STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265688	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center, The	2506 Linden Tree Parkway Marshall, MO 65340

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of 20 sampled residents, remained free from misappropriation of property when Certified Nurse Aide (CNA) F took the resident's cellular phone and made charges of approximately $200 to the resident's online shopping account without the resident's knowledge. The facility census was 69. On 7/3/24 at 4:08 P.M., the administrator was notified of the past noncompliance which occurred on 6/25/24. On 6/25/24, the administrator became aware of the violation of misappropriation of the resident's phone and charges made to the resident's online shopping account by CNA F. Upon discovery, the facility canceled the contract with CNA F through the contracting company, conducted an investigation, and notified appropriate parties. Staff reviewed the facility misappropriation policy, and all facility staff were educated on the facility misappropriation policy. CNA F was terminated. The deficiency was corrected on 6/26/24. Review of the facility's Abuse Prevention Program, revised 5/12/22, showed the following: -It is the policy of the facility to ensure that all alleged violations of misappropriation of resident property are reported to the administrator and to other officials immediately, not later than 24 hours if the events caused the allegation do not involve abuse and do not result in seriously body injury in accordance with state law through established procedure; -Misappropriation of resident property Is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of the resident's belongings or money without the resident's consent. For the purpose of this program, theft has the same definition as misappropriation of resident property. 1. Review of Resident #1's face sheet showed the following: The resident readmitted to the facility on [DATE]: The resident was his/her own responsible party. Review of a copy of an email sent from the wireless cellular phone provider to Resident #1, dated 6/23/24 at 5:59 A.M., showed the wireless cellular phone account password was successfully changed. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a screenshot from the resident's online shopping app account, dated 6/25/24, showed the addition of Certified Nurse Aide (CNA) F's home address was added to the account for delivery. Review of the police report, dated 6/30/24, showed the following: -The law enforcement officer had probable cause to believe CNA F committed one or more criminal offenses; -On 6/25/24, at approximately 12:53 P.M., the police department received a call in reference to a resident's cell phone possibly being stolen; -The facility administrator said the resident had a cell phone which went missing sometime between the night of 6/23/24 and the following morning, 6/24/24; -The administrator said the resident's family member, the resident, and staff, had been searching for the phone, but it was not located; -The resident's family member noticed the resident's password for his/her cellular phone account had been changed via an email on 6/24/24; -The resident's family member visited the resident on the evening of 6/24/24, and asked about the phone. The resident realized it was missing; -The family member said searching the room provided nothing and the phone was no longer able to be tracked with the Find my Phone app; -The family member checked the resident's online accounts and found activity on the resident's online shopping account with an order placed by CNA F to be delivered to CNA F's address; -The family member said the cell phone was an iPhone SE20, black in color with a pink phone case. It was worth between $600 and $700; -The family member said due to the resident's declining health, he/she made decisions for the resident. During a phone interview on 7/3/24 at 11:08 A.M. and 7/9/24 at 8:51 A.M., the resident's family member said the following: -He/She received an email message from the resident's cellular phone service provider stating the account password was changed; -The family member no longer had access to the resident's cellular phone account; -The family member still had access to the online shopping account that the resident had on his/her phone; -A new name and address was added to the account for CNA F; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA F added several items to purchase on the resident's online shopping app, equaling approximately $200.00. - --He/She found the items in the cart before the transaction was completed, so it was canceled before the transaction was made. Review of the facility's staffing sheet, dated 6/23/24, showed CNA F worked from 7:00 P.M. to 7:00 A.M. on the resident's hall. During an interview on 7/3/24 at 4:00 P.M., Certified Medication Technician (CMT) E said the resident's family member came to the facility at approximately 9:00 A.M. on 6/25/24 and reported he/she had received emails from the wireless cellular phone provider regarding the resident's cell phone. The password had been changed, but not by the resident or the family member. During an interview on 7/3/24 at 2:45 P.M., the resident said he/she did not know who took his/her cell phone and didn't know how long it had been missing before he/she noticed. No one previously asked him/her to use the phone. He/She just wanted to use it one day and it was gone. During an interview on 7/3/24 at 10:30 A.M. and 3:40 P.M., the administrator said the resident's family member, reported the phone missing on 6/25/24 to Certified Medication Technician (CMT) E. CMT E started the investigation. The agency CNA F worked for was notified of the misappropriation and that he/she was not to return to the facility. MO238161

