STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265479	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sikeston Convalescent Center	103 Kennedy Drive Sikeston, MO 63801

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to document a code status for one resident (Resident #9) outside the sample of 17 sampled residents. The facility census was 66. Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR - lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped), revised [DATE], showed: - CPR will be provided to a resident who suddenly ceases to have a spontaneous pulse and respirations unless there is a physician's order for no CPR, Do Not Attempt Resuscitation (DNAR), or a do not resuscitate (DNR) order, Out of Hospital Do Not Resuscitate (OHDNR), or allow a natural death; - A minimum of one CPR certified staff will be available on each shift; - The policy did not address code status documentation throughout the resident's medical record. 1. Review of Resident #9's medical record showed: - admitted [DATE]: - Diagnoses of urinary tract infection (UTI - a bacterial infection that affects the bladder and kidneys), altered mental status (a change in someone's usual level of thinking or ability to respond to their surroundings) and cerebral infarction (stroke); - No documentation of a code status on the face sheet. Review of the resident's baseline care plan, dated [DATE], showed: - No documentation of the resident's code status. Review of the resident's [DATE] Physician's Order Sheet (POS), showed: - No order for the resident's code status. Review of the resident's care plan, dated [DATE], showed: (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of the resident's code status. During an interview on [DATE] at 3:56 P.M., the Director of Nursing (DON) said she would expect a code status to be on the baseline care plan when a new resident was admitted to the facility. If not, it should be on the face sheet, POS, and should be care planned. During an interview on [DATE] at 4:16 P.M., the Administrator said he would expect a code status to be on the baseline care plan when a new resident was admitted to the facility. If not, it should be on the face sheet, POS, and should be care planned. 48532

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview and record review, the facility failed to monitor and keep one resident's (Resident #4) equipment in good, working order. The facility also failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 66. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting such as a clean, sanitary and orderly environment. 1. Observations on 01/07/25 at 10:31 A.M., 01/08/25 at 9:24 A.M., and 01/09/25 at 8:34 A.M., showed: - A buildup of spider webs and dirt on the outside ceiling of the awning located at the front entrance; - A buildup of spider webs and dirt on the outside ceiling of the awning located at the exit near the personnel dining room and kitchen. 2. Observations on 01/07/25 at 10:41 A.M., 01/08/25 at 9:29 A.M., and 01/09/25 at 9:40 A.M., of room [ROOM NUMBER] showed: - Several long areas of exposed sheetrock and peeled paint behind the bed next to the door; - Several small areas of exposed sheetrock and peeled paint on the wall behind the nightstand by the bed next to the door. 3. Observations on 1/07/25 at 9:01 A.M., 01/08/25 at 9:48 A.M., and 1/09/25 at 9:26 A.M., of room [ROOM NUMBER] showed: - A large area of peeled paint and dark scuff marks along the bottom wall behind the door; - Several broken slats on the mini-blind hanging in front of the window. 4. Observations on 1/07/25 at 11:30 A.M., 01/08/25 at 9:56 A.M., and 1/09/25 at 9:30 A.M., of room [ROOM NUMBER] showed: - Several small areas of exposed sheetrock and peeled paint located on the bottom left-side wall in the hallway next to the door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Observations on 1/07/25 at 11:30 A.M., 01/08/25 at 9:56 A.M., and 1/09/25 at 9:30 A.M., of Resident #4's Geri-chair (specialized recliner) showed: - The protective covering worn off and with rough edges on the left-side armrest. Observation on 01/13/25 at 11:12 A.M., of Resident #4 showed: - The resident sat in his/her Geri-chair in the dining room and his/her left arm lay on the left-side armrest. Review of the maintenance log, dated 12/01/24 - 01/09/25, showed no documentation of areas of concern addressed. During an interview on 01/09/25 at 4:15 P.M., the Maintenance Supervisor (MS) said he/she was responsible for the upkeep of the outside grounds and the building. The outside entrance awning and ceiling should be free of cobwebs and debris. Staff should be writing down any environmental concerns found inside the facility to be addressed in a timely manner on the maintenance log. During an interview on 01/09/25 at 12:18 P.M., the Administrator said he would expect maintenance to ensure the outside grounds and building to be free of debris and cobwebs. He would expect staff to write down environmental concerns inside the facility on the maintenance log to be addressed in a timely manner. During an interview on 01/13/25 at 9:19 A.M., Housekeeper A said there was a maintenance log at the nurse's station that staff could use to write down any environmental issues. Each housekeeper was assigned a hall and should be writing down any repairs that were found during the daily cleaning rounds. Housekeeping helped with some things outside the facility like window cleaning, but maintenance was responsible for most of the upkeep outside.