STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265468	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granby House	301 South Main Granby, MO 64844

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to promote each resident's right to self-determination when staff failed to provide routine baths or showers to one resident (Resident #196) out of a sample of four residents. The facility had a census of 46. Review of the facility's policy titled, Resident Bathing, undated showed staff shall provide person-centered care that emphasizes the resident's comfort, independence, personal needs, and preferences. 1. Review of Resident #196's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included major depressive disorder, muscle weakness, and pain. Review of the resident's care plan, revised 06/19/24, showed the following: -Staff to provide the resident with assistance to gather items for bathing and assistance to the bathing area as needed; -Make the resident's bathing process pleasant by ensuring a non-hurried atmosphere; -Encourage the resident to wash, rinse, and dry the areas that are within his/her physical ability. (Staff did not care plan the resident's preferred frequency of showers/baths.) Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/27/24, showed the following: -Moderately impaired cognitive skills; -No rejection of care; -Required partial/moderate assistance of staff with showers and bathing; (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required partial/moderate assistance of staff with the ability to get in and out of a tub/shower. Review of the resident's shower sheets, dated 06/19/24 through 06/24/24, showed staff did not document providing or offering a shower/bath to the resident. Observations and interviews on 06/25/24, at 11:11 A.M., and on 06/26/24, at 3:06 P.M., showed the following: -The resident sat in his/her wheelchair outside in the designated smoking area. The resident had facial hair. His/her hair appeared not combed; -The resident said he/she wanted shaved; -The resident said he/she had not had a shower since his/her admission to the facility; -He/she feels grungy. During an interview on 06/26/24, at 1:04 P.M., Certified Nurse Aide (CNA) F said the following: -The resident had not had a shower since his/her admission; -The facility did not really have a shower schedule; -He/she was the shower aide and now is the restorative nurse aide; -The former Director of Nursing (DON) gave him/her a calendar for the shower schedule; -Staff should complete the shower sheet and turn in to the DON; -He/she did not report to anyone if a resident refused a shower, he/she would just pick the resident up for a shower the next time around. During an interview on 06/26/24, at 12:33 P.M., CNA B said the following: -He/she worked Wednesday and Thursdays and staff try to get the showers completed; -He/she did not know about a shower schedule. During an interview on 06/26/24, at 1:26 P.M., Licensed Practical Nurse (LPN) A said the following: -A new shower aide just moved into the position; -Residents should get two showers a week; -He/she did not know for sure about the shower schedule; -Staff should document the shower on a shower sheet; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses review the completed shower sheets and turn them into the DON; -He/she did not know of the computer system the CNAs document in; -Residents have complained about showers not getting done. The shower aide is pulled to work the floor at times; -He/she expects staff to complete showers and inform him/her if they are not completed. During an interview on 06/27/24, at 10:13 A.M., the interim DON said the following: -Residents should get a showers twice per week; -The shower aide completes the shower sheet and documents it in the computer system; -She expects staff to complete showers and report to the nursing management if not completed. During an interview on 06/27/24, at 10:13 A.M., the Corporate Nurse said the following: -Staff document yes or no in the computer system after a shower is completed; -Staff should report to the DON if a resident refuses a shower; -Staff give the shower sheet to the DON who reviews the sheet for any skin issues; -She expects staff to complete showers and report to the nursing management if not completed. During an interview on 06/27/24, at 4:30 P.M., the Administrator said she expects staff to report to the charge nurse, Assistant Director of Nursing (ADON), or DON if showers are not completed. Staff should give two showers per week and as needed to residents.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34871 Based on interview and record review, the facility failed follow their abuse prevention policy when staff failed to ensure the Nurse Aide (NA) Registry was checked and staff did not have a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them to work in a certified facility for two staff members (Maintenance Supervisor and Registered Nurse (RN) P) and did not check the NA registry in a timely manner for one staff (Interim Director of Nursing (DON)). The facility census was 46. Review of the facility's policy titled, Abuse Prevention Program, revised September 2021 , showed the following: -The nurse aide registry will be checked prior to employment for each state where a nurse aide has shown to have worked, or has listed certification. Nurse aides will not be hired whose name is on any state abuse registry; -Verification of background checks, nurse aide registry checks and reference checks will be maintained in the personnel file of each employee. A notation by facility staff member of telephone contacts for registry check and previous employer checks would constitute verification. 1. Review of the Maintenance Supervisor's personnel record showed a hire/start date of 11/21/23. Review of the facility's background checks for the Maintenance Supervisor showed facility staff did not check the NA registry for a Federal Indicator. During an interview on 06/27/24, at 2:03 P.M., the Medical Record Staff said he/she did not know for sure if he/she should run the Maintenance Supervisor's NA registry check. 2. Review of RN P's personnel records showed a hire/start date of 11/30/23 . Review of the facility's background checks for RN P showed the facility did not check the NA registry for a Federal Indicator. During an interview on 06/27/24, at 2:03 P.M., the Medical Record Staff said he/she ran RN P's NA registry check, but could not find the documentation. 3. Review of the interim DON's personal records showed a hire date of 12/28/23. Review of the facility's background checks for the interim DON showed the facility checked the NA registry for a Federal Indicator on 06/18/24 (six months after his/her hire/start date). During an interview on 06/27/24, at 2:03 P.M., the Medical Record Staff person said he/she ran the interim DON's NA registry several months after hire. He/she only looked at the nurse website and did not run the NA registry check prior to that 4. During an interview on 06/27/24, at 2:03 P.M., the Medical Record Staff said the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she checked the NA registry on new employees; -The department head gives him/her the new hire information; -He/she should check the NA registry on a new hire before they start working on the floor; -The former Business Office Manager (BOM) did not explain how to do the job. 5. During an interview on 06/27/24, at 4:30 P.M., the Administrator said the following: -The medical record staff person is responsible for conducting NA registry checks; -She expects staff to check the NA registry for new employees.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to complete the required Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for a mental disorder or intellectual disability prior to admission) prior to or at admission for one resident (Resident #21), out of five sampled residents, to ensure the resident received appropriate care and services. The facility census was 46. Review of the facility's policy titled Fiscal Management and Control, dated December 2021, showed the following: -DA-124C (form completed prior to admitting the resident to a skilled nursing facility to ensure the resident doesn't trigger a level II screening, part of the PASARR process) must be dated on or before the date of admission; -No resident will be admitted without a level II screening if the diagnosis indicates that one is required. 