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 42592 Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS), a federally mandated resident assessment completed by the facility staff, was completed no less than once every three months for one resident (Resident #34), of 20 sampled residents and four additional residents (Resident #13, #38, #48 and #54). The facility census was 69. 1. During an interview on 07/18/24 at 3:59 P.M., Registered Nurse (RN) A said the facility followed the Resident Assessment Instrument (RAI) manual to guide completion of all of the MDS assessments and the facility did not have a specific policy related to MDS completion. 2. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual MDS 3.0, dated 2023, showed the following: -The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS; -Assessment Reference Date (ARD - item A2300)) refers to the specific endpoint for the observation (or look-back) periods in the MDS assessment process. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and PPS) and varies by assessment type and facility determination; -The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1; -For an admission assessment the completion date must be no later than the admitted +13 days; -The annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA (significant change in status assessment) or an SCPA (significant correction in prior comprehensive assessment) has been completed since the most recent comprehensive assessment was completed; -The quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type; -For a quarterly or annual assessment, the MDS completion date (item Z0500B) must be no later than the ARD +14 days. 3. Review of Resident #34's MDS record showed the following: -Quarterly MDS assessment ARD of 08/22/23; (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Completion date of 09/18/23, 27 days after ARD (13 days late); -Quarterly MDS assessment ARD of 11/21/23; -Completion date of 12/06/23, 15 days after ARD (1 day late); -Quarterly MDS assessment ARD of 02/20/24; -Completion date of 3/12/24, 21 days after ARD (7 days late); -Annual MDS assessment ARD of 05/21/24; -Completion date of 07/11/24, 51 days after ARD (37 days late). 4. Review of Resident #13's MDS record showed the following: -Quarterly MDS assessment ARD of 09/05/23; -Completion date of 10/03/23, 28 days after ARD (14 days late); -Quarterly MDS assessment ARD of 03/05/24; -Completion date of 3/21/24, 16 days after ARD (2 days late); -Annual MDS assessment ARD of 06/04/24; -Completion date of 07/19/24, 45 days after ARD (31 days late). 5. Review of Resident #38's MDS record showed the following: -Annual MDS assessment ARD of 09/05/23; -Completion date of 10/10/23, 35 days after ARD (21 days late); -Quarterly MDS assessment ARD of 06/04/24; -Completion date of 07/11/24, 37 days after ARD (23 days late). 6. Review of Resident #48's MDS record showed the following: -Quarterly MDS assessment ARD of 08/24/23; -Completion date of 09/18/23, 25 days after ARD (11 days late); -Annual MDS assessment ARD of 02/22/24; -Completion date of 3/21/24, 28 days after ARD (14 days late); (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Quarterly MDS assessment ARD of 05/23/24; -Completion date of 07/09/24, 47 days after ARD (33 days late). 7. Review of Resident #54's MDS record showed the following: -Quarterly MDS assessment ARD of 08/24/23; -Completion date of 09/18/23, 25 days after ARD (11 days late); -Quarterly MDS assessment ARD of 11/23/23; -Completion date of 12/08/23, 15 days after ARD (1 day late); -Quarterly MDS assessment ARD of 02/22/24; -Completion date of 3/13/24, 20 days after ARD (6 days late); -Annual MDS assessment ARD of 05/21/24; -Completion date of 07/09/24, 49 days after ARD (35 days late). During an interview on 7/17/24 at 4:55 P.M., MDS coordinator #1 said the following: -She has been the MDS coordinator for a while; -She follows the RAI manual for the completion of an MDS; -MDS's are supposed to be completed within 14 days of the ARD date; -The RN signature for completion is supposed to be within 14 days of the ARD date; -She covered for MDS coordinator #2 during staff medical leave, and she covered on the floor during staff turnover, causing her to get behind on completing the MDS assessments. During an interview on 7/18/24 at 4:18 P.M., MDS coordinator #2 said the following: -She followed the RAI manual for the completion of an MDS; -The MDS assessments should be completed by day 14 once an ARD is set; -Her goal was to have the MDS completed by day 14 after the ARD date is set; -She just got back from an extended medical leave and recently returned to her role. During an interview on 7/18/24 at 4:11 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The only part of the MDS she completed was to sign off on the process once they were completed by the team; -She was unaware of what that time frame was for completion; -She was not familiar with the RAI manual as had never done a complete MDS; -She would expect an MDS to be completed in a timely manner; -She was unsure if the MDS assessments were getting done in the required time frame. During an interview on 7/18/24 at 4:23 P.M., the administrator said the following: -MDS coordinator #1 completes the MDS's for the long-term care residents and MDS coordinator #2 completes the MDS's for the skilled residents; -RN A has also been helping complete the MDS assessments during a staff medical leave; -She believed the skilled side MDS's had to be completed in 14 days and the long-term care side seven days after the opening date; -She recently found out the MDS's were not being completed on time; -She would expect staff to follow the RAI manual and to complete the assessments within the appropriate time frame.