STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265457	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Crossing Rehab and Healthcare Center	11278 Schuetz Road Saint Louis, MO 63146

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40291 Based on observation, interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity and respect for one sampled resident (Resident #22) after Housekeeper E dismissed the resident when he/she was trying to talk to him/her. Housekeeper E told the resident he/she did not speak the resident's language. In addition, the facility failed to follow their policy and ensure residents could participate in their treatment in a language they understood. The sample size was 19. The census was 87. Review of the facility's Resident's Rights policy, revised 5/1/23 showed: -Purpose: To promote and protect the rights of all residents at the facility; -Policy: -All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy; -The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance and enhancement of his or her quality of life, recognizing each resident's individuality; -The facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source; -The facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. -Procedure: -State and federal laws guarantee certain basic rights to all residents of the facility. These rights include, but are not limited to, a resident's right to: -Be informed about what rights and responsibilities they have; -Be fully informed and participate in their treatment in a language that they, can understand. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/9/24, showed: -Rarely/never understood; -Rarely/never understands; -Speech Clarity: Unclear words- slurred or mumbled words; -Race: Vietnamese; -Language: -Preferred language: Cantonese; -Diagnoses included atrial fibrillation (A-Fib, irregular heart rhythm), hypertension (high blood pressure), diabetes mellitus (DM, metabolic disease), hyperlipidemia (high cholesterol), Alzheimer's Disease (dementia), and stroke (CVA). Review of the resident's electronic care plan, undated, and in use during the survey, showed: -Focus: resident has a communication problem related to aphasic (unable to speak, write, or understand speech or writing because of damage to the brain) due to CVA. He/She is also in need of an interpreter as he/she speaks Cantonese; -Goal: He/she will be able to make basic needs known; -Interventions: Anticipate and meet needs. Be conscious of resident's position when in groups, activities, dining room to promote proper communication with others. Observation on 1/23/25 at 2:25 P.M., showed the resident sat in his/her wheelchair, in the dining room on the 300/400 hall across from the nurse's station. The resident motioned for Housekeeper E to come to him/her. He/She was trying to communicate something to Housekeeper E. At that time, Housekeeper E shrugged his/her shoulders and said he/she didn't speak the resident's language and kept walking. Certified Nurse Assistants (CNA) G and CNA H giggled at that time. Housekeeper E did not attempt to stop and see what the resident needed when the resident tried to talk to him/her. During interviews with CNA G and CNA H on 1/23/25 at 2:21 P.M., both said they were familiar with the resident and have worked with him/her. Neither CNA were assigned to the resident that day. CNA G said the resident communicates via pointing and motioning towards things (using hand gestures). The resident does not understand staff, but his/her family member went to the facility three times a day and was pretty good about saying/translating what the resident didn't understand. The family member was also pretty good about saying what the resident wanted and/or needed. The resident had been at the facility for a couple of months. Both CNA G and CNA H said they would not know how the resident would communicate to staff if the resident was in pain. CNA G said yeah that would be kind of hard. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/25 at 3:30 P.M., Licensed Practical Nurse (LPN) C said if a resident did not speak English, he/she would use a translator or use Google translator to communicate with the resident. Residents should be treated with dignity and respect. During an interview on 1/24/25 at 3:33 P.M., Certified Medication Technician (CMT) D said if a resident did not speak English, he/she would ask the resident simple questions like are you thirsty or if they wanted to go to the bathroom. The CMT said he/she could also call the power of attorney/resident representative to help translate. Residents should be treated with dignity and respect. During an interview on 1/24/25 at 3:56 P.M., the Administrator said residents should be treated with dignity and respect. During an interview on 1/29/25 at 11:13 A.M., the Assistant Director of Nursing (ADON) said typically when he communicated with the resident, he/she had been able to answer yes or no questions with a nod of the head or with hand gestures. This was pretty much universal. Staff knew the resident's dementia had progressed, so they were implementing a communication board and things of that nature. There was not a communication board in place for nursing staff prior to or during the survey. The reason a communication board was not used was because up until recently, the resident was able to answer yes or no questions or with a head nod or hand gestures. Often times, if the resident needed peri care he/she would point to the front of his/her private area. With this particular staff person involved, he did not think the situation could have been avoided because this was Housekeeper E's first time working in long term care. The ADON thought Housekeeper E just wasn't knowledgeable on what to do in this situation. The encounter between the resident and Housekeeper E was absolutely not dignified. Ultimately it was the ADON's responsibility to ensure that there were means of communicating put in place for residents. Before the facility admits residents, they would want to make sure a means of communication was in place. With this particular resident, he/she was able to communicate. The resident's family said they were even having a hard time communicating with the resident in his/her native language.