STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265739	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Manor Health & Rehabilitation	2005 South Lexington Holden, MO 64040

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on interview and record review, the facility failed to obtain an authorization signature from one sampled resident (Resident #291) to allow the facility to open and maintain a resident trust account out of four sampled residents sampled for resident trust accounts. The facility census was 46 residents. 1. Review of Resident #291's trust account on 8/2/24 showed: -The resident was admitted to the facility on [DATE]. -The resident had a balance of $0.0 in his/her account -The absence of an authorization form that was signed by the resident. During an interview on 8/2/24 at 10:21 A.M. the Regional Business Office Manager (BOM) said he/she gave the form to the new facility BOM, but the new facility BOM did not have the resident sign the authorization form. During a telephone interview on 8/8/24 at 2:42 P.M., the previous BOM said: -He/she worked as the BOM until 7/15/24 then became the Activity Director. -The resident's account was opened on 7/22/24.

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 19916 Based on interview and record review, the facility failed to maintain evidence (via receipts or signatures) for monetary transactions in the resident trust fund accounts for two sampled residents (Resident #2 and #3) out of four sampled residents; and failed to maintain a proper accounting of the end of month petty cash (the amount of cash that is accessible for residents with resident trust that residents can request funds from) amounts from July 2023 through April 2024. This practice potentially affected 22 residents with resident trust. The facility census was 46 residents. 1. Review of Resident #2's resident trust fund transactions list dated 4/1/24 through 7/31/24 showed: - A transaction dated 5/6/24 for $40.41 without a receipt or signature for that transaction. - A transaction dated 6/14/24 for $18.97, without a receipt for that transaction. 2. Review of Resident #3's resident trust fund transaction list dated 4/1/24 trough 7/31/24, showed a transaction for $28.56, without a receipt or a signature for that transaction. During an interview on 8/2/24 at 10:32 A.M. the Regional Business Office Manager (BOM) said: -The previous BOM placed multiple transactions on one receipt and that made the transactions hard to distinguish. -The previous BOM did not keep specific receipts for each grocery store transaction. 3. Review of the resident trust records from July 2023 through June 2024, showed the absence of petty cash records from July 2023 through April 2023. During an interview on 8/2/24 at 10:18 A.M., the Regional BOM said there was not an actual form that was used, to do the petty cash calculations for the petty cash.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 19916 Based on interview and record review, the facility failed to ensure the funds of one discharged resident (Resident #93) was forwarded to the resident within 5 days of the resident moving to a new facility; and failed to ensure that Third Party Liability (TPL- a form which is sent to Missouri (MO) Health Net, which gives an accounting of the remaining balance of that resident's funds in the resident trust account) forms were completed and sent to Missouri (MO) Healthnet (a state agency which administers the provision and payment of services for Missouri's Medicaid program) within 30 days of death for two discharged residents (Resident #91 and #92). The facility census was 46 residents. 1. Review of Resident #93's medical record, showed: -He/she was discharged from the facility to a hospital on 1/25/24. - The residents' fund account, showed he/she had $80.24 in his/her resident trust account at the time of discharge. - The resident was discharged from the hospital to another facility on 2/6/24. -There was no documentation that showed the resident's money was sent to the resident at the new facility. During an interview on 8/2/24 at 10:51 A.M., the Regional Business Office Manager (BOM) said: -The facility BOM was only in his/her job for a short time and was not trained yet, so he/she conducted the resident trust fund review. -The facility was waiting for approval for the FA465 (a form which is sent to the nursing home, which included the effective date a participant is eligible for vendor payments the level of care for a participant and the surplus amounts and dates) to come from the family support division after the resident was approved for Medicaid to let the facility know what the patient's share of expenses were. -He/she closed the account on 7/30/24 (176 days after the resident was admitted to a different Long Term care Facility). During a telephone interview on 8/8/24 at 2:23 P.M., the Former BOM said: -He/she was not trained well on the new resident trust management program. -In order to forward money from this facility to the next facility, he/she would have to submit a request and he/she was not trained in how to enter that request properly into the system. -He/she had not requested a refund. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #91's medical record showed the resident passed away on 3/28/24 and $121.79 was in his/her trust fund account account. During an interview on 8/2/24 at 11:15 A.M., the Regional BOM said the former BOM did not complete a TPL form for the resident. 3. Review of Resident #92's medical record showed the resident passed away on 9/7/23 with $50.00 in his/her account. During an interview on 8/2/24 at 11:17 A.M., the Regional BOM said the former BOM did not complete a TPL form for the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on interview and record review, the facility failed to obtain a timely advanced directive for one sampled resident (Resident #291) when he/she elected to be a Do Not Resuscitate (DNR, an election to have Cardio-Pulmonary Resuscitation [CPR] withheld in the event of cardiac arrest) out of 14 sampled residents. The facility census was 46 residents. Review of the undated facility policy titled Advanced Directives showed the facility was to: -Inform and offer the resident a choice to elect to be a DNR on admission. -Assist the resident in obtaining an advanced directive. -Ensure coordination with the physician to enact the advanced directive. -Update the plan of care and place orders in the medical record. 1. Review of the resident's medical record showed: -An admission to the facility on [DATE]. -An out of hospital DNR form signed by the resident on [DATE] with no other signatures. Review of the resident's Physician Order Summary (POS) on [DATE] showed an order for the resident to be a full code (an election to receive CPR in the event of cardiac arrest). During an interview on [DATE] at 9:41 A.M., the resident said he/she signed a DNR order on admission and would not want facility staff to perform CPR in the event his/her heart stopped. During an interview on [DATE] at 2:33 P.M., Registered Nurse (RN) A said: -The resident had an order to be a full code. -He/She would have performed CPR on a resident with a full code order in the medical record. -It should have taken a week or less to get the physician to sign a DNR order. -Two staff members could have witnessed the resident sign the DNR to enact it while waiting for the physician to sign the order. -The resident wished to be a DNR and this should have been followed up on by nursing or social services. During an interview on [DATE] at 10:16 A.M., the Minimum Data Set (MDS) Coordinator said: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents who wished to be a DNR would sign a DNR form. -The form would then be signed by either the resident's physician or two staff members to be verified. -Medical records would scan the verified order into the resident's medical record and nursing staff would input a physician's order for the DNR. -He/She would like the DNR to be enacted within 72 hours of the resident signature to ensure the resident's wishes were followed in the event of cardiac arrest. -A DNR should not go from [DATE] to [DATE] without being verified by the physician or two staff witnesses. During an interview on [DATE] at 11:58 A.M., the Director of Nursing (DON) said: -Staff were to ensure DNR orders were signed by the physician to ensure the resident's wishes were carried out. -He/She would expect the DNR to be verified and enacted within 24 hours of initiation. -Follow up on an unsigned DNR would be a team effort from admissions, nursing and social services. -A DNR signed by the resident on [DATE] should have been verified prior to the time of this interview.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 19916 Based on observation, interview and record review, the facility failed to maintain the ambient (pervasive quality of the surrounding environment) temperature of Resident #291's room, and resident rooms [ROOM NUMBERS], within the required Centers for Medicaid and Medicare Services (CMS) regulatory requirement of 71-81 F (degrees Fahrenheit) failed to monitor temperatures of those rooms when those rooms felt warm, failed to ensure all staff knew where the locations of the thermometers and failed to ensure that two of the facility thermometers were properly operating. The facility also failed to maintain the restroom floor in resident room [ROOM NUMBER] free from a pungent urine odor; failed to maintain the floors in resident rooms [ROOM NUMBER] free from a buildup of debris; failed to maintain the filter of the climate control unit in resident room [ROOM NUMBER] free of dust and mildew; failed to maintain the fans in resident rooms [ROOM NUMBERS] and the therapy room free of a heavy buildup of dust; failed to maintain the shower curtain in the North Hall shower room free from red colored stains; and failed to maintain the ceiling vent in the South Hall shower room, free from buildup of dust inside the vents. This practice potentially affected at least 6 residents with temperatures in their room above 81 F and at least 25 residents in other areas of the facility. The facility census was 46 residents. Review of the Ambient Temperature Checks section of the facility's policy entitled Emergency Electrical Outage Procedure, dated 3/30/23, showed: -The ambient temperatures of all residents spaces will be monitored every 30 minutes and documented on flow sheets provided in this section. -The acceptable range of temperature is 71-81 F. -There are wall thermometers placed above the fire extinguishers on each hall and one in the dining room outside the kitchen door. -Staff will also check temperatures in two resident rooms on each hall every 30 minutes. -Probe thermometers for this use are in the Maintenance Director's Office. -Notify the charge nurse, Administrator and Maintenance Director immediately, if monitored temperatures, range beyond 71-81 F. 1. Review of Resident #291's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/11/24, showed: -The full MDS was not completed. -Section C cognitive function was completed and it indicated the resident was cognitively intact. During an interview on 7/30/24 at 9:03 AM, the resident said it was hot in his/her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/30/24 at 9:13 AM, showed the ambient temperature in the resident's room was 82.4 F. Observation on 7/30/24 at 12:08 P. M, showed the ambient temperature in the resident's room was 84.3 F. Observation on 7/30/24 at 1:01 P. M, showed the ambient temperature in the resident's room was 84.2 F. Observation on 7/30/24 at 1:39 P.M. showed the ambient temperature in the resident's room was 85 F. During an interview on 7/31/28 at 9:54 A.M., the resident said 7/30/24 was not a good day because the air conditioning was out and his/her room was hot and he/she felt miserable. 2. Observation on 7/30/24 at 1:35 P.M. showed the ambient temperature in resident room [ROOM NUMBER] was 82 F. 3. Observation on 7/30/24 at 1:44 P.M. showed the ambient temperature in resident room [ROOM NUMBER] was 82 F. 4. During an interview on 7/30/24 at 2:03 P.M. the Maintenance Director (MD) said: -He/she did not know of anyone who took temperatures of those rooms. -There was not a thermometer at the nurse's station. -If a facility staff member needed to monitor room temperatures they would have to ask him/her for the other thermometers. Observation on 7/30/24 at 2:07 P.M., showed: -The MD brought three thermometers out to the Main dining room to verify how they recorded temperatures. -The following temperatures were recorded from all three of the facility's thermometers and one of the surveyor's thermometer. -Facility thermometer A recorded a dining room temperature of 41.2 F. -Facility thermometer B recorded a temperature of 35.2 F. -Facility thermometer C recorded a temperature of 76.6 F. -The surveyor's thermometer recorded a temperature of 77.3 F. During an interview on 7/30/24 at 2:16 P.M., the MD said: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It had been since 4/24 or 5/24, since he/she had checked the thermometers to verify the thermometers worked properly. -He/she did not document the maintenance of the thermometers. -He/she did not know that facility thermometers A and B were so far out of range. During an interview on 7/31/24 at 9:14 A.M., Licensed Practical Nurse (LPN) C said: -On 7/30/24, Resident #291's room was the worst, but resident room [ROOM NUMBER] and 30 were warm, but not as hot as Resident #291's room. -He/she did not check temperatures in the rooms. -He/she shut the curtain in rooms [ROOM NUMBERS]. -The Maintenance Assistant had to clean out the climate control units in those rooms. During an interview on 7/31/24 at 9:21 A.M., Certified Nursing Assistant (CNA) B said: -On 7/30/24, he/she felt that Resident #291's and resident room [ROOM NUMBER] were warm. -The climate control units were on, but the air did not blow out cool. -He/she told the Director of Nursing (DON). -He/she did not take any temperatures of the rooms. -None of the residents said anything regarding the warm temperatures in their rooms. -He/she did not notice any warm temperatures in room [ROOM NUMBER]. During an interview on 7/31/24 at 9:39 A.M., the MD said: -The coils (heat exchangers that transfer heat to and from the refrigerant running in the loop between the outdoor A/C condenser and the cooling equipment inside a building) were filled with dirt and lawn debris. -The maintenance staff sprayed a cleaning chemical on the coils and then power washed the coils. -If the coils were filled with dust and lawn debris and that debris would affect how well they worked. -How often he/she and the Maintenance staff cleaned the coils in the individual room climate control units, depended on how hot it got. -In the past three months, the maintenance staff had to pull the individual units for cleaning, at a rate of 10 units at a time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she had to replace the climate control unit in Resident #291's room. During an interview on 7/31/24 at 9:46 A.M., the DON said: -He/she asked facility staff to ask residents in those rooms if they wanted to go to the dining room, where it was cooler. -He/she did not do any monitoring and he/she did not ask the staff to do any monitoring. -He/she did not know where the thermometers that would be used for monitoring temperatures, were located. During an interview on 7/31/24 at 12:49 P.M., the Administrator said: -He/she expected the charge nurse to be notified if the resident rooms were hot. -He/she expected the facility staff to monitor the thermometer in the hallway. -If it felt overly hot or cold and voiced by the residents, then the employees should notify their immediate supervisor or charge nurse and offer residents the opportunity to come out to the dining room. -He/she would expect that an employee would get a thermometer to monitor the temperatures. -He/she would expect new employees to be oriented to the locations of the thermometers. During a phone interview on 8/8/24 at 11:19 A.M., the Care Plan Coordinator said during the orientation, he/she did not go over the location of thermometers with the new DON when the new DON started at the facility about two weeks prior to the survey. 