1. Review of Resident #21's face sheet (brief information sheet about the resident) showed the following information: -admitted [DATE]; -Diagnoses included recurrent major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument, completed by facility staff), dated 04/11/24, showed the following information: -admitted [DATE]; -Moderately impaired cognition; -Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), depression, bipolar disease (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Parkinson's Disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves); -Resident received antidepressant medications. Review of resident's DA-124 A/B PASARR form (used to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 10/13/21, showed the following information: -Diagnoses included major depressive disorder; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Potential problem areas included aggression with intermittent combativeness; -Level one screening criteria for serious mental illness showed resident diagnosed with depressive disorder and dementia with Lewy Bodies (progressive dementia that leads to a decline in thinking, reasoning, and dependent function); -Dementia with Lewy Bodies is the primary reason for nursing facility placement. (The screening was completed almost six months after the resident's admission.) During an interview on 06/27/24, at 9:31 A.M., the Social Services Director said the following: -He/she did not complete the PASARR for the resident as he/she had only been in the position 10 months; -When a resident is at the hospital the hospital will began the PASARR or level one screening. If there was a level II needed, the resident is supposed to stay in the hospital until that's completed; -If the level one is not started from the hospital, he/she completed the PASARR as soon as the resident admitted ; -If the PASARR isn't completed at the hospital, the case manager at the hospital provides SSD with a code and he/she submits the level one screening; -He/she has been checking weekly to see what resident applications have been processed. During an interview on 06/27/24, at 11:25 A.M., the Administrator said the following: -The hospital usually completes the level I screening; -SSD is responsible for making sure the level one is completed upon admission; -If a Level II is triggered, there is a code from the hospital where the SSD can view on the progress of the application; -The resident admitted in April and his/her level one screening should've been completed in April.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on interview and record review, the facility failed to ensure all residents received care per professional standards of practice when staff failed to obtain ordered blood tests in a timely fashion for one resident (Resident #19), out of five sampled residents. The facility census was 46. Review of the facility's policy titled, Laboratory, Radiology and other Diagnostic Services, undated, showed the following: -Provide or obtain laboratory, and other diagnostic services only when ordered by a physician, in accordance with state law, including scope of practice laws; -The facility is responsible for assuring the quality and timeliness of laboratory services; -The facility must provide or obtain laboratory, and other diagnostic services to meet the needs of its residents. Review showed the facility did not provide a policy regarding physician's orders. 1. Review of Resident #19's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included hearing loss, osteoarthritis (protective tissue at the ends of the bones, wears down), cerebral atherosclerosis (arteries in the brain become hard, thick and narrow due to plaque buildup), anemia (problem of having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue), and personal history of transient cerebral ischemic attack (interruption of blood supply to the brain). Review of the resident's care plan, dated 02/12/24, showed the following: -Report any changes in condition to physician; -Administer cardiac and diuretic medications as ordered; -Report any abnormal labs to physician. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/15/24, showed the following: -Cognitively intact; -Resident received an anticoagulant medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's June 2024 Physician Order Sheet (POS) showed an order, dated 02/09/24, for a comprehensive metabolic panel (CMP), complete blood count (CBC), and lipids (blood test that measures the amount of certain fat molecules in the blood), be drawn every three months and yearly. Review of the resident's medical records showed the facility obtained the labs including a CMP, CBC, and lipids on 02/13/24. Review of the resident's medical record, on 06/27/24, showed staff had not obtained the CMP, CBC, and lipids labs due in May 2024. During an interview on 06/27/24, at 1:30 P.M., Certified Medication Technician (CMT) H said he/she looked in the resident's paper medical record and said the last labs were completed on 02/13/24. The labs have not been completed since then; During an interview on 06/27/24, at 1:45 P.M., Licensed Practical Nurse (LPN) I said the following: -He/she knows what labs a resident is supposed to have based upon the orders in the medical record; -The facility now has a lab tracking book where all of the lab orders are kept; -When a resident has an order for labs, staff print off the lab sheet and when the lab company comes in to draw the labs, they're given the sheet; -He/she looked on the lab company's website and did not see an order for the resident to have labs drawn; -He/she looked at the resident's orders and verified the resident did have an order to have labs drawn every three months; -The resident should have had labs drawn in May, if they were last drawn in February; -He/she doesn't know if anyone monitors to ensure the labs are being done as ordered. During an interview on 06/27/24, at 1:53 P.M., LPN J said the following: -Nurses put in orders for labs; -When a nurse received an order from physician, he/she put that order into the electronic record and made a nurse's note; -The facility now has a lab log book, where staff keeps track of what labs are being drawn and what they're being drawn for; -He/she isn't sure if lab book includes on-going orders, or only new orders; -The facility just began using this book recently; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The computer system pops up when the resident needs labs to be drawn. The night shift is usually the ones that print those out when the lab people arrive and the lab people receive a copy of the sheet. The facility keeps a copy and puts it into the book; -He/she isn't sure how it populates those labs if the labs are drawn on 02/13/24 and needed again in three months. During an interview on 06/27/24, at 2:45 P.M., the Director of Nursing (DON) and Corporate Nurse said the following: -Nurses put lab orders into the computer; -The facility now has a lab tracking book binder at the nurses' station and they are to check daily to see who needs labs drawn and when; -The nurses are supposed to pull lab orders monthly, review, and see if any are needed that month; -Nurses put the requisition in to the lab system the day the labs need to be drawn. This was not being done; -If the resident had blood drawn in February, and there was an order for every three months, he/she should've had blood drawn in May; -The orders say when the residents should have blood drawn and they should be followed; -The medical records system does not pop up a notification for when labs are to be completed, that's why the facility implemented the lab draw binder this month; -Staff are told to bring any new orders to morning meetings. They're supposed to write new orders in the books, including who they've reported the results too; -The DON is to check daily during clinical meetings to ensure labs have been completed; -The DON is to pull the labs from the system daily and input into the lab system; -CMT H is assisting with this process monthly; -The lab long binder is to record the results and responses; -The nursing staff are to notify the doctor of the results and this is documented in the lab book. During an interview on 06/27/24, at 4:30 P.M., the Administrator, DON, and Corporate Nurse said the following: -The facility now has the lab tracking binder. The nurses are pulling the orders monthly so they ensure they are being done and they are being tracked in the log; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident had an order for labs to be drawn every three months, they should be drawn every three months.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, interview, and record review, the facility failed to provide services all dependent residents to maintain good grooming and personal hygiene when three dependent residents (Resident #7, #29 and #246), of four sampled residents, did not receive timely showers and had hair that appeared matted or unkept. The facility's census was 46. Review of the facility's policy titled, Resident Bathing, undated showed staff shall provide person-centered care that emphasizes the residents' comfort, independence. personal needs, and preferences. 