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40291 42247 Based on interview and record review, the facility failed to ensure residents who received dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys are not working properly) services had written communication with the dialysis center. The facility identified seven residents who received dialysis services. Three residents were sampled (Resident #32, #58 and #60), and issues were found with all three residents. The sample was 19. The census was 87. Review of the facility's Dialysis Care policy, dated 10/24/22, showed: -Policy: The facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing all non-dialysis needs of the resident including during the time period when the resident was receiving dialysis; -The nursing staff, dialysis provider staff, and the attending physician (dialysis staff) will collaborate on a regular basis concerning the resident's care as follows: -Nursing staff will communicate pertinent information in writing to dialysis staff which may include: -Any medication changes; -Any recent changes in condition; -The resident's tolerance of dialysis procedures; -The dialysis provider will communicate in writing to the facility: -The resident's current vital signs (blood pressure, pulse, respirations, and temperature); -Pre and post weight; and -Any problems encountered while the resident was at the dialysis provider; -Nursing staff may use NP-225-Form A- Nurse Dialysis communication record to convey information to the dialysis provider. Review of the facility's Nurse Dialysis Communication Record (NP-225 Form A), revised 10/24/22, showed: -Note: nursing facility/dialysis treatment sheet to be filled out prior to dialysis treatment. (Attach medication administration records (MAR) and new orders to this form. Dialysis center to complete lower half of the form at the end of treatment and send back to skilled nursing facility (SNF); (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Information for the facility to prepare: -Residents name and date; -Fasting blood sugar and time. The insulin dose; -Last medications given and times; -Vital signs and pain scale; -Bruit (an abnormal sound that indicates turbulent blood flow through a narrowed artery or vascular channel) pulse and location; -Access site: note if redness, swelling or drainage; -Changes noted in the last 24-48 hours: falls/trauma; shortness of breath; nausea; vomiting; diarrhea; vertigo (dizziness), edema-specify location; antibiotic; behavioral; lung sounds; other changes in the last 24-48 hours (new meds, orders); -Nurse signature and date; -Dialysis center to complete and return with resident: -Dialysis center name, address and primary nurse; -Access site: redness, swelling or drainage; -Diet change; -Lab result to send first week of each month; -Pre-dialysis weight, vital signs, and pain scale; -Post dialysis weight, vital signs, and pain scale; -Other orders/changes today; -Special instructions/progress notes; -Post dialysis monitoring: -Vital signs every shift for 24 hours and bruit check every four hours for 24 hours; -Time returned to the unit. 1. Review of Resident #32's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 12/26/24, showed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted on [DATE]; -Cognitively intact; -Impairment on one side of both upper and lower extremities; -Diagnoses included anemia, heart disease, high blood pressure, end-stage kidney disease (ESRD, chronic irreversible kidney failure), diabetes, high cholesterol, stroke, hemiplegia, or hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and depression; -On dialysis. Review of the resident's electronic record showed orders for dialysis on Mondays, Wednesdays, and Fridays. During an interview on 1/21/25 at 9:38 A.M., the resident said he/she received dialysis treatment three times a week. The facility provided transportation. During an interview on 1/24/25 at 2:35 P.M., the resident said no paperwork was provided by the facility for the dialysis center. There was not any type of communication paperwork or forms he/she had to take back and forth. He/She said the dialysis center checked the vital signs and weight but not the facility. He/She did not notice the driver carrying any paperwork related to his/her dialysis treatment. 2. Review of Resident #58's admission MDS, dated [DATE], showed: -admitted to the facility on [DATE]; -Cognitively intact; -Special treatment: Dialysis; -Diagnoses included end stage renal disease, heart failure, and high blood pressure, diabetes, anxiety disorder, and maniac depression. Review of the resident's electronic undated care plan, in use during the survey, showed: -Focus: Resident needs hemodialysis (dialysis) related to end stage renal failure; -Goal: the resident will remain free from discomfort or further complications related to renal disease. He/She will have no signs or symptoms from complications from hemodialysis. He/She will adequate fluid balance as evidence by (AEB) good skin turgor pink and moist mucous membranes, and sufficient fluid intake ; -Interventions: Communicate and collaborate with dialysis center regarding weights, medication, diet, and lab results. Dialysis three times a week on Tuesdays, Thursdays, and Saturdays at 9:00 A.M. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician order sheet (POS), dated January 2025, showed: -An order for: dialysis on Mondays, Wednesdays, and Fridays with a pickup time at 5:00 A.M., start date 12/6/24. Review of the resident's medical record, showed no documentation the resident was assessed before and/or after dialysis. During an interview on 1/21/25 4:09 P.M., the resident said he/she received dialysis on Mondays, Wednesdays, and Fridays. 3. Review of Resident #60's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included: anemia (low red blood count), high blood pressure, diabetes, stroke and depression; -Special treatment: dialysis. Review of the order summary report dated 1/22/25, showed an order for dialysis on Monday, Wednesday, and Friday. Review of the medical record, dated 1/1/25 through 1/22/25, showed no dialysis communication records. During an interview on 1/24/25 at 8:42 A.M., the resident said he/she received dialysis treatment on Mondays, Wednesdays, and Fridays. The resident, nor did the driver, took any paperwork back and forth to his/her dialysis appointments. He/She said the facility did not check his/her vital signs. The dialysis center weighed him/her and checked his/her temperature. 4. During an interview on 1/23/25 at 1:00 P.M., the Director of Nursing (DON) said the nurse should check the residents for bruit and thrill, check the dressing site to be sure it is clean and intact. She believed the facility had a dialysis communication form. Staff needed in-service to implement the form. Currently, the facility did not have a dialysis communication form. The dialysis centers were so good with doing the residents' weights and vital signs. The facility was aware of the residents' vital signs and a lot of things on the dialysis form. The information was just not technically on the communication form. When a resident went out for dialysis, the nurse would document the resident had dialysis, did well, returned with no signs and symptoms, ate dinner and things like that. This should be documented in the progress notes. 5. During an interview on 1/24/25 at approximately 2:00 P.M., the DON said the facility did not use the dialysis communication forms. 6. During an interview on 1/24/25 at 3:56 P.M., the Administrator said there should be communication between the facility and dialysis. 45083

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37681 Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. The RN working on the hall was serving as the acting Director of Nursing (DON). This deficiency had the potential to affect all residents. The census was 87. Review of the nursing schedules provided by the facility, dated 12/30/24 through 1/23/25, showed: -On 1/3, 1/4, 1/5, 1/6, 1/8, 1/12, 1/13, 1/20 and 1/22, there was no RN; -On 12/31/24, 1/1, 1 /2, 1/7, 1/9, 1/10, 1/11, 1/14, 1/16, 1/17, 1/18, 1/21 and 1/23/25 the only RN scheduled was the DON. During interviews on 1/22/25 at 3:30 P.M. and at 4:13 P.M., the Administrator said the facility missed having RN coverage for four out of 30 days. The facility had posted an ad for an RN. The facility said the RN who was on the schedule was the DON. During an interview on 1/23/25 at 1:00 P.M., the DON said she was an RN. She had been training with the Regional Nurse since September for the acting DON position. She had been working on the floor because the facility was very short on nurses. They needed to do something about that, and they were trying hard. The Assistant Director of Nursing (ADON), was an Licensed Practical Nurse (LPN), assumed the DON responsibilities many days because that was what he preferred, and she preferred to work the floor. The DON said she usually worked on Tuesdays, Thursdays and Fridays. She had just started picking up some weekends, but she was reachable by phone. She had been coming in more often just to fill in. There were some days when there was no RN coverage, but the other staff were very competent. During an interview on 1/24/25 at 3:56 P.M., the Administrator said she expected for the facility to have an RN on duty for 8 hours daily. MO00246742

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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** 40291 Based on observation and interview, the facility failed to follow recipes for three of four pureed meals observed to ensure that the desired consistency was achieved for nine residents on pureed diets. In addition, the facility failed to ensure food at time of service measured at least 120 degrees Fahrenheit (F) for hot food, and the cold food measured under 41 degrees F and to ensure that food was palatable. This had the potential to affect all residents who consumed food from the facility kitchen. The census was 87. 1. Observation on 1/23/25 at 11:14 A.M., showed Dietary [NAME] (DC) I prepared pureed chicken. He/She placed an unmeasured amount of the chicken from a white plastic container into the blender and started the blender. He/She thought it may have been about 8 ounces in the container but to be on the safe side he/she said it may have been 12 ounces. He/She then poured an unmeasured amount of broth into the blender. DC I said the broth will stretch it so he/she will let the blender run. He/She pureed the items for approximately one minute. DC I took the lid off the blender and said that may be enough. He/She looked at it and started the blender again. DC I said he/she would add salt and pepper to taste. He/She then added an unmeasured amount of chicken broth in the mixture and continued to add an unmeasured amount as the chicken pureed. DC I said the pureed chicken would be enough because the mixture was all the way at the top. DC I just didn't want it to run out. DC I had stopped the blender after about approximately one minute and thirty seconds. He/She stopped the blender and said if he/she needed to add bread then