5. Observation on 7/30/24 at 11:01 and on 8/1/24 at 9:30 A. M, 10;20 A.M., 11:52 A.M. and 1:06 P.M., showed a pungent urine odor emanating from the restroom in resident room [ROOM NUMBER]. During an interview on 8/1/24 at 1:07 P.M., the MD said: -He/she could remove the epoxy (a material incorporating such ingredients as carbon and aramid fibers, graphite, epoxies and ceramics, which are corrosion-resistant and used for building materials) paint and clean the floor underneath. -He/she could still smell the urine odor in that room, even though the floor looked like it had been mopped earlier that day. 6. Observation on 7/30/24 with the MD showed: -At 11:02 A.M. there was a buildup of dust on the fan and a buildup of debris under the nightstand in resident room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:15 A.M., there was a buildup of dust and mildew in the filter of the climate control unit in resident room [ROOM NUMBER]. -At 11:16 A.M. there was the presence of a brown substance on the leg of the commode riser in room [ROOM NUMBER]. -At 11:24 A.M., there was a buildup of debris on and cobwebs (spider webs) behind the furniture in resident room [ROOM NUMBER]. -At 11:43 A.M., there was a heavy buildup of dust in the fans in resident room [ROOM NUMBER]. During an interview on 7/30/24 at 11:44 A.M., the MD said the housekeepers were supposed to clean the fans. 7. Observation on 7/30/24 at 12:02 P.M., in the shower room across from the sprinkler room showed: -There were red colored stains on the shower curtain. -The presence of debris and papers under the tub. -A heavy buildup of dust inside the ceiling vent. During an interview on 7/30/24 at 12:06 P.M., the MD said he/she did not know about the stains on the shower curtains. During an interview on 7/30/24 at 12:08 P.M., CNA B said he/she saw the stains on the shower curtain for the first time that morning. 8. Observation on 7/30/24 at 2:21 P.M., showed there was a heavy buildup of dust in the fan in the therapy room. One resident was president in the therapy room at that time. During an interview on 7/30/24 at 2;22 P.M., the Certified Occupational Therapist Assistant (COTA) said the therapy staff have not been on top of cleaning the fans like they needed to. 9. Observation on 7/30/24 at 2:29 P.M., showed at 2:52 P.M., there was a buildup of dust in the vent in the South Hall shower room.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on interview and record review, the facility failed to complete Minimum Data Set assessments (MDS-a federally mandated comprehensive assessment) in a timely manner (within 14 calendar days after admission) for two sampled residents (Resident #291 and Resident #292); and failed to complete an accurate MDS assessment for one sampled resident (Resident #1) out of 14 sampled residents. The facility census was 46 residents. Review of an undated facility policy titled MDS Completion and Submission Timeframes showed the facility was to complete and submit MDS assessments within federal requirements but lacked mention of the specific guidelines. No other policies for MDS assessments were received. The Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated October 2023, showed facilities were to complete and submit resident admission assessments within 14 calendar days of admission to the facility. 1. Review of Resident #291's face sheet on 8/1/24 showed: -An admission on 7/8/24. -Diagnoses including femur fracture, depression, and chronic kidney disease (longstanding disease of the kidneys). Review of the resident's medical record on 8/1/24 showed a lack of a comprehensive MDS admission assessment. 2. Review of Resident #292's face sheet on 8/1/24 showed: -An admission on 7/10/24. -Diagnoses including malnutrition, asthma (a restrictive disease of the airway), dysphagia (difficulty swallowing), and reduced mobility. Review of the resident's medical record on 8/1/24 showed a lack of a comprehensive MDS admission assessment. 3. During an interview on 8/01/24 at 10:14 A.M., the MDS Coordinator said: -He/She was responsible for completing residents' MDS assessments. -Admission assessments should be completed within 14 days of admission. -He/She was behind on completing MDS assessments. -The assessments for Resident #291 and Resident #292 have not been completed and are past due. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/24 at 11:58 A.M., the Director of Nursing (DON) said: -The MDS Coordinator was responsible for ensuring timely completion of MDS assessments. -Admission MDS assessments were to be completed within 14 days of admission. -The facility was behind on MDS assessments. -He/She expected staff to ensure all MDS assessments were completed on time. 46519 4. Review of Resident #1's face sheet showed he/she admitted to the facility with the diagnosis of depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of the resident's Annual MDS dated [DATE] showed: -Section C- Cognitive Patterns had not been filled out/completed. -Section D- Mood had not been filled out/completed. Review of the resident's CHC-PHQ-2 to 9 (inquires about the degree to which an individual had experienced depressed mood and anhedonia (the inability to experience joy or pleasure) over the past two weeks) dated 3/24/24 showed: -The resident had little pleasure in doing things. --The resident experienced these 12-14 days (nearly every day) during the assessment period. -The resident had felt down, depressed, or hopeless. --The resident experienced these 7-11 days (half or more of the days) during the assessment period. -The resident had felt down or had little energy. --The resident experienced these 7-11 days during the assessment period. -The resident felt like he/she was moving or speaking so slowly that other people had noticed. --The resident experienced these 12-14 days during the assessment period. Review of the resident's Quarterly MDS dated [DATE] showed: -Section C- Cognitive Patterns had not been filled out/completed. (continued on next page)

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Holden Manor Health & Rehabilitation	2005 South Lexington Holden, MO 64040

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Section D- Mood had not been filled out/completed. Review of the resident's CHC-PHQ-2 to 9 dated 6/24/24 showed: -The resident had little pleasure in doing things. --The resident experienced these 7-11 days during the assessment period. -The resident had felt down, depressed, or hopeless. --The resident experienced these 7-11 days (half or more of the days) during the assessment period. -The resident had felt down or had little energy. --The resident experienced these 2-6 days (several days) during the assessment period. -The resident had trouble concentrating on things, such as reading the newspaper or watching the television. -The resident felt like he/she was moving or speaking so slowly that other people had noticed. --The resident experienced these 12-14 days during the assessment period. During an interview on 8/1/24 at 11:19 A.M. Certified Medication Technician (CMT) B said the MDS Coordinator was responsible for submitting the MDS assessments. During an interview on 8/1/24 at 11:41 A.M. Licensed Practical Nurse (LPN) B said the MDS Coordinator was responsible for submitting the MDS assessments. During an interview on 8/1/24 at 12:42 P.M. the MDS Coordinator said: -The cognitive and mood assessments were to be completed during each MDS assessment. -He/She was not the MDS Coordinator at the time of the previous MDS submissions. During an interview on 8/2/24 at 11:58 A.M. the DON said: -The MDS Coordinator was responsible for completing the MDS submissions timely and accurately. -He/She would have expected the MDS assessments to be completed accurately for Resident #1 including the sections for cognition and mood, especially with Resident #1's diagnosis of depression. -He/She would be responsible for overseeing that the MDS assessments were completed and accurate.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50579 Based on interview and record review, the facility failed to create person-centered comprehensive care plans to guide facility staff in resident care of new admissions for two sampled residents (Residents #291 and #292) out of 14 sampled residents. The facility census was 46 residents. Review of an undated facility policy titled Comprehensive Person-Centered Care Plans showed the facility was to: -Complete a person-centered care plan for all residents. -Complete the care plan within seven days of a comprehensive Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff for care planning) admission assessment. --The policy lacked direction for staff on when to complete the comprehensive care plan without completion of the comprehensive assessment. The Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated October 2023, showed facilities were to complete a comprehensive, person-centered care plan within seven days of completion of the MDS admission assessment but no later than 21 days after admission. 1. Review of Resident #291's face sheet showed: -Diagnoses including femur fracture (broken thighbone), depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act), and chronic kidney disease (a gradual loss of kidney function over time). Review of the resident's care plan dated 7/22/24 showed: -A focus on Activities of Daily Living (ADL) assistance with no goals and incomplete interventions. -A focus on limited physical mobility with no goals or interventions. -A focus of a nutritional problem with no goals but included interventions. -A focus of impaired vision, complete with goals and interventions. --The care plan lacked information on the diagnoses of depression and chronic kidney disease as well as surgical site care related to the resident's recent surgical intervention of the femur fracture. 2. Review of Resident #292's face sheet showed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses including malnutrition (not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), asthma (a restrictive disease of the airway), dysphagia (difficulty swallowing), and reduced mobility. Review of the resident's care plan dated 7/29/24 showed the care plan lacked information regarding the resident's reduced mobility and ADL assistance. 3. During an interview on 8/1/24 at 10:14 A.M., the MDS Coordinator said: -He/She was responsible for completing residents' comprehensive care plans. -He/She liked the care plans to be completed within 14 days from admission but was unsure on what the regulation was. -He/She was behind on completing comprehensive assessments. During an interview on 8/2/24 at 11:58 A.M., the Director of Nursing (DON) said: -The MDS Coordinator was responsible for completing comprehensive care plans. -The facility was behind in completing comprehensive care plans. -He/She was unsure of how soon comprehensive care plans had to be completed.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to ensure bathing was completed per choice for one sampled resident (Resident #2) and failed to ensure the resident's care plan showed the resident's care needs and abilities regarding Activities of Daily Living (ADL-bathing, dressing, toileting, eating and mobility) out of 14 sampled residents. The facility census was 46 residents. Review of the facility's ADL policy and procedure dated March 2018, showed: -Residents would be provided with care, treatment and services to ensure their ADLs do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADLS are unavoidable. -Appropriate care and services would be provided for resident's who were unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care. -A resident's ability to perform ADLs will be measured using clinical tools, including the Minimum Data Set (MDS- a federally mandated assessment tool to be completed by facility staff for care planning). 