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32530 Based on observation, interview, and record review, the facility failed to adequately document appropriate diagnoses of residents or resident behaviors to justify the implementation for continued use of antipsychotic medications (a type of psychiatric medication used to treat certain types of mental health problems, such as schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), for three residents (Resident #12, #34 and #56), and failed to complete a 14-day review for the PRN (as-needed) use of a benzodiazepine (a drug that produces sedation and hypnosis) for three residents (Resident #42, #57 and #63) in a review of 20 sampled residents. The facility census was 69. Review of the facility's policy, Antipsychotic Medication Use, dated (revised) December 2016, showed the following: -Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed; -Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction (GDR) and re-review; -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; -The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications; -The attending physician and the facility staff will identify acute psychiatric episodes, will differentiate them from enduring psychiatric conditions; -Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (DSMM, the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders), current or subsequent editions: -a. Schizophrenia; -b. Schizo-affective disorder; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-d. Delusional disorder; -e. Mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression); -f. Psychosis in the absence of dementia; -For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are: -b. Persistent or likely to reoccur without continued treatment; -Antipsychotic medications will not be used if the only symptoms are one or more of the following: -c. Restlessness; -e. Mild anxiety; -f. Insomnia; -k. Uncooperativeness; - Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record; -The need to continue PRN orders for psychotropic medications beyond 14 days require that the practitioner document the rationale for the extended order, the duration of the PRN order will be indicated in the order; -PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication; -The staff will observe, document and report to the attending physician, information regarding the effectiveness of any interventions, including antipsychotic medications in 30 days; -The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. Review of www.drugs.com for Seroquel (generic name quetiapine) showed the following: -Seroquel is used to treat schizophrenia and to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder), a disease that causes episodes of depression, episodes of mania, and other abnormal moods); -Seroquel is used in combination with antidepressant medications to treat major depressive disorder in adults; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Seroquel may increase the risk of death in older adults with mental health problems related to dementia; -Potential adverse effects of Seroquel include somnolence (sleepiness), postural hypotension (a drop in the blood pressure when a person stands), motor and sensory instability, which may lead to falls, and consequently, fractures (broken bones) or other injuries. 1. Review of Resident #56's admission form, undated, showed the following: -He/She had a legal guardian; -Medical diagnoses of unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), unspecified severity, without behavioral disturbance, and insomnia. Review of the resident's physician orders (undated) showed an order for quetiapine (an antipsychotic medication) 25 milligrams (mg), oral tablet, one daily at bedtime (hs) for insomnia, start date 12/20/23. Review of the resident's care plan, dated 3/28/24, showed the following: -Behavior: the resident had a diagnosis of dementia and insomnia; -He/She had some of the following behavioral issues: agitation, medication refusals and poor safety awareness; -He/She usually exhibited Sundowner's (a state of confusion that occurs in the late afternoon and lasts into the night) and these were attributed to the diagnosis of dementia; -Goal: the resident will take his/her medications as prescribed over the next 90-day period; -Interventions: staff will encourage the resident to take his/her medication; -Staff will learn any triggers the resident may have to help guide the resident; -Staff will help keep others out of the resident's space unless invited; -Staff will report any changes in behaviors to charge nurse; -Behavior: the resident had a history of falls at home and since coming to the facility; -The resident was up often throughout the night but did not remember it; -Goal: the resident would be free from falls with injury over the next 90 days; -Interventions: monitor the resident and help him/her to the restroom throughout the day and night. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician office/clinic note, dated 4/03/24, showed the physician documented the resident's psychiatric exam was cooperative, with appropriate mood and affect. Review of the resident's pharmacy note, dated 4/16/24 at 9:09 A.M., showed the consulting pharmacist documented the following: -The resident had an order for quetiapine 25 mg by mouth daily at bedtime since 12/20/23; -Consider a gradual dose reduction to quetiapine 12.5 mg by mouth at bedtime. (Review of the resident's medical record showed no documentation the resident's physician had been notified of the recommendation or a response given.) Review of the resident's nursing progress notes, from 4/25/24 through 4/30/24, showed no documentation of behaviors related to the resident's diagnosis of dementia without behavioral disturbance. Review of the resident's Medication Administration Record (MAR), for the month of May 2024, showed staff administered quetiapine (Seroquel) 25 mg oral at hs (bedtime) daily at 09:00 P.M. from 5/01/24 through 5/30/24 with no diagnosis listed. Review of the resident's physician office/clinic note, dated 5/01/24, showed the physician documented the resident's psychiatric exam was cooperative, with appropriate mood and affect. Review of the resident's Note to Attending Physician/Prescriber, dated 5/17/24, showed the consulting pharmacist documented the following: -The resident had an order for quetiapine 25 mg by mouth daily at bedtime since 12/20/23 for insomnia; -Consider a gradual dose reduction to quetiapine 12.5 mg by mouth at bedtime. Review of the resident's Note to Attending Physician/Prescriber, dated 5/17/24, showed the resident's attending physician's response to the consulting pharmacist was that she disagreed due to the resident still gets up at night. Review of the resident's nursing progress notes, dated 5/17/24 at 4:27 P.M., showed staff documented the following: -The resident was found on the floor at the foot of the bed without his/her shoes on; -The resident said his/her stomach hurt, and he/she was trying to go to the bathroom; -The call light was not on at the time of the fall; -The