he/she would. DC I pureed the chicken for another thirty seconds. He/She looked at the mixture and said it was still a little coarse so pureed it for approximately another two minutes. DC I stopped the blender and added an unmeasured amount of Mrs. Dash seasoning and pepper to the mixture and then pureed the chicken for approximately an additional forty-five seconds. He/She then tasted the pureed chicken and said it was great. The consistency was smooth with a small slight coarseness. Review of the pureed baked chicken recipe, showed the following for twelve servings: -Remove the number of pureed portions required from the regular recipe (3 oz per serving) (weigh meat only, do not include cooking juices or gravy); -Add to food processor and process to fine consistency; -Prepare broth by dissolving soup base in boiling water; -If thickener is needed, combine hot broth and thickener. Gradually add to meat while processing. All liquid may not be required; -Scrape down sides of the processor and process for thirty seconds. 2. Observation on 1/23/25 at 4:05 P.M., showed the DC J prepared pureed creamed bean soup. He/She said he/she had nine purees but will prepare for ten. DC J placed ten (10) ounce scoops of the cream bean soup in the blender. DC J pureed the soup for one minute. He/She stopped and looked at the mixture and then blended for an additional minute and thirty seconds. The consistency was a thin and soupy texture. DC J said the soup should be a little thicker but it was going to thicken up. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pureed bean soup with ham recipe, showed the following for ten servings: -Measure the number of pureed portions required from the regular recipe; -Drain liquid from the soup ingredients and reserve; -Add soup ingredients to food processor and process to fine consistency; -Scrape down sides of the processor and process for thirty seconds; -Add reserve liquid and process until smooth. 3. Observation on 1/23/25 at 4:15 P.M., showed DC J prepared pureed cornbread. He/She cut ten squares of unmeasured cornbread and placed them inside the blender. He/She then placed an unmeasured amount of chicken base inside the blender along with one pint of milk. DC J pureed the items for approximately one minute. The consistency was a thick doughy, pasty texture. Review of the pureed cornbread recipe, showed the following for ten servings: -Remove the number of pureed portions required from the regular recipe after prepared; -Add to food processor and process to fine consistency; -Combine milk and thickener and gradually add to cornbread while processing; -Scrape down sides of the processor and process for thirty seconds; -Chill to serving temperature; -The recipe did not specify how much milk should be combined. During an interview on 1/24/25 at 1:58 P.M., the Dietary Manager (DM) said she would not expect the cornbread to be thick and pasty. The DM expected staff to follow recipes and use accurate measurements due to nutritional values as well as some residents may have swallowing problems or issues with their stomachs. The DM said pureed foods should be appealing and palatable. 5. Review of the email dated 1/24/25 at 3:38 P.M., received from a local nutrition specialist company regarding purees, addressed to Registered Dietician (RD) O showed: -The expectation is that the standardized recipes are followed for all pureed items to ensure appropriate/desired consistencies are achieved; 6. Review of the facility's Food Temperature policy, dated 10/24/22, showed: -Policy: foods prepared and served in the facility will be served at proper temperatures to ensure food safety; -Measuring food temperatures: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Take the temperature of each pan of product before serving; -Acceptable serving temperatures: -Cereal, gravy, temperature required (F degree) 135 F; -Casseroles, meat entrees; potatoes, pasta; soup; vegetables, the temperature required was greater than 135 F; -Milk, juice, temperature required was less than 41 F; -If temperature do not meet the required serving temperatures listed above, reheat the product or chill the product to the proper temperature; -If temperature are not at acceptable levels and cannot be corrected in time for meal service, an appropriate menu substitution should be implemented; -Do not put food on the tray line until 30 minutes prior to meal service; -Cold food may be put in the freezer 30 to 45 minutes prior to meal service to obtain serving temperature; -Bring only one tray at a time out to the tray line. Place on ice. Ice down all cold foods on tray line; -Heat hot plates. A pellet underline may also be used to maintain temperature. 7. Review of the facility's Resident Council Meetings, showed: -On 10/24/24: hall trays arriving cold (has this improved): 12 residents stated it had not improved. They did state that this is not dietary's fault as the dining room residents witnessed meals coming out hot and quickly. They state it's dependent on how long it takes the Certified Nurse Aides (CNA) to pass out hall trays. As residents on the end of the hall tend to get their food last; -On 11/21/24: hall trays arriving cold (has this improved): 12 residents stated it had not improved. They did state that this is not dietary's fault as the dining room residents witnessed meals coming out hot and quickly. They state it's dependent on how long it takes the CNAs to pass out hall trays. As residents on the end of the hall tend to get their food last. 8. During the Resident Council Meeting on 1/22/25 at 11:00 A.M., the residents said in the main dining room, the food was served quickly and was usually warm. The hall trays were served cold. This happened for all three meals. Sometimes the food will sit on the trays for 15 minutes, while five