1. Review of Resident #7's face sheet (gives basic profile information) showed the following information: -admitted [DATE]; -Diagnoses included left artificial hip joint, osteomyelitis (infection in a bone), fibromyalgia (widespread musculoskeletal pain accompanied by fatigue, sleep and mood issues), morbid obesity (overweight), neuromuscular dysfunction of bladder (lack bladder control due to brain, spinal cord, or nerve problems), and rheumatoid arthritis (chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility). Review of the resident's care plan, dated 12/23/23, showed the following information: -The resident will maintain self care as evidenced by assisting with bathing face and upper/lower body; -Resident requires staff assistance with mobility and transfers; -Resident requires two person extensive assist with bed mobility Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 06/07/24, showed the following: -Cognitively intact; -Partial/moderate assist for transferring from bed to chair, shower transfers, and showers/baths. Review of the resident's May 2024 Shower Sheets showed staff documented providing a shower on 05/03/24. Review of the resident's June 2024 Shower Sheets showed the following: -Staff provided a shower on 06/04/24 (31 days since the resident's last documented shower); -Staff provided a shower on 06/07/24; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff did not document a shower provided or offered between 06/08/24 and 06/26/24. Observations and interviews on 06/25/24, at 1:42 P.M., and on 06/26/24, at 3:30 P.M. and 5:09 P.M., showed the following: -The resident had matted hair on the back of his/her head and his/her hair was unkept; -The resident said his/her last shower was on 06/06/24; -He/she felt nasty because it had been so long since he/she had received a bath; -The facility used to have a different shower aide and he/she got showers at least one time per week which is what he/she prefers; -The new shower aide doesn't asked if the resident wants a shower. The resident will ask and sometimes the aide will do it and sometimes the aide won't give him/her a shower. During an interview on 06/26/24, at 1:04 P.M., CNA F said the following: -The resident did good with him/her with showers. The resident informed him/her when being weighed recently that staff did not come in and ask him/her for a shower. During an interview on 06/26/24, at 1:26 P.M., Licensed Practical Nurse (LPN) A said the resident was alert and oriented and can get up for a shower with the use of a slide board. 2. Review of Resident #29's face sheet showed the following information: -admitted [DATE]; -Diagnoses included heart disease, aphasia (affects how you communicate), physical debility (slower process of slowing and weakening), anxiety disorder (persistent feelings of worry or fear), legal blindness, deformity of right hand, personal history of transient ischemic attack and cerebral infarction (short period of symptoms similar to those of a stroke). Review of the resident's care plan, dated 04/29/24, showed the following information: -Resident required assistance to complete daily activities of care safely related to weakness in his/her lower extremities and unsteady gain; -Resident uses a wheelchair for ambulation with staff assist with transfers and mobility. He/she required assistance with dressing, toileting, and bathing; -Resident is occasionally incontinent of the bladder and bowel. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Substantial assistance required for transfers, personal hygiene, showers, dressing, and toileting hygiene. Review of the resident's May 2024 Shower Sheets showed staff document a shower provided to the resident on 05/13/24. Staff did not document any other showers/baths offered or provided in May 2024. Review of the resident's June 2024 Shower Sheets showed the following: -Staff provided a shower on 06/07/24 (25 days since the resident's last documented shower); -Staff provided a shower on 06/12/24; -Staff did not document offering or providing additional showers between 06/13/24 and 06/26/24 Observations and interviews on 06/25/24, at 11:36 A.M., and on 06/27/24, at 8:47 A.M., showed the following: -The resident's hair appeared unkept and stood straight; -The resident said he/she felt dirty. During an interview on 06/26/24, at 1:04 P.M., CNA F said the resident did not refuse showers and liked to have them as scheduled During an interview on 06/26/24, at 1:26 P.M., LPN A said the resident did not refuse showers usually. During an interview on 06/27/24, at 10:13 A.M., the interim DON said the resident has dementia and staff should provide the resident showers. 3. Review of Resident #246's face sheet showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease, stage 3 (kidneys have mild to moderate damage and they are less able to filter waste and fluid out of the body), muscle weakness, unsteadiness on feet, type 2 diabetes (body doesn't regulate insulin properly), osteoarthritis, and metabolic acidosis (cells throws off the chemical balance in the blood). Review of the resident's entry tracking MDS, dated [DATE], showed the following: -Moderately impaired cognition. -Required partial/moderate assistance with showers, lower body dressing, and supervision with transferring. Review of the resident's care plan, dated 06/06/24, showed staff did not address the resident's need for assistance with bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's June 2024 Shower Sheets showed the resident did not receive showers during his/her stay from 06/06/24 through discharge on 06/26/24. Observations and interviews on 06/24/24, at 2:30 P.M., and on 06/27/24, at 8:47 A.M., showed the following: -The resident's hair appeared unkept and stood straight up; -The resident said he/she hadn't received a shower since he/she was admitted ; -The resident said he/she felt dirty. During an interview on 06/26/24, at 1:04 P.M., CNA F said the resident had been in isolation since his/her admission to the facility. The resident had not had a shower since his/her admission During an interview on 06/26/24, at 01:26 P.M., LPN A said staff should offer the resident a bed bath. The resident did not come out of his/her room. During an interview on 06/27/24, at 10:13 A.M., the interim DON said the previous shower aide asked about the resident last week since he/she is on isolation, the interim DON instructed the shower aide to give the resident a bed bath. She did not find documentation on the completed bed bath. 4. During an interview on 06/26/24, at 12:33 P.M., CNA B said the following: -He/she worked Wednesday and Thursdays and staff try to get the showers completed; -He/she did not know of the shower schedule. 5. During an interview on 06/26/24, at 1:04 P.M., CNA F said the following: -The facility did not really have a shower schedule; -He/she was the shower aide and now is the restorative nurse aide; -The former DON gave him/her a calendar for the shower schedule; -Staff should complete the shower sheet and turn in to the DON; -He/she did not report to anyone if a resident refused a shower, he/she would just pick the resident up for a shower the next time around. 6. During an interview on 06/27/24, at 8:50 A.M., CNA G said the following: -The facility did have a shower aide, but he/she will be taking over the showers; -The residents are given showers Monday through Friday; -There is a sheet completed each time a resident receives a shower and it shows any skin issues; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents are offered showers at least one timer per week, and if they refuse that's documented on the sheet; -He/she doesn't know which residents have been given showers and when; -He/she doesn't know if residents on isolation gets showers, but believe they should be offered. 7. During an interview on 06/26/24, at 1:26 P.M., LPN A said the following: -A new shower aide just moved into the position; -Residents should get two showers a week; -He/she did not know for sure of the shower schedule; -Staff should document the shower on a shower sheet; -Nurses review the completed shower sheets and turn them into the DON; -He/she did not know of the computer system the CNAs document in; -Residents have complained about showers not getting done. The shower aide is pulled to work the floor at times; -He/she expects staff to complete showers and inform him/her if they are not completed. 8. During an interview on 06/27/24, at 9:00 A.M., LPN J said the following: -He/she doesn't know if the aides have a certain process or specific days they give showers to specific residents; -Aides are to complete the shower sheets and if a resident refuses a shower, they should be marking that on the shower sheets; -Residents on isolation should still be offered showers. 9 During an interview on 06/27/24, at 10:13 A.M., the interim DON said the following: -Residents should get a showers twice per week; -The shower aide completes the shower sheet and documents it in the computer system; -She expects staff to complete showers and report to the nursing management if not completed. 10. During an interview on 06/27/24, at 10:13 A.M., the Corporate Nurse said the following: -Staff document yes or no in the computer system after a shower is completed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should report to the DON if a resident refuses a shower; -Staff give the shower sheet to the DON who reviews the sheet for any skin issues; -He/She expected staff to complete showers and report to the nursing management if not completed; -The facility replaced the former shower aide. The former aide did not report or document to staff about showers; -The DON and/or nursing management are responsible for ensuring showers are completed. 11. During an interview on 06/27/24, at 4:30 P.M. the Administrator said she expects staff to report to the assistant Director of Nursing (ADON), or DON if showers were not completed. Staff should give two showers per week and as needed to residents. 34871

