STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265716	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monticello House	1115 K Land Drive Jackson, MO 63755

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47678 Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 45. The facility did not provide an environment policy. 1. Observation on 11/05/24 at 10:35 A.M., showed room [ROOM NUMBER] with a one foot (ft) by six inches (in) hole in the dry wall on the right side of the window. 2. Observation on 11/05/24 at 10:48 A.M., of room [ROOM NUMBER] showed: - A hole in the dry wall at the foot of the bed three in by six in; - A hole in the dry wall under the bathroom sink three in by six in; - Missing dry wall which exposed the metal corner mold along the wall by the bathroom door; - Multiple scraped areas of the dry wall along the wall by the room exit door. During an interview on 11/05/24 at 10:49 A.M., the resident in room [ROOM NUMBER] said he/she was unsure how long the walls had been like this but at least a few months. 3. Observation on 11/05/24 at 10:50 A.M., showed a two ft missing section of base cove around the corner of room [ROOM NUMBER]. During an interview on 11/08/24 at 12:30 P.M., the Maintenance Director said he/she had forms to fill out if something needed fixed but most of the time, everyone just told him/her if something needed fixed or looked at. During an interview on 11/08/24 at 1:33 P.M., the Administrator said she would expect the building to be in good repair. 49152

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a facility initiated transfer when two residents (Residents #6 and #30) out of five sampled residents transferred to the hospital. The facility's census was 45. Review of facility policy titled, Discharge/Transfer of Resident, undated, showed: - Give copy of a signed transfer or discharge notice to the resident and/or representative or person responsible for care; - If an emergency transfer, a transfer or discharge notice form may be completed later, but as soon as possible. 1. Review of Resident #6's medical record showed: - The resident transferred to the hospital on 04/09/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 04/09/24. 2. Review of Resident #30's medical record showed: - The resident transferred to the hospital on 03/08/24, and readmitted to the facility on [DATE]; - No documentation of written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 03/08/24. During an interview on 11/08/24 at 11:28 A.M., the Director of Nursing (DON) said they had not been able to find any transfer/discharge notices. During an interview on 11/08/24 at 1:33 P.M., the Administrator said she would expect transfer/discharge notices to be given when residents transfer to the hospital. 49152 49999

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152 Based on interview and record view, the facility failed to inform the resident and/or the resident's representative of the facility bed hold policy at the time of transfer to the hospital for two residents (Residents #6 and #30) out of five sampled residents. The facility's census was 45. Review of facility policy titled, Discharge/Transfer of Resident, undated, showed: - Explain and give a copy of the bed hold form to the resident and/or representative. 1. Review of Resident #6's medical record showed: - The resident transferred to the hospital on 04/09/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 2. Review of Resident #30's medical record showed: - The resident transferred to the hospital on 03/08/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. During an interview on 11/08/24 at 11:28 A.M., the Director of Nursing (DON) said bed hold policies prior to her and the Administrator starting at the facility were not found. During an interview on 11/08/24 at 1:33 P.M., the Administrator said she would expect bed hold policies were to be given when residents transfer to the hospital. 49999

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49999 Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accident hazards by not maintaining water temperatures between 105 degrees Fahrenheit (F) to 120 degrees F in seven occupied resident room sinks and two community showers, which put the residents at an increased risk of injuries from exposure to the hot water. These practices had the potential to affect all the residents at the facility. The facility census was 45. The facility did not provide a policy regarding water temperatures. Review of the Burn Foundation website showed hot water caused third degree burns (full thickness burns which go through the skin and affect deeper tissue resulting in white or blackened, charred skin) at the following temperatures and time parameters: - In one second at 156 degrees F; - In two seconds at 149 degrees F; - In five seconds at 140 degrees F; - In 15 seconds at 133 degrees F; - In one minute at 127 degrees F. Observation on 11/05/24 at 12:15 P.M. through 12:33 P.M., of water temperatures taken at 60 seconds with a digital thermometer showed: - room [ROOM NUMBER] hot water temperature recorded at 128 degrees F; - room [ROOM NUMBER] hot water temperature recorded at 132 degrees F; - room [ROOM NUMBER] hot water temperature recorded at 124 degrees F; - room [ROOM NUMBER] hot water temperature recorded at 129 degrees F; - The 400 Hall shower room water temperature recorded at 122 degrees F. Observation on 11/08/24 at 10:04 A.M. through 10:15 A.M., of water temperatures taken at 60 seconds with a digital thermometer showed: - room [ROOM NUMBER] water temperature