resident had multiple skin tears on the right hand, right thumb, palm, index finger, middle finger and ring finger; -Staff notified the resident's physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's physician office/clinic note, dated 5/29/24, showed the physician documented the resident's psychiatric exam was cooperative, with appropriate mood and affect. Review of the resident's nursing progress notes, for the month of May 2024, showed documentation of behaviors related to the resident's diagnosis of dementia without behavioral disturbance. Review of the resident's MAR for the month of June 2024, showed staff administered quetiapine 25 mg oral at hs daily at 09:00 P.M. from 6/01/24 through 6/30/24 with no diagnosis listed. Review of the resident's nursing progress notes, for the month of June 2024, showed no documentation of behaviors related to the resident's diagnosis of dementia without behavioral disturbance. Review of the resident's physician office/clinic note, dated 6/06/24, showed the physician documented the resident's psychiatric exam was cooperative, with appropriate mood and affect. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 6/18/24, showed the following: -Severe cognitive impairment; -No hallucinations or delusions; -Independent in mobility; -One fall in the last month prior to admission; -Received an antipsychotic on a routine basis; -Last GDR attempted on 05/17/24; -GDR not documented by a physician as clinically contraindicated. Review of the resident's pharmacy note, dated 6/21/24 at 2:51 P.M., showed the consulting pharmacist documented the following: -The resident has an order for quetiapine 25 mg by mouth daily at bedtime since 12/20/23; -Consider a gradual dose reduction to quetiapine 12.5 mg. by mouth at bedtime. (Review of the resident's medical record showed no documentation the resident's physician had been notified of the recommendation or a response given.) Review of the resident's MAR for the month of July 2024, showed staff administered quetiapine 25 mg oral at hs daily at 09:00 P.M. from 7/01/24 through 7/31/24 with no diagnosis listed. Observation on 7/15/24 at 12:00 P.M. showed the resident sat quietly in a chair at the dining room table and was smiling. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/15/24 at 3:30 P.M. showed the resident sat quietly in his/her recliner while his/her family visited. Observation on 7/16/24 at 12:10 P.M. showed the resident sat quietly at the dining room table and fed himself/herself. Review of the resident's Note to Attending Physician/Prescriber, dated 7/17/24, showed the consulting pharmacist documented the following: -The resident had an order for quetiapine 25 mg by mouth daily at bedtime since 12/20/23 for insomnia; -Consider a gradual dose reduction to quetiapine 12.5 mg by mouth at bedtime. Review of the resident's Note to Attending Physician/Prescriber, dated 7/17/24, showed the resident's attending physician's response to the consulting pharmacist was that she disagreed due to the resident was stable. Review of the resident's nursing progress notes, from 7/1/24 through 7/17/24, showed no documentation of behaviors related to his/her diagnosis of dementia without behavioral disturbance. During an interview on 7/15/24 at 3:35 P.M., the resident's family member said the following: -He/She was not aware of any behavior issues with the resident; -The resident would get up at night, he/she figured it was to go to the bathroom, but that was not something new; -He/She was not aware of the resident's medications or what they were for. During an interview on 7/17/24 at 7:30 P.M., Licensed Practical Nurse (LPN) C said the following: -He/She was not aware of any behavior issues with the resident; -The resident will sometimes go to the facility door after his/her family leaves, but does not try to elope and does not become agitated. During an interview on 7/18/24 at 11:00 A.M., LPN D said the following: -The resident did not have any behaviors, more like anxiety at times, and would pace more, especially after the resident's family would leave after visiting; -The resident could be easily redirected. Observation on 7/18/24 at 11:00 A.M., showed the resident sat quietly in a recliner in his/her room and would smile when spoken to. 2. Review of Resident #12's face sheet showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She admitted to the facility on [DATE]; -Diagnoses included advanced dementia and anxiety disorder. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognition was severely impaired; -The resident did not show any behaviors/hallucinations/delusions in the previous seven days; -Diagnoses included dementia and anxiety; -His/Her medication regimen included the use of an antipsychotic medication; -GDR last attempted on 4/3/23 and was documented by the physician as contraindicated. Review of a pharmacist to physician communication sheet, dated 3/20/24, showed the following: -Pharmacist requested GDR for quetiapine (an antipsychotic medication) 25 mg by mouth daily for dementia with anxiety; -Consider GDR to quetiapine 12.5 mg daily; -If a GDR is contraindicated, a rationale is documented for why an attempted dose reduction would impair the resident's function or cause psychiatric instability -Evaluate diagnosis associated with medication as anxiety was not an acceptable diagnosis for quetiapine. The resident's diagnosis list did contain dementia, but was listed as without behaviors; -Physician documented he/she disagreed with recommendations on 3/25/24 without an explanation/rationale given. Review of the resident's care plan, last reviewed on 6/26/24, showed the following: -His/Her diagnoses included advanced dementia; -He/She had behavioral issues which consisted of agitation with staff, refusal of medication, and poor safety awareness; -Staff were to encourage him/her to take medications; -He/She took antipsychotic medication for anxiety and sleep; -Have pharmacy review his/her medication monthly; Review of the resident's physician's orders, dated July 2024, showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included dementia without behavioral disturbances, psychiatric disturbances, mood disturbances, anxiety, and Alzheimer's dementia; -Quetiapine 25 mg by mouth every day (original order dated 1/1/20). Review of the resident's medical record showed no documentation the physician provided a psychiatric diagnoses to support the use of the antipsychotic medication, and no justification for continued use of the medication at the current dose (originally ordered on 1/1/20). 