STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265792	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to ensure three residents (Resident #80 and #403) in a review of 35 sampled residents, were treated in a manner to maintain dignity and respect. The facility census was 149. Review of the facility's undated Residents' Rights policy, showed the following: Dignity and Respect: -Your right to be treated with dignity and respect is the foundation on which all other resident rights and responsibilities are based. You have the right to expect that we will: 1. Treat you as an individual and assist you in getting the most out of the programs and services we offer; 4. Provide safeguards against any kinds of harsh or abusive treatment. 1. Review of Resident #403's care plan, dated 4/29/24, showed the following: -The resident is at risk for falls due to weakness; -The resident has a deficit in mobility related to weakness, current weight bearing status is weight bearing as tolerated, one person transfer; -The resident has a deficit in activities of daily living (ADL) self-care and impaired functional mobility related to hospitalization for stroke; -Provide assistance with ADLS as indicated. Review of the resident's admission Minimum Data Set (MDS) (a federally mandated assessment instrument completed by facility staff), dated 5/3/24, showed the following: -Cognitively intact; -Upper extremity impairment on one side; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Delmar Gardens of O'Fallon		STREET ADDRESS, CITY, STATE, ZIP CODE 7068 South Outer 364 O Fallon, MO 63368	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required supervision or touching assistance for toileting hygiene and rolling from left to right; -Always continent of bladder and bowel; -Diagnoses of stroke and diabetes; -Is taking a diuretic. During an interview on 5/7/24 at 3:05 P.M. and 5/10/24 at 1:35 P.M., the resident said the following: -He/She was incontinent and made a mess in the bathroom; -One of the aides (the resident did not know his/her name) came into his/her room; -The aide was mean and yelled at him/her and said, I'm on my lunch break!; -The aide was hateful about having to change him/her and got mad about him/her making a mess in the bathroom; -The aide ripped his/her brief and the blanket off and didn't even tell him/her what he/she was going to do; -He/She doesn't like the way that aide treats him/her. He/She told his/her family member about it the next day; -It really upset him/her and made him/her cry. During an interview on 5/10/24 at 10:15 A.M., the resident's family member said the following: -The resident called him/her earlier this week crying; -The resident said he/she had an accident (went to the bathroom in his/her pants); -The aide came in and was rude and didn't speak to the resident when spoken to ; -It upset him/her when the resident is in the facility and he/she is out of state and the resident called him/her crying; -This is the first time the resident has complained to him/her about treatment by a staff member. During an interview on 5/10/24 at 1:45 P.M., the Director of Nursing (DON) said the following: -The social worker did talk with the resident this week and the resident complained about a night staff member that was rude, but the resident did not know the staff member's name; -She was not aware the resident had a complaint about a staff member on Tuesday. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Delmar Gardens of O'Fallon		STREET ADDRESS, CITY, STATE, ZIP CODE: 7068 South Outer 364, O Fallon, MO 63368	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #80's admission MDS, dated [DATE], showed the following: -Moderately impaired cognition; -No behaviors; -No rejection of care. Review of the resident Physician Order Sheet (POS), dated 5/2024, showed the following: -Diagnoses included Alzheimer's (progressive disease that destroys memory and other important mental functions), age related osteoporosis (condition in which bones become weak and brittle) with current pathological fracture (fracture due to a weakened bone); -Weight bear as tolerated (WBAT). Review of the resident's care plan, last revised 5/4/24, showed the following: -Impaired cognition related to Alzheimer's: Be patient and positive, maintain a calm environment and approach to the resident; -Resident can be physically and verbally abusive: Avoid power struggles with resident, Convey an attitude of acceptance toward the resident; -Activities of Daily Living: Cheerful dialogue with resident while providing care to encourage and maintain self esteem, provide peri-care after each incontinent episode, weight bear as tolerated with two staff assist. Observation on 5/13/24 at 2:30 P.M. showed the following: -Nurse Aide (NA) T and Certified Nurse Assistant (CNA) WW entered the resident's room where he/she sat in the a wheelchair; -They transferred the resident to bed with a sit to stand lift and performed incontinent care; -The resident cried out with cares; -Before exiting the room and within ear shot of the resident, NAT T said to the state surveyor, The resident (called by first name) is a cry baby. He/She likes to cry. During an interview on 5/14/24 at 1:45 P.M , NAT T said staff should not call a resident a cry baby and should treat resident's with dignity and respect. During an interview on 5/14/24 at 12:52 P.M. the DON said she would not expect staff to refer to a resident as a cry baby or state that he/she cried all the time within ear shot of the resident. This would be inappropriate. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 5/22/24 at 1:10 P.M., the administrator said she would expect staff to treat residents with dignity and respect. 34003 36219

