STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Lutheran Convalescent Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 723 South Laclede Station Rd Webster Groves, MO 63119	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40290 Based on interview and record review, the facility failed to ensure services provided met professional standards of practice when staff failed to complete neuro checks (neurological assessments) following unwitnessed falls or falls in which the resident hit their head, for two residents (Residents #44 and #35). The sample was 20. The census was 123 with 99 residents in certified beds. Review of the facility's Neurological Evaluation policy, revised 5/25/21, showed: -Purpose: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition; -Steps in the procedure included: -Perform neurological checks with the frequency as ordered or per falls protocol; -Determine resident's orientation to time, place and person; -Observe resident's patterns of speech and speech clarity; -Take temperature, pulse, respirations, blood pressure; -Check pupil reaction; -Determine motor ability. Review of the facility's Clinical Documentation Standards - Care Center policy, -Electronic medical record (EMR) process for Adverse Event - Fall: -Completed for each adverse event fall; -Complete Post Fall Observation form and follow up is every shift for 72 hours. Residents should have increased monitoring for the first 72 hours after a fall. Each shift, the nurse should record in the medical record a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/2/24, showed: -Short and long term memory problem; -Cognitive skills for daily decision making: Severely impaired; -Inattention behavior present, fluctuates; -Altered level of consciousness behavior present, fluctuates; -Diagnoses included Alzheimer's disease, dementia, anxiety, depression, restlessness and agitation; -Two or more falls with injury (except major) since last assessment. Review of the resident's progress note, dated 9/20/24 at 11:09 P.M., showed resident found on floor at 8:00 P.M. this evening. No apparent injury. Unwitnessed. Full range of motion, denies pain, no discomfort observed. Assisted resident back into bed. Returned to resident's room at 8:10 P.M. and found the resident on the floor again. Neuro checks within normal limits (WNL). Review of the resident's post fall observation, dated 9/20/24 through 9/23/24, showed neuro checks not documented as completed as follows: -Two consecutive four-hour checks on 9/21/24; -One eight-hour check on 9/22/24. Review of the resident's progress note, dated 9/26/24 at 10:13 P.M., showed resident was found lying on his/her right side near the bathroom. Resident unable to tell staff what happened. Resident has full range of motion in all extremities. Skin tear to left elbow. Review of the resident's post fall observation, dated 9/26/24 through 9/29/24, showed neuro checks not documented as completed as follows: -One eight-hour check on 9/28/24; -One eight-hour check on 9/29/24. Review of the resident's progress note on 10/14/24 at 4:00 A.M., showed at 3:00 A.M., resident was found by staff in the doorway to his/her bathroom on his/her back on the floor. His/her head was in the bathroom and his/her torso was in the doorway to his/her room. Resident denied hitting his/her head, although he/she told the supervisor that he/she hit his/her head. No injuries noted. Review of the resident's post fall observation, dated 10/14/24 through 10/16/24, showed neuro checks not documented as completed as follows: -One four-hour check on 10/14/24; (continued on next page)

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	265600	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Convalescent Home	723 South Laclede Station Rd Webster Groves, MO 63119