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to ensure all dialysis residents received services consistent with professional standards of practice when staff failed to routinely communicate and collaborate with the dialysis (a process of filtering and removing waste products from the bloodstream when the kidneys can no longer sufficiently do so) center after appointments for one resident (Resident #15) out of a sample of one resident. The facility census was 46. Review of the facility's policy titled 'Hemodialysis Catheters (a flexible tube inserted through a narrow opening into a body cavity), revised February 2023, showed the nurse should document in the resident's medical record every shift as follows: -Any part of report from dialysis nurse post-dialysis being given; -Observations post-dialysis. (The policy did not refer to use of a communication form.) 1. Review of Resident #15's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included end stage renal disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids), type 2 diabetes (an impairment in the way the body regulates and uses sugar (glucose) as a fuel) and muscle weakness. Review of the resident's care plan, revised 06/09/24, showed the following: -Dialysis on Monday, Wednesday and Friday; -The facility provides and coordinates transportation to the dialysis center. (The care plan did not refer to the use of a communication form.) Review of the resident's current Physician Order Sheet (POS) showed an order, dated 06/13/24 , for dialysis every Monday, Wednesday, and Friday. Review of the resident's medical record showed it did not include dialysis communication forms between the facility and the dialysis center. The nurses did not document follow-up contact with the dialysis center after each dialysis visit. During an interview on 06/25/24, at 10:50 A.M., the resident said he/she did not take a form to his/her dialysis appointments. During an interview on 06/26/24, at 11:28 A.M., the Transportation Staff said he/she did not take a communication form to or from the appointment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24, at 4:09 P.M., Licensed Practical Nurse (LPN) A said he/she did not send a communication form with the resident to dialysis appointments. The dialysis company will provide routine labs and will call the facility with any abnormal lab results. During an interview on 06/26/24, at 4:11 P.M. LPN J said staff used to send the communication forms to the dialysis appointments, but the company did not send them back to the facility. During an interview on 06/27/24, at 10:13 A.M., the Corporate Nurse said the following: -Nurses should complete the communication form and give to the transportation staff person and the dialysis company should send back to the facility upon the resident's return; -She did not see any communication forms completed for the resident's dialysis appointments. During an interview on 06/27/24, at 4:30 P.M., the Administrator said she expects staff to send the communication form with the resident and it should be returned with the resident.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 33187 Based on interview and record review, the facility failed to have a system in placed to ensure nurse aides (NA) completed their training, competencies, and testing in a timely manner when eighteen NA's failed to complete a state approved certified nursing assistant (CNA) training program, competency evaluation, and certification test timely and continued to work providing direct care to residents. The facility's census was 64. Review of the facility policy titled, Nurse Aide Qualifications and Training Requirements, revised August 2022, showed the facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem or otherwise unless: -That individual is competent to provide nursing care and nursing related services, and -That the individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state, or; -That individual has been deemed competent as provided in 483.150 (a) and (b) of the requirements of participation; -Nurse assistants failing to successfully complete the required training program within the first four months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services. Review of the facility's Nurse Aide program syllabus form, Rules of Engagement for Class #11, undated, showed students may work as a nurse aide following the sixteen hours of orientation. If students fail the state test, students may continue to work as a nurse aide until they pass the test or satisfy a total of 120 calendar days from the beginning of the classroom training, whichever event occurs first. 1. Review of the facility's Staff Position Report, provided 06/24/24, showed the following employees' hired dates with no termination dates: -NA V was hired as a NA on 10/12/23; -NA C was hired as a NA on 10/19/23; -NA W was hired as a NA on 10/26/23; -NA X was hired as a NA on 11/08/23; -NA Y was hired as a NA on 12/04/23; -NA Z was hired as a NA on 12/14/23; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NA AA was hired as a NA on 12/21/23; -NA BB was hired as a NA on 12/21/23; -NA CC was hired as a NA on 01/04/24; -NA DD was hired as a NA on 01/22/24; -NA EE was hired as a NA on 01//11/24; -NA FF was hired as a NA on 02/05/24; -NA GG was hired as a NA on 02/23/24; -NA HH was hired as a NA on 02/22/24; -NA II was hired as a NA on 02/23/24; -NA JJ was hired as a NA on 02/29/24; -NA KK was hired as a NA on 02/29/24; -NA ZZ was hired as a NA on 03/14/24. Review of the facility's Certified Nurse Assistant Competency Score Sheet, dated December 2007, for NA C showed the following: -Started the program on 02/07/24. NA completed the required classroom, training hours, competency testing, and written exams at the facility on 05/08/24; -The NA had not completed the final written/oral exam and practicum exam. Review of the facility's Certified Nurse Assistant Competency Score Sheet, dated December 2007, for NA EE showed the following: -Started the program on 02/07/24. NA completed the required classroom, training hours, competency testing and written exams at the facility on 05/08/24; -The NA had not completed the final written/oral exam and practicum exam. Review of the facility's Certified Nurse Assistant Competency Score Sheet, dated December 2007, for NA FF showed the following: -Started the program on 02/07/24. NA completed the required classroom, training hours, competency testing and written exams at the facility on 05/08/24; -The NA had not completed the final written/oral exam and practicum exam. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/24, at 11:55 A.M., the Clinical Instructor (Nurse Aide Program) said the following: -Has worked at the facility completing the nurse aide training program for a year and a half; -The students have twelve weeks to complete the course and then complete the remainder of the final testing at a local college by appointment; -Currently there are three students waiting to take their test, but are unable to secure an appointment date. The students have one year to take the test and can work as a nurse aide during that time period. The students have three attempts to pass before they need to restart the program. Students will usually quit the program or work as a hospitality aide until they pass the course; -He/she was not aware of the 120 day regulatory timeframe to complete the course, but the staff should enforce the regulation. During an interview on 06/27/24, at 2:02 P.M., NA KK said the following: -Started at the end of February 2024 as a nurse aide in the facility training program; -Has completed his/her required prerequisite sixteen hours of training to start the program; -Scheduled to start 07/01/24 for the clinical portion of the program due to a lack of available classes; -Has not been informed of how long the course is suppose to take or how long he/she has to complete the course; -Has not been informed of any work restrictions if the course is not completed in the required training period or after the clinical portion is complete and work as a nurse aide; -Is currently working as an NA. During an interview on 06/27/24, at 2:06 P.M., NA JJ said the following: -Started at the end of February 2024 as a nurse aide in the facility training program; -Has completed his/her required prerequisite sixteen hours of training to start the program; -Scheduled to start 07/01/24 clinical portion of the program due to a lack of available classes; -Has not been informed of how long the course is suppose to take or how long he/she has to complete the course and work as a nurse aid; --Has not been informed of any work restrictions if the course is not completed in the required training period or need to work as a non-nursing hospitality aide if he/she does not pass their nurse aid testing; (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Is currently working as an NA. During an interview on 06/27/24, at 2:09 P.M., NA ZZ said the following: -Started at the end of May 2024 as a nurse aide in the facility training program; -Has only completed initial orientation and is due to start the clinical portion of the program sometime next month; -Has not been informed of how long the course is supposed to take or how long he/she has to complete the course and work as a nurse aide; -Is currently working as a NA. During an interview on 06/27/24, at 4:30 P.M., with the Administrator, Cooperate Nurse, interim Director of Nursing (DON), and Clinical Instructor (Nurse Aide Program) said the following; -They were aware of the delay in getting the staff trained in the required four month completion of the course requirement; -The current staff have had to wait up to four months to start the program for a new class to begin; -The next class (starting next month) will be at a sister facility not at the current facility; -If the course is not completed within the required timeframe, the DON will make them as needed staff, hospitality and housekeeping, if available. All others will be terminated and made to restart the program. 34871

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, record review, and interview, the facility staff failed to follow approved menus for all residents when staff failed to provide cornbread, or comparable substitute, at a meal for two resident (Resident #3 and #40), out of two sampled residents, who received pureed diets. The facility census was 46. Review of the facility's policy titled, Menu and Diet Guidelines, dated 2022, showed the following: -The pureed diet is designed for those individuals who have difficulty swallowing or cannot chew foods of the dental soft consistency; -Serve with appropriate scoop number or divide equally to provide number of portions; -All of the pureed food must be used in order to deliver the correct nutrient density to each resident. 1. Review of the facility menu, dated 06/26/24, showed turkey crunch, peas, cornbread, and pudding for the noon meal. Observations on 06/26/24, at 10:30 A.M., showed the following: -Dietary Aide (DA) K had the menu items cooked and he/she had pureed the peas; -DA K pureed the Turkey Crunch; -DA K did not puree the cornbread listed on the menu. Observation on 06/26/24, at 11:21 A.M., showed DA K placed the correct amount of pureed peas and pureed turkey crunch on the residents' plates. He/she did not give the residents cornbread, or something to replaced the cornbread. 2. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included cardiac pacemaker (used to control or increase the heartbeat) and gastro-esophageal reflux disease (GERD - stomach acid repeatedly flows back up into the tube connecting the mouth). Review of the resident's June 2024 Physician Order Sheet (POS) showed the resident received a purred diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 06/14/24, showed the following: -Resident on a pureed diet with nectar thickened liquids and shake with all meals; -Provide diet as ordered. Observations and interviews on 06/26/24, at 11:48 A.M. and 3:00 P.M., showed the following: -The resident had pureed peas, turkey crunch and pudding, but no cornbread; -He/she isn't sure if he/she gets the same things as other residents; -He/she likes cornbread. 3. Review of Resident #40's face sheet showed the following: -admitted [DATE]; -Diagnoses included cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), type 2 diabetes (problem with the way the body regulates and uses sugar), GERD, and dysphagia (difficulty swallowing). Review of the resident's June 2024 POS showed the resident to receive a puree diet and nectar thick liquids. Review of the resident's care plan, dated 04/22/24, showed staff did not care plan regarding a pureed diet. Observations and interviews on 06/26/24, at 11:52 A.M. and 2:57 P.M., showed the following: -The resident had pureed peas, turkey crunch, pudding, and yogurt. The resident did not have cornbread; -He/she said he/she gets pureed foods and loves cornbread. 4. During an interview on 06/26/24, at 12:43 P.M., DA L said the following: -Residents receiving puree foods should receive the same food options as those on a regular diet; -He/she doesn't know if the residents on pureed foods were given the same foods normally, as those on regular foods. 5. During an interview on 06/26/24, at 12:51 P.M., DA K said the following: -Residents receiving pureed foods get the same foods as those on regular foods; -He/she can puree all foods, including rolls and cornbread; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she forgot to puree the cornbread today so the two residents did not receive cornbread. 6. During an interview on 06/26/24, at 12:51 P.M., DA M said the following: -There is a book in the back of the kitchen that shows how to puree all foods; -Residents on pureed foods get the same foods and amounts as those on regular diets; -If the menu has cornbread, the residents should all get cornbread unless they have a different preference. 7. During an interview on 06/26/24, at 1:21 P.M., the Dietary Manager said the following: -Residents on pureed foods are served the same foods most days; -One of the cooks likes to give chicken instead of pork that's stringy; -Residents on pureed foods should receive the same foods as those on different diets, taking into consideration their preferences and orders; -He/she did not know the residents did not receive cornbread during lunch. They should be offered cornbread. 8. During an interview on 06/27/24, at 3:05 P.M., the Registered Dietician (RD) said the following: -All residents receive the same foods, whether on pureed diet or regular. If the meal includes cornbread, the residents on pureed foods should also be given pureed cornbread; -He/she had not been told of any issues regarding staff not providing all residents the same food choices; -The staff should be following the menu and spreadsheets and this should be carried over to the pureed foods in every aspect. 9. During an interview on 06/26/24, at 2:34 P.M., the Administrator said the following: -All residents should be offered the same foods, considering their diets and preferences; -He/she was not aware that the residents did not receive cornbread during the lunch meal today.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility failed to maintain a complete infection prevention and control program when the facility failed to implement their policy regarding 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) or any resident who has a chronic wound and/or indwelling medical device), resulting in staff not being trained on EBP, personal protective equipment (PPE) and signage present not being present for residents that met the guidelines for EBP, and staff not wearing PPE in accordance with the Centers for Disease Control (CDC) guidelines for one resident (Residents #36), of two sampled resident, who met the guidelines for EBP. The facility also failed to administer the required two step tuberculosis (TB - a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) screening test for six sampled staff members (Dietary Aide Q, Nurse Aide (NA) R, Certified Nurse Aide (CNA) S, Dietary Aide T, Registered nurse (RN) P and CNA U.) A total sample of 16 residents was reviewed in a facility with a census of 46. 