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for five residents (Resident #78, Resident #26, Resident #140, Resident #87, and Resident #43) in a review of 35 sampled residents when call lights were not accessible at all times to the residents. The facility also failed to accommodate one resident's (Resident #121's) need for assistance, including assistance with toileting, which resulted in incontinence. The facility census was 149. Review of the facility policy, Call Lights, last reviewed 6/21, showed the following: -Purpose was to get to the resident when he/she calls for assistance and to assist the nurse in meeting the resident's requests; -Check to see that the resident's call light is within reach; -Go to the resident as soon as he/she calls. Answer within 5-15 minutes. Emergency lights should be responded to immediately to prevent injury. 1. Review of Resident #78's Continuity of Care document (CCD) showed the resident's diagnoses included malignant neoplasm of lungs and brain (cancer), difficulty in walking, and lower extremity contracture (condition that prevents normal movement of a joint or other body part) of right foot and right ankle. Review of the resident's Significant Change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/24, showed the following: -Moderately impaired cognition; -Dependent on staff for transfers and toileting; -Always incontinent of bowel and bladder; -Dependent on staff for manual wheelchair mobility. Review of the resident's care plan, revised 4/12/24, showed the following: -Incontinent of bowel and bladder; -Staff to give reminders to use call light and wait for assistance; -Ensure call light is in reach and educate on the use of call light, if indicated. Observation on 5/8/24 at 7:25 P.M. showed the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident sat near the end of his/her bed, in his/her geri chair (high back chair that the sitter is not able to self-propel in) with foot pedals in place; -The call light lay across the bedside table at the end of the bed; -The call light was not within reach for the resident's use. During an interview on 5/7/24 at 12:55 P.M., the resident said he/she used to self propel to get around, but now he/she has these foot pedals that prevent him/her from being able to get around. During an interview on 5/8/24 at 7:25 P.M., the resident said the following: -He/She asked a staff member walking by his/her room to change him/her about 15 minutes ago and no one returned; -He/She had been incontinent of bowel and bladder and needed his/her brief changed; -His/Her call light was not within reach, so he/she had to ask someone walking by the room for help. Observation on 5/8/24 at 9:06 P.M. showed the following: -Certified Nurse Aide (CNA) RR and CNA SS entered the resident's room with a mechanical lift to transfer the resident, change the resident and provide incontinence care; -The resident's peri area was red and irritated all the way to the thigh area with a small superficial opening on the left upper thigh area just below the crease of the thigh; -Following cares, CNA SS placed the call light within reach after the resident requested the call light. During an interview on 5/8/24 at 9:25 P.M., the resident said he/she asked staff for his/her call light to be in place before leaving the room because he/she had been without it and had been sitting for a while waiting to be changed. As a result of waiting, he/she now has skin irritation between his/her legs. Observation on 5/9/24 at 10:45 A.M. showed the following: -The resident asleep in his/her wheelchair in his/her room; -The call light was on the floor near the wall on the other side of the bed and not within reach for the resident to use. Observation on 5/10/24 at 10:06 A.M. showed the following: -The resident was asleep in his/her wheelchair in his/her room; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The call light was on the side of the bed near the wall hanging to the floor and not within reach for the resident to use. 2. Review of Resident #121's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Mobility device: wheelchair; -Required substantial/maximal assistance for toileting hygiene; -Dependent on staff for sit-to-stand and toilet transfers; -Urinary and bowel continence not marked; -Diagnoses of cancer, anxiety and depression; -Taking a diuretic medication. Review of the resident's care plan, dated 5/1/24, showed the following: -Resident is at risk for falls due to weakness; -Resident has a deficit in mobility related to weakness; -Current weight bearing status is weight bearing as tolerated, two person transfer Sara lift (a powered sit-to-stand lift designed for active transfers, balance, stepping and gait training); -Resident has a deficit in activities of daily living (ADL) self-care and impaired functional mobility related to weakness; -Provide assistance with ADLs as indicated. During an interview on 5/7/24 at 4:23 P.M., the resident said the following: -He/She requires use of the sit to stand lift in/out of bed and assistance of two staff; -He/She has waited for 40 minutes to go to the bathroom; -He/She has had several urinary tract infections (UTIs) and when he/she has to go there's not much time to get there; -He/She ended up having an accident (was incontinent) and went down to the head nurse after 35 minutes and the nurse had to find the aide to assist him/her; -He/She just hates it when he/she urinates in his/her pants, it upsets him/her; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One agency aide told him/her that he/she was helping someone else and he/she would just have to hold it. 3. Review of Resident #26's CCD showed the resident's diagnoses included muscle weakness, difficulty in walking, Parkinson's disease (a disease affecting the nervous system), and neuromuscular dysfunction of bladder. Review of the resident's annual MDS, dated [DATE] showed the following: -Intact cognition; -Dependent on staff for toileting and transferring. Review of the resident's care plan, revised 5/8/24, showed the following: -Incontinent of bowel and bladder; -Ensure call light in place prior to leaving room. Observation on 5/8/24 at 9:20 A.M. showed the following: -The resident sat in bed and ate his/her breakfast from the bedside table that was positioned over his/her lap; -The call light was near the foot of the bed on top of the upright mattress against the wall and not accessible to the resident. During an interview on 5/8/24 at 9:20 A.M., the resident said he/she normally hits the call light if he/she needs assistance from staff, but he/she was unable to locate it and he/she needed assistance with eating. Observation on 5/9/24 at 10:55 A.M. showed the following: -The resident was asleep in his/her bed; -His/Her call light lay near the end of the bed and not within the resident's reach. 