recorded at 141 degrees F; - room [ROOM NUMBER] water temperature recorded at 129 degrees F; - room [ROOM NUMBER] water temperature recorded at 129 degrees F; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- room [ROOM NUMBER] water temperature recorded at 131 degrees F; - The 500 Hall shower room water temperature recorded at 124 degrees F. Observation on 11/08/24 at 10:18 A.M., of the mechanical room on the 200 Hall showed one hot water heater with two non-digital external thermometers for monitoring and setting the temperatures. Both thermometers showed temperatures of 122 degrees F. Observation on 11/08/24 at 10:20 A.M., of the mechanical room on the 100 Hall showed one hot water heater with two non-digital external thermometers for monitoring and setting the temperatures. The first thermometer showed 140 degrees F and the second thermometer showed 130 degrees F. Observation on 11/08/24 at 10:22 A.M., of the mechanical room on the 400 Hall showed one hot water heater with two non-digital external thermometers for monitoring and setting the temperatures. Both thermometers showed temperatures of 132 degrees F. During an interview on 11/05/24 at 2:34 P.M., Certified Nurse Assistant (CNA) F said no residents had reported the water being too hot or being scalded by the water on the 400 Hall. During an interview on 11/08/24 at 10:50 A.M., the resident in room [ROOM NUMBER] said the water had been really cold but today it was scalding hot. During an interview on 11/08/24 at 10:00 A.M., the Maintenance Supervisor said the plumber was at the facility yesterday and fixed the water heater pump for the 100 Hall. The plumber set the the hot water heater thermometer at 125 degrees F. During an interview on 11/20/24 at 10:30 A.M., the Administrator said she expected the water temperatures in the resident rooms and resident care areas to be between 105 and 120 degrees F.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47678 Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was dated when changed for one resident (Resident #12) and failed to ensure a physician's order for oxygen with the use of a bilevel positive airway pressure (BIPAP - a noninvasive ventilation device that helps people breathe by delivering pressurized air into the airways) was followed for one resident (Resident #195) out of two sampled residents. The facility census was 45. Review of the facility's policy titled, Oxygen Administration, undated, showed: - The purpose is to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues; - Prefilled disposable humidifiers may be changed when empty; - Set the flow meter to the rate ordered by the physician; - Label the humidifier with the date and time opened; - Change humidifier and tubing per cleaning guidelines; - At regular intervals, check and clean the oxygen equipment, masks, tubing and cannulas; - At regular intervals, check the liter flow contents of the oxygen cylinder, fluid level in the humidifier, and assess the resident's respiration. Review of the facility policy titled, Physician Orders, undated, showed oxygen orders must specify the rate of flow, route, and rationale for use. 1. Review of Resident #12's medical record showed: - admitted [DATE]; - Diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that causes restricted airflow and breathing problems) and chronic kidney disease (kidneys do not filter waste and fluid like they should). Review of the resident's Physician Order Sheet (POS), dated October 2024, showed: - An order for oxygen at 2 liters per minute (LPM) by nasal cannula (NC - a flexible tube inserted into the nose to administer supplemental oxygen) as needed for shortness of breath, dated 08/13/24; - An order to change oxygen tubing monthly on the first of the month, dated 08/13/24. Observation of the resident on 11/06/24 at 2:42 P.M., showed the resident sat on the side of the bed with oxygen on at 2 LPM via NC and the oxygen tubing was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident on 11/08/24 at 9:29 A.M., showed the resident sat in the wheelchair with oxygen on at 2 LPM via NC and the oxygen tubing was not dated. During an interview on 11/06/24 at 2:43 P.M., Resident #12 said the nurses changed the tubing but was unsure when it was changed last. 2. Review of Resident #195's medical record showed: - admitted [DATE]; - Diagnoses of acute respiratory failure, heart failure (heart not pumping as it should), and chronic kidney disease. Review of the resident's POS, dated October 2024, showed: - An order for oxygen at 2 LPM by NC continuous, dated 10/18/24; - No order for BIPAP. Review of the resident's care plan, revised 10/23/24, showed: - Administer oxygen as prescribed; - Did not address the BIPAP. Observation on 11/06/24 at 10:15 A.M., showed Resident #195 lay in bed sleeping on his/her left side with a BIPAP and 2 LPM of oxygen bled in. Observation on 11/06/24 at 11:55 A.M., showed the resident sat on the side of the bed and did not wear oxygen. Observation on 11/07/24 at 10:28 A.M., showed the resident sat on the side of the bed and did not wear oxygen. Two staff were assisting the resident with a dressing change. Observation on 11/08/24 at 10:45 A.M., showed the resident sat in a wheelchair, did not wear oxygen, and one staff in the room. During an interview on 11/08/24 at 8:20 A.M., Registered Nurse (RN) I said he/she thought Resident #195 was supposed to have oxygen 2 LPM bled into the BIPAP. He/She couldn't find an order for the resident's BIPAP with the settings. During an interview on 11/08/24 at 12:02 P.M., RN G said nurses were responsible for BIPAP equipment and changing the tubing monthly. During an interview on 11/08/24 at 12:35 P.M., the Director of Nursing (DON) said nurses were responsible for managing the BIPAP and for changing the tubing monthly. There should be an order for the BIPAP with the settings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/24 at 1:33 P.M., the DON and Administrator said they would expect the resident to have an order for the BIPAP use including the settings. 49152