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Two consecutive eight-hour checks on 10/15/24; -One eight-hour check on 10/16/24. Review of the resident's progress note, dated 11/2/24 at 4:37 A.M., showed at 1:00 A.M., resident was found in the doorway to his/her bathroom on his/her back on the floor. When asked what happened, resident was silent. Resident denied hitting his/her head. No injuries noted. Review of the resident's post fall observation, dated 11/2/24 through 11/4/24, showed neuro checks not documented as completed as follows: -Three consecutive four-hour checks on 11/2/24; -Two consecutive eight-hour checks on 11/3/24; -Three consecutive eight-hour checks on 11/4/24. During an interview on 11/7/24 at 10:07 A.M., Licensed Practical Nurse (LPN) C said the resident is confused and needs staff assistance with transfers. He/She falls frequently from trying to get up on his/her own. Due to his/her cognitive status, the resident would not be able to tell staff what happened in the event of a fall. 2. Review of Resident #35's significant change MDS, dated [DATE], showed: -Moderate cognitive impairment; -Upper and lower extremity impairment on one side; -Diagnoses included Alzheimer's disease, dementia, seizure disorder, anxiety, and depression; -One fall without injury, two or more falls with injury (except major), and one fall with major injury since last assessment. Review of the resident's progress note, dated 10/3/24 at 9:16 P.M., showed at 8:45 P.M., staff went to the resident's room to check on him/her and found the resident on his/her bathroom floor. Resident lying on his/her left side with his/her head under the sink. Resident assessed and neuro checks WNL. Review of the resident's post fall observation, dated 10/3/24 through 10/6/24, showed neuro checks not documented as completed as follows: -One hourly check on 10/3/24; -Two consecutive four-hour checks on 10/4/24; -One eight-hour check on 10/5/24. (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 progress note, dated 10/13/24 at 3:12 P.M., showed upon taking another resident to the restroom, Resident #35 was yelling, Help, get me off my hip, please. Upon going into resident's room, resident was on floor laying on right side near the sink. Vital signs within normal limits. Resident did not hit head. Skin tear to right elbow, both knees red. Review of the resident's post fall observation, dated 10/13/24 through 10/16/24, showed neuro checks not documented as completed as follows: -One hourly check on 10/13/24; -One four-hour check on 10/13/24; -Two consecutive eight-hour checks on 10/15/24. Review of the resident's progress note, dated 10/21/24 at 11:40 P.M., showed resident was found on the floor on the side of the bed by oncoming staff. Resident did not have any injuries. Resident did not recall what happened. Neuro checks WNL. Review of the resident's post fall observations, dated 10/21/24 and 10/22/24, showed: -Hourly neuro check completed 10/21/24 at 11:00 P.M.; -Hourly neuro checks missed at 12:00 A.M., 1:00 A.M., and 2:00 A.M.; -Neuro checks completed 10/22/24 at 6:00 A.M.; -On 10/22/24 at 7:00 P.M., staff started a new post fall observation document with neuro checks starting over on 10/22/24 at 7:00 P.M., and no neuro checks documented in between 6:00 A.M. and 7:00 P.M. that day. During an interview on 11/7/24 at 10:07 A.M., LPN C said the resident is very confused and his/her health has recently declined a lot. He/She falls frequently and he/she has no sense of safety and will try to stand on his/her own, but he/she needs assistance from staff to stand. Due to his/her cognitive status, the resident would not be able to tell staff what happened in the event of a fall. 3. During an interview on 11/7/24 at 10:07 A.M., LPN C said neuro checks must be initiated for all unwitnessed falls. Neuro checks are performed to assess residents for internal head injuries. Neuro checks should be completed at various intervals for the 72 hours following a resident's fall. Nurses should document neuro checks in the EMR. Once neuro checks are triggered in the EMR, it pops up as an order for staff to follow at all shifts until the conclusion of the 72 hour period. 4. During an interview on 11/7/24 at 11:04 A.M., LPN D said neuro checks should be initiated following all unwitnessed falls. Immediately following a fall, the nurse completes a full assessment of the resident and documents it in the EMR. After entering the fall in the EMR, it should trigger staff to continue neuro checks hourly, then every four hours, then every eight hours for 72 hours following the resident's fall. Neuro checks are completed to assess residents for injury. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview on 11/7/24 at 2:21 P.M., the Director of Nurses (DON), Interim Administrator, and Administrator said Residents #35 and #44 are confused, disoriented, and have frequent falls. It would be expected for staff to complete neuro checks following falls for Residents #35 and #44, and any unwitnessed fall for residents who are not alert and oriented. Neuro checks should also be completed for any fall in which the resident hits their head. Neuro checks are performed to make sure residents do not have head injuries. They are documented as post-fall assessments in the EMR and should be performed in accordance with the times on the post-fall assessment flow sheets. 46888