4. Review of Resident #140's CCD showed the resident's diagnoses included multiple sclerosis (disease causing muscle weakness), restlessness and agitation, and fracture of right femur (leg fracture). Review of the resident's admission MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Dependent on staff for transfers and toileting; -Always incontinent of bowel and bladder. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note, dated 3/20/24 at 5:25 P.M. showed the following: -The resident required assist of two or more staff members; -The resident required a mechanical lift for transfers; -The resident required a broda chair (specialized wheelchair) with assistance for mobility. Review of the resident's care plan, revised 3/4/24, directed to ensure call light is in reach and educate on the use of the call light, if indicated. Observation on 5/8/24 at 7:35 P.M. showed the following: -The resident was awake and sat in a wheelchair next to his/her bed; -His/Her call light was near the foot of the bed next to the wall and not within reach. During an interview on 5/8/24 at 7:35 P.M., the resident said he/she wasn't sure where his/her call light was, but was able to use it if he/she had it and needed something. Observation on 5/9/24 at 10:50 A.M. showed the following: -The resident was awake and sat in his/her wheelchair next to his/her bed; -His/Her call light lay across the bed, and not within his/her reach. 5. Review of Resident #43's CCD showed the resident's diagnoses included speech and language deficits, stroke, muscle weakness, difficulty in walking, and insulin dependent diabetes mellitus. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Dependent on staff for transfers, dressing, personal hygiene and bathing. Review of the resident's care plan, revised 4/3/24 , showed the following: -Always incontinent of urine; -Keep call light in reach at all times; -Respond to call light requesting to get up in a timely manner. During an interview on 5/7/24 at 12:55 P.M., the resident said that he/she was able to use a call light. Observation on 5/8/24 at 8:00 P.M. showed the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was asleep in his/her bed; -His/Her call light was on the floor next to the wall and not accessible to the resident. Observation on 5/9/24 at 10:50 A.M. showed the following: -The resident was awake in a broda chair; -His/Her call light was on the bed, and not accessible to the resident. 6. Review of Resident #87's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Minimal depression; -Scheduled and as needed pain medication; -Partial to moderate assist for transfers and toileting; -Manual wheelchair (dependent for mobility). Review of the resident's POS dated 5/2024 showed the following: -Diagnoses included chronic diastolic heart failure (condition that causes shortness of breath and exercise intolerance); -Hospice (3/25/24). Review of the resident's care plan, last revised 4/19/24, showed the following: -Deficit in mobility related to weakness; -Required assist of one staff with transfers and toileting; -Keep call light in easy reach, encourage the use of call light for assistance; -Respond to call light requesting to get up in a timely manner. Observation on 5/13/24 at 11:00 A.M. showed the resident sat in his/her wheelchair in his/her room. The call light was out of the resident's reach on the over-the-bed table. Observation on 5/14/24 at 10:30 A.M. showed the resident lay in his/her bed. The call light was on the over-the-bed table out of the resident's reach. During an interview with the Director of Nursing (DON) on 5/14/24 at 12:55 P.M., she said the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She would expect call lights to be within reach for all residents; -She would expect call lights to be within reach when the resident is in bed and when the resident is out of bed. During a phone interview on 5/22/24 at 1:10 P.M., the administrator said the following: -She would expect staff to have call light within reach for all residents; -She would expect staff to answer call lights and respond to resident's needs within a timely fashion. 45563

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47008 Based on interview and record review, the facility failed to provide a written notice of bed hold policy to the resident and/or resident representative for two residents (Resident #5 and #81), in a review of 35 sampled residents, when they were transferred to the hospital. The facility census was 149. Review of the facility's undated Bed Hold Policy, showed the following: -Purpose: To notify the resident and/or representative(s) of the Bed-Hold Policy in writing at the time of Admission, upon change or revision and when transferred to a hospital or during therapeutic leave, as well as the intent for readmission according to state and federal regulations; -Procedure: The facility will inform and give a written copy of this policy to the resident and/or representative upon admission. The facility will also give a copy of this policy to the resident and/or representative if transferred to a hospital or during therapeutic leave. 