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to develop and implement a baseline care plan (initial plan for delivering of care and services) within 48 hours of admission for one resident (Resident #9) outside the sample of two sampled residents that included the instructions needed to provide effective and person-centered care to meet professional standards of quality care. The facility census was 66. Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, showed: - A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission; - The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, discussion with the resident/representative and physician orders; - The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed; - Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #9's medical record showed: - admitted [DATE]: - Baseline care plan, dated 12/24/24; - The facility did not complete the resident's baseline care plan within 48 hours after admission to the facility. During an interview on 01/09/25 at 3:56 P.M., the Director of Nursing (DON) said she would expect a baseline care plan to be completed within 48 hours of a new admission to the facility which should reflect pertinent information regarding the resident's care areas. During an interview on 01/09/25 at 4:16 P.M., the Administrator said he would expect a baseline care plan to be completed within 48 hours of a new admission to the facility addressing the resident's care areas.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48532 Based on interview and record review, the facility failed to ensure staff reconciled narcotics (a process that allows one staff to reconcile the exact narcotic inventory on hand with another staff) at each shift change for five out of five medication carts. This practice had the potential to affect all residents. The facility census was 66. The facility did not provide a policy on narcotic reconciliation documentation. 1. Review of the A Hall Certified Medical Technician (CMT) Narcotic Count Log for Controlled Substances on 01/09/25 at 10:17 A.M., showed: - For 7 A.M. - 7 P.M. shift on 11/27/24 - 12/18/24, the staff missed 11 out of 44 opportunities to reconcile the narcotics; - For 7 P.M. - 7 A.M. shift on 12/18/24 - 01/08/25, the staff missed 13 out of 44 opportunities to reconcile the narcotics. 2. Review of the B Hall CMT Narcotic Count Log for Controlled Substances on 01/09/25 at 10:15 A.M., showed: - For 7 A.M. - 7 P.M. shift on 12/01/24 - 12/19/24, the staff missed 20 out of 44 opportunities to reconcile the narcotics; - For 7 A.M. - 7 P.M. shift on 12/20/24 - 01/05/25, the staff missed 11 out of 44 opportunities to reconcile the narcotics; - For 11 P.M. - 7 A.M. shift on 12/24/24 - 01/09/25, the staff missed nine out of 42 opportunities to reconcile the narcotics; - For 7 P.M. - 7 A.M. shift on 01/05/25 - 01/09/25, the staff missed four out of 10 opportunities to reconcile the narcotics. 3. Review of the C Hall CMT Narcotic Count Log for Controlled Substances on 01/09/25 at 10:17 A.M., showed: - For 11 P.M. - 7 A.M. shift on 11/23/24 - 12/09/24, the staff missed 20 out of 44 opportunities to reconcile the narcotics; - For 3 P.M. - 7 A.M. shift on 12/09/24 - 12/25/24, the staff missed nine out of 44 opportunities to reconcile the narcotics; - For 3 P.M. - 6 A.M. shift on 12/25/24 - 01/09/25, the staff missed nine out of 43 opportunities to reconcile the narcotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the D Hall CMT Narcotic Count Log for Controlled Substances on 01/09/25 at 10:18 A.M., showed: - For 7 A.M. - 7 P.M. shift on 11/24/24 - 12/09/24, the staff missed 12 out of 44 opportunities to reconcile the narcotics; - For 3 P.M. - 7 P.M. shift on 12/09/24 - 12/24/24, the staff missed four out of 44 opportunities to reconcile the narcotics; - For 7 A.M. - 3 P.M. shift on 12/25/24 - 01/08/25, the staff missed five out of 44 opportunities to reconcile the narcotics; - For 7 A.M. - 3 P.M. shift on 01/07/25 - 01/09/25, the staff missed one out of six opportunities to reconcile the narcotics. 