1. Review of the CDC's Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms, dated 07/12/22, showed the following: -MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs; -EBP are infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities; -EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO; -Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care; -EPB use of PPE refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; -Examples of high-contact resident care activities requiring gown and glove use for EBP includes dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central line, urinary catheter (flexible tubing that is used to drain urine from the bladder), feeding tube, and tracheotomy/ventilator, and wound care on any skin opening requiring a dressing; -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves; -Make PPE, including gowns and gloves, available immediately outside of the resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled 'Infection Control, revised October 2018, showed the following: -This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmissions of diseases and infections; -The objectives of the infection control policies and practices are to prevent, detect, investigate, and control infections in the facility; maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the general public; establish guidelines for implementing isolation precautions, including standard and transmission-based precautions; establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission-based precautions; maintain records of incidents and corrective actions related to infections; and provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment; -The quality assurance and performance improvement committee, through the infection control committee, shall establish, review, and revise infection control policies and practices and help department heads and managers ensure that they are implemented and followed; -All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. Review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, showed the following information: -EBPs are utilized to prevent the spread of MDROs to residents; -EBPs are used and as an infection prevention and control intervention to reduce the spread of MDROs to residents; -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply; -Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room); -PPE is changed before caring for another resident; -Face protection may be used if there is also a risk of splash or spray; -Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting toileting, device care or use (central line, urinary catheter, feeding tube, tracheotomy/ventilator), and wound care (any skin opening requiring a dressing); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's June 2024 Physician's Orders Sheet (POS) showed the following: -An order, dated 05/28/24, for a wound treatment to left knee. Clean with hypochlorous acid (a cleaning agent), pat dry, apply calcium alginate (a type of wound treatment), cover with ABD pad (a gauze dressing), and change daily; -An order, dated 06/12/24, for Zyvox 600 milligrams (mg) capsule (an antibiotic to treat serious highly resistant bacterial infections), administer one capsule by mouth twice a day for ten days; During an observation on 06/25/24, at 12:40 P.M., Certified Nurse Aide (CNA) F assisted the resident to the bathroom in his/her room. CNA F donned gloves, but did not put a gown on. CNA F assisted the resident to the bathroom. The CNA walked out of the resident's bathroom after he/she assisted the resident on the toilet without wearing a gown. The CNA assisted the resident off of the toilet and did not don a gown. The resident wore a bandage on his/her left knee. Observation on 06/26/24, at 9:06 A.M., showed the following: -No signage on the resident's door indicating resident was on EBP; -No PPE outside or inside of the resident's room; -Resident was up on the wheelchair with the left leg up on a footrest in the bathroom with CNA B assisting the resident. CNA B did not wear any personal protective equipment other than a pair of gloves; -Licensed Practical Nurse (LPN A) entered the room, sanitized hands, and put on a pair of gloves and completed the resident's wound treatment. The LPN did not put on any other personal protective equipment such as a gown. During an interview on 06/27/24, at 9:39 A.M., CNA F said staff did not provide education or inservices to wear a gown and gloves when he/she provides care to residents with wounds and/or indwelling devices. He/she did not know to wear gown with the resident the other day when he/she helped the resident in the bathroom. During an interview on 06/26/24, at 1:38 P.M., CNA F said the following: -One resident was on contact precautions where they had to wear gloves and gown in the room; -He/she had not heard of EBP and had not been instructed or trained regarding this. During interview on 06/26/24, at 1:45 P.M., CNA G said the following: -The staff put on gown for a resident in isolation in their room. If the door is shut or sign on the door about isolation, he/she will speak to the nurse first. -He/she did not know of EBP and had not been instructed or trained on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/26/24, at 2:09 P.M., Certified Medication Technician (CMT) H said the following: -Staff were to use gowns, gloves, mask, and goggles, if airborne infection is present. They will put up signs so the aides will know or everybody will know what to do; -He/she had not been instructed or trained on EBP. During an interview on 06/26/24, at 2:22 P.M., CNA E said the following: -He/she worked as needed; -He/she had not heard of EBP. During an interview on 06/26/24, at 2:29 P.M., Licensed Practical Nurse (LPN) A said the following: -He/she had heard of EBP with putting on gloves and gown for doing care with wounds, catheters, and colostomy bags; -Staff discussed it one time, but staff were not doing this. During an interview on 06/26/24, at 3:27 P.M., the Medical Director said the facility discussed the EBP precautions, but they are not implemented yet. During an interview on 06/27/24, at 2:31 P.M., the interim Director of Nursing (DON) said he/she had not been trained or educated in EBP. During an interview on 06/27/24, at 2:34 P.M., the Corporate Nurse said they had updated their infection control policy with an EBP policy, but it was not in effect at this facility. During an interview on 06/27/24, at 2:35 P.M., the Administrator said the following: -They had not trained or educated staff about EBP process; -The staff were not doing the EBP process at the facility. 2. Review of the facility's policy titled Employee Screening for Tuberculosis, revised March 2021, showed the following: -All employees are screened for latent tuberculosis infections (LTBI) and active tuberculosis (TB) disease, using tuberculin skin test or interferon gamma release assay (a blood test that measures the body's immune response to the bacteria that causes TB) and symptom screening prior to beginning employment; -Each newly hired employee is screened for LTBI and active TB disease after an employment offer has been made, but prior to the employee's duty assignment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Review of Dietary Aide T's personnel record showed the following information: -Hire/start date of 09/07/23; -Staff administered the first test on 09/07/23; -Staff did not document the results of the first TB skin test; -Staff did not document administering the second step TB skin test. 7. Review of RN P's personnel record showed the following information: -Hire/start date of 11/30/23; -Staff did not document administering the first or second step TB skin test. 6. Review of CNA U's personnel record showed the following information: -Hire/start date of 07/28/23; -Staff did not document administering the first or second step TB skin test. 7. During an interview on 06/27/24, at 5:12 P.M., LPN J said he/she would sometimes administer a TB test on a new employee when they come in for orientation. He/she administered the first step and read it in three days or 72 hours later. He/she did not usually administer the second step TB skin test due to the DON or assistant DON did this. Any nurse can read the TB test. He/she documented on a paper and gave it to the DON or assistant DON. 8. During an interview on 06/27/24, at 2:03 P.M., the Corporate Nurse said the former DON was responsible for completing the employee TB skin tests. The facility has had several DONs and assistant DONs. 9. During an interview on 06/27/24, at 11:23 A.M., the Administrator said she did not find the TB skin tests for the employees. The former DON was responsible for completing the employee TB skin tests. The charge nurse can administer the TB skin test. Staff should administer the first TB skin test and read the results three days later. Staff should not work until the first TB skin test results are read. 33187 34871