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49992 Based on interview and record review, the facility failed to ensure the pharmacist reported any irregularities to the attending physician and the facility's Medical Director and Director of Nursing (DON), and failed to ensure these reports were acted upon for two residents (Residents #47 and #52). The sample was 20. The census was 123 with 99 residents in certified beds. Review of the facility's Drug Regimen Review policy, provided as the facility's policy and procedure for the required monthly medication review for residents, revised February 2019, showed: -Policy Statement: It is the policy of the community that a licensed pharmacist will review the resident drug regimen including the resident chart at least once a month. The consultant pharmacist may need to conduct the medication regimen review more frequently depending on the resident condition, review of short stay resident and risk of adverse consequences. The licensed pharmacist will report in writing, any irregularities to the attending physician, the community's Medical Director and the Director of Nursing to be acted upon; -Policy Interpretation and Implementation: 1. The pharmacy consultant will perform a monthly drug regimen review on each resident unless the resident condition/risk will indication a more frequent schedule that is individualized and communicated between the community clinical staff and the pharmacy consultant. 2. Irregularities identified will be documented on a separate, written report and sent to the physician, Medical Director, and Director of Nursing, listing the resident's name, relevant drug and irregularity the pharmacist has identified. If in the professional judgment of the Pharmacy Consultant that an irregularity requires urgent action, the Pharmacy Consultant will immediately report the irregularity to the Director of Nursing and or charge nurse and the attending physician by phone. 3. The physician will document in the resident record that the identified irregularity has been reviewed and any action taken to address it. If the physician chooses not to act upon the Pharmacy Consultant recommendations, the physician must document the rationale as to why the change is not indicated in the resident record. 4. All medication regiment review documents will be maintained in the resident medical record. 1. Review of Resident #47's medical record, showed: -Diagnoses included dementia, healed traumatic fracture and high blood pressure; -An order dated 4/30/20, for acetaminophen (used to treat pain or fever) 325 milligram (mg). Administer 650 mg by mouth every 4 hours as needed for pain; -An order dated 8/8/24, for oxycodone-acetaminophen (to treat pain) 5 mg/325 mg tablet, one tablet every eight hours as needed for severe pain. Review of the resident's Consultant Pharmacist Recommendation to Physician, dated 9/26/24, showed: -Recommendation Category: Potential High Dose Therapy; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Please add the following warning to current order(s) for acetaminophen 1. oxycodone-acetaminophen 5 mg/325 mg tablet, one tablet every eight hours as needed for severe pain; 2. acetaminophen 325 mg. Administer 650 mg by mouth every 4 hours as needed for pain. Maximum dose is 3 grams (GM) in 24 hours from all sources. Please update the Medication Administration Record (MAR) to reflect this change. -There is no record the recommendation was addressed, and the physician's orders do not reflect a change in the medications. 2. Review of Resident #52's medical record, showed: -Diagnoses included diabetes, stroke, dementia, high cholesterol, poor appetite, depression, and high blood pressure; -An order dated 1/9/24, for escitalopram (to treat depression) 5 mg. Administer 15 mg by mouth every day; -An order dated 9/18/23, for mirtazapine (to increase appetite) 7.5 mg tablet, by mouth every day. Review of the resident's Consultant Pharmacist Recommendation to Physician, dated 8/28/24, showed: -Federal nursing facility regulations require that consideration be given to the gradual does reduction (GDR) for psychopharmacologic therapies unless documentation exists which GDR in contraindicated; -Please consider a GDR for the following 1. Escitalopram 15 mg by mouth daily; 2. Mirtazapine 7.5 mg daily by mouth daily; -There is no record that the recommendation was addressed, and the physician's orders do not reflect a change in the medications. 3. During an interview on 11/7/24 at 8:58 A.M., Licensed Practical Nurse (LPN) I said the Medication Management Review (MRR) reports are sent the supervisor and then each charge nurse will address the recommendations assigned to their unit. He/She expected staff to address the recommendations within a week. 4. During an interview on 11/7/24 at 2:21 P.M., the Director of Nursing (DON) said she distributes the MRRs to the Unit Managers to have the nurses address the recommendations. Some of the recommendations are addressed in person at the facility and the remainder are done via fax or by phone. The MRR should be addressed within 30 days. After several attempts, if a physician does not address the MRR, the recommendations are forwarded to the Medical Director. She does not currently have a system in place to follow up on the recommendations. 