to six staff members are at the desk. 9. Review of Resident #60's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/25/24, showed: -Cognitively intact; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included stroke, high blood pressure, diabetes and gastroesophageal reflux disease (GERD). During an interview on 1/21/25 at 2:39 P.M., the resident said the food was cold and it did not matter if he/she ate in the dining room or in his/her room. 10. Review of Resident #11's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition; -Diagnoses included heart failure, high blood pressure, diabetes and dementia. During an interview on 1/21/25 at 2:54 P.M., the resident said he/she ate in his/her room. He/She did not like the food and sometimes the food was served cold. 11. Observation on 1/22/25 at 12:45 P.M., showed a metal cart with open sides, arrived on the 300-400 hall dining room. Staff removed the plastic that covered the cart and passed out the trays to the residents in the dining room. At 12:47 P.M., staff delivered the trays to the residents on the 400 halls. At 12:53 P.M., the last room tray was delivered. A test tray was removed from the cart and tested . The temperature (T) of the food was: Chicken Parmesan [NAME] 109.2 degrees F, garlic buttered vegetables 105.8 degrees F, and the garlic bread 90.5 F. 12. Observation on 1/23/25 at 8:54 A.M., showed a metal cart with open sides, arrived on the 300-400 hall dining room. Staff passed out the trays to the residents in the dining room. At 8:56 A.M., staff delivered trays to the residents on the 400 halls. At 9:08 A.M., the last room tray was delivered. A test tray was removed, and the T was taken. The biscuits and gravy were 102.5 degrees F, the orange juice cup was 67.1 degrees F, and the carton of milk was 66.6 degrees F. 13. Review of Resident #62's quarterly MDS dated , 1/3/2025, showed: -Cognitively intact; -No psychosis behaviors; -Diagnoses included heart disease, high blood pressure, kidney disease, diabetes, depression and asthma. Review of the resident's diet order, showed regular diet, regular texture and regular consistency. During an interview on 1/21/25 at 12:09 P.M., the resident said, the food sucks here. The food was usually cold and did not taste appetizing. The resident's parent visits up to three times a week and brings food so he/she can eat decent food at times. During an interview on 1/23/25 at 9:30 A.M., the resident had not eaten breakfast and said he/she did not want to eat breakfast because it was not good anyway. 14. During an interview on 1/24/25 at 3:56 P.M., the Administrator said she expected hot foods to be served hot and cold foods to be served cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42247 45083

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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 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. 40291 Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to label, date and cover food. The facility also failed to ensure kitchen equipment and the floor was kept clean during three of four days of observation, in addition to ensuring that staff followed sanitary conditions when staff used their bare hands to clean out a mixing bowl and failed to ensure the mixing bowl was properly clean before preparing the next pureed dish. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 87. 1. Observation on 1/21/25 at 9:35 A.M., 1/22/25 at 4:06 P.M., and 1/23/25 at 11:38 A.M. of the kitchen, showed the following: -Dry storage room: -A bag of chocolate chips wrapped in plastic and without a date; -A bag of tortilla chips wrapped in plastic and without a date; -A bag of crispy onions wrapped in plastic and without a date; -A bag of powder sugar wrapped in plastic and without a date; -A bag of bow noodles wrapped in plastic and without a date; -A bag of croutons wrapped in plastic open, not closed and exposed to air and without a date. -Freezer: -Three door stand alone: -A plastic bag contained chicken patties without a date; -A blue plastic bag contained an unidentified frozen meat item without a date. 2. Observation on 1/21/25 at 9:35 A.M. and 1/22/25 at 4:06 P.M., of the two-door stand-alone freezer, showed a box contained a bag of biscuit dough which was open and exposed to air. 3. Observation on 1/22/25 at 4:06 P.M. a and 1/23/25 at 11:38 A.M. of the three-door stand-alone freezer, showed a plastic bag contained chicken nuggets without a date. 4. Observation on 1/21/25 at 9:35 A.M. and 1/22/25 at 4:06 P.M., of the kitchen, showed the following: -The stove: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Heavy caked-on stains on the stove burners; -Heavy caked-on stains along the front of the stove; -The deep fryer: -Heavy caked-on stains along the front; -Old grease in the fryer. -Heavy caked on grease and batter along the inside of the fryer. 5. Observation on 1/21/25 at 9:35 A.M. and 1/22/25 at 4:06 P.M., of the kitchen floor, showed following: -The floor dirty with debris on the floor; -The floor dirty with debris and food in between the stove and the fryer; -The floor stained in front of the stove and in between the stove and the fryer. 6. Observation on 1/23/24 of the kitchen, showed the following: -At 11:14 A.M., Dietary [NAME] (DC) I pureed chicken. After he/she pureed the chicken, he/she rinsed out the blending bowl with plain water. He/She did not clean the blending lid used during the chicken puree. He/She then proceeded to place the contents for the carrot puree in the blending bowl and blended the contents. There was chicken puree residue still in the blending bowl along the insides of the bowl as well as inside the lid; -At 4:05 P.M., DC J pureed creamed bean soup. After he/she pureed the soup, he/she rinsed out the blending bowl and the lid with plain water. He/She then used his/her bare right hand to wipe out the inside of the bowl. DC J then grabbed the blending bowl with his/her fingers inside the bowl and placed the blending bowl on the base. He/She then proceeded to place the contents for the cornbread puree in the bowl and blended the contents. There was still soup puree residue in the blending bowl along the inside of the bowl. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. During an interview on 1/24/25 at 1:58 P.M., the Dietary Manager (DM) said the deep fryers are cleaned one time a month. She believes in all hands-on deck approach. She just recently started this and has already seen an improvement. On Wednesday, everyone comes in and they deep clean the stove and ovens. The cooks clean the grease trays daily and wipe down the equipment to try to keep everything clean. Staff are to clean with a degreaser. They empty the grease in the deep fryer every three weeks or after they fry fish. The DM has seen the sides of the equipment and said it looked bad. Her expectation is for equipment to be clean and grease traps emptied. The deep fryer is cleaned every three weeks. The oven has caked on stuff. The DM was aware of it and said she was in the process of taking care of it. The cooks are responsible for cleaning their equipment. The DM's expectations are for the floors and all the equipment to be clean and for everything to work properly. It was her expectation that all sanitary practices should be followed while preparing and cooking food. It was also her expectation that all food should be properly labeled, dated, and stored. It is the responsibility of her cook to ensure that all food is labeled, dated, and properly stored.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45083 Based on interview and record review, the facility failed to follow their policy and accepted professional standards and practices for complete and thorough documentation, when staff failed to follow-up and document appropriately when one resident experienced a change of condition (Resident #82). The sample was 19. The census was 87. Review of the facility's Change of Condition Notification policy, revised on [DATE], showed: -Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner; -Documentation: A Licensed Nurse will document the following; -Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes; - The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received; -The time the family/responsible person was contacted; - Update the Care Plan to reflect the resident's current status; -The incident and brief details in the 24-Hour Report; -If the resident is transferred to an acute care hospital, complete an inter-facility transfer form; -Complete an incident report per Facility policy; -A Licensed Nurse will communicate any changes in required interventions to the Interdisciplinary Team (IDT) members involved in the resident's care; -A Licensed Nurse will document each shift for at least seventy-two (72) hours; -Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-Hour Report. Review of Resident #82's entry Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated [DATE], showed: -admitted [DATE]; -Entered from short-term general hospital; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All other sections left blank. Review of the resident's electronic health records (EHR), showed diagnoses included acute respiratory failure with hypoxia (a condition where the lungs are unable to adequately provide oxygen to the body, resulting in a deficiency of oxygen in the blood), generalized muscle weakness, abnormal posture, cognitive communication deficit, dysphagia (difficulty swallowing) and protein-calorie malnutrition. Review of the progress notes dated [DATE] at 10:04 P.M., showed: -Contacted MD (physician) related to resident's status, noticed resident's mouth had an increased droop and appears to have increased drowsiness. During assessment, resident denied pain or wanting to go to the hospital. Vitals stable but pulse is elevated, sweat noted on his/her nose. Vitals recorded in chart and sister and brother notified of resident's current status. Sister said to just leave her since he/she is responding. Sister stated she was told there was nothing else could be done for the resident. Resident appears to be resting in bed, HOB (head of bed) elevated with call light in reach. MD will see the resident in the morning during visit to the facility. Will continue to monitor for any other changes; -On [DATE] at 6:07 A.M., documentation showed the resident passed away in his/her bed on [DATE]; -No follow-up notes regarding the resident's change of condition that was observed on [DATE]. During an interview on [DATE] at 4:45 P.M., Licensed Practical Nurse (LPN) F said during evening medication administration, he/she observed the resident with facial drooping and disfigured mouth. LPN F called and notified the physician and was advised to call the family on what they wanted to do. LPN F said the resident's sister or responsible party said to keep the resident in the facility as long as he/she remained responsive. LPN F reported his/her observations to the oncoming shift nurse. During an interview on [DATE] at 1:09 P.M., the acting Director of Nursing (DON) said she would expect the staff to notify the physician and family of any changes of condition, and document properly. She would follow up, assess, and document observations after receiving a report from a previous shift's nurse of a resident's change of condition. She said they also utilize an SBAR (Situation, Background, Assessment, Recommendation) sheet. During an interview on [DATE] at 9:55 A.M., the physician/medical director said when he receives calls from facility for resident concerns, he would normally send the resident out to the hospital for further evaluation, however, he also wanted to have the family involved in the decision-making. He said the family decided to have Resident #82 to stay in the facility. He saw the resident on [DATE], with a stable condition and no changes of condition observed. He did not see the resident on [DATE]. He expected the staff to follow-up and document appropriately. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on [DATE] at 12:26 P.M. and on [DATE] at 3:24 P.M., the Assistant Director of Nursing (ADON) said he recalled the resident was very sick, and the sister was very involved with the resident's care. The resident was hospitalized for quite some time and the condition had not improved. The resident had declined upon returning to the facility following hospitalization in [DATE]. The ADON said the sister wanted to cancel follow-up appointments and considered hospice care. The ADON was notified that the resident was found unresponsive and was coded on the early morning of [DATE]. The ADON said the staff performed CPR (cardiopulmonary resuscitation, is an emergency lifesaving procedure performed when the heart stops beating) and called 911 when the resident was found unresponsive. The resident expired that morning. The ADON expected the staff to follow-up and document appropriately after receiving a report of the resident's change of condition. During an interview on [DATE] at 12:45 P.M., the ADON verified that there was no follow-up documentation, nurses' notes, physician's notes, or SBAR sheets regarding the resident's change of condition. He said he spoke with the physician and was notified that no further interventions were provided due to the family's decision. During an interview on [DATE] at 3:55 P.M., the Administrator said she expected the staff to complete the documentation on any residents' change of condition.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42247 45083 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when staff failed to change gloves and perform hand hygiene during wound care for one resident (Resident #75). In addition, the staff disconnected the catheter tubing from the drainage bag to untwist the tubing and reconnected the tubing without disinfecting the catheter tubing for one resident (Resident #236). Furthermore, the staff failed to wear appropriate personal protective equipment (PPE), in accordance with the facility's policy, during high-contact activities with residents on enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO, microorganisms that are resistant to one or more classes of antimicrobial agents) for one resident (Residents #46). The sample was 19. The census was 87. Review of the facility's Infection Prevention and Control Program policy, revised on 10/24/22, showed its purpose is to ensure the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. Review of the facility's Hand Hygiene policy, revised on 10/24/22, showed: -Purpose: To ensure that all individuals use appropriate hand hygiene while at the facility; -Policy: The facility considers hand hygiene the primary means to prevent the spread of infections; -Hand hygiene is always the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand hygiene procedures. Review of the facility's Care of Catheter policy, dated 10/24/22, showed catheters (a sterile tube inserted into the bladder to drain urine) and drainage bags will be changed based on clinical indications such as infection, obstructions or when the closed system is compromised. Routine fixed internal changes of the indwelling catheter drainage bag is not recommended; -Aseptic technique (strict procedure to prevent the spread infection) must be used to change the drainage bag (a bag that collects urine from the catheter). The catheter tubing junction must be disinfected with alcohol or chlorhexidine sponge (antiseptic) prior to connecting the new drainage bag. Review of the facility's Standard and Enhanced Precautions policy, revised 4/1/24, showed: -Purpose: To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy: The facility will utilize current guidance from the Centers for Disease Control (CDC) and the Centers for Medicare & Medicaid Services (CMS) to determine the appropriate PPE to be utilized during the care of residents to minimize the risk of infection or spread of infection; -EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (such as urinary catheter, feeding tube, endotracheal (tube inserted through the mouth or nose) or tracheostomy tube (tube inserted through a surgically created opening in the neck), vascular catheters (flexible tube inserted into a vein to draw blood or deliver medication)) and wounds or presence of unhealed pressure ulcers; -For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: -Dressing; -Bathing/showering; -Transferring; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; -Wound care: any skin opening requiring a dressing. 1. Review of Resident #75's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/24/24, showed: -Cognitively intact; -Substantial or maximal assist to roll left and right mobility; -Dependent to transfer; -Diagnoses included anemia, high blood pressure, diabetes, dementia and malnutrition; -Two Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) that were present upon admission; -One unstageable pressure ulcer (Slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined.) that was present upon admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Treatment Administration Record (TAR), dated 1/22/25, showed: -Vashe Wound Therapy External Solution (wound cleanser used to remove damaged tissue from chronic skin ulcers), apply to affected areas topically every day shift for wound care; -Santyl ointment 250 units per gram (used to remove damaged tissue from chronic skin ulcers), apply