1. Review of Resident #2's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including stroke, arthritis (an inflammatory condition of the joints), history of falling, muscle weakness and obesity (excessive weight). Review of the resident's Care Plan dated 11/3/22, showed there was no documentation showing the resident's abilities and need for assistance regarding his/her bathing status. There were no updates to the resident's care plan after this time. Review of the resident's quarterly MDS dated [DATE], showed the resident: -Was cognitively intact. -Had no upper or lower body limitations. -Needed partial to moderate assistance with bathing and dressing. Review of resident's Electronic Bathing/Shower record showed resident received bathing on 7/2, 7/3, 7/4, 7/6, 7/7, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15, 7/16, and 7/21. There were no further bathing/showers documented after 7/21/24. Review of the resident's handwritten Bath Sheets showed the resident received bathing on 7/1, 7/3, 7/12 and 7/15. There were no bath sheets documented after 7/15/24, showing bath/showers were completed. None of the bath sheets were signed by the nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 7/29/24 at 8:02 A.M. showed the resident was sitting in his/her recliner dressed for the weather watching television. He/She was alert and oriented and said: -He/She had a concern with receiving his/her showers. -Nursing staff assisted him/her to the shower and he/she could assist with bathing but needed help. -He/She usually was supposed to shower twice weekly on Sunday and Thursday, but he/she did not receive his/her shower yesterday (on Sunday) and had not had a shower for 8 days as of today. Observation and interview on 7/29/24 at 11:28 A.M., showed the resident was sitting in his/her recliner with his/her eyes closed, resting comfortably. There was no outstanding odors coming from the resident. The resident woke and said he/she still had not received a shower today and was hoping to receive one by the days end. Observation and interview on 7/31/24 at 9:22 A.M., showed the resident was sitting up in his/her wheelchair in his/her room watching television. There were no outstanding odors coming from the resident or his/her room. He/she said that he/she had not gotten a shower this week at all and it had been 10 days now since his/her last shower. The resident said staff was assisting him to change his/her clothes, but he/she would really like to receive a shower today. Observation and interview on 8/1/24 at 9:50 A.M., showed the resident was dressed for the weather and sitting in the dining room in his/her wheelchair. He/she said he/she still had not received a shower and it had now been 11 days since his/her last shower. He/she said in the morning, to keep from having body odor, he/she has been using a wet cloth to wipe himself/herself off at the sink but he/she wanted to take a bath/shower. He/she said the shower aide that usually gave the showers was unable to give it because he/she had been working on the floor and had not been able to give his/her shower. During am interview on 8/01/24 at 9:58 A.M., Certified Nursing Assistant (CNA) A said: -The shower aide was supposed to give the resident baths/showers and residents were supposed to receive showers at least twice weekly. -The other nursing staff were also able to give baths/showers. -It has been rough getting the resident baths completed but the shower aide had been pulled to work on the floor and was not able to give the showers daily. -The nursing staff was trying to get the resident showers completed as they were able. -They usually document the showers under tasks in the electronic medical record for each resident. -They also documented on the bath sheets when they saw a skin issue and provided that documentation to the nurse. -He/She has tried to assist with giving showers and had given some on occasion. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When the shower aide was not working on the floor, he/she was able to get all of the resident showers completed. During an interview on 8/01/24 at 10:13 A.M., CNA B said: -He/She was the shower aide in the facility and this was his/her primary job when he/she was not assisting with providing cares on the floor. -Residents are supposed to get baths at least twice weekly but some residents get baths more often if they choose. He/She said they try to accommodate the residents. -He/She has not been able to get all of the showers done recently because he/she has been pulled to work on the floor. -When he/she had down time, he/she was able to get some showers completed, maybe three to four daily if possible. -He/She usually bathes 12 to 14 people per day and kept a shower assignment sheet that has all of the residents he/she has to bathe. -His/Her normal schedule is Monday through Friday and every other Sunday but it has changed recently. -He/She has been pulled to work on the floor for the past two weeks due to call ins and lack of staff. -When he/she gives showers, he/she documented them in the resident's electronic record and also completed the shower sheet to document if the resident has any skin issues. -On days that he/she was not working, the CNAs were supposed to split giving the showers on each shift. -He/She was working on the floor today so he/she would not be able to get many showers completed. -Management staff have tried to call in staff to assist but usually they don't have anyone to come in. -Regarding Resident #2, he/she had not been able to get his/her showers completed and it had been at least a week since he/she completed his/her shower. -He/She would try to get it done today. During an interview on 8/2/24 at 10:18 A.M., Licensed Practical Nurse (LPN) A said: -They have a shower schedule and residents were supposed to get showers twice weekly, but the shower aide has been pulled to the floor recently due to staffing and it may be that all of the resident showers had not been given as normal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All of the nursing staff are crossed trained to assist with bathing, so any of the CNA staff can give showers. -When the shower aide was pulled to work on the floor, all of the nursing staff have tried to give showers when able, but they have not been able to get all of the showers completed. -He/She only worked on Fridays so she/he was not there during the week to know what showers were/were not given, but he/she tried to keep up with what showers were being given when he/she is in the building and when they have a shower aide available to give the resident showers. -Staff should try to ensure residents are bathed at least once weekly when staffing was low. -They have been trying to hire and retain staff but it had been difficult at times. During an interview on 8/2/24 at 11:58 A.M., the Director of Nursing (DON) said: -Bathing was to be given twice weekly or per resident preference. -He/She was aware baths haven't been given twice weekly. -They have a shower aide, but the shower aide has been pulled to work on the floor a lot lately. -When the shower aide is pulled to the floor, he/she is supposed to track who was being given showers and who has not been given a shower. -They have not been getting showers completed as they should due to staff call ins and lack of staff but they were working to try to improve this. -Residents should receive bathing at least weekly and should not go 11 days without having a bath/shower.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to provide the necessary services to address one sampled the resident's behavioral symptoms in order to manage known behaviors, failed to ensure the resident's behaviors were monitored and documented by staff as they occurred and failed to ensure actions and interventions were implemented upon the first aggressive behavior and subsequently followed up on to ensure resident behaviors toward his/her roommate did not continue for sampled resident (Resident #141) out of 14 sampled residents. The facility census was 46 residents. Review of the facility's Behavioral Assessment, Intervention and Monitoring policy and procedure dated March 2019, showed: -As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, substance use disorder or mental disorder. -As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of the resident's medical record and general observations the resident's usual pattern of cognition, mood and behavior, usual method of communicating needs, typical or past responses to stress, fear, anxiety, frustration and other triggers, and patterns of coping with stress, anxiety and depression. -Nursing staff would identify, document and inform the physician about specific details regarding changes in an individual's mental status, behavior and cognition. -New onset or changes in behaviors would be documented regardless of the degree of risk to the resident or others. -The Interdisciplinary Team would evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a care plan. Safety strategies would be implemented immediately if necessary to protect the individual and others from harm. -Interventions would be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. If the resident was being treated for altered behavior or mood the team would seek and document any improvements or worsening in the individual's behavior, mood and function. -Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #141's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). The document did not include the resident's behavior diagnoses from his/her hospital discharge. Review of the resident's Hospital Medical Record dated 6/7/24 showed the resident: -Had a diagnosis of adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life) with mixed anxiety and depressed mood, and history of stroke with left side weakness. -Had been receiving psychiatric medications for symptoms related to anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus)and depression. -Had a mental health evaluation that showed the resident was referred for adjustment concerns at his/her current placement. The resident reported that he/she was taking his/her psychiatric medications daily and they seemed to be working well. The evaluation showed the resident was alert and oriented, demonstrated adequate judgement and insight and had no ideations of hallucinations, delusions, suicidal or homicidal ideations at that time. The resident was provided supportive consultation. Review of the resident's Entry Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 7/11/24, showed the resident was admitted to facility on 6/28/24. ARD dated 7/11/24 showed the MDS was incomplete showed 20 days overdue. Documentation showed the resident: -Was cognitively intact with no delirium, disorganized thought or altered level of consciousness. -Had little interest, feeling bad about self, trouble concentrating and sleeping and social isolation. -Had no verbal or physical behavioral symptoms, hallucinations or delusions. Review of the resident's Care Plan dated 6/30/24, showed the resident had potential to be verbally/ physically aggressive to staff related to ineffective coping skills, and mental/emotional illness. Interventions showed staff would: -Monitor behaviors (specify the frequency) and document observed behavior and attempted interventions. -Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. -Provide a Psychiatric/Psychogeriatric consult as indicated. -When the resident became agitated, staff would intervene before agitation escalates; guide the resident away from the source of distress; engage calmly in conversation; If response was aggressive, staff were to walk calmly away, and approach the resident later. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plan did not show the resident had adjustment disorder, anxiety and depression and what symptomatic behaviors were exhibited when the resident was distressed, it did not show interventions to address the resident's adjustment disorder and how the facility was managing these behaviors, based on the information provided in his/her hospital discharge records. Review of the resident's Admission Trauma Neglect Screening dated 7/1/24 showed a score of 7.0 (on a scale of zero to 7, zero was no trauma). The screening showed the resident: -Had exposure to any form of trauma (including natural disaster, community violence/war, serious injury or illness, serious accident, assault with a weapon, impoverishment, homelessness, persistent bullying). -There were factors that increase the resident's vulnerability (dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of being exploited, for example, giving away money or personal items). -Had a history of substance use/abuse (alcoholism, drug abuse including prescription drug abuse/narcotic seeking) and/or compulsive behavior (uncontrolled or poorly controlled gambling, overeating, exercise, obsessions). -Had a psychiatric history and/or present mental health diagnosis, including psychotic and possible misinterpretation of events and the intentions of others. -Had a depressive illness and/or present signs/symptoms of depression/mood distress. Low self-esteem, isolation and withdrawn behavior. Complaints of chronic pain, illness, fatigue and/or persistent anger, fear and/or anxiety. -Had a history or presence of dysfunctional behavior (provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior) including roaming/wandering into peer's rooms/personal space. -Had a history of mistreating others and/or information presented by a reliable source indicates a history of mistreating others. -The document showed the risk measure for likelihood for psychiatric, behavioral and/or physical symptomology related to trauma showed the resident had some symptomology. Notes showed the resident had a long history of making poor decision in life. He/She had expressed that he/she has abused both alcohol and drugs which has contributed to him/her being incarcerated for years. Review of the resident's Behavior Notes showed: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/23/24, staff documented the resident was verbally aggressive, cursing, making derogatory statements and speaking in a forceful tone. The resident said motherfucker fucking fuck and making statements I am going to lose my shit and get the fuck out of here referencing himself/herself and making statement to nurse, after the resident's roommate (Resident #21) reported the resident had been mishandling his/her food items in the refrigerator in their room and had been leaving the bedroom door open during the night while he/she was trying to sleep. Non-pharmacological interventions showed the nurse attempted to mediate the situation with both roommates advising both speak to each other kindly and respectfully. The resident refused to speak to his/her roommate regarding having door closed at night stating, I don't talk, I lose my shit! You can't keep me in this cell like this. The nurse explained to resident, resident rights and this was not prison. The resident continued to curse at the nurse regarding his/her roommate and the situation and stated, You are just a fucking nurse, you have nothing to do with this. I wanna talk to the director. The resident also reported no preference to the room door being opened and admitted to leaving the door open at night to intentionally irritate his/her roommate. The resident was also upset regarding his/her roommate having a recliner and requested the facility provide a recliner for him/her as well. The nurse explained to the resident that the facility does not provide lounge furniture and the resident would need to provide his/her own recliner. The nurse advised both resident's he/she would notify the facility management staff of this conflict and for this night, the nurse would not close the door but would recommend the resident to close door. The nurse documented he/she left the resident's room due to the resident's ongoing verbal aggression and volatility. The resident did not close the door and his/her roommate did not express any further frustration this night. Intervention failed. Duration of Time for Non-Pharmachological Intervention to determine success or failure: This nurse spent approximately 10 minutes with resident and roommate attempting to mediate this conflict. -On 7/25/24, staff documented the resident was calling his/her roommate derogatory names such a [NAME]. The nurse entered the resident's room to provide his/her roommate's evening medications. The nurse greeted the resident upon entering and upon leaving the room he/she spoke to the resident stating, Sleep well, have a good night. The resident said it is kinda hard to sleep with [NAME] over there banging around. The nurse stated to resident, Do not call him/her names, that is not nice. He/She is going to bed. Stop calling him/her names and proceeded to leave room. The resident's reaction to attempted intervention was further behaviors. The Intervention failed. -On 7/25/24 at 12:30 A.M., staff documented the resident intentionally provoked conflict toward his/her roommate. The nurse documented the resident's roommate called for the nurse due to resident had opened the door. Upon entering the room, the resident's roommate told the nurse that upon completion of the meeting earlier in the day it was agreed that their room door would be closed from 11:00 P.M. to 11:00 A.M. and kept open at all other times. When the nurse questioned the resident on opening door, the resident again began calling his/her roommate [NAME] and complaining regarding his/her roommate going to bed late. Non-pharmacological interventions showed the nurse asked the resident to stop provoking his/her roommate and stated if the agreement was the door was to be closed from 11:00 P.M. to 11:00 A.M., then that is when the door will be closed. The nurse told the resident to stop calling names, and stop being mean. The nurse told the resident he/she would close the door and it would stay closed. The nurse then left and closed the door. The door remained closed this shift. The intervention was successful. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Manor Health & Rehabilitation	2005 South Lexington Holden, MO 64040