5. During an interview on 11/7/24 at 2:21 P.M., the Administrator said she expected nursing staff to follow the facility's policy on pharmacy recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49992 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 27 opportunities observed, four errors occurred resulting in a 14.81% error rate (Residents #31, #10, #12 and #88). The census was 123 with 99 residents in certified beds. Review of the facility's Administering Medications policy, review date 1/30/24, showed: -Purpose: Medication shall be administered in a safe and timely manner and as prescribed. The community shall provide resident with the necessary medication(s) when they leave the community temporarily; -Policy Interpretation and Implementation: 1. Medications must be administered in accordance with the orders, including any required time frame. 2. Medications must be administered within one hour of their prescribed time, unless otherwise specified. 3. If a medication is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate in the medication administration record that the medication was not given and the reason. Review of the facility's Crushing Medications policy, review date 1/30/24, showed: -Policy statement: Medication shall be crushed only when it is appropriate and safe to do so and consistent with physicians orders; -Policy Interpretation and Implementation: 1. The following guidelines shall be followed when crushing a medication, the medication administration record (MAR) must indicate it is necessary to crush the medication. Crush medications in paper cups or folded plastic sheets to prevent contact between the drug and the crushing device. Use only the approved crushing device in the drug preparation area to crush medications. Crushed medications should be administered with liquids or soft foods to ensure that the resident receives the entire dose ordered. 1. Review of Resident's #31's medical record, showed: -Diagnoses included diabetes, depression, kidney disease, low thyroid hormone level, and stroke; -An order dated 11/15/23, for fluticasone propionate (nasal spray used to treat allergies) 50 micrograms (mcg)/actuation nasal spray, one spray into each nostril one time daily. Observation on 11/6/24 at 8:33 A.M., showed Certified Medication Technician (CMT) R assisted the resident to place the bottle with the spray into each nostril. While CMT R held the bottle, the resident pushed the pump device and two sprays went into each nostril. 2. Review of Resident #10's medical record, showed: -Diagnoses included elevated cholesterol, low thyroid hormones, and stroke; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order dated 9/10/21, for Deep Sea Nasal 0.65% spray aerosol two drops (gtts) in each nostril, two times daily for nasal dryness; Observation on 11/6/24 at 8:57 A.M., showed CMT R inserted the nasal spray bottle in each nostril and administered one drop into each nostril. 3. Review of Resident's #12's medical record, showed: -Diagnoses included high cholesterol, depression, high blood pressure, seasonal allergies, and low thyroid hormone; -The following medications: -An order dated 11/29/19, for lisinopril 10 milligrams (mg) by mouth daily for high blood pressure; -An order dated 12/8/19, for citalopram 10 mg by mouth daily for depression; -An order dated 10/23/20, for loratadine 10 mg by mouth daily for sinus drainage; -An order dated 3/2/23, for Mucus DM 30 mg-600 mg, two tablets by mouth twice daily for cough; -An order dated 2/15/24, for Senna 8.6 mg by mouth twice daily for constipation; -An order dated 10/3/23, for diltiazem CD 120 mg capsule, extended release one time daily for high blood pressure; -An order dated 9/4/24 for vitamin D3 125 mcg (5,000 unit) tablet by mouth one time daily; -No orders for crushing the lisinopril, citalopram, loratidine, mucus DM, Senna or vitamin D3. Observation on 11/6/24 at 9:17 A.M., showed CMT R pulled the medication strip from the medication cart, opened the individual packets and emptied lisinopril, citalopram, loratadine, lisinopril, mucus DM, Senna, and vitamin D3 into a folded plastic envelope and crushed the medications using a pill crushing device. CMT R verified that the contents of the plastic envelope were crushed into a powder form and he/she poured the contents into a 30 milliliter (ml) cup. CMT R opened the capsule of diltiazem and emptied the contents into the 30 ml cup with the other medications. Using a spoonful of yogurt, CMT R mixed the powder of medication and administered the medication to the resident. 4. Review of Resident #88's medical record, showed: -Diagnoses included high blood pressure, arthritis, anemia, anxiety, and high blood pressure; -An order dated 9/23/24, for acetaminophen (pain reliever) extended release 650 mg one time a daily at 7:00 A.M. Observation on 11/6/24 at 9:24 A.M., showed CMT R administered acetaminophen 650 mg to the resident, that was due at 7:00 A.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 11/7/24 at 8:58 A.M., Licensed Practical Nurse (LPN) I said physician's orders for medication administration should be followed to prevent medication errors and injuries to the residents. Medications should not be crushed unless ordered by the physician. 6. During an interview on 11/7/24 at 9:05 A.M., CMT R said he/she should administer medications as ordered by the physicians. If a resident refuses a medication or does not want to follow the physician's order, he/she would hold the medication and contact the nurse immediately. Medication should be given at the time listed on the MAR. It is important to follow physician's orders for medication administration to prevent a medication error. 7. During an interview on 11/7/24 at 2:21 P.M., the Director of Nursing (DON) said that nurses should follow the policy and procedure for medication administration. Medications should only be crushed when there is an order from the physician. 8. During an interview on 11/7/24 at 2:21 P.M., the Administrator said that the nursing staff should follow the policies on medication administration.