5. Review of the Medication Room Nurse Narcotic Count Log for Controlled Substances on 01/09/25 at 10:18 A.M., showed: - For 7 P.M. - 7 A.M. shift on 11/19/24 - 12/10/24, the staff missed nine out of 44 opportunities to reconcile the narcotics; - For 11 P.M. - 7 A.M. shift on 12/10/24 - 01/01/25, the staff missed 13 out of 44 opportunities to reconcile the narcotics; - For 7 P.M. - 7 A.M. shift on 01/01/25 - 01/09/25, the staff missed one out of 16 opportunities to reconcile the narcotics. During an interview on 01/09/25 at 10:18 A.M., CMT D said there should be two signatures on the Narcotic Count Log, one from on-coming staff and one from the out-going staff for each shift. During an interview on 01/13/25 at 11:23 A.M., the Corporate Nurse said the facility did not have a policy regarding how many staff and which staff should sign the narcotic reconciliation log, but it was best practice to have the on-coming staff member and the off-going staff member count the narcotics on each medication cart. During an interview on 01/13/25 at 12:09 P.M., the Director of Nursing said the on-coming staff and the off-going staff should sign the narcotic reconciliation log when counting the medication cart. That was the best standard of practice. During an interview on 01/13/25 at 12:10 P.M., Licensed Practical Nurse (LPN) E said CMT's on-coming to their shift should count with the off-going nurse. On-coming nurse counts with the off-going nurse in the medication room. There should be two signatures on the narcotic reconciliation log. During an interview on 01/15/25 at 11:12 A.M., the Administrator said it was the best practice to have two staff sign off for each shift, but the facility didn't have a specific policy to follow regarding the narcotic reconciliation.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview and record review, the facility failed to ensure an appropriate diagnosis for the use of a psychotropic (any drug that affects brain activities associated with mental processes and behavior) medication for one resident (Resident #45) out of five sampled residents. The facility census was 66. Review of the facility's policy titled, Antipsychotic (medications that treat psychosis-related conditions and symptoms) Medication Use, dated July 2022, showed: - Residents will not receive medications that are not clinically indicated to treat a specific condition; - Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; - The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others; - Antipsychotic medications shall generally be used only for the following conditions/diagnosis as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders: a. Schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations); b. Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder); c. Schizophreniform disorder (a type of mental health disorder with symptoms similar to those of schizophrenia, but lasting for less than 6 months); d. Delusional disorder (a mental health disorder that causes people to have false beliefs, that are difficult to distinguish from reality); e. Mood disorder (e.g., bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence of dementia (a set of symptoms characterized by delusions, hallucinations, disordered thinking and speech and agitation); g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids); (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Tourette's Disorder (a neurological disorder that causes people to have sudden, repetitive and involuntary movements or sounds); i. Huntington Disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down); j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. - Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. sadness or crying alone that is not related to depression or other psychiatric disorders; - Residents will be informed of the recommendations, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Residents may refuse medications of any kind. 1. Review of Resident #45's medical record showed: - An admitted [DATE]; - Diagnoses of congestive heart failure (CHF- a chronic condition where the heart can't pump enough blood to the body), type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar), muscle weakness, and insomnia; - An order for Seroquel (an antipsychotic medication) 50 milligram (mg) by mouth at bedtime for depression, dated 10/17/24; - No documentation of behaviors; - No documentation of an appropriate diagnosis for the Seroquel; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A patient note, dated 01/09/25, showed the Family Nurse Practitioner (FNP) reviewed the resident's extensive medical history. The resident had been on several different depression medications in the past, without success. He/She was started on Seroquel along with Zoloft (an antidepressant medication) to improve