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 47447 Based on interview and record review, the facility failed to ensure two nurse aides (NAs) (NA B and NA C) completed a nurse aide training program within four months of his/her employment in the facility out of two sampled NAs. This deficient practice had the potential to affect all residents in the facility. The facility census was 45. The facility did not provide a policy on the nurse aide training program. 1. Review of NA B's Training Record showed: - Hire date of 06/12/24; - NA B attended an online nurse aide program; - The facility failed to ensure the completion of the program within four months of the hire date. 2. Record review of NA C's Training Record showed: - Hire date of 06/25/24; - NA C attended an online nurse aide program; - The facility failed to ensure the completion of the program within four months of the hire date. During an interview on 11/07/24 at 9:30 A.M., the Director of Nursing (DON) said the currently employed NAs were taking nurse aide training through an online program. She thinks NA B and NA C had completed the program and were waiting on permission to take their tests. During an interview on 11/07/24 at 9:45 A.M., the Administrator said she would expect NAs to complete a nurse aide training program within four months of their hire date.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47447 Based on interview and record review, the facility failed to provide nurse aide's annual individual performance review or evaluation, and failed to provide annual in-service training based on the outcome of performance reviews for two Certified Nurse Assistants (CNAs) (CNA D and CNA E) out of two sampled CNAs. The facility census was 45. The facility did not provide a policy on CNA performance review and training requirements. 1. Review of CNA D's in-service record showed: - CNA D with a hire date of 02/22/22; - CNA D did not receive an annual individual performance review or evaluation; - No annual in-service training for February 2023 through February 2024. 2. Review of the CNA E's in-service record showed: - CNA E with a hire date of 02/18/15; - CNA E did not receive an annual individual performance review or evaluation; - No annual in-service training for February 2023 through February 2024. During an interview on 11/07/24 at 9:00 A.M., the Administrator said no employee performance reviews or evaluations had been done since she started in May 2024, and there was no documentation they had been done prior to her employment either.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to ensure an appropriate diagnosis for the use of an antipsychotic (medications that treat psychosis-related conditions and symptoms) medication for one resident (Resident #37) out of five sampled residents. The facility census was 45. Review of the facility's policy titled, Antipsychotic Medication Use, not dated, showed: - Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective; - Antipsychotic medications shall only be used for the following conditions/diagnoses as documented in the record: schizo-affective disorder (a chronic mental illness that combines symptoms of schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors) and a mood disorder (a mental health condition that involves a persistent change in a person's emotional state)), mood disorders, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) with psychotic (a severe mental disorder that causes a person to lose touch with reality) features, psychosis not otherwise specified, brief psychotic disorder, schizophrenia , delusional disorder (a psychiatric condition characterized by a person having one or more fixed false beliefs), schizophreniform disorder (a mental health condition that causes symptoms similar to schizophrenia, but for a shorter period of time), atypical psychosis, dementing (causing or characterized by dementia, a disease that can cause memory loss, confusion, and disorientation) illness with associated behavioral symptoms. 1. Review of Resident #37's medical record showed: - admitted to the facility on [DATE]; - Diagnoses of dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), generalized anxiety disorder (a disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression, and insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get quality sleep); - An order for olanzapine (an antipsychotic medication) 2.5 milligrams (mg) at bedtime for insomnia, dated 08/21/24; - No documentation for an appropriate diagnosis for the olanzapine. Review of the resident's Pharmacist monthly Medication Regimen Review (MRR) for September and October 2024 showed: - No recommendation for an appropriate diagnosis for the olanzapine. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 2:30 P.M., the Director of Nursing (DON) said insomnia was not an appropriate diagnosis for an antipsychotic medication. During an interview on 11/19/24 at 12:38 P.M., Pharmacist N said insomnia was not an appropriate diagnosis for an antipsychotic medication. Physician orders were reviewed on a monthly basis, but Resident #37's olanzapine was not due for a gradual dose reduction yet, so it may not have been reviewed during the MRR.