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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.

46888

Based on observation, interview and record review, the facility failed to ensure dietary staff used proper hand hygiene during meal service and failed to ensure the kitchen ceiling was free from dust accumulation. The sample was 20. The census was 123 with 99 residents in certified beds.

Review of the facility's hygiene and sanitary practices policy, revised 2/16/24, showed:

-Policy statement: Dining services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness;

-Policy implementation: Employees must wash their hands after personal body functions, after using tobacco, eating or drinking, whenever entering or re-entering the kitchen; before coming in contact with any food surfaces, after handling raw meat, poultry or fish and when switching between working with raw food and working with ready-to-eat food, after handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or after engaging in other activities that contaminate the hands. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing.

Review of the facility's kitchen cleaning schedule, dated 1/9/20, showed:

-Ceiling tiles and ceiling vents are to be cleaned weekly.

1. Observation of the Forest Park dining room on 11/4/2024 at 11:46 A.M., showed Dietary Aide (DA) L prepping plates of food in the kitchen with no gloves. DA L left the kitchen to propel residents to their tables, locking brakes on the wheelchairs. He/She returned to the kitchen, grabbed a plate from the top of the stack, and began prepping the plate with food, not wearing gloves. He/She returned to the dining room and assisted residents with setting up their food, touching the resident's utensils, with no hand hygiene between residents. DA L returned to the kitchen, picked up a piece of paper from the floor, placed it in the garbage receptacle, and continued to prep plates with ungloved hands.

2. Observation of the Forest Park dining room on 11/5/2024 at 11:31 A.M., showed DA L propelled residents in wheelchairs to their tables. DA L returned to the kitchen and did not wash his/her hands. He/She pulled back the clear covering to the hot food container and took the temperatures of each container of food. DL A did not perform hand hygiene or wear gloves between resident interaction and checking the temperatures of the large containers of cooked food.

3. Observation of the Forest Park dining room on 11/5/2024 at 12:07 P.M., showed DA M wore gloves while washing dishes. He/She collected a plate of prepared food and delivered it to a resident while wearing the same pair of gloves.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Convalescent Home		STREET ADDRESS, CITY, STATE, ZIP CODE 723 South Laclede Station Rd Webster Groves, MO 63119	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation of the Forest Park dining room on 11/6/2024 at 6:11 A.M., showed DA L prepped the kitchen for breakfast by wiping counters, gathering serving utensils, checking water in a bucket with a chemical strip, preparing resident plates with food, and assisting residents, without wearing gloves or performing hand hygiene in between tasks. 5. Observation on 11/5/24, of the main kitchen, showed: -At 7:34 A.M., a light fixture and the five surrounding ceiling tiles, above the main food prep station, had dark dust accumulation and build up. An uncovered pot of gravy was on the prep station counter; -At 8:33 A.M., a light fixture above the second food prep station had dust accumulation. 6. Observation on 11/6/24, of the main kitchen, showed: -At 8:40 A.M., a light fixture and the five surrounding ceiling tiles, above the main food prep station, had dark dust accumulation and build up; -At 8:41 A.M., a light fixture above the second food prep station had dust accumulation. There were opened cans of fruit on the prep station below the light. 7. During an interview on 11/7/2024 at 8:47 A.M., DA N said he/she washes his/her hands about four to six times during a meal service, and gloves should be worn while prepping a plate of food to prevent cross contamination. 8. During an interview on 11/7/24 at 12:15 P.M., the Manager of Dining Services said he would expect the main kitchen ceiling to be free from dust accumulation and build up. He said the ceiling should be cleaned as necessary. He would except for hand hygiene to be performed during meal service. He would expect the dietary staff to be frequently washing their hands and wearing gloves. 9. During an interview on 11/7/24 at 2:33 P.M., the Director of Nursing (DON) and Administrator said they would expect for proper hand hygiene to be performed during meal service. They would expect for the main kitchen ceiling to be clean and free from dust accumulation and build up. 49992