3. Review of Resident #34's undated note to attending physician/prescriber showed the following GDR requests was made: -Fluoxetine (an antidepressant medication) 20 mg daily for treatment of anxiety since 6/12/22; -Risperidone (an antipsychotic medication) 0.25 mg twice a day (BID) since 6/11/22 (decreased from three times a day (TID) on 6/22/22) -On 2/8/24, the physician documented he/she disagreed with the GDR recommendation, but did not give a rationale as to why he/she disagreed. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognition was severely impaired; -No psychosis/hallucinations/delusions in the previous seven days; -Diagnoses include nontraumatic brain dysfunction, Alzheimer's disease, dementia, anxiety, and depression; -Medications included use of antipsychotics and antidepressants with indication for use; -Last attempted gradual dose reduction (GDR) was on 2/17/22; -Physician documented GDR was clinically contraindicated on 2/8/24. Review of the resident's psychiatry note, dated 6/7/24, showed the following: -Diagnoses included Alzheimer's disease with behavioral disturbances, depression, dementia, insomnia, and social withdrawal; -He/She mumbled and did not answer most questions during the assessment; -Risperidone (an antidepressant medication) 0.25 mg twice a day (BID); -Fluoxetine (an antidepressant medication) 20 mg once daily; -No documented behaviors; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Continue current medications as ordered. Review of the resident's physician's progress note, dated 6/8/24, showed the following: -Diagnoses included Alzheimer's disease with behavioral disturbances, depression, dementia, insomnia, and social withdrawal; -He/She did not talk much; -Staff reported he/she seemed to be doing well and they had no concerns; -Risperidone 0.25 mg BID; -Fluoxetine 20 mg once daily; -Continue current medications as ordered. Review of the residents' care plan, last reviewed on 6/26/24, showed the following: -The resident spent most of the time in his/her room; -Impaired cognition related to dementia and memory issues; -He/She had times where he/she wanted to lay in his/her bed and sleep; -He/She had chronic back pain which could cause behavioral issues; -He/She seldom communicated his/her needs; -He/She used antidepressant and antipsychotic medications to treat depression, anxiety, and feeling others are trying to cause him/her ill will; -Interventions included to follow with psychiatric physician as needed and approved, and pharmacy to review medications monthly. Review of the resident's physician orders, dated July 2024, showed the following -Risperidone 0.25 mg; 1 tablet BID for treatment of mood disorder (6/22/22); -Fluoxetine 20 mg 1 PO daily for treatment of anxiety (6/12/22). Review of the resident's medical record showed no documentation of a physician justification for continued use of the medications at the current dose (originally ordered June 2022). Review of the resident's MAR dated July 2024 showed the following: -Staff administered risperidone 0.25 mg BID from 7/1/24 through 7/17/24; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff administered fluoxetine 20 mg daily from 7/1/24 through 7/17/24 Observation of the resident on 7/17/24 at 12:50 P.M. showed he/she lay in his/her bed with eyes closed. Observation of the resident on 7/17/24 at 2:00 P.M., showed he/she lay in his/her bed with eyes closed. During an interview on 7/17/24 at 2:00 P.M., Certified nursing assistant (CNA) B said that the resident did not like to come out of his/her room. 4. Review of Resident #63's face sheet showed the following: -admitted [DATE]; -Diagnoses included anxiety. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognition was severely impaired; -Diagnoses included dementia and anxiety; -No documented behaviors, delusions, and/or hallucinations in the previous seven days; -Medication regimen included use of antipsychotics, antidepressants, and antianxiety medications. Review of the resident's care plan, dated 6/7/24, showed he/she admitted with orders for as needed (PRN) antianxiety medications for his/her mood/delusions/agitation/and sleep. Review of resident's nursing progress note, dated 6/28/24 at 1:30 P.M., showed the resident's physician wanted to continue PRN lorazepam for anxiety for another 30 days and would review the medication again at that time. Review of the resident's physician's orders, dated 6/28/24, showed an order for lorazepam (anti anxiety medication) 0.5 mg every four hours PRN anxiety. Review of the resident's medical record showed no documented rationale by the physician for extended use of PRN lorazepam beyond 14 days. Review of the resident's physician's orders, dated July 2024, showed an order for lorazepam 0.5 mg every four hours PRN anxiety for 30 days (original order dated 6/28/24). Review of the resident's MAR dated July 2024 showed staff administered PRN lorazepam 0.5 mg on 7/4/24 at 12:07 A.M. and 10:38 A.M., on 7/5/24 at 8:21 A.M., on 7/6/24 at 7:00 P.M., on 7/7/24 at 7:14 P.M., on 7/8/24 at 7:02 P.M., on 7/12/24 at 7:27 P.M., on 7/13/24 at 7:55 P.M., and on 7/14/24 at 7:37 P.M. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #42's face sheet showed the following: -Admission to the facility on [DATE]; -Diagnoses include non-Hodgkin's lymphoma (cancer that starts in the lymphatic system) and epilepsy (seizure disorder). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Has had no behaviors; -Inattention and disorganized thinking is present but fluctuates; -Takes a daily anti-anxiety; -Is on hospice care. Review of the resident's May 2024 physician orders showed an order for lorazepam (a medication used to treat anxiety) 0.5 mg every 4 hours PRN for anxiety for 30 days, with a start date of 4/19/24 and a stop date of 5/19/24. Review of the resident's care plan, updated 5/03/24, showed the following: -He/She takes and anti-anxiety medication for seizures and has a PRN anxiety medication for comfort; -Have pharmacy review his/her medications monthly. Review of the resident's nursing progress notes PRN psychotropic review, dated 5/17/24 at 7:12 A.M., showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician would like to continue medication for another 30 days and will re-evaluate the medication again at that time. Review of the resident's medical record showed no documentation, from the physician, regarding his/her rationale for extending the use of the resident's PRN Lorazepam beyond the 14 day stop date. Review of the resident's May 2024 MAR showed an entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 5/17/24 and an end date of 6/17/24. Review of the resident's monthly medication regimen review (MRR), dated 5/21/24, showed comments of no recommendations at this time. Review of the resident's May 2024 MAR showed no PRN lorazepam administered during the month of May. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's June 2024 physician orders showed an order for lorazepam 0.5 mg every 4 hours PRN for anxiety for 30 days, with a start date of 5/17/24 and a stop date of 6/16/24. Review of the resident's nursing progress notes PRN psychotropic review, dated 6/15/24 at 3:01 P.M., showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician would like to continue medication for another 30 days and will re-evaluate the medication again at that time. Review of the resident's medical record showed no documentation, from the physician, regarding his/her rationale for extending the use of the resident's PRN lorazepam beyond the 14 day stop date. Review of the resident's June 2024 MAR showed an entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 6/14/24 and an end date of 7/14/24. Review of the resident's MRR, dated 6/21/24, showed comments of no recommendations at this time. Review of the resident's June 2024 MAR showed staff administered PRN lorazepam one time on 6/26/24, during the month of June. Review of the resident's nursing progress notes PRN psychotropic review, dated 7/14/24 at 3:40 P.M. showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician would like to continue medication for another 30 days and will re-evaluate the medication again at that time. Review of the resident's medical record showed no documentation, from the physician, regarding his/her rationale for extending the use of the resident's PRN Lorazepam beyond the 14 day stop date. Review of the resident's July 2024 physician orders showed an order for lorazepam 0.5 mg every 4 hours PRN for anxiety for 30 days, with a start date of 7/14/24 and a stop date of 8/13/24. Review of the resident's MRR, dated 7/17/24, showed comments of no recommendations at this time. Review of the resident's July 2024 MAR, from 7/1/24 through 7/18/24, showed no PRN lorazepam administered during the month of July. Review of the resident's medical record on 7/18/24 showed there was no documented rationale by the physician for the extended use of PRN Lorazepam beyond the 14 day stop date. 6. Review of Resident #57's face sheet showed the following: -Admission on 7/10/23; -Diagnoses include anxiety disorder and basal cell carcinoma (skin cancer) of the skin. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No delirium or behaviors present; -Takes daily anti-anxiety and antidepressant medication. Review of the resident's May 2024 physician orders showed the following: -An order for lorazepam 0.5 mg twice a day for restless/comfort with a start date of 7/17/23; -An order for lorazepam 0.5 mg every 4 hours as needed for anxiety for 30 days, with a start date of 4/12/24 and a stop date of 5/12/24. Review of the resident's nursing progress notes PRN psychotropic review, dated 5/10/24 at 3:10 P.M. showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician would like to continue medication for another 30 days and will review medication again at that time. Review of the resident's medical record showed no documentation from the physician, regarding his/her rationale for extending the use of the resident's PRN Lorazepam beyond the 14 day stop date. Review of the resident's May 2024 MAR showed the following: -Administration of lorazepam 0.5 mg twice a day each day of May; -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 4/12/24 and an end date of 5/10/24; -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 5/10/24 and an end date of 6/07/24. Review of the resident's MRR, dated 5/21/24, showed comments of no recommendations at this time. Review of the resident's May 2024 MAR showed no PRN lorazepam administered during the month of May. Review of the resident's June 2024 physician orders showed the following: -An order for lorazepam 0.5 mg twice a day for restless/comfort with a start date of 7/17/23; -An order for lorazepam 0.5 mg every 4 hours PRN for anxiety for 30 days, with a start date of 5/10/24 and a stop date of 6/09/24. Review of the resident's nursing progress notes PRN psychotropic review, dated 6/07/24 at 4:19 P.M. showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician wants to continue medication for another 30 days and will review medication again at that time. Review of the resident's medical record showed no documentation, from the physician, regarding his/her rationale for extending the use of the resident's PRN Lorazepam beyond the 14 day stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's June 2024 MAR showed the following: -Administration of lorazepam 0.5 mg twice a day each day of June; -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 5/10/24 and an end date of 6/07/24; -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 6/07/24 and an end date of 7/07/24. Review of the resident's MRR, dated 6/21/24, showed comments of no recommendations at this time. Review of the resident's care plan, updated 6/28/24, showed the following: -He/She takes and anti-anxiety medication for his/her anxiety/comfort in his/her end of life; -Have pharmacy review his/her medications monthly. Review of the resident's June 2024 MAR showed no as needed lorazepam administered during the month of June. Review of the resident's nursing progress notes PRN