his/her symptoms. The resident's Patient Health Questionnaire evaluations in the past reflected feeling down, depressed and hopeless. Some of the symptoms have improved due to being in a safe, clean environment now. The previous psychiatric physician had treated the resident, made appropriate adjustments in the medications. The resident's diagnosis was corrected to major depressive disorder. Review of the resident's Pharmacy Consultant note, dated 09/03/24, showed: - A request to update the diagnosis associated with the Seroquel; - Seroquel was not indicated for the treatment of insomnia/depression. Review of the resident's progress notes dated 10/10/24 showed: - The facility staff sent a request to the previous psychiatric physician on 10/10/24, because the resident had requested the Seroquel 100 mg be decreased due to making the resident too sleepy and the resident refused the medication due to this; - An order, dated 10/10/24, was received to decrease the Seroquel to 50 mg by mouth at bedtime. Observation on 01/07/25 at 11:45 A.M., showed Resident #45 ate lunch in his/her room with the spouse. Observations on 01/07/25 at 3:00 P.M., 01/08/25 at 9:30 A.M., and 01/09/25 at 8:50 A.M., showed Resident #45 sat in his/her room and visited with the spouse. During an interview on 01/09/25 at 11:00 A.M., the Director of Nursing (DON) said after the pharmacy consultant was here, the recommendations came to her, and she sent them to the physicians or wherever they needed to go. During an interview on 01/13/25 at 9:23 A.M., Resident #45 said the medication caused him/her to be really sleepy, even after the dose had been reduced, so he/she had been refusing the medication. The resident did not want to take the medication. During an interview on 01/13/25 at 10:56 A.M., Licensed Practical Nurse (LPN) B said the resident had not had any behaviors that he/she knew of. He/She worked nights a few times and knew the resident took the Seroquel at bedtime. During an interview on 01/13/25 at 11:00 A.M., Certified Medication Technician (CMT) C said the resident had not had any behaviors. He/She didn't think the resident took the Seroquel anymore. During an interview on 01/13/25 at 11:15 A.M., the Director of Nursing (DON) said psychiatry would be here next month to see the resident. He/she said that it was discussed with psychiatry on the phone and the depression diagnosis was the only diagnosis that would cover that medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48532 Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 27 opportunities with two errors made, resulting in an error rate of 7. 41% for two residents (Residents #7 and #16) out of nine sampled residents. The facility's census was 66. Review of the facility's policy titled, Insulin Administration, last reviewed September 2014, showed: - Depress the plunger and remove the needle after approximately five seconds; - This policy did not address the priming of the insulin pen prior to each use. Review of the Humalog/lispro (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) Kwik Pen (insulin in a pen-type device) instructions, revised, July 2023, showed: - Prime the pen by turning the dose knob to two units; - Hold the pen with the needle pointing up; - Tap the cartridge holder gently to collect air bubbles at the top; - Push the dose knob in until it stops, and zero is seen in the dose window, insulin will be visible at the tip of the needle; - Select the dose; - Give the injection after selecting the area and cleaning the site with an alcohol swab. Leave the needle under the skin while counting to five slowly. Review of the Fiasp/insulin aspart (fast-acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed: - Prime the pen by turning the dose selector to two units; - Keep the needle upwards and press the push-button until the dose selector reads zero; - Turn the dose selector to select the number of prescribed units; - Push the needle into the skin, then press the dose button until dose selector indicates zero; - Keep the push-button fully pushed in after the injection; - Leave the needle under the skin for six seconds and then remove it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #7's Physician Order Sheet (POS), dated January 2025, showed: - An order for insulin aspart inject five units subcutaneously (injection under the skin) before meals, dated 10/17/24; - An order for insulin aspart subcutaneous before meals per a sliding scale of blood sugar if 140-180= 2 units; 181-220=4 units; 221-400=6 units, dated 10/17/24; Observation of Resident #7's medication administration on 01/09/25 at 11:09 A.M., showed: - Licensed Practical Nurse (LPN) F administered 9 units of insulin aspart subcutaneously per the resident's insulin aspart Kwik Pen for a blood sugar of 191 and the meal dosage. LPN F left the needle under the resident's skin for approximately one to two seconds after administering the insulin; - LPN F failed to prime the insulin aspart Kwik Pen per the manufacturer's instructions prior to the administration to the resident; - LPN F failed to leave the needle under the skin per the manufacturer's instructions. 