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40290 44948 Based on observation, interview, and record review the facility failed to follow enhanced barrier precautions (EBPs) to prevent risks of infection for three of 20 sampled residents (Residents #29, #40, and #74) and failed to provide direct care following acceptable infection control procedures for another resident (Resident #39). This failure had the potential to affect all residents in the facility. The census was 123 with 99 residents in certified beds. Review of the facility's Enhanced Barrier Precautions policy, revised on 4/9/24, showed: -Enhanced barrier precautions are used as an infection prevention control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents; -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply; -EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following: Vancomycin (antibiotic)-resistant Enterococci (VRE, a drug resistant chronic infection process), drug resistant streptococcus pneumonia (a gram-positive bacterial infection in the lungs), and carbapenemase-producing drug resistant organisms (an enzyme produced by bacteria making carbapenem antibiotics ineffective); -Signs are posted in the door or wall outside the resident room indicating the type of precautions and Personal Protective Equipment (PPE) required. Review of the facility's Hand Hygiene policy, revised on 1/30/24, showed: -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; -Staff should use an alcohol-based hand rub containing at least 60% alcohol, or soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents, before and after handling an invasive device (urinary catheters (thin tubing that empties the bladder), IV (intravenous, a small line placed into the vein of the patient to deliver medication or fluids) access sites), after contact with a resident's intact skin, before entering isolation precaution settings and after leaving isolation precaution settings, before and after eating or handling food, and before and after assisting a resident with meals. 1. Review of Resident #29's medical record, showed diagnoses included dementia, personal history of Methicillin (antibiotic)-resistant staphylococcus (bacteria that is resistant to many antibiotics) infection, and unspecified abnormal findings in urine. Review of the resident's urine culture results, dated 8/24/24, showed positive results for Vancomycin resistant enterococcus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician order summary (POS), showed an order, dated 8/26/24, for enhanced barrier precautions. Notes: VRE urine - wear gowns/gloves for high contact resident care activities. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident has an activities of daily living (ADL) self-care deficit related to decreased mobility, decreased cognition, and muscle weakness; -Interventions included, VRE in urine - wear gowns/gloves for high contact resident care activities. Observation on 11/4/24 at 12:24 P.M., showed a cart outside of the resident's room containing gowns. A sign posted on the front door of the resident's room to Stop, see nurse for instructions. A sign posted on the inside of the resident's door for EBP. Licensed Practical Nurse (LPN) J and Certified Nurse Aide (CNA) K entered the resident's room and donned gloves. LPN J positioned a mechanical lift in front of the resident, who was seated in his/her Broda (recliner) chair. LPN J and CNA K positioned a sling around the resident's waist, and the staff members' torsos and forearms touched the resident's upper body while LPN J and CNA K positioned the sling and adjusted the resident. LPN J operated the mechanical lift while CNA K used his/her hands to adjust the resident's positioning during the transfer. Neither LPN nor CNA K wore gowns during the resident's transfer. Observation on 11/5/24 at 11:20 A.M., showed Certified Medication Technician (CMT) A entered the resident's room and put a glove on his/her right hand. He/She used his/her left hand to pull the collar of the resident's shirt away from the resident's body, and inserted his/her right hand inside the collar of the resident's shirt to rub the resident's left arm. CMT A said the resident just had a shot and his/her arm was itchy. CMT A's forearm brushed against the resident's skin while he/she rubbed the resident's arm. During an interview on 11/7/24 at 10:50 A.M., CMT A said the resident is on EBP. EBP means staff should wear gowns and gloves when providing personal care or bathing assistance. Gowns are not required when assisting residents on EBP with transfers. He/She did not need to wear a gown when he/she rubbed the resident's arm after his/her shot the other day because CMT A was not assisting the resident with personal care or bathing. During an interview on 11/7/24 at 10:07 A.M., LPN C said the resident is on EBP. Staff should wear gowns and gloves when providing care to residents on EBP, including dressing, transfers, and any activity that requires direct contact. 