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/27/24, staff documented the resident was making derogatory remarks, using abusive language and disturbing other residents. The resident was loudly drawing attention to himself/herself while in the hallway while residents were sleeping. The nurse advised the resident to return to his/her room if he/she continued to be disrespectful and disruptive to other residents. The resident returned to his/her room and did not leave his/her room again. The intervention was successful. Observation and interview on 7/29/24 at 7:43 A.M., the resident was laying on his/her bed. He/She was dressed for the weather, alert and oriented. There was a privacy curtain pulled between him/her and his/her roommate (who was not in the room). The resident said: -He/She and his/her roommate did not get along and both him/her and his/her roommate have approached staff to get them to separate them or to move to another room but management staff told him/her there were no other rooms available (he/she said he requested to move to another room last week). -He/She tried to stay out of his/her roommate's way and did not interact with him/her much. Review of the resident's Social Services Note dated 8/1/24, showed: -On 7/29/24 the Administrator and other management staff spoke with the resident in an attempt to find a way to resolve the issue between the resident and his/her roommate. A discussion was had about the option to move to another room, but the resident did not want to move to any of the available beds. The resident and his/her roommate decided that they would prefer to remain together and each apologized for their behavior. They were both instructed to leave the room and to seek assistance from staff if a conflict were to develop again. Both agreed to do so. Review of the resident's Care Plan on 8/1/24 showed there were no updates to the resident's care plan from 6/30/24. The care plan did not show the resident's prior psychiatric history, substance abuse, prior dysfunctional behaviors, current behaviors and specifically those behaviors the resident had toward his/her roommate and interventions implemented to mitigate those behaviors. There were no indications that a psychological referral for counseling services was implemented or any supportive services to assist with managing his/her anger and volatility on an ongoing basis. Review of the resident's Medical Record on 8/1/24 showed there was no additional documentation showing any referrals for behavior management, counseling/therapeutic services, or outside supportive behavioral services were implemented once the resident began expressing dysfunctional behaviors. There was no documentation showing any attempts to intervene timely after the resident's first behavioral incident with his/her roommate. Observation and interview on 8/01/24 at 9:39 A.M., showed the resident was in his/her wheelchair in the hallway. The resident said: -The issues that he/she had with his/her roommate had to do with him/her being able to sleep at night and his/her roommate making noise at night because he/she liked to stay up late. -His/Her roommate would stay up late typing at 1:00 A.M., and it wakes him/her up and keeps him/her up. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nursing and management staff spoke with him/her about how they were getting along. He said some days were good and there were no problems, and other days it would occur again. -He/She and his/her roommate have had verbal incidents I get hot headed I do have a temper but they have not had any physical incidents. -Where he/she comes from, you don't make a lot of noise at night when you see someone was sleeping. He/She said it was hard for him/her to sleep at night and he/she was also having pain that was finally addressed. -Earlier this week, on 7/29/24, they had an incident and he/she threw a shoe at the privacy curtain in the direction of his/her roommate, but it did not hit his/her roommate. He/She threw the shoe because the resident was typing at 2:00 A.M. and he/she was letting his/her roommate know that he/she was trying to sleep and to stop. He/she said he/she knew that it would not hit his/her roommate. -A couple days after this incident, the administrative staff spoke with him/her and told him/her that he/she could not have that type of aggression in the facility. -He/She said he/she still wanted to change rooms. 2. Review of the Resident #21's quarterly MDS dated [DATE], showed the resident was cognitively intact. During an interview on 7/30/24 at 12:57 P.M., the resident said: -Regarding his/her roommate, Resident #141. -He/She and his/her roommate had had a problem last week when his/her roommate slammed his/her wheelchair against his/her tray table for no reason and against his/her bed. He/She had not provoked Resident #141, but the resident has some anger problems and behaviors and does not get along with people. -On Monday at around 6:30 A.M., he/she was laying down in bed resting and the privacy curtain was pulled. Resident #141 threw a book at him/her which hit the curtain, but it did not hit him/her. -He/She had not provoked his/her roommate or said anything to him/her to warrant his/her behavior. -Most of their issues had to do with keeping the room door closed. He/She likes the door closed between 11:00 P.M. and 11:00 A.M. and his/her roommate wants the door open. -They decided to compromise and will keep the door open between 11:00 A.M. to 11:00 P.M. and closed between 11:00 P.M. to 11:00 A.M. 3. During an interview on 8/1/24 at 9:58 A.M., Certified Nursing Assistant (CNA) A said: -He/She was aware that Resident #141 had problems with his/her roommate. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The issues between the roommates usually occurred at night and he/she was not aware of any incidents regarding the resident occurring during the day. -Usually they received information about any resident incidents during resident rounds at shift change. -It had been reported that the resident had been calling his/her roommate names and was keeping his/her roommate awake at night. -Usually if there are any incidents or behaviors regarding residents, they notify the Charge Nurse and management (DON and Administrator). -The facility management staff have spoken with both the resident and his/her roommate and he/she was told their conflict had been resolved. -He/She had not seen the resident have any negative behaviors toward any of the other residents, his roommate or staff. -One of the interventions was to move the resident's bed to be placed against the wall to cut down on conflict with his/her roommate and this seemed to resolve some of the resident's concerns. -Additional interventions they have been given is to try to separate him/her from the conflict and try to talk to him/her to get him/her to calm down when he/she becomes irritated/angry. -He/She was not aware if the resident participated in any counseling services. During an interview on 8/02/24 at 10:18 A.M., Licensed Practical Nurse (LPN) A said: -He/She was notified that Resident #141 and his/her roommate had been having disagreements and different preferences regarding their room and lighting. -There were only a couple of incidents between the resident and his/her roommate that were more verbal in nature. -He/She was not aware of exactly what had occurred between the resident and his/her roommate on 7/29/24. -He/She knew that management staff spoke with both residents about their conflicts and tried to mitigate, but he/she was not sure that there was anything that had formally been put in place behaviorally for either resident. -The resident had also had inappropriate behaviors with female staff and management staff determined that the female staff would need to go in to provide care to him two at a time. -These behavioral interventions should have been in the resident's care plan. -He/She did not think that the resident was receiving any counseling/therapy or behavioral management. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-(After looking in the resident's medical record) he/she did not see anything in the resident's care plan about any referrals for or actual therapy/counseling services and there was no information regarding his behaviors with his/her roommate. -He/She was unaware of the resident's request to move to another room. -He/She would expect to see documentation about the resident's behaviors in his/her care plan. -If the resident's behaviors continued, they should look at separating the resident from his/her roommate. -On 7/29/24 there was a note showing the Social Service Director and Administrator met with the resident to discuss a room change. During an interview on 8/2/24 at 10:52 A.M., the Social Service Designee (SSD) said: -He/She was familiar with the resident and his/her roommate. -The resident's roommate had several roommates before the resident was admitted to the facility, but at the time the resident came, the roommate was in a room by himself/herself. -Once the resident was admitted , they found they had similarities and asked to room together. -After the resident moved into the room they began having conflicts related to their sleep patterns and preferences and they would complain about each other and instigate each other. -He/She was made aware of the resident's behaviors since his/her admission and was not aware that any interventions had been put in place regarding conflicts with his/her roommate. -He/She was out of the facility from 7/2/24 through 7/23/24 and returned to work on 7/29/24. -On 7/29/24, staff informed him/her that the resident's roommate reported that earlier that morning or the night before, the resident had thrown a book at him/her and the book had hit the privacy curtain. -He/She went to talk with the resident's roommate and he/she told him/her that he/she did not want to room with the resident anymore, that the resident had done several things since moving into his/her room like rearranging his/her food in his/her personal refrigerator, banging his/her wheelchair against his/her bed, keeping the door open at night and the roommate gave him/her a handwritten paper with these complaints documented (the complaints started on 7/17/24). The roommate also reported that the resident had thrown a book that hit the privacy curtain this morning. He/She advised the roommate to stay away from Resident #141 and to report any additional conflict to the management staff. -He/She went to speak with the resident about the incident and he/she acknowledged throwing the book. The resident said he/she would stay away from his/her roommate and agreed to report any conflict to management staff. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She then informed the Director of Nursing (DON) and Administrator about the issue and they spoke with both residents. At that time they were looking at moving one of them out of the room. -The incident should have been documented in the resident's medical record at the time it occurred and there was an incident report documented but he/she could not find it currently. -Both residents were offered the choice to move to another room and they both declined to move. They apologized to each other and said they would not have further difficulties and would talk with management staff if they had further conflicts. -Since this mediation occurred, the residents seemed to have resolved their issues and there have been no further behaviors from either resident. -He/She was not sure what additional action they could have taken other than to keep them away from each other on 7/29/24. -To his/her knowledge, they did not document any behavior monitoring on either resident and he/she did not take any further action to ensure the resident was monitored to ensure there was no further behaviors. -The resident had mental health diagnoses, but he/she was unaware if there have been any therapy or counseling referrals set up for him/her. -They have a vendor for counseling services that comes in weekly and the resident had signed the consent to receive services but Resident #141 had not seen the therapist. -They probably should have monitored the residents after the incident occurred and it should have been care planned. During an interview on 08/02/24 at 11:58 A.M., the DON said: -He/She was aware of the resident and his roommate having conflicts prior to this but did not know in detail what occurred before 7/29/24. -On 7/29/24, the resident threw something towards his/her roommate and had banged his/her wheelchair against his/her roommate's bed. -He/She was aware of the resident's diagnoses and his behavioral history was documented in his/her medical record related to his/her history of aggression and adjustment disorder. -If you know of the residents diagnoses and of (him/her) having an incident of aggression, he/she would probably want to implement psychiatric services and counseling services after the first behavioral incident. -On 7/29/24, he/she would have expected staff to separate the residents and to implement behavior monitoring of both residents to begin immediately and on every shift for at least three days after the incident occurred. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The incident should have been documented in the resident's medical record. -He/She would have expected staff to put a behavior plan in place to try to mitigate to resident's behaviors and prevent the escalation of his/her behaviors. -All of these interventions should have been documented in the resident's care plan in detail.