2. Review of Resident #16's POS, dated January 2025, showed: - An order for Humalog insulin pen subcutaneous before meals per a sliding scale of blood sugar if 150-199=1 unit, 200-249=2 units, 250-299=3 units, 300-349=4 units, 350-399=5 units, 400+=6 units, dated 11/22/24. Observation of Resident #16's medication administration on 01/09/25 at 10:57 A.M., showed: - LPN F administered 3 units of Humalog subcutaneously per the resident's Humalog Flex Pen for a blood sugar of 250. LPN F left the needle under the resident's skin for approximately one second after administering the insulin; - LPN F failed to prime the Humalog Flex Pen per the manufacturer's instructions prior to the administration to the resident; - LPN F failed to leave the needle under the skin per the manufacturer's instructions. During an interview on 01/09/25 at 11:10 A.M., LPN F said he/she primed the insulin pens with one unit of insulin prior to each administration. During an interview on 01/09/25 at 11:15 P.M., LPN E said before administering insulin, the insulin pen must be primed with 2 units of insulin before administering the insulin to the resident. During an interview on 01/09/25 at 2:10 P.M., the Corporate Nurse said staff should prime insulin pens with 2 units with every insulin administration. During an interview on 01/15/2025 at 9:55 A.M., the Director of Nursing (DON) said staff should prime the insulin pen using 2 units before administering insulin to a resident.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sikeston Convalescent Center	103 Kennedy Drive Sikeston, MO 63801

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to affect all residents. The facility census was 66. Review of the facility's policy titled, Sanitization, revised [DATE], showed: - The food service area is maintained in a clean and sanitary manner; - All utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracked and chipped areas that may affect their use or proper cleaning; - All equipment, food contact surfaces, and utensils are cleaned and sanitized; - The policy did not address refrigerator and/or freezer defrosting. Review of the facility's policy titled, Food Receiving and Storage, revised [DATE], showed: - Foods shall be received and stored in a manner that complies with safe food handling practices; - Dry foods and goods are handled and stored in a manner that maintains the integrity of the package until they are ready for use; - Dry foods that are stored in bins are removed from original packaging, labeled and dated, (use-by date). Such foods are rotated using a first in - first out system; - All foods stored in the refrigerator or freezer are covered, labeled and dated; - Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. 1. Observations on [DATE] at 10:05 A.M., and [DATE] at 8:42 A.M., of the kitchen area, showed: - A buildup of grease and a black substance on several cooking pans on top of a four-tier metal shelf rack in front of the stove; - A buildup of grease and a black substance on several cooking pans on top of a five-tier metal shelf rack near the walk-in freezer; - A buildup of a white substance on the top and side surfaces of the dish machine; - A dirty bristle brush, dirty scrubbing pads, and miscellaneous debris under the three chemical dispensing switches on top of the dish machine; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two soiled blankets lay on the floor in front of the dish machine. 2. Observations on [DATE] at 10:16 A.M., and [DATE] at 8:48 A.M., of the walk-in freezer near the five-tier metal shelf rack with the cooking pans, showed: - A bag of mozzarella cheese opened and expired [DATE]; - A plastic container of miscellaneous sliced cheeses with no label or date; - A metal container with a frozen thick white substance with no label or date; - An opened package of butter not sealed or dated; - A roll of deli bologna hung out of a zip lock bag, not sealed or dated. 3. Observations on [DATE] at 10:21 A.M., and [DATE] at 8:52 A.M., of the dry foods and can goods area, showed: - A bag of bread crumbs opened with no label or date; - A bag of marshmallows opened and not sealed; - A five pound (pd.) bag of yellow cake mix opened, not sealed and dated; - A bag of instant mashed potatoes opened, not sealed and dated. 