2. Review of Resident #40's medical record, showed: -Diagnoses included: Diabetes, anxiety, right side heart failure, and liver disease; -Severe cognitive impairment. Review of the resident's POS, in use at the time of survey, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 7/31/24, for EBP. Wear gloves and gown for high contact resident care activities due to a non-pressure related wound on the resident's left lower leg. Review of the resident's care plan, in use at the time of the survey, showed: -Problem: Resident is at risk for developing impaired skin integrity related to mobility and incontinence. Left lower leg wound that is treated at wound clinic, started as a skin tear complicated by lymphedema (a chronic condition causing swelling due to increased lymph fluids) and cardiac (heart related) status; -Goal: Resident will have no new alteration in skin integrity and demonstrate progressive wound healing/improvement through next review; -Interventions: Complete weekly skin assessments. Enhanced barrier precautions due to wounds. Observation on 11/4/24 at 4:45 P.M., of the resident's room, showed: -A sign on the back of the resident's door indicating the resident is on Enhanced Barrier Precautions. The sign indicated that everyone who enters the resident's room must wash their hands before entering and when leaving. The sign also indicated that staff should wear a gown and gloves when providing high contact care for the resident; -No PPE in the resident's room or outside the resident's room. During an interview on 11/4/24 at 4:54 P.M., the resident said he/she has a vascular wound on his/her left leg. When staff come into his/her room to provide care, they do not wear gowns. Observation on 11/5/24 at 11:37 A.M., showed CMT F and CNA E in the resident's room. The resident lay on his/her bed with the mechanical lift sling underneath his/her body. Both CMT F and CNA E touched the resident's arms and sides to assist the resident to turn on his/her left side. CMT F pulled up the resident's shirt, repositioned the lidocaine (a local anesthetic that prevents pain by blocking pain receptors at the location) patch on the residents back, and then pulled the resident's shirt back down. CNA E positioned the mechanical lift next to the bed and then both CNA E and CMT F connected the mechanical lift sling to the lift. CNA E operated the mechanical lift while CMT F used his/her hands to adjust the resident's positioning during the transfer. CMT F had on gloves and no gown. CNA E had no gown or gloves on. During an interview on 11/7/24 at 8:18 A.M., CNA H said EBP was a medical cream. He/She then identified EBP as the sign on the door of any resident's room that indicated a gown and gloves should be worn during care. PPE should be kept either in the resident's room or outside the resident's room at the door. During an interview on 11/7/24 at 8:24 A.M., CMT F said the resident used to be on EBP but is not now because the resident's wound healed. A gown and gloves should be worn when providing high contact care when the resident is on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and Director of Nursing (DON) on 11/7/24 at 2:22 P.M., the DON said the resident is currently being treated at a wound clinic outside of the facility for his/her vascular wound on his/her left lower leg. The Administrator and DON expected for a gown and gloves to be worn by staff when providing care to the resident. 3. Review of Resident #74's medical record, showed diagnoses included dementia, hardening of the vessels that carry blood to the heart, high blood pressure, and depression. Review of the resident's care plan, in use at the time of survey, showed: -Problem: The resident has an indwelling suprapubic urinary catheter (urinary catheter inserted through the lower abdomen into the bladder) due to being unable to urinate; -Interventions: Enhanced Barrier Precautions due to presence of the suprapubic urinary catheter. Observation on 11/5/2024 at 9:32 A.M., showed CNA P entered the resident's room, provided perineal care (peri care, washing of the genital and anal area), dressed the resident, and assisted the resident to transfer without wearing gown or gloves. During an interview on 11/7/24 at 9:10 A.M., CNA P said that Enhanced Barrier Precaution is the cream that is used for the residents. If a resident has a urinary catheter, staff should wear gown and gloves to provide care. He/she admitted that during the observation, he/she was in a hurry and did not stop to put on a gown or gloves. 