at this time there is not an antibiotic stewardship program, nor are there any records. The Infection Preventionist said the previous Infection Preventionist had removed all records and programs. During an interview on 04/05/24 at 01:47 P.M., the Director of Nursing (DON) said the facility lost all records for the infection prevention program including the antibiotic stewardship program. The previous infection preventionist had just left this past week and removed all the information and records, and at this time the antibiotic stewardship program had not been set up. During an interview on 04/04/24 at 02:12 P.M., the administrator said the new infection preventionist had started working on the certification and had not started the antibiotic stewardship program. He/She said the previous infection preventionist had recently quit without advance notice in time to arrange a replacement and had removed all records from the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on interview and record review, facility staff failed to document the administration of the pneumococcal (lung inflammation caused by bacteria or viral infection) vaccine for two residents (Resident #4 and #35) out of six sampled residents and failed to document the administration of the influenza (contagious respiratory infection caused by a virus) vaccine for two residents (Resident #35 and #37) of six sampled residents. The facility census was 38. 1. Review of the facility's policies showed staff did not provide a policy for pneumococcal vaccines or influenza vaccines. Review of the Center for Disease Control (CDC) guidelines, dated 03/15/23, showed the following: -People age 65 or older who have no pneumococcal vaccines should receive 20 valent pneumococcal conjugate vaccine (PCV20) or 15 valent pneumococcal conjugate vaccine (PCV15), and then one year later pneumococcal polysaccharide vaccine (PPSV23); -People age 19 through 64 who have no pneumococcal vaccines should receive PCV20 or PCV1, and then one year later PPSV23. Review of the CDC, Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities, reviewed 2/5/24, showed: -If possible, all residents should receive inactivated influenza vaccine (IIV) annually before influenza season; -In the majority of seasons, influenza vaccines will become available to long-term care facilities beginning in September, and influenza vaccination should be offered by the end of October; -Informed consent is required to implement a standing order for vaccination, but this does not necessarily mean a signed consent must be present; -Although vaccination by the end of October is recommended, influenza vaccine administered in December or later, even if influenza activity has already begun, is likely to be beneficial in the majority of influenza seasons because the duration of the season is variable, and influenza activity might not occur in certain communities until February or March. -In the event that a new patient or resident is admitted after the influenza vaccination program has concluded in the facility, the benefits of vaccination should be discussed, educational materials should be provided, and an opportunity for vaccination should be offered to the new resident as soon as possible after admission to the facility. -According to requirements, each resident is to be vaccinated unless contraindicated medically, the resident or legal representative refuses vaccination, or the vaccine is not available because of shortage. This information is to be reported as part of the CMS Minimum Data Set (MDS), which tracks nursing home health parameters. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #4's medical record showed: -The resident was age 81; -admitted to facility on 03/12/15; -The record did not contain documentation the resident received or refused the pneumococcal vaccine. 3. Review of Resident #35's medical record showed: -The resident was age 69; -admitted to the facility on [DATE]; -The record did not contain documentation the resident received or refused the pneumococcal or influenza vaccine. 4. Review of Resident #37's medical record showed: -admitted to the facility on [DATE]; -The record did not contain documentation the resident recieved or refused the influenza vaccine. During an interview on 04/03/24 at 09:31 A.M., the Infection Preventionist said he/she thought all of the immunization information for residents was up to date and a system was in place, and the Director of Nursing would be responsible for the program. During an interview on 04/05/24 at 01:47 P.M., the Director of Nursing (DON) said he/she was responsible for the resident flu and pneumococcal vaccine program, and thought the vaccination program was up-to-date in the residents' medical records.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on interview and record review, facility staff failed to develop and implement policies and procedures to ensure each resident was offered the COVID-19 (a highly contagious virus that causes serious illness or death) vaccine. Failed to ensure the residents' medical records included documentation which indicated the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine, and each dose of COVID-19 vaccine administered to the resident or if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal) for three residents (Resident #4, #35, and #37) of six sampled residents. The facility census was 38. 1. Review of the Centers for Disease Control (CDC) COVID-19 Long-Term Care (LTC) Residents guidance, dated 9/25/23, showed: -CDC recommends everyone aged five years and older including people who live in long term care settings, get one updated COVID-19 vaccine; -People who are moderately or severely immunocompromised can get additional COVID-19 vaccines; -People who live in LTC settings must give consent or agree to a COVID-19 vaccine. Review of the facility's policies showed staff did not provide a policy for COVID-19 immunizations for residents. 3. Review of Resident #4's medical record showed: -admitted [DATE]; -Recived one dose of the COVID-19 vaccine on 11/22/21; -The record did not contain documentation the resident received education, refused, was offered the second dose or an updated booster of the COVID-19 vaccine. 4. Review of Resident #35's medical record showed: -admitted [DATE]; -The record did not contain documentation the resident received education, refused, offered, or refused the COVID-19 vaccine. 5. Review of Resident #37's medical record showed: -admitted [DATE]; (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The record did not contain documentation the resident received education, refused, offered, or refused the COVID-19 vaccine. 6. During an interview on 04/03/24 at 9:31 A.M., the Infection Preventionist said residents, or the resident representative should receive information regarding the benefits and risks of the COVID-19 vaccination and every resident should be offered the COVID-19 vaccination. The Infection Preventionist said all COVID-19 vaccination documentation, either immunization information or refusal of the vaccine, should be in the residents' electronic medical record. He/She thought all residents were up to date with COVID-19 requirements. During an interview on 04/04/24 at 01:47 P.M., the Director of Nursing (DON) said the COVID-19 Immunization records for residents were the responsibility of the DON. The DON said these records should be in the residents' electronic medical record and in addition, refusals of vaccines should be documented. During an interview on 04/04/24 at 02:12 P.M., the administrator said the previous Infection Preventionist had recently left the position and took all policies and records with him/her. The administrator said the resident immunization program would be re-developed with the new DON and Infection Preventionist but was not currently underway.