4. Observations on [DATE] at 10:28 A.M., and [DATE] at 8:56 A.M., of the walk-in freezer next to the dry foods and can goods area, showed: - Large clumps of ice buildup on the floor and under the metal racks containing boxes of food; - A large clump of ice buildup on the double-fan freezer unit above the top shelf on the left side; - A bag of burritos opened, unsealed, with no label or date; - A bag of okra opened, unsealed, with no label or date; - A bag of hot dogs opened, unsealed, with no label or date; - A bag of hash browns opened, unsealed, with no label or date; - A bag of onion rings opened, unsealed, with no label or date; - A bag of fish sticks opened, unsealed, with no label or date; - A large bag of garlic bread opened, unsealed, with no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:17 P.M., the Assistant Dietary Manager (ADM) said he/she would expect staff to seal, label, and date any foods once it had been opened and placed back on the shelf or freezer. He/She would expect staff to keep the kitchen equipment cleaned, sanitized daily or after it was used for preparing food. During an interview on [DATE] at 4:07 P.M., the Dietary Manager (DM) said he/she would expect staff to seal, label, and date any foods once it has been opened and placed back on the shelf or freezer. He/She would expect staff to keep the kitchen equipment cleaned, sanitized daily or after it was used for preparing food. During an interview on [DATE] at 4:58 P.M., the Administrator said he would expect staff to seal, label, and date any food once it had been opened and placed back on the shelf or freezer. He would expect staff to keep the kitchen equipment cleaned, sanitized daily or after it is used for preparing food. The walk-in freezers and refrigerators should be free of ice buildup and defrosted as needed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45872 Based on observation, interview, and record review, the facility failed to ensure the dumpsters were closed at all times and maintained to keep pest out and/or to keep the garbage contained in the dumpster. The facility census was 66. Review of the facility's policy titled, Food Related Garbage and Refuse Disposal, revised October 2017, showed: - Food-related garbage and refuse (trash) are disposed of in accordance with current state laws; - Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests; - Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. Observations made on 01/07/25 at 8:58 A.M. and 3:47 P.M., 01/08/25 at 8:36 A.M. and 3:10 P.M., 01/09/25 at 9:11 A.M. and 2:40 P.M., of the outside dumpster area showed: - A bed mattress lay on the ground behind the right side of the dumpster; - A box spring mattress lay on the ground beside the right side of the dumpster; - Several scattered white foam cups and bowls on the ground; - The dumpster lid on the right side opened with visible boxes, trash bags, soiled briefs, gloves, and scattered food; - The dumpster lid on the left side opened with visible boxes, trash bags, soiled briefs, gloves, and scattered food. During an interview on 01/09/25 at 5:07 P.M., the Assistant Dietary Manager (ADM) said staff should be closing the dumpster lids after trash or any other miscellaneous items were discarded. During an interview on 01/09/25 at 3:17 P.M., the Dietary Manager (DM) said staff should be closing the dumpster lids after trash or any other miscellaneous items were discarded. During an interview on 01/09/25 at 4:37 P.M., the Maintenance Supervisor (MS) staff should be closing the dumpster lids after trash or any other miscellaneous items were discarded. He/She was responsible for the upkeep of the outside grounds. During an interview on 01/09/25 at 4:58 P.M., the Administrator said he would expect all staff to close the dumpster lids after trash or any other miscellaneous items were discarded. He would expect no debris or large items to be laying around on the ground by the outside dumpsters. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/25 at 9:19 A.M., Housekeeper A said staff should always close the lid to the dumpsters after trash or anything else had been discarded into it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 26904 Based on observation, interview, and record review, the facility failed to implement Enhance Barrier Precautions (EBP) during wound care for five residents (Residents #24, #32, #45, #46, and #60) out of five sampled residents and one resident (Resident #3) outside the sample. The facility census was 66. Review of the facility's policy titled, Enhanced Barrier Precautions, not dated, showed: - It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms; - EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities; - High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, and wound care of any skin opening requiring a dressing; - Initiation of Enhanced Barrier Precautions: enhanced barrier precautions will be initiated