1. Review of Resident #5's face sheet showed the resident had a power of attorney (POA). The resident has a diagnosis of Alzheimer's disease (a type of dementia). Review of the resident's census showed the resident was hospitalized on [DATE]. Review of the resident's progress notes, dated 5/24/23 at 10:06 A.M. and 10:26 A.M., written by Licensed Practical Nurse (LPN) EE, showed the following: -The resident had touched multiple staff this morning inappropriately, interventions unsuccessful and behavior was escalating; -The resident was attempting to leave the division frequently and repetitive; -The physician ordered the resident to be sent for behavioral evaluation; -The family was updated and made aware; -The hospital reported the resident was admitted to behavioral health. During interview on 5/22/24 at 9:54 A.M., (LPN) EE, said the following: -He/She will call family when a resident needs to go to the hospital; -He/She sends a transfer packet with the resident to the hospital; -A copy of the Notice of Emergency Hospital Transfer form and a copy of the bed hold policy is in the transfer packet that is sent to the hospital; (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	-He/She does not fill out the Notice of Emergency Hospital Transfer form that is sent in the transfer packet; -He/She does not make a copy of the Bed Hold and Hospital Transfer Form to be retained for the EHR. -He/She does not give written notice of the bed hold policy to the resident or the resident's representative. Review of the resident's census showed the resident returned to the facility on [DATE]. Review of the resident's progress notes, dated 6/06/23 at 7:12 P.M., showed the following: -The resident was transported back to the facility by EMS after hospital admission; -The resident was admitted to the hospital for behavioral health management and later treated for pneumonitis (inflammation of the lungs), aspiration (accidentally inhaling food or liquid through your vocal cords into your airway, instead of swallowing through your food pipe, or esophagus, and into your stomach) and acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues). Review of the resident's medical record showed no documentation the facility provided the resident or his/her representative with written information regarding the bed hold policy when the resident was transferred to the hospital on 5/24/23. During an interview on 5/22/24 at 11:02 A.M., the resident's responsible party/family member said he/she did not receive any documentation in writing regarding the bed hold policy when his/her family member was sent to the hospital. 2. Review of Resident #81's face sheet showed the resident had a POA. The resident has a diagnosis of Alzheimer's disease. Review of the resident's census showed the resident was hospitalized on [DATE]. Review of the resident's progress notes, dated 1/06/24 at 8:05 A.M., written by Licensed Practical Nurse (LPN) DD, showed the following: -The resident was vomiting profusely; -The resident was flushed and diaphoretic; -The resident had a temperature of 99.9 Fahrenheit (F) (A normal temperature for adults is in the range of 97 F to 99 F); -The resident's pulse was 114 (a normal resting heart rate for adults' ranges from 60 to 100 beats per minute); (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	-The resident's oxygen saturation on room air was 90 percent (%) (for most people, a normal pulse oximetry reading for your oxygen saturation level is between 95% and 100%); -The resident requested to go to the hospital; -The resident's family wanted him/her to be sent to the hospital. Review of the resident's progress notes, dated 01/06/24 at 8:09 A.M., written by LPN DD, showed the following: -A statement when a resident was discharged included: -1. Date and time of discharge (DC) : 01/06/2024 07:30 A.M.; -2. DC Location: the specific hospital the resident was sent; -4. Bed Hold Policy and Hospital Transfer Form sent with the resident: Yes; -5. Copy of Bed Hold and Hospital Transfer Form retained for electronic health record (EHR):Yes. During an interview on 5/22/24 at 9:17 A.M., LPN DD said when a resident has a change in condition, he/she will contact the physician and the family. He/She will confirm which hospital the family would like the resident to be sent. He/She will send a transfer packet with the resident, including the Notice of Emergency Hospital Transfer and Bed Hold Policy. He/She does not make a copy of the Bed Hold and Hospital Transfer Form to be retained for the EHR. He/She does not give written notice of the bed hold policy to the resident or the resident's representative. Review of the resident's census showed the resident returned to the facility on [DATE]. Review of the resident's progress notes, dated 1/10/24 at 9:11 P.M., showed the following: -The resident returned to the facility from the hospital by ambulance; -He/She was hospitalized for flu (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the)/Respiratory syncytial virus (RSV) (is a common respiratory virus that usually causes mild, cold-like symptoms). Review of the resident's medical record showed no documentation the facility provided the resident or his/her representative with written information regarding the bed hold policy when the resident was transferred to the hospital on 1/06/24. During an interview on 5/14/24 at 9:27 A.M. and 5/16/24 at 9:53 A.M., the staffing coordinator said the following: -When a resident is sent to the hospital a transfer packet is sent with the resident; -He/She has job duties which include checking the twenty four hour report and the census report each morning he/she works at the facility; (continued on next page)

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	265792	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	-The residents who have been sent to the hospital will populate on these reports; -He/She is responsible for calling the responsible family member and mailing out the bed hold policy to the responsible party within twenty four hours transfer; -He/She keeps track of the phone calls and mailing of the bed hold policy in a written log; -All of the residents who have been transferred to the hospital should be listed in his/her log book. Review of the written log, showing the mailings the facility sent out, showed the following: -No documentation the facility had sent written information regarding the bed hold policy to Resident #5 or his/her POA for his/her hospital transfer on 5/24/23; -No documentation the facility had sent written information regarding the bed hold policy to Resident #81 or his/her POA for his/her hospital transfer on 1/06/24. Review of email communication on 5/26/24 showed the Administrator said the following: -When a resident is transferred out of the facility to the hospital a transfer packet which includes a Notice of Emergency Hospital Transfer form and a Bed Hold Policy is sent with the resident for the family and the hospital. The family is contacted for permission prior to the transfer, and another notice is also mailed by the business office to the representative within twenty four hours. The business office makes a second phone call to the representative within twenty four hours and copies the form which had been mailed out and the form is scanned into the EMR. The business office might have mailed the information and failed to enter the resident's name or who was contacted in the log which is maintained by the business office.