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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. 46519 Based on interview and record review, the facility failed to ensure residents' monthly Medication Regimen Review (MRR-thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) were completed by the pharmacy to ensure irregularities were identified so they could be acted upon for one sampled resident (Resident #1) out of 14 sampled residents. The facility census was 46 residents. Review of the facility's policy titled MRRs dated May 2019 showed: -The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. -The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medications errors, and other irregularities. -Copies of MRR reports, including physician responses, were maintained as part of the permanent medical record. 1. Review of Resident #1's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Malignant Neoplasm of Unspecified Site of Left Breast (breast cancer). -Personal History of Transient Ischemic Attack (TIA- a mini stroke which happens when there is a temporary disruption in the blood supply to part of the brain). -Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). -Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats). Review of a Listing of Residents Reviewed with No Recommendation dated 2/5/24 completed by the Pharmacy Consultant (PC) A showed the resident was not on this list, indicating a recommendation for the resident was made for the month of January 2024. Review of a Listing of Residents Reviewed with No Recommendations dated 3/31/24 completed by PC A showed the resident was not on this list, indicating a recommendation for the resident was made for the month of March 2024. Review of a Listing of Residents Reviewed with No Recommendations dated 4/30/24 completed by PC A showed the resident was not on this list, indicating a recommendation for the resident was made for the month of April 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Electronic Medical Record (EMR) on 7/30/24 showed: -No documentation was found related to the MRRs for the months of January 2024, March 2024, and April 2024. -No documentation was scanned into the resident's EMR related to the months of January 2024, March 2024, and April 2024. During an interview on 8/1/24 at 11:42 A.M. Licensed Practical Nurse (LPN) B said: -The nurses were in charge of completing the MRRs. -He/She would fax the recommendations, if needed, and once a response was received by the physician, then he/she would put in a nurse's note and change orders if indicated. -The DON was responsible for ensuring completion of the MRRs. -If there was not a note in place or the MRR was not scanned into the resident's EMR, then there would be no way to verify the completion of the recommendation. -The facility was playing catch-up with the MRRs. During an interview on 8/2/24 at 11:58 A.M. the Director of Nursing (DON) said: -The PC was responsible for emailing the MRRs to the facility. -Once received, he/she was responsible for printing the MRRs and would give or send a copy to the facility's physicians. -Once completed, the staff person in charge of medical records was responsible for scanning the recommendations into the residents' EMRs. -The nurses were responsible for making any order changes related to the MRRs. -He/She expected the nurses to document a note for any order that was made or changed. -He/She expected staff to keep better documentation and record of the MRRs.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to complete recommended Gradual Dose Reduction (GDR- involves the stepwise tapering of a dose of medication to determine if symptoms, conditions, or risks can be managed by a lower dose or the medication can be discontinued altogether) and/or (MRR-thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for psychotropic medications (drugs which affect psychic function, behavior, or experience) for three sampled residents (Resident #1, #18 and #33) out of 14 sampled residents. The facility census was 46 residents. Review of the facility's policy titled MRRs dated May 2019 showed: -The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. -The MRR involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medications errors, and other irregularities. -Copies of MRR reports, including physician responses, were maintained as part of the permanent medical record. Review of the facility's policy titled Tapering Medications and Gradual Dose Reduction (GDR) dated April 2007 showed: -Residents who used antipsychotic drugs should receive GDRs and behavioral interventions, unless clinically contraindicated, in an effort to discontinue the medications. -Within the first year after a resident was admitted on an antipsychotic medication or after the resident had been started on an antipsychotic medication, the staff and practitioner should attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. 1. Review of Resident #1's Face Sheet showed he/she admitted to the facility with the diagnosis of depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/16/23 showed the resident was cognitively intact. Review of a Physician Recommendation dated 5/30/24 completed by Pharmacy Consultant (PC) A showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had been taking Venlafaxine (Effexor- used to treat depression) Extended Release (ER) 24 hour 150 milligrams (mg), since September 2023 and a GDR needed to be attempted. -The facility had not responded to this recommendation. Review of the resident's Physician Order Sheet (POS) dated July 2024 showed the resident had an order for Venlafaxine ER 24 hour 150 mg, give one tablet by mouth one time a day. 2. During an interview on 8/1/24 at 11:45 A.M. Licensed Practical Nurse (LPN) B said: -When a GDR was recommended, he/she would reach out to the doctor and verify the recommendation. -He/She would then place a note in the resident's medical record with the pertinent information related to the GDR. -He/She had not remembered a GDR recommendation for the resident. -He/She reviewed the resident's chart and could not verify the recommendation had been completed or signed off by the physician. -The Director of Nursing (DON) was responsible for verifying the completion of all pharmacy recommendations. During an interview on 8/1/24 at 12:48 P.M. the MDS Coordinator said: -There would be notes in place in a resident's medical record if a GDR was followed-up on and the physician's response. -He/She was unsure if the resident's GDR had been completed or what the physician's response had been. -If the GDR had been completed, he/she would have expected to see a nurse's note in the resident's medical record. -The DON was responsible for ensuring all pharmacy recommendations were completed. During an interview on 8/2/24 at 11:58 A.M. the DON said: -Once a GDR recommendation was made, he/she would give a copy to the doctor and monitor for the completion of the recommendation. -Medical records was responsible for scanning the signed recommendations into the residents' medical charts. -The nurses were expected to make a note in the residents' medical charts once a recommendation was completed and if any new orders were received. -He/She could not find the documentation of the resident's GDR completion. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	33409 2. Review of Resident #18's Admission Face Sheet showed the following diagnosis: -Had diagnoses including Depression (is classified as a mood disorder. It may be described as feelings of sadness, loss, or anger that interfere with a person's everyday activities). -Autism (refers to a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech). -Affective Mood Disorder-is a mental disorder characterized by dramatic changes or extremes of mood. Review of the undated facility list of residents from the consulting pharmacy's MRRs showed there was no documentation found for the resident's MRR for February 2024. Review of the resident's care plan revised on 2/12/24 showed: -Administer psychotropic medication as ordered by physician. -Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly. Review of resident's MRR dated 4/30/24 with recommendations showed: -The resident had a recommendation to the physician related to Risperdal (an atypical antipsychotic drug. It is sometimes used to treat depression), the medication lacked the allowable diagnosis to support use. -This was faxed to the resident's physician and there was no written response from physician. Review of the resident's Quarterly MDS dated [DATE], showed the resident: -Was severely cognitively impaired. -Had diagnoses including Depression, Autism and stroke. Review of resident's MRR dated 5/30/24 with recommendations showed: -The pharmacist had a recommendation to the physician, which required an allowable diagnosis for use of Divalproex, (is anticonvulsant, is used to treat seizure disorders, certain psychiatric conditions, such as manic phase of bipolar disorder) and it was listed for mood disorder. -There was no documentation from the resident's physician related to the pharmacy's request. Review of the resident's MRR dated 5/30/24 with recommendations showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a recommendation to the physician, required a allowable diagnosis for use of Risperidone. -There was no documentation from the resident's physician related to the pharmacy's request. Review of the resident's Physician Order Sheet (POS), July 2024 showed: -Risperidone 1 millagram (one tablet, Give 1 tablet orally at bedtime related to Depression. -Divalproex SOD DR 500 mg, give one tablet orally every 12 hours related to Affective Mood Disorder. -Divalproex SOD DR Give with 250 mg tab to equal 750 mg). -Divalproex SOD DR 250 mg TA Give 1 tablet orally every 12 hours related to Mood Disorder. 3. Review of Resident #33's Admission Face Sheet, showed the resident: -Had diagnoses including dementia with behavioral disturbance (is commonly associated with memory loss) Alzheimer's dementia (is a type of dementia that affects memory, thinking, and behavior), depression, and anxiety (Feelings of panic, doom, or danger , Sleep problems or feeling tired). Review of the undated facility list of residents from the consulting pharmacy's MRRs showed there was no documentation found for the resident's MRR for February 2024. Review of resident's a MRR dated 3/31/24 with recommendations showed: -The resident had a recommendation to the physician related to Zyprexa, the medication lacks the allowable and appropriate diagnosis to support use. Had signature of the physician as reviewed on 4/14/24. Had no documentaion related to a change of diagnosis was made. Review of the resident's care plan on revised on 5/29/23 showed: -The resident uses antidepressant and antipsychotic medications related to depression and mood disorder. -The resident will be free from discomfort or adverse reactions related to antidepressant/antipsychotic therapy through the review date. -Administer medications as ordered by physician. -The pharmacy consultant to review medication monthly. Review of the resident Quarterly MDS dated [DATE], showed the resident: -Severely cognitive impaired. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had diagnoses including dementia with behavioral disturbance, Alzheimer's, depression, and anxiety. Review of the resident's POS, dated 8/1/24, showed the following physician's orders: -Zyprexa Oral Tablet 7.5 milligrams (mg) (an antipsychotic medication) Give one tablet by mouth at bedtime related to Anxiety disorder. (no change in diagnosis per pharmacy MRR request): 4. During an interview on 7/31/24 at 9:16 A.M., LPN B said: -The pharmacist came to the facility monthly and completed MRRs for all residents. -He/she would then call the physician or fax pharmacy recommendation to the resident physician for review. -Once a response was received by the physician, then he/she would put in a nurse's note with any change in medication orders or if no changes at this time. -The DON was responsible for ensuring completion of the MRRs. -The resident had not had any recent changes to his/her medication. During an interview on 8/2/24 at 11:58 A.M. the DON said: -MRRs were completed monthly by a contracted pharmacy consultant company. -The reports and recommendation were to be emailed to DON for review. -He/she would then print and send to the resident's physician for review for any recommendation. -The physician would write his/her response and sign the form. -The medical records staff and DON would be responsible for ensure have recommendation were documented and to ensure have current physician orders scan into the resident medical record. -He/she was not aware the pharmacy MRR/GDR recommendations were not acted upon for Resident #18 and Resident #33's medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on observation, interview, and record review, the facility failed to ensure medications brought in by one sampled resident's (Resident #33) family member was labeled and stored correctly in the Certified Medication Technician (CMT) cart out of 14 sampled residents; failed to ensure other medications in the CMT cart were stored and labeled appropriately and failed to dispose of expired medical supplies found in the medication room which had the potential to affect all residents in the facility. The facility census was 46 residents. Review of the facility's policy titled Labeling of Medication Containers dated [DATE] showed: -Medication labels were to be legible at all times. -Labels for individual resident medications included all necessary information, such as: --The resident's name. --The prescribing physician's name. --The name, address, and telephone number of the issuing pharmacy. --The name, strength, and quantity of the drug. --The prescription number, if applicable. --The date the medication was dispensed. --Appropriate accessory and cautionary statements. --The expiration date, when applicable. --Directions for use. -Medications were not to be transferred between containers. Review of the facility's policy titled Medications Brought to the Facility by the Resident/Family dated [DATE] showed: -The facility discouraged the use of medications brought in from outside and would inform residents and families of that policy as well as applicable laws and regulations. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a medication was not otherwise available and/or it was determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the Director of Nursing (DON) services and nursing staff, with support of the attending physician and consultant pharmacist, should check to ensure that: --State laws and regulations allow such use. --The contents of each container were labeled in accordance with established policies. --The contents of each container had been verified by a licensed pharmacist. Review of a facility policy titled Pharmacy Services-Role of the Consultant Pharmacist dated [DATE] showed the consultant pharmacist should provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services, including procedures to support resident quality of life such as safe, individualized medication administration programs. 