for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling/implanted medical devices (e,g., central lines, ports, urinary catheters, feeding tubes tracheostomy/ventilator tubes) even if the resident is known to be infected or colonized with a MDRO; - Implementation of Enhanced Barrier Precautions: make gowns and gloves available immediately near or outside of the resident's room. 1. Observation on 01/08/25 at 9:30 A.M., of Resident #60's wound care showed: - EBP signage not posted outside of the resident's room; - Licensed Practical Nurse (LPN) B did not put on an isolation gown, entered the room, performed hand hygiene, and put on gloves; - LPN B removed the saturated dressing from the resident's left heel; - LPN B performed hand hygiene and changed gloves; - LPN B cleaned the wound with wound cleanser, performed hand hygiene, changed gloves, applied Xeroform (a fine mesh gauze containing medications to promote wound healing) to the open area and placed a border gauze (a three layer adherent dressing) on top of the Xeroform; - LPN B removed the gloves, performed hand hygiene, and left the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 01/09/25 at 2:43 P.M., of Resident #32's wound care showed: - EBP signage not posted outside of the resident's room; - LPN B did not put on an isolation gown, entered the resident's room, performed hand hygiene, and put on gloves; - LPN B cleaned the resident's wound on the coccyx (the small, curved bone at the base of the spine) with wound cleanser, changed gloves, performed hand hygiene, applied Santyl (an ointment that removes dead tissue from skin ulcers), and covered with border gauze. - LPN B removed the gloves, performed hand hygiene, and left the resident's room. 3. Observation on 01/09/25 at 2:56 P.M., of Resident #46's wound care showed: - EBP signage posted outside of the resident's room; - LPN B did not put on an isolation gown, entered the resident's room, performed hand hygiene, put on gloves, and removed the resident's saturated dressing from the right heel area; - LPN B changed gloves, performed hand hygiene, cleaned the wound with wound cleanser, patted dry with a 4 x 4 gauze, applied Santyl to the wound bed, cut and applied calcium alginate (highly absorbent wound dressing), and covered with a dressing; - LPN B removed the gloves, performed hand hygiene, and left the resident's room. 4. Observation on 01/09/25 at 3:16 P.M., of Resident #45's wound care showed: - EBP signage posted outside of the resident's room; - LPN B did not put on an isolation gown, entered the resident's room, performed hand hygiene, put on gloves, and cleaned the resident's left lower leg with wound cleanser; - LPN B changed gloves, performed hand hygiene, applied a large piece of Xeroform over the opened area, wrapped with a compressive bandage, performed hand hygiene, and left the resident's room. 5. Observation on 01/09/25 at 3:21 P.M. of Resident #24's wound care showed: - EBP signage posted outside of the resident room; - LPN B did not put on an isolation gown, entered the resident's room, performed hand hygiene, and put on gloves; - LPN B assisted the consultant wound care nurse with repositioning, provided stability for the resident to turn, removed gloves, performed hand hygiene, and left the resident's room. 6. Observation on 01/09/25 at 3:37 P.M., of Resident #3's wound care showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- EBP signage not posted outside of the resident's room; - LPN B did not put on an isolation gown, entered the resident's room, performed hand hygiene, put on gloves, and used wound cleanser to clean the wound; - LPN B changed gloves, performed hand hygiene, applied Santyl to the wound bed, and covered the wound with a border gauze dressing; - LPN B removed gloves, performed hand hygiene, and left the resident's room. During an interview on 01/09/25 at 5:00 P.M., the Corporate Nurse said he/she would expect the staff to wear a protective gown and gloves when caring for residents with wounds, catheters, feeding tubes, and anything like that. During an interview on 01/13/25 at 10:38 A.M., the Infection Preventionist said residents that require EBP were residents that had any kind of opening, such as catheters, ostomies, wounds with drainage or required a dressing change. Staff should put on gown and gloves when providing high contact care, such as incontinent care, wound dressing changes and anything that required a sterile technique. During an interview on 01/13/25 at 10:54 A.M., LPN B said gloves and gowns should be worn when going into a resident's room with EBP and he/she just forgot to put a gown on when doing the residents' wound care. During an interview on 01/13/25 at 11:04 A.M., the Director of Nursing (DON) said gown and gloves should be worn anytime during resident care with EBP. 48532