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34003 Based on observation, interview and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice for three residents (Resident #307, #309 and #403) in a review of 35 sampled residents. The facility census was 149. Review of the facility policy for Following Physician Orders, dated 7/29/21, showed: -It is the policy of the community to ensure that all Licensed Professional Nurses (Registered Nurses (RN), Licensed Practical Nurses (LPN)) and other Healthcare Professionals, follow Physician Orders in accordance to State, Federal regulations and their respective practice acts; -All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record; -If an order is questionable according to the seven Rights of Medication Administration, a clarification order will be obtained; -All physician or other health care professional's verbal, telephone or written orders will be immediately entered in the Electronic Health Record (EHR) by the nurse obtaining the order. Review of the facility policy for Weight Monitoring, dated 11/18/2018, showed residents are weighed on admission, weekly for the first four weeks and monthly thereafter, unless other wise ordered by nursing order or the attending physician. Review of the facility policy, Thickened Liquids/nothing by mouth (NPO), reviewed 5/2021, showed the following: Purpose: -To decrease the risk of aspiration and increase functional ability of swallowing; -A resident's physician's order for thickened liquids describing the consistency as nectar, honey or pudding will be communicated to the nursing, dining services, and other appropriate staff; -Assure the resident is receiving the appropriately thickened liquids. 1. Review of Resident #403's care plan, dated 4/29/24, showed the following: -Mechanical soft diet with nectar thick (where an agent is added to a liquid to make it of the ordered consistency to decrease the risk of choking) liquids; -Monitor for signs and symptoms of dysphagia (difficulty swallowing), coughing and choking with liquids and/or meal intake. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's May 2024 physician's orders showed an order for mechanical soft diet with nectar thick liquids (start date 4/29/24). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 5/3/24 showed the following: -Cognitively intact; -Upper extremity impairment on one side; -Required set up or clean up assistance for eating; -Diagnoses of stroke and diabetes. Observation on 5/13/24 at 12:35 P.M., in the dining room, showed the following: -The resident sat at the dining room table; -The resident had a glass of thin (not thickened) water and glass of thin (not thickened) lemonade; -The resident took a sip of the water and said I can't have that; -The resident then took a sip of the lemonade and said that isn't nectar thick. During an interview 5/13/24 at 12:35 P.M., the resident said the following: -He/She has had an order for nectar thick liquids since April; -He/She had a stroke and has difficulties swallowing; -More than once, staff have brought him/her regular liquids and he/she can't have them. During an interview on 5/13/24 at 12:40 P.M., Certified Nurse Aide (CNA) ZZ said the following: -He/She may have given the resident his/her liquids at lunch today, but he/she didn't know for sure; -He/She knew the resident had an order for nectar thick liquids. During an interview on 5/14/24 at 10:25 A.M., Licensed Practical Nurse (LPN) V said the following: -CNA staff can access diet orders in the kiosk (electronic point of care charting); -Diet orders and thickened liquids are also on the condensed care plan sheet; -Nursing staff are responsible for and should serve thickened liquids to residents with orders for thickened liquids. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/24 at 12:53 P.M. the Director of Nursing (DON) said she would expect for staff to serve nectar thick liquids to residents with orders for nectar thick liquids. 2. Review of Resident #307's Face sheet showed the resident admitted to the facility on [DATE]. He/She resided on the rehab unit. Review of the resident's care plan for nutrition, dated 4/23/24, showed: -Resident has the potential for nutritional deficits related to recent hospital stay; -Goal: will provide balanced nutritional diet and prevent unintended weight loss: -Interventions: Monitor weekly weight for four weeks after admission. Review of the resident's POS, dated May 2024, showed an order dated 4/23/24 for weekly weight to be done on Sundays. Review of the resident's comprehensive MDS, dated [DATE], showed: -admitted to the facility on [DATE]; -Weight of 208 pounds (lbs). Review of the resident's weights in the EHR on 5/13/24 showed the following: -4/22/24 weight of 208 lbs; -4/23/24 weight of 222.4 lbs; -No weekly weight documented on Sunday, 4/28/24 or for 4/29/24 or 4/30/24 (a week from the previous weights); -The facility had not obtained the resident's weight weekly per physician orders or as their policy or the resident's care plan instructed. 3. Review of Resident #309's face sheet showed the resident admitted on [DATE]. He/She resided on the rehab unit. Review of the resident's care plan for Nutrition, dated 5/4/24, showed the following: -Resident has the potential for nutritional deficits related to recent hospital stay; -Goal: Will provide balanced nutritional diet and prevent unintended weight loss; -Intervention: monitor weekly weight for four weeks after admission. Review of the resident's POS, dated May 2024, showed an order dated 5/4/24 for a weekly weight on Sunday. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's weights documented in the EHR on 5/13/24 showed the following: -Weight on 5/2/24 of 139.4 lbs; -No other weights were documented; -No weekly weight documented on Sunday, 5/5/24; -No weekly weight documented on Sunday, 5/12/24. -There was no documented weight after the resident's admission weight. The facility had not obtained the resident's weight weekly per physician orders or as their policy or the resident's care plan instructed. During an interview on 5/14/24 at 10:00 A.M., CNA II said the following: -Residents on the Rehab hall are weighed every Sunday; -On the CNA charting screen, only the day that is being charted can be seen; you cannot go back to see if something was charted the previous days; -There was no way to tell if a resident had or had not been weighed. During an interview on 5/13/24 at 2:00 P.M., LPN Z said the following: -Residents who reside on the rehab unit are weighed every Sunday, regardless of their admitted ; -Aides take the weights and log them in the point of care (POC) system for charting. POC will populate on the nurses Sunday notes that weights are to be done; this is how the nurses monitor weights. If the order is not entered correctly, and they put it under the Activities of Daily Living (ADL) section of the nurse aide charting, then it will not show up on the nurses screen to be monitored; -Residents #307's orders for weekly weight were entered incorrectly in the computer, so the order does not show up on the nurses screen. Resident #306 did not get an order entered to have the weight done weekly. During an interview on 5/15/24 at 9:15 A.M. LPN JJ said the following: -He/She worked on 5/12/24 on the Rehab hall; -He/She could not remember which residents were to be weighed; -He/She would have written on the daily assignment sheet which residents were indicated on the nurses screen to be weighed. During an interview on 5/14/24 at 12:23 P.M., the Registered Dietician said the facility has a standing order for new admissions to be weighed weekly for four weeks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/24 at 12:52 P.M., the Director of Nursing (DON) said the following: -Residents on the rehab hall should be weighed upon admission then every Sunday for four weeks; -Depending on how the order was entered into the EHR, was how the order will populate for the CNA's and nurses to chart; -Resident #307's order was entered incorrectly and the nurses were not aware that the weight was not done; -Resident #306 did not have the order entered; -She would expect the nurses to be monitoring if a resident has been weighed, as every resident on the Rehab hall was weighed on Sunday. During an interview on 5/22/24 at 1:10 P.M., the administrator said she would expect staff to follow physicians orders. 36219 50851

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32899 Based on observation, interview and record review, the facility failed to ensure staff provided eight residents (Resident #11, #89, #80, #83, #78, #306, #307 and #311) in a review of 35 sampled residents and one additional resident (Resident #120), activities of daily living (ADL) care, including showers, nail care, shaving, oral care, incontinence care and assistance at meal time. The facility census was 149. Review of the facility policy titled Shaving, dated 5/2021, showed the following: Purpose: -To remove excessive hair from the face; -To provide cleanliness; -To improve resident morale and appearance. Review of the facility policy titled Nails, Care of (Finger and Toe), dated 5/2021, showed the following: Purpose: -To provide cleanliness; -To prevent spread of infection; -For comfort; -To prevent skin problems; -NOTE: Fingernails of diabetic residents are to be cut by the nurse. Review of the facility policy for Perineal Care, dated 3/2021 showed: -Purpose: to establish routine practices for providing perineal care, which will cleanse, prevent skin breakdown, prevent infection and prevent odors; -All residents will receive perineal care, as needed, in the morning before breakfast, every evening with evening care at bedtime, as needed after bowel movement or urination, and each time the resident is incontinent. -Procedure: Wash hands, gather equipment, put on gloves. Remove the resident's brief, remove gloves, wash hands and apply new gloves; -Position resident on their back and separate resident's legs; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Make a mitten with the wash cloth, wet and apply soap or peri-wash; -Wash front peri area with soap and water or use disposable peri-wipes. Wash inner thighs and all exposed areas with soap and water or disposable peri-wipes; -Rinse wash cloth in basin if using soap or gram warm wash cloth from plastic bag -Rinse all cleansed areas if using soap and water, and dry thoroughly; -Apply protective ointment to front peri area; -Remove gloves, wash hands and apply clean gloves; -Turn resident on side away from you; -Lather wash cloth and wash rectal area and buttocks if using soap and water, otherwise use disposable peri-wipes; -Rinse all cleansed areas where soap and water was used, and dry thoroughly; -Remove gloves and wash hands; -Put on clean gloves; -Apply lotion, or moisture barrier to buttocks and rectal area if indicated; -Position resident for comfort; -Remove gloves and wash hands. Review of the facility policy, Bathing, dated 6/2021, showed the following: -Purpose was to cleanse the skin of micro-organisms thus preventing infections and preserving the integrity of the skin, to provide comfort and relaxation, stimulate circulation, encourage passive and active range of motion and improve self-esteem through improved appearance; -Policy for bath days and the type of bath to be given will be assigned by the charge nurse according to the resident's preference. Review of the facility policy, Oral Hygiene, dated 5/2021, showed the following: -Purpose was to ensure cleanliness, prevent odor, improve appetite, prevent cavities, tartar buildup, and gum disease, and to stimulate circulation of blood in the gums; -Frequency: every morning and bedtime, at least every two hours from residents that are nothing by mouth (NPO); (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oral care refers to the maintenance of a healthy mouth, which includes not only teeth, but the lips, gums, and supporting tissues. This involves not only activities such as brushing of teeth or oral appliances, but also maintenance of oral mucosa. 