1. Review of Resident #33's face sheet showed he/she admitted to the facility with the following diagnoses: -Neurocognitive Disorder with Lewy Bodies Disorder (a type of dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses) characterized by changes in sleep, behavior, cognition, movement, and regulation of automatic bodily functions). -Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE] showed: -The resident was severely cognitively impaired. -The resident had a short term and long-term memory problem. Review of the resident's Physician Order Sheet (POS) dated [DATE] showed: -An order for Causticum (used in homeopathy (a medical system based on the belief that the body can cure itself) for a broad spectrum of conditions) 200c, 10 drops under the tongue twice daily for incontinence). -SeaBD one capsule (a homeopathic medication used as an antioxidant and has anti-inflammatory benefits), chew and then spit out every night at bedtime then mouth wash. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nuadapt one capsule (a unique blend of botanicals and nutrients that supports the stress response, improves cognition and in particular, promotes cortisol (a hormone that assists in regulating the body's stress response, helping control metabolism, and suppressing inflammation) balance), open and mix with applesauce at least 30 minutes before breakfast and supper daily. -Hyoscyamus (used in the ancient times to treat pain or insomnia (persistent problems falling and staying asleep) 30 milliliters (ml), give 10 drops under the tongue three times a day. -NuxVom (a homeopathic medication with purported benefits for a wide range of conditions including heart disease and cancer) 200c drops, administer 10 drops under the tongue every night at bedtime. -Cardiovascular (referring to the heart and blood vessels) Research Magnesium (used for heart health), one teaspoon (tsp.) mixed with applesauce at least 30 minutes before breakfast daily. Observation on [DATE] at 1:53 P.M. of the resident's medications stored in the CMT cart showed: -A dropper bottle of Causticum inside a pill bottle with the label indicating the medication had five refills available before [DATE]. -A SeaBD bottle with no label or expiration date. -A Nuadapt bottle with no label and the expiration date was illegible. -A dropper bottle of Hyoscyamus only labeled with pharmacy name and use as directed. -A dropper bottle of Nux Vomica only labeled with the pharmacy name and use as directed. -A bottle of Magnesium solution, unlabeled, and had expired [DATE]. During an interview on [DATE] at 1:53 P.M. CMT A said the resident's family had just brought in the magnesium solution and someone should have checked the expiration date before accepting the medication. 2. Observation on [DATE] at 1:53 P.M. of the CMT medication cart showed: -A budesonide and formoterol fumarate (used to help control symptoms of asthma (a condition in which a person's airways become inflamed, narrow, and swell which makes it difficult to breath) and improve lung function) unlabeled and not in any storage bag/box/or container. -A fluticasone propionate (used to treat allergies or non-allergic nasal symptoms) nasal spray stored outside of its original container without a visible expiration date on the bottle. -A bottle of whole produce fruits balance of nature dietary supplements (used to support general well-being) without a resident label or expiration date. -A bottle of whole produce veggies balance of nature dietary supplements (used to support general well-being) without a resident label or expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on [DATE] at 2:21 P.M. of the medication storage room showed: -Four intravenous (IV) start kits that expired on [DATE]. -Four IV start kits that expired on [DATE]. -One box of safety blood collection sets and [NAME] adapters (connection between syringes and needles) which expired on [DATE]. 4. During an interview on [DATE] at 11:20 A.M. CMT B said: -All medications were to stay in the original container. -Medications should be labeled with the medication name, resident's name, quantity, and expiration date. -Any unlabeled medications or supplements should be discarded. -If the expiration date of a medication could not be found or was illegible, then the medication should be disposed of. -If a family member brought in medication for the resident to use while at the facility and was expired, he/she would inform the nurse and have the nurse speak with the family. -There should not be any expired supplies stored in the medication room. During an interview on [DATE] at 11:48 A.M. Licensed Practical Nurse (LPN) B said: -All medications were to stay in the original container. -Any unlabeled medication or supplements should be discarded because there would be no way to verify who the medication was for or if it's the correct medication for the resident. -Any medications brought in by family members needed to be labeled and have a verification slip. -Medications should be labeled with the resident's name, dose, frequency of use, description of use, expiration date, and the quantity. -If a resident's family member brought in an expired medication, he/she would not accept the medication. -There should not be any expired supplies in the medication room. During an interview on [DATE] at 12:51 P.M. the MDS Coordinator said: -Any medications brought in by family members needed to be approved by the physician and verified by the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All medications needed to be stored in the original container. -If he/she found an unlabeled medication in the medication cart, then he/she would discard the medication. -All medications and supplements needed to be labeled with the resident's name, route of administration, directions of use, expiration date, and open date. -Any medications that did not have an expiration date or the expiration date was illegible needed to be discarded and re-ordered. -A staff person that accepts medications brought in by families needed to verify that it was labeled appropriately and not expired. -Expired medical supplies should not be stored in the medication room. During an interview on [DATE] at 11:58 A.M. the DON said: -The facility allowed family members to bring over the counter and prescription medications to the facility. -Any medications brought in by family members needed to be verified and unopened. -Resident #33's medication usually came from a different pharmacy and was sealed in a prescription bag when given to the facility by Resident #33's family member. -All medications should be stored in the original container. -Medications brought in my families needed to be labeled just like a pharmacy label. -He/She expected staff to discard and reorder any medications that were not labeled appropriately. -He/She expected staff to discard and reorder any medications that were expired or if the expiration date was illegible. -The staff person should not have accepted the bottle of Magnesium Solution brought in by Resident #33's family member due to it being unlabeled and expired. -Expired medical supplies should not be stored in the medication room.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 19916 Based on observation, interview and record review, the facility failed to ensure recipes were available for dietary staff to use while making pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) waffles, chicken tenders and pureed mixed vegetables; and the facility failed to ensure the recipes for the pureed versions of those items were detailed enough to include the amounts of liquids and/or thickener that were needed to make the recipe properly. This practice potentially affected five residents with pureed diets. The facility census was 46 residents. 1. Observation on 7/29/24 at 8:17 A.M., showed Dietary [NAME] (DC) A made pureed waffles without having the recipe book open. During an interview on 7/29/24 at 8:41 A.M. the Dietary Director said he/she was not able to print off the recipe for pureed waffles because the computer was down. Review of the pureed recipe for waffles on 7/29/24 showed: -The recipe was dated 9/15/17. -Remove desired number of servings and add nutritive liquid (milk, broth, etc.). Blend until desired consistency and add approved thickener to achieve desired consistency if needed. During an interview on 7/29/24 at 8:46 A.M., the Dietary Director said the recipe was inadequate because the recipe did not state how much liquid or how much thickener to add per the number of servings of waffles. 2. Observation on 7/29/24 at 10:59 A.M., showed DC A made pureed chicken tenders without having the recipe book open. DC A added an unmeasured amount of chicken base to the processed chicken, then added water to the food processor. DC A processed the chicken into a pureed form. Review of the pureed recipe for chicken tenders on 7/29/24 showed: -The recipe was dated 9/15/17. -Remove desired number of servings and add nutritive liquid (milk, broth, etc.). Blend until desired consistency. Add approved thickener to achieve desired consistency if needed. The recipe did not state how much liquid or thickener to add per the number of servings that needed to be pureed. 3. Observation on 7/29/24 at 11:11 A.M., showed: - DC A was making pureed french fries. - DC A added cold milk to pureed fries. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- DC A did not have the recipe book opened to look at the recipe for pureed french fries. 4. Observation on 7/29/24 at 11:31 A.M., showed: - DC A pureed the mixed vegetables - DC A did not have a recipe book open. Review of the pureed recipe for the mixed vegetable on 7/29/24 showed: -The recipe was dated 11/11/15. -Remove desired number of servings and add nutritive liquid (milk, broth, etc.). -Blend until desired consistency. Add approved thickener to achieve desired consistency if needed. The recipe did not state how much liquid or thickener to add per the number of servings that needed to be pureed. During an interview on 7/29/24 at 12:08 P.M., the Dietary Director said: -He/she did not have printed recipes for pureed french fries. -There was a little bit of chunk in the pureed french fries. -He/she did not know why they did not have a recipe for the pureed french fries. and -He/she expected facility staff to use the recipes if they were available for use. During an interview on 7/29/24 at 12:43 P.M., DC A said he/she did dnot use the recipe book to make the pureed items. and the Dietary Director could taste some of the pureed items. During a phone interview on 8/5/24 at 3:45 P.M., the Consultant Registered Dietitian (CRD) said: -He/she expected the dietary cooks to use the recipe book, while they made pureed food. -It has been difficult to have an in-service because gathering the dietary staff was difficult to get together for a functional in-service. -Most of the time, he/she spoke with the cook regarding food consistency and temperatures. During a phone interview on 8/6/24 at 2:21 P.M., the Consultant RD said the recipes for the pureed items did not provide enough information and the recipes for the pureed items could be made more specific.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview and record review, the facility failed to ensure the pureed french fries were palatable and failed to ensure the dinner rolls were cooked properly for the lunch meal on 8/2/24. The facility census was 46 residents. 1. Review of Resident #15's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by the facility for care planning) dated 12/20/23, showed the resident was cognitively intact. Review of Resident #31's quarterly MDS dated [DATE], showed the resident was cognitively intact. Review of the Resident Council minutes dated 12/5/23 showed: -Resident #15 said the food was not good. -Resident #31 said the food was bad. Review of the Resident Council Minutes dated 1/2/24 showed Resident #15 said the food was still not good. 2. Observation on 7/29/24 at 11:16 A.M., showed DC A pureed French Fries in the food processor, DC A added cold milk to the fries in the food with no recipe book used at that time. DC A did not taste the pureed fries after the fries were finished being processed. During a taste test on 7/29/24 at 11:57 A.M., showed the pureed fries with a chunky texture. During an interview on 7/29/24 at 12:01 P.M., DC A said the pureed fries had a bland taste because the fries had a bland taste. During an interview on 7/29/24 at 12:08 P.M., the Dietary Director said he/she did not have printed recipes for pureed fries. During an interview on 8/1/24 at 2:39 P.M., Resident #15 said: -The part of the food that was not good, was the taste. -The French Fries served on Monday (7/29/24) were not crispy, but mushy and -The food was undercooked. and the French Fries were too mushy. 3. Review of Resident #21's quarterly MDS, dated [DATE], showed Resident #21 was cognitively intact. During an interview on 8/2/24 at 12:10 P.M., Resident #21 said the dinner rolls, which were served for lunch, were undercooked. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/2/24 at 12:11 P.M., showed the resident was able to pull the roll apart and the dough able to be stretched for an inch (in.) or more. Observation on 8/2/24 at 12:15 P.M., in the kitchen showed the dinner rolls were cooked on the outside but it was not done on the inside because the roll was able to be pulled the dough was able to be stretched. During an interview on 8/2/24 at 12:16 P.M., Dietary [NAME] (DC) A said the dinner rolls were not completely cooked. During an interview on 8/2/24 at 12;24 P.M., the Dietary Director said he/she noticed the rolls were not cooked because he/she was not working in the kitchen on that day.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 19916 Based on observation, record review and interview, the facility failed to ensure the pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) chicken tenders and french fries were pureed to smooth consistency. This practice potentially affected 5 residents with pureed diets. The facility census was 46 residents. 1. Review of the pureed recipe for chicken tenders dated 9/5/17, showed: -Remove desired number of servings and add nutritive liquid (milk, broth, etc.). -Blend until desired consistency. Add approved thickener to achieve desired consistency if needed. The recipe did not state how much liquid or thickener to add per the number of servings that needed to be pureed. Observation on 7/29/24 at 10:59 A.M., showed: - Dietary [NAME] (DC) A pureed the chicken, by adding an unmeasured amount of chicken base, and added water to the food processing container which contained the chicken and the base and pureed the ingredients together. - DC A did not have a recipe book opened. - DC A did not taste the pureed chicken tenders and placed the pureed product in a metal pan and placed it into oven to maintain food warmth. During a taste test on 7/29/24 at 11:54 A.M., the texture of the pureed chicken was grainy (contained small bits). 2. Observation on 7/29/24 at 11:16 A.M., showed DC A pureed french fries in the food processor, DC A added cold milk to the fries in the food with no recipe book used at that time. DC A did not taste the pureed fries after the fries were finished being processed. During a taste test on 7/29/24 at 11:57 A.M., showed the pureed fries with a chunky texture. During an interview on 7/29/24 at 12:01 P.M., DC A said he/she should have pureed the fries a little longer to make it or smooth. During an interview on 7/29/24 at 12:08 P.M., the Dietary Director said: - He/she did not have printed recipes for pureed fries. - There was a little bit of chunk in the pureed fries. - He/she did not know why they did not have a recipe for the pureed fries. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/she did not discuss the recipes with the Consultant Registered Dietitian (RD) - He/she expected facility staff to use the recipes if they were available for use. During an interview on 7/29/24 at 12:43 P.M., DC A said he/she did dnot use the recipe book to make the pureed items. and the Dietary Director could taste some of the pureed items.