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45176 Based on observation, record review, and interview, the facility staff failed to ensure the facility was maintained in a sanitary and comfortable fashion when light fixtures in the kitchen and dining area had dead bugs present, were not clean, were missing covers, and were not good working order; when the lower shelf of the prep table was not good repair with rust visible; when staff failed to keep the outside of the ice machine clean; and when the floor in the stock room had debris present and was dirty. The facility census was 46. Review of the facility's policy titled Sanitization, dated November 2022, showed the following: -All kitchens, kitchen areas, and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects; -All utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. 1. Observations on 06/24/24, beginning at 10:00 A.M., and on 06/26/24, beginning at 10:30 A.M., of the kitchen and dining areas showed the following: -Two lights located over the steam table had several dead bugs present; -The light at the back of the kitchen, located over the cabinet, had several bugs inside the light fixture and brown spots on the outside of the fixture; -The light over the refrigerator had the cover missing from the light; -Two lights located over the stove had dead bugs in the light fixture; -One light in the back of the dining room was not working. Review of the facility's weekly June 2024 Cleaning Schedule showed no task for cleaning the ceiling lights, replacing the covers, or ensuring the lights are functioning. During an interview on 06/26/24, at 12:43 P.M., Dietary Aide (DA) L said the following: -Ceiling lights are maintained by maintenance; -He/she doesn't pay close attention to the ceiling lights so he/she didn't notice there were bugs in them, or that one of the covers was missing in the kitchen; -He/she wasn't aware of any lights not working in the dining room; -He/she doesn't let maintenance know about issues with lights. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/26/24, at 12:51 P.M., DA K said the following: -Maintenance takes care of the ceiling lights. They clean them on the inside and outside, replace the bulbs, and put on new covers; -He/she is not aware if the maintenance person knows the lights have bugs in them, that one of the lights in the dining room isn't working, or that one of the lights in the kitchen doesn't have a cover; -He/she verbally tells the maintenance person if there is needed repairs in the kitchen. During an interview on 06/26/24, at 12:51 P.M., DA M said the following: -Maintenance is responsible for cleaning the ceiling lights, changing the bulbs, and replacing the covers; -He/she would dust the outside of the light,s but that's about all for the ceiling lights; -Staff verbally tell the maintenance person if there are repairs needed, bulbs needing replaced, or cleaning needed for the ceiling lights; -He/she hasn't told maintenance the lights need repaired and cleaned as he/she doesn't look at the ceiling so probably didn't notice. During an interview on 06/26/24, at 1:21 P.M., the Dietary Manager (DM) said the following: -The maintenance person is responsible for cleaning the ceiling lights inside and out and replacing the covers and bulbs. He/she didn't realize the light was out in the dining room or there were bugs in several of the lights in the kitchen; -He/she knew one of the light covers were missing. There have been new covers ordered and they have been broken when they arrive or shatter when maintenance tries to install them; -He/she tells maintenance when something needs to be done. During an interview on 06/27/24, at 9:50 A.M., the Maintenance Director said the following: -He/she is responsible for changing the bulbs on the ceiling and cleaning the lights inside and out. He/she tries to keep that done; -There were covers in the dining room that were broken when they arrived. He/she wasn't aware of one of the bulbs in the dining room being burned out or the lights in the kitchen had bugs in them; -He/she needed to order new bulbs and light covers; -He/she has weekly and monthly checks, but no paperwork that assists him/her of keeping track. He/she doesn't have cleaning the lights as one of his/her checks. He/she just tries to wash them off as needed; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The kitchen staff will let him/her know when they notice something wrong. During an interview on 06/26/24, at 2:34 P.M., the Administrator said the following: -Maintenance is responsible for cleaning the inside and outside of the ceiling lights, changing the covers, and replacing lights that are burned out; -The facility has ordered several covers for the lights and they always crack; -Staff should be telling maintenance when there are issues with the ceiling lights; -Currently the maintenance person if using paper to track things that need to be done in his/her maintenance binder, where there are work orders; -The DM should be following up and overseeing to ensure maintenance is told about the things that need to be done in the kitchen and dining room and making sure they're completed. 2. Review of the 2013 Missouri Food Code showed the following information: -Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris; -Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues; -The physical facilities shall be cleaned as often as necessary to keep them clean. Observations on 06/24/24, beginning at 10:00 A.M., and on 06/26/24, beginning at 10:30 A.M., of the kitchen and dining areas showed the lower shelf of the prep table had grime around the edge of the shelf, was missing the initial coating over much of the top, and there was about a 16 inch X 16 inch area that had orange rust visible. Review of the facility's weekly cleaning schedule for June 2024 showed the following: -Wipe down prep table as needed on Saturday; -The week of 06/03/24, staff initialed as being completed; -The week of 06/10/24, staff initialed as being completed; -The week of 06/17/24, staff initialed as being completed. During an interview on 06/26/24, at 12:43 P.M., DA L said the following: -He/she is aware the table has grime and some of the top layer is missing and has rust. The staff put the plastic top sheet over it so the pans that sit on top won't get dirty; -They have a cleaning schedule, but there aren't many that mark things off. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/26/24, at 12:51 P.M., DA K said the following: -He/she is aware of the grime, and top layer of the table that's missing, as well as the rust; -The DM is aware of the issue and they put the plastic sheet over it to keep the pans from getting the rust on them; -They also put foil around the edge of the table to help keep it clean, but there's still grime and we routinely clean the table. During an interview on 06/26/24, at 12:51 P.M., DA M said the following: -He/she is aware and so is all staff of the table having the top coat missing, and the rust and grime. It's been like that for a long time; -Staff put the plastic sheet over the table between it and the pans, but the rust and grime could still get on the pans; -They clean the table and anything else that needs to be cleaned. During an interview on 06/26/24, at 1:21 P.M., the DM said the following: -They have gone through different cleaning schedules and everything they need to do isn't on them. They add and change as they go and he/she monitors the schedule to ensure the staff are completing the tasks; -The table has some of the top coat missing and rust, that's why they put the plastic on it. They try to make sure it's clean. During an interview on 06/26/24, at 2:34 P.M., the Administrator said the following: -He/she is aware the table has the top layer missing and the rust and grime. They probably need a new table. -The DM should be overseeing the cleaning schedule to ensure the dietary staff are following it. 3. Observations on 06/24/24, beginning at 10:00 A.M., and on 06/26/24, beginning at 10:30 A.M., of the kitchen and dining areas showed the outside of the ice machine in the back had several streaks of white substance and the vent on the front of the ice machine, just over the door, had fuzzy lint on it. Review of the facility's weekly cleaning schedule for June 2024 showed no task for cleaning the outside of the ice machine. Review of the facility's deep clean schedule showed no task for cleaning the ice machine. During an interview on 06/26/24, at 12:43 P.M., DA L said the following: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she doesn't know whose supposed to clean the outside of the ice machine; -He/she wasn't aware there was fuzzy lint on the vent over the door. During an interview on 06/26/24, at 12:51 P.M., DA K said the following: -He/she said there's been arguments