psychotropic review, dated 7/07/24, at 12:56 P.M., showed nursing staff documented the resident's physician reviewed the resident's PRN lorazepam order for anxiety and end of life comfort measures. The physician wants to continue medication for another 30 days and will review medication again at that time. Review of the resident's medical record showed no documentation, from the physician, regarding his/her rationale for extending the use of the resident's PRN lorazepam beyond the 14 day stop date. Review of the resident's July 2024 physician orders showed the following: -An order for lorazepam 0.5 mg twice a day for restless/comfort with a start date of 7/17/23; -An order for lorazepam 0.5 mg every 4 hours PRN for anxiety for 30 days, with a start date of 7/07/24 and a stop date of 8/06/24. Review of the resident's July 2024 MAR showed the following: -Administration of lorazepam 0.5 mg twice a day each day of July (up to the end of annual survey on 7/18/24); -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 6/07/24 and an end date of 7/07/24; -An entry for lorazepam 0.5 mg every 4 hours PRN for 30 days for a diagnosis of anxiety with a start date of 7/07/24 and an end date of 8/06/24; -No as needed lorazepam administered during the month of July. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's MRR, dated 7/17/24, showed comments of no recommendations at this time. Review of the resident's medical record on 7/18/24 showed there was no documented rationale by the physician for the extended use of PRN Lorazepam beyond the 14 day stop date. During an interview on 7/18/24 at 4:11 P.M., the Director of Nurses (DON) said the following: -A PRN medication, like an anti-anxiety or antipsychotic, should have a stop date of 14 days; -The attending physician should document in the progress notes why he/she did not want to stop a PRN anti-anxiety or antipsychotic medication and/or why they wanted to continue the medication; -The consulting pharmacist would send the GDRs to her and she would print those and given them to the RN supervisors; the RN supervisors would then review those with the physician, get new orders if necessary and give them back to the DON; -The RN supervisor and the DON were responsible for following up on the GDRs; -An antipsychotic medication should have an appropriate medical diagnosis as an indication for its use; -If a diagnosis for an antipsychotic is not appropriate, the consulting pharmacist should let the physician know; -She would expect the physician to address an inappropriate medical diagnosis for an antipsychotic being used by a resident; -The licensed staff who entered the anti-anxiety or antipsychotic medication order would be responsible for ensuring there is an appropriate medical diagnosis; -If there was a question about the diagnosis, then that staff person would ask the physician for clarification. During an interview on 7/18/24 at 4:23 P.M., the Administrator said the following: -A PRN anti-anxiety or

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32530 34536 Based on observation, interview, and record review, the facility failed to ensure two ice machines were free of a buildup of debris, failed to properly store an ice scoop in the serving kitchen, and failed to ensure the refreshment area ice machine was equipped with an adequate air gap. The facility also failed to safely store food items in two refrigerators in the serving kitchen. The facility census was 69. 1. Review of the facility policy, Infection Prevention and Control, Nutritional Services, dated May 2015, showed the following guidance for the Ice Machine in the Food Server Area: -Run the scoop through the dish machine and air dry daily. Store them in clean Ziploc bag; -Wipe the exterior of the machine with warm, sudsy water, rinse and sanitize weekly; -The vendor is responsible for cleaning ice machine quarterly; -Check the interior of the ice cabinet, lid and gaskets for any signs of mold or mildew between monthly vendor visits. If they're visible, follow the cleaning procedures. Observation on 07/15/24 at 10:33 A.M. in the dining room serving kitchen, showed an ice machine sat in an adjacent alcove. The ice scoop was not properly stored and sat on an exterior ledge on the side of the machine. A mild buildup of white flaky debris was on the exterior surface of the machine and directly under the scoop. A plastic ice machine scoop holder was mounted to the wall next to the ice machine and was empty. Inside the ice machine, the white plastic baffle had a mild buildup of dark-colored debris around the edges all the way around the baffle. The lowest portion of the baffle had a buildup of debris and came in direct contact with the accumulated ice Observation on 7/15/24 at 2:04 P.M. showed the ice machine's white plastic baffle had a mild buildup of dark-colored debris around the edges all the way around the baffle. The lowest portion of the baffle had a buildup of debris and came in direct contact with the accumulated ice. The ice scoop sat on the edge of the plastic holder on the wall, but directly touched the wall and wasn't stored in the wall holder. Observation on 7/16/24 at 8:55 A.M. showed the ice machine's white plastic baffle had a mild buildup of dark-colored debris around the edges all the way around the baffle. The metal scoop sat on the exterior ledge of the unit and made direct contact with the soiled exterior surface and was not stored in wall holder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265688	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Center, The	2506 Linden Tree Parkway Marshall, MO 65340