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49152 Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 32 opportunities with two errors made, for an error rate of 6.25%, which affected two residents (Residents #33 and #195) out of six sampled residents. The facility census was 45. The facility did not provide a medication error policy. Review of the insulin aspart manufacture guidelines for giving the airshot (prime) before each injection and administration, revised 02/2023, showed: - Turn the dose selector to select 2 units; - Hold the pen with the needle pointing up; - Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; - Keep the needle pointing upwards, press the push-button all the way in; - The dose selector returns to zero; - A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times; - Select your dose. 1. Review of Resident #33's Physician Order Sheet (POS), dated November 2024, showed an order for insulin aspart 18 units subcutaneous (an injection under the skin) at 7:00 A.M., 12:00 P.M., and 5:00 P.M., with meals every day, dated 09/30/24. Observation on 11/06/24 at 11:45 A.M., of the resident's insulin aspart administration showed Registered Nurse (RN) G failed to prime the insulin aspart pen before administering the 18 units. 2. Review of Resident #195's POS, dated November 2024, showed an order for insulin aspart 10 units subcutaneous at 7:00 A.M., 12:00 P.M., and 5:00 P.M., with meals every day, dated 10/16/24. Observation on 11/06/24 at 11:59 A.M., of the resident's insulin aspart administration showed RN G failed to prime the insulin aspart pen before administering the 10 units. During an interview on 11/06/24 at 11:46 A.M., RN G said he/she primed the insulin pens the first time they were used. The insulin pens didn't require priming after the first use. During an interview on 11/08/24 at 1:35 P.M., the Director of Nursing (DON) and the Administrator said they would expect staff to administer medications according to the manufacturer's guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49999 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices had the potential to affect the thirteen residents who were served food from the 400 Hall refrigerator. The facility census was 45. Review of facility policy titled, Receiving and Storage of Food, dated May 2015, showed: - All perishable items are stored in either refrigerators at a temperature of 40 degrees Fahrenheit (F) or below or freezers at a temperature of 0 degrees F or below. The facility did not provide refrigerator temperatures for the 400 Hall. 1. Observation on 11/07/24 at 12:10 P.M., of the 400 Hall unit refrigerator showed: - A temperature of 50 degrees F; - An opened container of milk, unlabeled and undated; - A pitcher of a purple liquid, unlabeled and undated; - An unopened container of yogurt. 2. Observation on 11/07/24 at 2:00 P.M., of the 400 Hall unit refrigerator showed: - A temperature of 50 degrees; - An opened container of milk, unlabeled and undated; - An unopened container of yogurt. 3. Observation on 11/08/24 at 8:56 A.M., of the 400 Hall unit refrigerator showed: - A temperature of 50 degrees; - An opened container of milk, unlabeled and undated; - A pitcher of yellow liquid, unlabeled and undated; - A pitcher of red liquid, unlabeled and undated. During an interview on 11/07/24 at 12:19 P.M., Nurse Aide (NA) B said the refrigerator on the 400 Hall was mainly used for employee's food but it was also used to store the residents' leftover drinks from meals. Maintenance monitored the refrigerator temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265716	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monticello House	1115 K Land Drive Jackson, MO 63755

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 12:19 P.M., Certified Nurse Aide (CNA) A said he/she brought the opened milk container over from the kitchen, but did not date the container when it was opened. During an interview on 11/07/24 at 3:50 P.M., the Maintenance Supervisor said he/she monitored the temperatures for the unit refrigerators and keeps a log which was kept in the kitchen. During an interview on 11/08/24 at 9:19 A.M., the Dietary Manager said he/she did not keep logs of the unit refrigerators and staff should be dating the milk when the containers were opened. During an interview on 11/8/24 at 1:33 P.M., the Administrator said she would expect unit refrigerator temperatures to be checked regularly and to be maintained below 41 degrees F.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47447 Based on interview and record review, the facility failed to ensure the quality assessment and assurance (QAA) committee attendees included an Infection Preventionist (IP). This failure had the potential to affect all 45 residents who reside at the facility. The facility's census was 45. The facility did not provide a policy regarding the QAA Committee. The facility did not provide QAA Committee Attendance records prior to September 2024. Review of the QAA Committee Attendance record, dated September 2024, showed the IP did not attend the meeting as required. During an interview on 11/06/24 at 8:50 A.M., the Administrator said the IP did not attend the QAA meeting because he/she had been working as the charge nurse on the night shift. She did not have the QAA Committee Attendance records prior to September 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47678 