to affected areas per additional directions topically every day shift for wound care for 30 days. Observation on 1/23/25 at 7:47 A.M., showed Licensed Practical Nurse (LPN) B assisted LPN A with wound care while the resident lay in bed. LPN B lifted the resident's left leg, held the top foot and ankle to expose the heel with wound, while LPN A applied the treatments as ordered. After wound care was finished, LPN B did not remove his/her gloves and perform hand hygiene. He/She then covered the resident with sheets and with the resident's personal blanket with his/her gloved hands, while wearing the same gloves used during wound care. LPN B then touched the sides of the bed, used the bed remote to adjust the bed and prepared the resident to be repositioned after the resident requested to be pulled up. Two Certified Nurse Assistants (CNAs) entered the room to reposition the resident. 2. Review of Resident #236's medical record, showed: -Alert and oriented times four (person, place, time, and situation); -Diagnoses included obstructive and reflex uropathy (urinary tract condition that occurs when urine can't drain properly); benign prostatic hyperplasia (BPH, enlarged prostate) with lower tract symptoms (frequency, urgency, straining, weak stream, straining, and incomplete bladder emptying). Review of the progress notes, dated 1/21/25 at 9:39 A.M., showed his/her past medical history included: the resident was admitted (to the hospital) for urinary pain, pus coming out catheter and hypotensive (low blood pressure) and found to have urinary tract infection (UTI) and treated with antibiotic. Review of the order summary report, dated 1/22/25, showed: -A physician order for a suprapubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) care every shift; -A physician order to change the catheter drainage bag as needed. Observation on 1/23/25 at 6:45 A.M., showed the resident lay in bed on his/her side. LPN A provided wound care, while LPN B held the resident in place. After they finished, LPN B assisted the resident by pulling up the resident's brief. The catheter tubing was twisted. LPN B disconnected the catheter tubing from the drainage bag to untwist the tubing and reconnected the tubing without disinfecting the catheter tubing junction with alcohol or a chlorhexidine sponge. 3. Review of Resident #46's annual MDS, dated [DATE], showed: -Cognitively intact; -Impairment to both upper and lower extremities on one side; (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent to chair/bed-to-chair transfer; -Diagnoses included stroke, anemia, heart failure, high blood pressure, diabetes and high cholesterol. Review of the facility's list of residents on EBP rooms for January 2025, showed Resident #46 as one of the 29 residents. He/She was placed on EBP due to ESBL (Extended-Spectrum Beta-Lactamase, an enzyme that makes bacteria resistant to certain antibiotics). Observation on 1/23/25 at 6:22 A.M., showed the resident lay in bed, and an EBP sign hung on the door which was visible to the hallway. Certified Nurses Aide (CNA) K and CNA L transferred the resident from bed to wheelchair. Neither CNA wore a gown. PPE supplies were hung on the resident's door. The resident had a facility gown on top and regular pants on the bottom half of his/her body. CNA L said morning care was provided while the resident was lying in bed. While in the wheelchair, CNA L removed the resident's gown and put the top shirt on then combed the resident's hair with no gown on. During an interview on 1/24/25 at 3:07 P.M., CNA M said gown, gloves and masks were to be worn during high contact care of the residents on EBP. He/She receives report from the nurse who identifies the residents on EBP. These residents had wounds, droplet (steps to prevent the spread of infections that are spread through respiratory droplets), and Foley catheter (a thin, flexible tube inserted into the bladder to drain urine) to be placed on EBP rooms. During an interview on 1/24/25 at 3:10 P.M., Registered Nurse (RN) N said EBP rooms were for residents who had wounds, lines, drains, such as Foleys. PPE supplies and door signs were placed in each room. The staff were expected to wear PPEs such as gowns and gloves in providing high-contact care to EBP residents. No PPEs were necessary if staff were to deliver meal trays only. 4. During an interview on 1/23/25 at 12:34 P.M., the Infection Control Preventionist (ICP) said the staff do not need to disconnect the catheter tubing for dressing and if they did, they need to clean the connection junction with alcohol before reconnecting it. Regarding EBP, the ICP said EBP rooms had supplies of PPEs and door signs were hung in each room. She said if the sign was placed by the doorknob, it was for the resident in the door bed, while if the sign was on the opposite side, it meant for the resident in the window bed. She said residents who had MDRO, tube feedings, Foley catheters and wounds were to be placed in EBP rooms. PPE were to be used when providing direct care and high-contact care to the residents on EBP. The staff would know which residents were on EBP through door signs and the monthly list placed in the nurses' stations. 5. During an interview on 1/23/25 at 1:00 P.M., the Director of Nursing (DON) said the catheter and drainage bag are a closed system and it did not need to be disconnected for dressing. If it was disconnected, the junction connection would need to be sanitized prior to reconnecting. The DON also expected staff to change gloves as needed and perform proper hand hygiene during care. The staff were expected to wear PPE while providing high-contact care to residents on EBP. 6. During an interview on 1/24/25 at 3:55 P.M., the Administrator said she expected staff to follow the facility's infection control policy and procedures.