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/16/24 at 10:34 A.M. showed a small countertop combination ice machine/water dispenser unit sat in the central refreshment area near the nurse's station. The ice dispensing spout had a heavy buildup of white crusty and dark-colored debris. The drip tray below the spout had a heavy buildup of white crusty debris and brown-colored debris. The ice machine was not equipped with an air gap and the drain was directly connected to the nearby sink drain near the p-trap under the counter inside a cabinet. 2. Review of the facility policy, Infection Prevention and Control, Nutritional Services, dated May 2015, showed the following guidance for Refrigeration: -The nutritional services staff shall check and record temperatures daily. Any out-of-range temperatures will be reported to the maintenance department. Notification will be documented on the temperature log; -All foods that have been prepared for service, but not shredded or chopped, shall be covered, dated and discarded after three days, if not used. Review of the facility policy, Temperatures of Refrigerators and Freezers, Nutritional Services, dated June 2015, showed the following: -Temperatures shall be recorded and kept on file of all refrigerators and freezers; -A thermometer is located in each refrigerator where it can be easily read; -Refrigerator temperatures shall be 41 degrees Fahrenheit (F) or colder; -At any time any refrigerator or freezer is not within the acceptable range, it must be reported to maintenance immediately. Review of the Refrigerator/Freezer Temperature Log for the Tea/Water Refrigerator, dated July 2024, showed the following: -July 11: At 5:45 A.M., 44 degrees F; At 5:38 P.M., 46 degrees F; -July 12: At 5:35 A.M., 48 degrees F; No measurement documented for P.M.; -July 13: At 5:42 A.M., 45 degrees F; -July 14: At 5:31 A.M., 48 degrees F; -July 15: At 6:00 A.M., 60 degrees F; At 6:58 P.M., 60 degrees F; -July 16: At 5:27 A.M., 58 degrees F; No measurement documented for P.M. Observation on 7/15/24 at 10:38 A.M. showed a vertically stacked double reach-in refrigerator, labeled as TLC tea/water fridge sat in the serving kitchen. The outside analog gauge showed an internal temperature of +60 degrees F. A separate thermometer inside the unit showed a temperature of +54 degrees F. The refrigerator contained carafes of tea and water and a box of buttery spread. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/15/224 at 2:06 P.M. showed the TLC tea/water fridge outside analog gauge showed an internal temperature of +60 degrees F. A separate thermometer inside the unit showed a temperature of +62 degrees F. The refrigerator contained carafes of tea and water and a box of buttery spread. The unit also had one clear pitcher with a green lid, labeled comfort care 7/15 with dark liquid inside. Two additional blue pitchers with blue lids were not labeled or dated and contained a dark liquid. Observation on 7/16/24 at 8:56 A.M. showed the TLC tea/water fridge outside analog gauge showed an internal temperature of +52 degrees F. A separate thermometer inside the unit showed a temperature of +48 degrees F. 3. Review of the Refrigerator/Freezer Temperature Log for the Kitchen Refrigerator (a separate unit used to store food items in the serving kitchen), dated July 2024, showed the following: -July 11: At 5:45 A.M., 44 degrees F; -July 12: At 5:32 A.M., 45 degrees F; -July 13: At 5:40 A.M., 45 degrees F; -July 14: At 5:30 A.M., 45 degrees F; -July 15: At 6:00 A.M., 46 degrees F; -July 16: At 5:26 A.M., 51 degrees F; No measurement documented for P.M. Observation on 7/15/24 at 10:49 A.M. showed an upright, three-door refrigerator located in the preparation area labeled as TLC kitchen fridge. The outside digital temperature display showed an internal temperature of +55 degrees F. A separate thermometer inside the unit showed a temperature of +50 degrees F. Perishable food items were located inside the refrigerator. Observation on 7/15/24 at 2:09 P.M. showed the the outside digital display showed an internal temperature of +60 degrees F. A separate thermometer inside the unit showed a temperature of +60 degrees F. The refrigerator contained eggs, trays of portioned salads, cottage cheese, produce, fruit, bulk ham salad, muffins, and bulk condiments. Observation on 7/16/24 at 8:57 A.M. showed the outside digital display showed an internal temperature of +52 degrees F. A separate thermometer inside the unit showed a temperature of +46 degrees F. The food items remained inside the refrigerator. During interview on 7/15/24 at 2:27 P.M., the Dietary Director said the refrigerator for tea/ice had started running higher temperatures over the weekend and she had asked staff to monitor the refrigerator more closely. She thought the broken air conditioning unit in the dining room/serving area kitchen may have affected the temperature in this refrigerator. She was unaware the temperature in the kitchen refrigerator (refrigerator used to store food items) was also running high. If staff found a refrigerator was not working properly, a request would be submitted to maintenance requesting a repair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 7/16/24 at 9:23 A.M., the Director of Facilities Maintenance said the following: -He was unaware that two refrigerators were not maintaining cold temperatures; -The broken air conditioning in the dining room/serving kitchen could be affecting the refrigerators; -He wasn't sure if there was a work order submitted for the tea/water refrigerator, but there may have been one for the three-door kitchen refrigerator (identified as TLC kitchen fridge) The three-door unit had some issues staying cold and had work done on it in the past; -Staff should put in a work order if units are not cooling properly; -A vendor cleaned the inside of the ice machine quarterly; -He was unaware of debris buildup on the inside of the unit; -The vendor was at the facility approximately one to two months ago. During interview on 7/16/24 at 11:05 A.M., the Dietary Supervisor said the following: -She had been the supervisor for two weeks; -She was aware of the warmer temperatures in the ice/tea refrigerator; -She wasn't aware the temperatures in the three-door refrigerator (identified as TLC kitchen fridge) were that high. She had only reported to one of the dietitians that the bottom seal on the 3-door unit needed to be replaced; -She was not aware there was an ice machine in the central refreshment area; -She was not aware that an ice machine was required to have an adequate air gap; -She was not aware the kitchen ice machine had a buildup of debris inside. She thought the vendor cleaned the unit; -The ice scoop should be stored in the wall-mounted scoop holder and not on the outside ledge. The scoop should be washed daily.