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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. 19916 Based on observation and interview, the facility failed to remove a buildup of dust and food debris from under the reach-in refrigerator; failed to label items that were not easily identifiable in the containers those items were in; failed to ensure employees washed hands after handling non-food items then going back to handling food items; failed to prevent the buildup of debris in the window unit air conditioner; failed to check the temperature of food items before placing those items on the steam table; failed to ensure the pot holder was free from damage that could allow fibers to contaminate food; failed to ensure dietary employees handled containers used or serving residents, without contaminating those containers; failed to use a three-step (wash, rinse and sanitize) process to wash the food processor container between foods; failed to store a box of individual packets of butter according to the storage instructions on the box; failed to maintain the lower part of the toaster free from a heavy buildup of crumbs. This practice potentially affected all residents. The facility census was 46 residents. 1. Observation on 7/29/24 from 7:26 A.M. through 8:36 A.M. during the breakfast meal preparation showed: - The presence of dust, food debris, and an old container of yogurt under the reach-in refrigerator - Dietary [NAME] (DC) A handled his/her phone and did not wash his/her hands before going back to the steam table to serve food on a plate. - The presence of grime and dust within the air conditioning unit. - The absence of a label on a shaker with a white granulated substance in the shaker. - DC A pulled broke a waffle a part with his/her ungloved hands and placed the waffle pieces into a plate. - DC A rinsed out the food processor instead of washing the food processor through a 3-step process, before processing the waffles after he/she processed another food. - DC A handled waffles with his/her bare hands from the toaster. 2. Observation on 7/29/24 from 11:05 A.M. through 1:10 P.M. during the lunch meal preparation showed: - Debris and dust in the window air conditioner unit. - A box of personal sized margarine containers that were not refrigerated with many of the margarine containers which lost their covers and the box which stated refrigerate. - DC A placed French fries on steam table did not check the temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- DC A used the damaged potholder to take the pan of pureed chicken out of oven and DC A did not check temperature, when he/she placed the pureed chicken on steam table. - DC A handled the dessert cups for the applesauce by using his/her fingers inside of the dessert cups while he/she placed portions of applesauce into the cups. - DC A did not wash the cover of the food processor container that was used previously to puree (to blend, chop, mash or strain a food item until that food turns into a soft and smooth consistency) the chicken, to puree the vegetables. During an interview on 7/29/24, DC A said: - At 11:28 A.M., he/she did not know how long the pot holder had been damaged. - At 12:40 A.M., he/she had been trained to wear gloves and he/she should have worn gloves during the time he/she handled the waffles. - At 12:42 A.M. he/she should have held the dessert cups on the bottom. - At 1:03 P.M., he/she had not cleaned the lower part of the toaster after he/she saw the heavy buildup of bread crumbs at the bottom of the toaster. During an interview on 7/29/24, the Dietary Director (DD) said: - At 12:14 P.M., the small butter condiments should have been refrigerated after he/she saw the box with a lot of missing covers from those containers. - At 12:17 P.M., the dietary employees moved the reach-in refrigerators out, every week, but they should be sweeping under those refrigerators nightly. - At 12:18 P.M., he/she expected the dietary staff to check the temperatures of food items when those food items were placed on the steam table. - At 12:20 P.M., the salt containers should be labeled. - At 12:26 P.M., he/she expected employees to use gloves, when they touched food directly. During an interview on 7/29/24 at 12:19 P.M., Dietary Aide (DA) A said he/she did not know the margarine containers needed to be refrigerated. During an interview on 7/29/24 at 12:52 P.M., the Maintenance Director said the dietary staff had not notified him/her about the grime in the air conditioner unit.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation, interview, and record review, the facility failed to ensure the facility's policy regarding the proper storage was followed, when food was stored in the resident use refrigerator. This practice potentially affected at least 4 residents who had food stored in the resident use refrigerator. The facility census was 46 residents. Review of the policy entitled Foods Brought by Family/Visitors dated ,d+[DATE], showed: -Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. -Nursing staff will provide family/visitors who wish to bring foods to the facility with a copy of this policy. Residents will also be provided a copy in a language and format he/she can understand. -Food brought by family/visitors that is left with the resident to consume later, will be labeled and stored in a manner that is clearly distinguishable from facility prepared food. -Non perishable foods will be stored in resealable containers with tight fitting lids. Intact fresh fruit may be stored without a lid. -Perishable foods must be stored in resealable containers with tightly fitting lids in a refrigerator. The container will be labeled with the resident's name, the item and the use by date. -Nursing staff will discard perishable foods on or before the use by date. -The nursing staff and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due expiration dates.) 1. Observation on [DATE] from 11:56 A.M. to 12:11 P.M., showed: -A sign, which stated the following, on the resident use refrigerator: --Resident's food only, Must have name and any prepared food needed to be dated, (expires and discard after 3 days). --Any food that was not a resident's food would be discarded daily. --Please put a name and date all food items; If not named and dated, it will be thrown away. -The following food items were in the resident use refrigerator: --A container with food that was later identified as food belonging to a staff member. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--A container of French Onion Dip which was without a resident's name or a date that it was received. --Another container of French Onion Dip with an expiration date of [DATE]. --A container of cottage cheese which expired [DATE]. --A package of hot dogs which was received on [DATE], a without a resident's name on it. --A container of creamy mayo which expired on [DATE], without a name or the date that the package was received. --A package of humus (a dip, spread, or savory dish made from cooked, mashed chickpeas blended with tahini, lemon juice, and garlic) without a name of a resident or a date that it was received. --A package of boiled eggs without a name of a resident or a date that it was received. --A package of peanut butter without a name of a resident or a date that it was received. --Food in a black foam container without a name of a resident or a date that it was received. --Food in an aluminum container without a name of a resident or a date that it was received. --The presence of applesauce and yogurt containers, and several bottles of nutritional supplements without a name of resident or a date those items were received. During an interview on [DATE] at 12:13 P.M., the Director of Nursing (DON) said: -The supplements were for general use by all residents. -The applesauce and yogurt were used for the medication administration. -The fridge should be cleaned weekly. -He/she expected staff to place the date the item was received, and the name of the resident the item was for. During an interview on [DATE] at 12:16 P.M., the Dietary Director said: -Staff food should be placed in the staff refrigerator located in a different area of the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46519 Based on observation, interview, and record review, the facility failed to perform adequate hand hygiene during medication pass for three supplemental residents (Resident's #11, #27, and #10) out of nine supplemental residents and failed to create and implement a Tubercolosis (TB, a potentially serious infectious bacterial lung disease) program when staff failed to complete two-step Mantoux skin tests (a test to show potential TB infection) for two sampled residents (Resident #141 and #241). The facility census was 46 residents. Review of the facility's policy titled Handwashing/Hand Hygiene dated August 2019 showed: -The facility considered hand hygiene the primary means to prevent the spread of infections. -All personnel should be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. -All personnel should follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Hands should be washed with soap (antimicrobial or non-antimicrobial) and water when hands were visibly soiled. -Use an alcohol-based hand rub or alternatively, soap (antimicrobial or anti-microbial) and water for the following situations --Before and after direct contact with residents. --Before preparing or handling medications. --After contact with a resident's intact skin. --After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. --After removing gloves. --Before or after eating or handling food. -Hand Hygiene is the final step after removing and disposing of personal protective equipment (PPE). -The use of gloves did not replace hand washing/hand hygiene. Review of the facility's policy titled Administering Medications dated April 2019 showed Staff were to follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of Resident #11's face sheet showed he/she admitted to the facility with the following diagnoses: -Permanent Atrial Fibrillation (an irregular heartbeat). -Dysphagia (difficulty swallowing). -Low Back Pain. -Age-Related Physical Debility. Review of the resident's Physician Order Sheet (POS) dated July 2024 showed: -An order for a regular diet with mechanical soft (any foods that could be blended, mashed, pureed, or chopped using a kitchen tool such as a knife, a grinder, a blender, or food processor) texture, regular/thin consistency (no additives and considered non-restrictive), crush pills. -Diclofenac Sodium External Gel 1% (Voltaren Gel- used to relieve pain from arthritis in certain joints such as those of the knees, ankles, feet, elbows, wrists, and hands), apply to both shoulders topically three times a day for pain, two grams (gm) each shoulder. -Lidocaine Pain Relief External Patch (a local anesthetic that numbs the nerves in a specific area of your body) 4%, apply to the lower back topically one time a day related to low back pain. Observation of the resident's medication administration on 7/30/24 at 9:52 A.M. completed by Certified Medication Technician (CMT) A showed: -He/She sanitized his/her hands and dispensed the resident's medication into a medication cup. -He/She then put on gloves and placed the medication into a pouch in order to crush the medication. -After crushing the medications, he/she kept his/her gloves on and placed the medication back into the medication cup and mixed the medication in some yogurt. -He/She then left the medication cart and walked down the hall and into the resident's room with the same gloves on. -With the same gloves on, he/she assisted the resident when giving him/her the medications and got some of the yogurt on his/her left glove. -He/She then threw the medication cup in the trash can and opened the Lidocaine Pain Relief External Patch with the same gloved hands. -He/She applied the Lidocaine Pain Relief External Patch to the resident's lower back and went on to use the Voltaren Gel on both of the resident's shoulders with the same gloved hands. -He/She then exited the resident's room and walked back to the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She then put the Voltaren Gel back into the assigned package and removed his/her gloves. During an interview on 7/30/24 at 10:05 A.M. CMT A said: -He/She would not have done anything different during the medication pass. -He/She was questioning whether or not his/her glove usage had been appropriate and stated that was how he/she had always done the medication pass. -He/She had not realized that yogurt had gotten on to his/her left glove. -If he/she had realized it during the medication pass, he/she would have removed his/her gloves. -If he/she had only been administering one route of medication to a resident, then he/she would sanitize his/her hands before entering and exiting the resident room/area. 2. Review of Resident #27's face sheet showed he/she admitted to the facility with the diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Review of the resident's POS dated July 2024 showed an order for Accu-Chek's (a test that measures glucose in whole blood) before meals and at night daily. Observation on 7/31/24 at 12:11 P.M. of the resident's Accu-Chek showed performed by Licensed Practical Nurse (LPN) B showed: -He/She gathered the supplies needed for the check, sanitized his/her hands, and took the resident to the shower room. -He/She did not sanitize his/her hands upon entry to the shower room. -He/She placed the resident in the center of the room and realized he/she forgot the cotton balls needed for the test. -He/She exited the shower room without sanitizing his/her hands. -After retrieving the cotton balls, he/she re-entered the shower room without sanitizing his/her hands. -He/She donned gloves and performed the Accu-Chek. -After completion of the test he/she removed his/her gloves and took the resident back into the dining room. During an interview on 7/31/24 at 12:32 P.M. LPN B said: -He/She would have sanitized his/her hands more often during the process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She should have sanitized his/her hands before and after donning/doffing gloves. -He/She should have sanitized his/her hands upon entrance and exit of the shower room. 3. Review of Resident #10's face sheet showed he/she admitted to the facility with the following diagnoses: -Heart Failure (a weakness of the heart that leads to a build-up of fluid in the lungs and surrounding tissues). -Hypertension (high blood pressure). -Chronic Obstructive Pulmonary Disorder (COPD- a disease process that decreases the ability of the lungs to perform ventilation). Review of the resident's POS dated July 2024 showed: -Spot check oxygen saturation each shift to assess need for Pro Re Nata (PRN- as needed) oxygen. -Ketoconazole Cream 2% (when in topical form, it can treat scaly areas on the skin or scalp), apply to face topically two times a day for darkening of the skin, apply to dark spots on face. Observation on 8/1/24 at 9:25 A.M. of the resident's medication administration completed by CMT A showed: -He/She grabbed the pulse oximeter (a non-invasive method for monitoring blood oxygen saturation) and entered the resident's room without sanitizing his/her hands. -He/She then exited the resident's room without sanitizing his/her hands. -After dispensing the resident's medication, he/she re-entered the resident's room and donned gloves without sanitizing his/her hands. -After administering the medication to the resident, he/she removed his/her gloves and donned new gloves without sanitizing or washing his/her hands. -He/She then applied the Ketoconazole Cream 2% to the resident's face. During an interview on 8/1/24 at 9:35 A.M. CMT A said he/she would not have done anything differently during the resident's medication administration. 