with maintenance over whose responsibility it is to clean the outside of the ice machine. The facility used to have a person that serviced the machine but not anymore. During an interview on 06/26/24, at 12:51 P.M., DA M said the following: -Housekeeping is responsible for cleaning the outside of the ice machine, but he/she doesn't know how often; -He/she is not aware of the vent above the ice machine door having lint on it. During an interview on 06/27/24, at 7:50 A.M., Housekeeper N said the following: -He/she has not been told housekeeping is responsible for cleaning the outside of the ice machine; -He/she believes the kitchen staff are responsible for cleaning the ice machine. . During an interview on 06/26/24, at 1:21 P.M., the Dietary Manager (DM) said the following: -Since he/she started housekeeping has been responsible for cleaning the outside of the ice machine and the vents on the ice machine; -There has been discussion on whose job it is to clean them and he/she is going to taking over cleaning the outside and will ensure the white substance is gone and the vents are clean. During an interview on 06/27/24, at 7:53 A.M., Housekeeper O said the following: -He/she used to have a deep clean sheet that included wiping down the outside of the ice machine; -He/she wipes down the outside of the ice machine and didn't realize there was white streaks down the back of the ice machine; -Housekeeping used to clean the vent. He/she believes its on the deep clean sheet. During an interview on 06/27/24, at 9:50 A.M., the Maintenance Director said housekeeping is responsible for cleaning the outside of the ice machine and the vent. During an interview on 06/26/24, at 2:34 P.M., the Administrator said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265468	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granby House	301 South Main Granby, MO 64844

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Housekeeping is responsible for wiping down the outside of the ice machine and should be cleaning the white substance on the outside; -Maintenance should be cleaning the vent that has fuzzy lint. It should be done monthly or as needed. 4. Observations on 06/24/24, beginning at 10:00 A.M., and on 06/26/24, beginning at 10:30 A.M., of the kitchen and dining areas showed the small stock room to the back of the kitchen, that holds large cans, had dirt/debris on the floor and a black substance present. Review of the facility's weekly cleaning schedule for June 2024 showed no task for sweeping or mopping the floors. Staff made a note on 06/15/24 that the kitchen floors were swept and mopped. During an interview on 06/26/24, at 12:43 P.M., DA L said the following: -They have a cleaning schedule for weekly cleaning, but there aren't many that mark things off; -Night shift is responsible for sweeping and mopping the floors; -He/she looked at the stock room and said the night shift should be sweeping it and cleaning it. During an interview on 06/26/24, at 12:51 P.M., DA K said staff have a cleaning schedule and the night shift usually clean the floor, including the storage room floors. During an interview on 06/26/24, at 12:51 P.M., DA M said the following: -Everyone helps with cleaning and there is a cleaning scheduled. Staff don't always remember to document when they clean something; -Night staff clean the storage rooms and they should be sweeping them; -He/she didn't know the storage room had a dirty floor. During an interview on 06/26/24, at 1:21 P.M., the DM said the following: -They have gone through different cleaning schedules and everything they need to do isn't on them. They add and change as they go and he/she monitors the schedule to ensure the staff are completing the tasks; -Evening shift should be cleaning the floors each night. Sometimes the stock rooms get forgotten since it is behind a closed door. During an interview on 06/26/24, at 2:34 P.M., the Administrator said the following: -All staff should be cleaning the kitchen and that would include the floors in the stock room. The floors should not be dirty; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The DM should be following up to make sure the kitchen is clean and the cleaning schedules are followed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the fly population when multiple flies were present in and around three residents (Residents #5, #12, and #29) and in resident common areas. The facility census was 46. Review of the facility policy titled Pest Control, revised May 2008, showed the following: -The facility shall maintain an effective pest control program; -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 1. Review of Resident #5's face sheet (admission data) showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly minimum data sheet (MDS - a federally-mandated assessment form completed by facility staff), dated 04/25/24, showed the following: -Memory problems; -Required supervision or touching assistance of staff while eating; -Partial/moderate assistance of staff with toileting hygiene and showers. Observation on 06/24/24, at 2:44 P.M., showed the following: -The resident sat in his/her wheelchair in the hallway with his/her eyes closed; -Three flies buzzed around the resident and one fly landed on his/her left arm. Observations on 06/26/24, at 9:27 A.M. and 11:14 A.M., showed the following: -The resident sat in his/her wheelchair in the hallway; -A fly crawled on his/her back; -Two flies buzzed around the resident. Observation and interview on 06/27/24, at 9:36 A.M., showed the following: -The resident sat in his/her wheelchair in the hallway; -Two flies buzzed around the resident and crawled on him/her; -The resident said, they bother him and land on his/her food. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #12's face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitive skills intact; -Set up assistance of staff with eating; -Substantial/maximal assistance of staff with toileting hygiene and showers. Observation and interview on 06/27/24, at 12:15 P.M., showed the following: -The resident sat in his/her room in his/her chair and swatted at flies; -He/she said the flies land on his/her face and had been in the facility for a while; -Beside of the resident's chair and there were two dead flies. 3. Review of Resident #29's face sheet showed the resident admitted on [DATE]. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Substantial assistance of staff with transfers, personal hygiene, showers, dressing, and toileting hygiene. Observation and interview on 06/24/24, at 10:45 A.M., showed the following: -The resident sat in his/her room in his/her wheelchair; -A fly landed on the resident's face and he/she waved his/her hand during the interview in an attempt to keep the fly from his/her face; -He/she said the facility had problems with flies for some time. 4. Observation on 06/24/24, at 11:54 A.M., showed several flies in the hallway leading into the dining room and several flies buzzed around in the dining room while residents ate their meal. 5. During an interview on 06/27/24, at 7:50 A.M., Housekeeper N said the following: -All residents complained about the flies trying to land on them; -The flies are in the rooms and all over the facility. 6. During an interview on 06/27/24, at 8:50 A.M., Certified Nurse Aide (CNA) G said the following: -Several residents complained about the flies; (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Many of the staff go around the facility with fly swatters and try to kill them; -He/she hasn't noticed any flies on the residents or their food. 7. During an interview on 06/27/24, at 09:39 A.M., CNA F said the following: -Flies are terrible every summer; -He/she used a fly swatter to kill the flies; -The facility had a fan on the inside of the door that goes to the smoking area; -The residents hold the door open day and night when they come inside from smoking; -Staff spray coffee on the concrete to help with the flies. 8. During an interview on 06/27/24, at 9:50 A.M., the Maintenance Director said the following: -The flies have been bad the past few weeks; -The pest company came to the facility on [DATE] and said a new product is coming out and the company will inform him/her how it works; -There is a bug light by the back door, one in the dining room, and the kitchen. 9. During an interview on 06/27/24, at 10:37 A.M. the Corporate Nurse said the following: -There is a blower by the black door and black light; -She knows it is an issue; -She expects staff to use a fly swatter to kill flies. 10. During an interview on 06/27/24, at 11:23 A.M., the Administrator said the following: -The pest control company visited the facility on 06/26/24 and is working on getting a new product out to kill the flies; -She expects the staff to kill the flies as needed. 45176