4. Review of Resident #39's medical record, showed diagnoses included dementia, long term use of blood thinners, high blood pressure, depression, and stroke. Review of the resident's care plan, in use at the time of survey, showed: -Problem: Resident is unable to complete activities of daily living due to a stroke and depression; -Interventions: To provide substantial/total assistance of one staff member to complete my dressing, grooming/hygiene, and toileting needs. Observation on 11/6/24 at 8:25 A.M., showed CNA O in the resident's room, standing at the bedside. The resident lay on his/her back with the lower half of the body covered. CNA O assisted the resident to roll onto his/her side, applied a protective skin cream and placed a clean brief under the resident. CNA O removed his/her gloves and continued to apply the brief to the resident with no hand hygiene or gloves. During an interview on 11/7/24 at 9:10 A.M., CNA P said staff should wear gloves when providing peri care to the residents. Gloves protects the employees as well as the residents. During an interview on 11/7/24 at 8:58 A.M., LPN I said staff should wear gloves when providing care, such as toileting and showering, to the residents. Gloves prevent the spread of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 11/7/24 at 9:55 A.M., CNA B said when there is a sign on a resident's door to see the nurse, it means staff should wear PPE when providing any touching care activity with the resident. Touching care activities include transfers, personal care, and any activity in which staff touches the resident. Staff know what type of PPE to wear by looking at the PPE placed outside of the resident's room. 6. During an interview on 11/7/24 at 11:04 A.M., LPN D said residents are placed on EBP when they have wounds, catheters, or anything that could increase their potential for infection. EBP means staff should wear gowns and gloves when providing direct, hands-on care with a resident. Gowns and gloves should be worn during transfers, including transfers using a mechanical lift, and any time staff are going to touch the resident. This is to protect the resident from possible infection from staff. 7. During an interview on 11/7/24 at 9:21 A.M. the facility Infection Preventionist said residents in the facility are placed on enhanced barrier precautions for current health conditions such as open wounds, urinary catheters, IV lines both peripheral and central, or anyone with a current or latent Multi-Drug Resistant Organism infection. Staff are instructed to wear personal PPE appropriate for the condition during high care, including but not limited to gowns and gloves stored in bins outside the resident's door. A sign on the door should indicate to staff what PPE to use for any high-contact care provided, including care that could expose them to bodily fluids or exposure to the wound or indwelling medical device. The Infection Preventionist would expect staff to follow the facility policy for enhanced barrier precautions and would expect staff providing high-contact care including routine hygiene care such as replacing a brief, to wear gloves and other PPE as indicated. 8. During an interview on 11/7/24 at 2:25 P.M. the facility DON said the facility Infection Preventionist is in charge of staff inservicing and education regarding infection control policies and the facility's policy on enhanced barrier precautions. The DON would expect staff to follow the facility's policies on enhanced barrier precautions and hand hygiene in the appropriate circumstances, and would expect any transmission or enhanced precautions signage to be placed outside the room per CDC (Centers for Disease Control and Prevention) recommendations and guidelines. The DON expected all nursing staff to follow the facility's policy on enhanced barrier precautions when selecting PPE to use during high-contact care situations. 9. During an interview on 11/7/24 at 2:25 P.M. the facility Administrator said staff are expected to don and doff PPE per CDC guidelines and recommendations. All facility staff are expected to follow the facility's policy on hand hygiene for resident care to reduce the spread of infection within the facility among the community. 46888 49992