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment by not wearing source control (facemasks) during a Coronavirus Disease 2019 (COVID-19 - a highly contagious respiratory disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 - a member of a large family of viruses called coronaviruses) outbreak. This deficient practice had the potential to affect all residents in the facility. The facility's census was 45. Review of the Infection Control Guidance, provided by the Centers for Disease Control and Prevention (CDC), updated on 05/08/23, showed: - Source control is recommended for those working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of a respiratory infection; - Universal use of source control could be discontinued once the outbreak is over; - Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility. Review of the facility's policy titled, Outbreak Management, SARS-CoV-2 for Long Term Care Facilities, last revised 05/15/23, showed: - The strategies CDC recommends to prevent the spread of SARS-CoV-2 in long term care communities are the same strategies used every day to detect and prevent the spread of other respiratory viruses like influenza; - Ensure facility staff are educated, trained, and have practiced the appropriate use of personal protective equipment (PPE) prior to caring for a resident; - Source control refers to the use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing; - Source control is recommended for those working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection. 1. Observations on 11/05/24 showed: - At 9:55 A.M., no sign posted on the entry door indicating the facility in COVID 19 outbreak status; - At 9:57 A.M., no signs indicating isolation on the rooms of the COVID 19 positive residents; - At 9:58 A.M., Licensed Practical Nurse, (LPN) L sat at the desk without a face covering or mask; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 10:00 A.M., LPN M placed isolation gowns on the isolation cart outside of the COVID 19 positive rooms, and returned to the common area with other residents present, without a face covering or mask; - At 12:23 P.M., staff assisted residents in the dining room without face coverings or masks. 2. Observations on 11/06/24 showed: - At 8:46 A.M., Certified Medication Technician (CMT) H failed to wear a mask when administering medications to residents in the common area; - At 8:58 A.M., CMT H failed to wear a mask when administering medications to residents in the common area; - At 9:16 A.M., CMT H failed to wear a mask when administering medications in room [ROOM NUMBER]; - At 9:20 A.M., CMT H failed to wear a mask when administering medications to residents in the common area on the locked unit; - At 11:32 A.M., Registered Nurse (RN) G failed to wear a mask when checking a blood sugar in room [ROOM NUMBER]; - At 11:37 A.M., RN G failed to wear a mask when checking a blood sugar in room [ROOM NUMBER]; - At 11:40 A.M., RN G failed to wear a mask when checking a blood sugar in room [ROOM NUMBER]; - At 11:45 A.M., RN G failed to wear a mask when checking blood sugar and administering insulin in room [ROOM NUMBER]; - At 11:59 A.M., RN G failed to wear a mask when administering insulin in room [ROOM NUMBER]. During an interview on 11/05/24 at 10:45 A.M., Housekeeper J said staff had to dress up with the PPE outside the COVID rooms before going in, but no one had said anything about wearing a mask outside the COVID rooms. During an interview on 11/08/24 at 9:10 A.M., CNA K said no one had said anything about wearing a mask outside the COVID rooms. If he/she needed to go into a COVID room, then needed to wear a faceshield, gown, gloves, and a N95 mask. During an interview on 11/05/24 at 2:30 P.M., the Director of Nursing (DON) said the facility's protocol at this time was for staff to wear face masks in the isolation rooms only. During an interview on 11/08/24 at 1:33 P.M., the Administrator and the DON said they expect staff to follow the CDC guidelines during a COVID-19 outbreak.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47447 Based on interview and record review, the facility failed to conduct at least twelve hours of certified nurse assistant (CNA) in-service education per year and failed to provide the required annual competencies of Dementia Care (care of a resident with an impaired ability to remember, think, or make decisions) for two CNAs (CNA D and CNA E) out of two sampled CNAs. The facility census was 45. The facility did not provide a policy on nurse aide training requirements. 1. Review of Certified Nursing Assistant (CNA) D's in-service record showed: - A hire date of 02/22/22; - Did not attend an annual competency in-service training on Dementia Care; - No annual in-service training for February 2023 through February 2024; - Less than twelve hours of in-service education for February 2023 through February 2024. 2. Review of CNA E's in-service record showed: - A hire date of 0218/15; - Did not attend an annual competency in-service training on Dementia Care; - No annual in-service training for February 2023 through February 2024; - Less than twelve hours of in-service education for February 2023 through February 2024. During an interview on 11/07/24 at 11:30 A.M., the Director of Nursing (DON) said she had started as DON in May 2024, and had been trying to catch staff up on the required training. During an interview on 11/08/24 at 1:45 A.M., the Administrator said she expects all CNAs to have at least 12 hours of continuing in-service training annually and the training should include training on Dementia Care.