1. Review of Resident #83's care plan, revised 2/2/24, showed staff was to provide assistance with activities of daily living (ADLs) as indicated and to document as required. (Review showed no documentation specifically related to showers, shaving or nail care.) Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/20/24, showed the following: -Intact cognition; -Required substantial/maximal assistance from staff for personal hygiene, dressing and shower/bathing; -Rejected care one to three days for the seven day lookback period. Observation on 5/7/24 at 12:30 P.M. showed the resident sat in the dining room with long, dirty finger nails. The resident's hair was greasy and disheveled, and he/she had facial stubble. During an interview on 5/7/24 at 12:30 P.M., the resident said the following: -He/She preferred to be clean shaven; -His/Her nails needed to be cut; -He/She required staff assistance to shower, shave and provide nail care. Review of the facility shower schedule showed the resident was to receive showers twice a week on Wednesdays and Saturdays. Review of the shower sheets for April 2024 showed the following: -No documentation a shower was offered, received or refused 4/1/24 through 4/9/24 (nine days); -The resident received a shower on 4/10/24; -No documentation a shower was offered, received or refused 4/11/24 through 4/16/24 (six days); -The resident received a shower on the 4/17/24, 4/21/24 and 4/24/24; -No documentation a shower was offered, received or refused 4/25/24 through 4/30/24 (six days). Review of the shower sheets on 5/9/24 for May 2024 showed the following: -No documentation a shower was offered, received or refused on 5/1/24 through 5/7/24; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident received a shower on 5/8/24 (14 days after his/her last documented shower on 4/24/24). Observation on 5/8/24 at 8:10 P.M. showed the resident sat in his/her wheelchair in his/her room with long, dirty finger nails. The resident's hair was greasy and disheveled and he/she had facial stubble. During an interview on 5/14/24 at 12:15 P.M., Certified Nurses Aide (CNA) O said the following: -The resident would only allow certain staff to give him/her a shower or shave him/her; -The resident often refused showers; -If a resident refused, he/she would offer again later and if they continue to refuse, he/she would inform the charge nurse; -He/She did not clip the resident's nails with every shower. The resident's nails were hard to keep clean because he/she ate snacks all of the time and food got under them; -If the resident refused a shower, there would still be a shower sheet filled out that said refused. 2. Review of Resident #78's Significant Change MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Dependent on staff for transfers and toileting; -Always incontinent of bowel and bladder. Review of the resident's care plan, revised 4/12/24, showed the following: -The resident was incontinent of bowel and bladder; -Provide incontinence care after each incontinent episode. During an interview on 5/8/24 at 7:25 P.M., the resident said he/she told staff (name unknown) walking by about 15 minutes prior that he/she was incontinent of bowel and bladder and needed to be changed. Observation on 5/8/24 at 9:06 P.M. showed the following: -The resident sat in his/her high back wheelchair in his/her room; (he/she had still been awaiting care from asking as the resident interview from 7:25 P.M. showed); -CNA RR, CNA SS and Licensed Practical Nurse (LPN) TT entered the resident's room; -Staff transferred the resident to bed and provided incontinence care; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's incontinence brief was soaked with urine and he/she had dried feces on his/her skin; -The resident's peri area was red and irritated all the way to the thigh area with a small superficial opening on the left upper thigh area just below the crease of the thigh. -LPN TT discovered a skin tear in the resident's gluteal cleft. During an interview on 5/8/24 at 9:25 P.M., the resident said the following: -He/She had been sitting for a while waiting to be changed; -He/She felt so irritated between his/her legs. During an interview on 5/14/24 at 12:55 P.M., the Director of Nurses (DON) said the following: -It was not appropriate for a resident to wait 30 minutes or more for assistance from staff; -She expected staff to respond immediately if a resident told them he/she was incontinent. 3. Review of Resident #307 face sheet showed his/her diagnoses included stroke with hemiplegia (paralysis on one side of the body). Review of the resident's care plan for Nutritional Status, dated 4/23/24, showed the following: -Resident has the potential for nutritional deficits; -Goal: will provide balanced nutritional diet and prevent unintended weight loss; -Interventions: Assess ability to feed self. Provide assistance/supervision as needed. Review of the resident's comprehensive MDS, dated [DATE], showed the following: -Sometimes understands and sometimes able to make self understood; -Able to make some decisions; -Independent with eating after staff sets up the tray; -Impairment of right side extremities. Observation of the dining room on 5/8/24 at 12:10 P.M. showed the following: -Nursing staff served the noon meal to the residents; -The meal consisted of minestrone soup, cold sandwich (Italian club on hoagie), broccoli salad, pickles in a cup, mayonnaise in a cup, lettuce and onion slice on the side of the plate, chocolate pudding served in a bowl and the silverware was in a sealed plastic wrapper; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No staff assisted the residents with eating; -The resident had difficulty when opening the silverware packet. He/She got the knife out of the package and began to eat