4. During an interview on 8/1/24 at 11:33 A.M. CMT B said: -During medication administration hand hygiene should be completed before and after each resident and washed after every three residents. -Hand hygiene should be performed before and after gloves are worn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hand hygiene should also be performed when entering and exiting resident areas including the shower room. -Gloves were not a substitution for hand hygiene. -Gloves were not to be worn in the hallway or into a resident's room. -If his/her gloves were to get soiled during a task, then he/she would remove the gloves, sanitize/wash his/her hands, and put on new gloves. -Resident #11's medication administration was nor performed correctly. -The staff person should have removed his/her gloves before leaving the medication cart. -The staff person needed to remove his/her gloves and sanitize between each route of medication during Resident #11's medication administration. During an interview on 8/1/24 at 12:01 P.M. LPN B said: -Hand hygiene needed to be completed before and after glove usage. -All medications were to be administered with gloves on. -Gloves were not a substitution for hand hygiene. -The staff person had not performed appropriate hand hygiene during Resident #11's or Resident #10's medication administration. -The staff person needed to remove his/her gloves and perform hand hygiene between each route of medication during Resident #11's medication administration. -Gloves were not to be worn outside of resident rooms. During an interview on 8/1/24 at 1:07 P.M. The Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) Coordinator said: -Hand hygiene should be performed before dispensing medications and in between each resident during medication administration. -Hand hygiene should be performed upon entry and when exiting resident rooms/areas. -Hand hygiene should be performed before and after glove usage. -Gloves were not a substitution for hand hygiene. -The CMT had not performed correct hand hygiene during Resident #11's and Resident #10's medication administrations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The CMT should have removed his/her gloves and sanitized between his/her hands between each route of medication during Resident #11's medication administration. -Gloves needed to be removed when soiled. During an interview on 8/2/24 at 11:58 A.M. the Director of Nursing (DON) said: -During medication administration he/she expected the staff to perform hand hygiene between each resident, upon entering and exiting resident rooms, and between vital sign checks and the dispensing of the medications. -He/She expected staff to perform hand hygiene before and after glove usage. -He/She expected staff to remove their gloves and perform hand hygiene if gloves were to be soiled during a task. -Gloves were not a substitution for hand hygiene. -CMT A had not performed hand hygiene appropriately during Resident #11's and Resident #10's medication administration. -He/She would have expected the CMT to remove his/her gloves and perform hand hygiene between each route of administration during Resident #11's medication administration. -LPN B had not performed appropriate hand hygiene during Resident #27's Accu-Chek. -He/She would have expected him/her to perform hand hygiene when entering and exiting the shower room. -Gloves were not to be worn when going in and out of resident rooms. 50579 5. Review of Section 19 CSR 20-20.100 (Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities) showed facilities were to screen their residents and staff for tuberculosis using a two-step Mantoux skin test (a test administered under a resident's skin, evaluated within 48 to 72 hours, and repeated one to three weeks afterward). Review of an undated facility policy titled Screening Residents for Tuberculosis showed: -All residents would be screened for tuberculosis. -New admissions would be screened for signs and symptoms of tuberculosis per state and federal regulations. -The admission nurse would be responsible for screening new residents for signs and symptoms of tuberculosis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Any residents who had been potentially exposed to TB or were at increased risk of TB infection would have been referred for further screening. -Any residents screening positive would be further isolated from other residents and staff. NOTE: The policy lacked information regarding administration of the two step TB skin test for newly admitted residents for screening. 6. Review of Resident #141's Treatment Administration Record (TAR) dated July 2024 showed: -One administration of the TB skin test on 7/1/24 with no documentation of the evaluation of the skin test. -There was no documentation of a second step being completed. Review of the resident's medical record showed no evidence of a two-step TB skin test administration. 7. Review of Resident #241's TAR dated June 2024 showed: -One administration of the TB skin test on 6/30/24 with no documentation of the evaluation of the skin test. -There was no documentation of a second step being completed. Review of the resident's medical record showed no evidence of a two-step TB skin test administration. 8. During an interview on 8/1/24 at 10:04 A.M., the Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) Coordinator said: -He/She was responsible for keeping track of the residents' TB screenings. -Newly admitted residents should have received a two-step TB skin test administered one to three weeks apart. -He/She was responsible for inputting physician orders into the residents' medical record for the two-step skin test. -The nurses who worked the floor on any given day would be responsible for administering the skin test per the physician orders. -If a resident were to miss the window for the second step of the test, the facility staff would have to begin the process from step one. During an interview on 8/2/24 at 11:58 A.M., the Director of Nursing (DON) said: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265739	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holden Manor Health & Rehabilitation	2005 South Lexington Holden, MO 64040

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She expected every new admission to have a two-step TB skin test completed on admission, with the second step being done one to three weeks after the first. -He/She expected any resident with a missed second step test to have been restarted in the testing cycle. -The skin test process should have been ensured by audits of residents' medical records. -The MDS Coordinator was the facility infection preventionist and was responsible for ensuring residents had the appropriate orders and received their skin test within the appropriate time frame.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on interview and record review, the facility failed to ensure pneumococcal pneumonia vaccines (a vaccine to protect against pneumococcal disease caused by the bacteria Streptococcus pneumoniae) were offered, administered, or documented for three sampled residents (Residents #10, #141, #241) out of five residents sampled for vaccination provision. The facility census was 46 residents. Review of an undated facility policy titled Pneumococcal Vaccines showed: -All residents would be offered pneumococcal vaccines to aid in preventing pneumococcal infections. -Upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine and, if eligible, receive the vaccine within 30 days of admission. -Assessments of the residents' vaccination status would occur within five days of admission. -Any vaccine refusals or administrations would be documented in the residents' medical record. Review of the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Timing for Adults, revised 2/9/24, showed the CDC recommended pneumococcal vaccination for adults [AGE] years old and older as well as for adults between 19 and [AGE] years old with certain medical conditions or risk factors including chronic (including end stage) renal disease and chronic liver disease, and any adult over 65 who received a single dose of the PPSV23 vaccine should have a dose of either PCV20 or PCV15 after one year of administration. 1. Review of Resident #10's face sheet showed: -The resident was older than [AGE] years old. -The resident had an admitted [DATE]. Review of the resident's immunization report on 8/1/24 showed: -No evidence of pneumococcal vaccination administration dates. -The report lacked documentation of education, consent or refusal and administration of the pneumococcal vaccine for which the resident was recommended per the CDC due to chronic renal disease. 2. Review of Resident #141's face sheet showed: -The resident was younger than [AGE] years old. -The resident had a diagnosis of chronic hepatitis C (a chronic liver disease). -The resident had an admitted [DATE]. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's immunization report showed: -No evidence of pneumococcal vaccination administration dates. -The report lacked documentation of education, consent or refusal and administration of the pneumococcal vaccine for which the resident was recommended per the CDC due to chronic liver disease. 3. Review of Resident #241's face sheet showed: -The resident was older than [AGE] years old. -The resident had a diagnosis of chronic renal disease. -The resident had an admitted [DATE]. Review of the resident's immunization report on 8/1/24 showed: -Resident #241 received a pneumococcal vaccine (PPSV 23) on 6/1/22. -The report lacked documentation of education, consent or refusal and administration of the PCV20 or PCV15 pneumococcal vaccine for which the resident was recommended per the CDC due to diagnosis of chronic renal disease and age. 4. During an interview on 8/01/24 at 10:00 A.M., the Infection Preventionist (IP) said: -Residents should have been screened for pneumococcal immunizations on admission. -All administered immunizations should have been documented in the resident medical record. -Any refusals should have been signed and documented in the resident's medical record. -Residents that were recommended pneumococcal vaccines should have been offered the vaccine by the facility. -He/She was responsible for ensuring resident's vaccine status along with refusals were documented and they were offered recommended vaccines. During an interview on 8/2/24 at 11:58 A.M., the Director of Nursing (DON) said: -Residents should have been screened for pneumococcal immunizations on admission. -All administered immunizations should have been documented in the resident medical record. -Any refusals should have been signed and documented in the resident's medical record. -Residents that were recommended pneumococcal vaccines should have been offered the vaccine by the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19916 Based on observation and interview, the facility failed to maintain the kitchen area and resident rooms [ROOM NUMBERS], free of ants. This practice affected the kitchen and affected 4 residents who resided in those rooms. The facility census was 46 residents. Review of the policy entitled Foods Brought by Family/Visitors dated 10/17, showed: -Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. -Non perishable foods will be stored in resalable containers with tight fitting lids. Intact fresh fruit may be stored without a lid. 1. Observations on 7/29/24 at 11:06 A.M., showed the presence of ants at the 3-compartment sink location. During an interview on 7/29/24 at 11:49 A.M., the Maintenance Director said he/she was unaware of ants in the kitchen before today. 2. Observation on 7/30/24 at 11:12 A.M., showed the presence of ants in resident room [ROOM NUMBER]. Observation on 7/30/24 at 11:33 A.M., showed the presence of ants in resident room [ROOM NUMBER] behind the nightstand and the presence of snacks which were not in containers. During an interview on 7/30/24 at 11:40 A.M. the Social Service Designee said he/she needed to speak with the resident in resident room [ROOM NUMBER], about placing his/her snacks in containers to keep the ants out. During an interview on 8/1/24 at 1:07 P.M., the Maintenance Director said ants have not been an ongoing issue within the rooms and no one had brought it to his/her attention before this week. During an interview on 8/1/24 at 2:48 P.M., Housekeeper A said he/she saw ants in one of the resident rooms approximately a week ago. He/She brought the ants to the attention of the Maintenance Director and the Maintenance Director gave him/her spray for the ants.