the soup with the knife; -The resident spilled the soup on the plate and onto the brace that was on his/her right hand and arm. The resident tried to clean the soup off the brace with a fork then used his/her shirt to wipe the brace; -He/She picked up the bowl of soup and drank from the bowl; -Several staff members walked by the resident as they served other residents their food; -No one stopped to assist the resident. During an interview on 5/13/24 at 3:15 P.M., LPN KK said the following: -There was a staff member assigned to the dining room who was responsible to monitor and to provide assistance as needed; -Any staff member could assist in the dining room and should help when a resident needed help opening an item or cutting up food. During an interview on 5/14/24 at 12:52 P.M., the DON said the following: -A CNA should be in the dining room for all meals providing assistance as needed; -She expected a CNA to help with the opening silverware as needed and assist if a resident needed help with eating. 4. Review of Resident #311's face sheet showed his/her diagnoses included fracture of the vertebrae. Review of the resident's care plan for dentures, dated 4/29/24, showed the following: -The resident wears dentures; -The resident will have comfortable, proper-fitting dentures; -Instruct resident in proper care, handling and storage of dentures. Observation on 5/08/24 at 2:55 P.M. showed a partial denture plate on the sink in the resident's bathroom. A denture cup, containing dirty water, sat next to the partial denture plate. During an interview on 5/8/24 at 2:55 P.M., the resident said the following: -He/She had a partial set of dentures; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not get help with putting them in, taking them out or putting them in the denture cup; -Staff did not assist with brushing his/her teeth or with the dentures. During an interview on 5/13/24 at 3:15 P.M., LPN KK said the following: -The aides and the nurses can help with oral care and ensure that residents have their dentures in their mouths; -The aides should put dentures in a resident's mouth in the morning when they get the residents up. During an interview on 5/14/24 at 12:52 P.M., the DON said she expected staff to assist the residents with dentures, brushing their teeth, and caring for their dentures. 5. Review of Resident #120's admission MDS, dated [DATE], showed the following: -Able to make self understood and understood others; -Some difficulty in making decisions; -Dependent on staff for toileting and hygiene; -Continent of bowel and bladder. Observation on 5/8/24 at 8:23 P.M. showed the following: -The resident lay in his/her bed; -CNA AAA and LPN Z entered the resident's room to provide incontinent care and to change the resident's dressing; -LPN Z removed the resident's urine soiled incontinence brief, and wiped the resident's buttock with a disposable wipe. He/She wiped down the center of the buttocks; -LPN Z retrieved treatment supplies and placed a clean dressing on the wound; -CNA AAA stood at the resident's bedside while LPN Z retrieved the wound supplies; -LPN Z then placed a clean brief under the resident, and with the assistance of CNA AAA, rolled the resident to his/her back and fastened the brief; -Neither CNA AAA or LPN Z performed frontal pericare for the resident. During an interview on 5/8/24 at 9:20 P.M., CNA AAA said he/she thought LPN Z cleaned the front of the resident when he/she was cleaning the resident's back. During an interview on 5/8/24 at 9:00 P.M., LPN Z said he/she did not wipe the front of the resident as he/she thought CNA AAA did that while he/she was getting treatment supplies. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #306's care plan for incontinence, dated 5/7/24, showed the following: -Resident experiences incontinence; -The resident will not exhibit skin breakdown, urinary tract infections, or impaired social interactions, lowered self esteem secondary to incontinence; -Provide incontinence care after each incontinent episode. Observation of the resident on 5/9/24 at 11:11 A.M. showed the following: -CNA MM and CNA NN transferred the resident to his/her bed and removed the resident's urine and feces soiled incontinence brief; -With the resident on his/her side, CNA MM wiped feces from the resident's rectum and buttocks. He/She put his/her hand between the resident's legs and wiped the resident's peri-area from front to back; -CNA NN placed a clean incontinence brief under the resident; -CNA MM rolled the resident onto his/her back, and with out cleansing the resident's groin area that had come into contact with urine, fastened the clean brief around the resident. During an interview on 5/9/24 at 11:30 A.M., CNA MM said the following: -The resident did not have a lot of urine in the brief, so he/she wiped the buttocks where the urine would have touched; -He/She was able to cleanse the front of the resident when he/she wiped the resident from behind. During an interview on 5/9/24 at 12:30 P.M., CNA NN said the following: -He/She did not help with incontinence care; -Staff should clean any area of skin that came into contact with urine or feces. Staff need to place the resident on their back to clean the front of the resident. 7. Review of Resident #11's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Required substantial to maximal assistance with personal hygiene. Review of the resident's care plan, dated 5/8/24, showed the following: -The resident had deficit in ADL self-care and impaired functional mobility related to weakness/again/new environment; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide assistance with ADLs as indicated. Observation on 5/8/24 at 8:35 A.M. showed the following: -The resident lay in bed eating breakfast; -His/her face was covered with hair stubble; -His/Her fingernails were long and had brown debris under them. Observation on 5/10/24 at 12:10 P.M. showed the following: -The resident lay in bed; -His/Her face was covered with facial hair approximate 1/2 inch in length; -The resident's fingernails were long and had brown debris under them. During an interview on 5/10/24 at 12:10 P.M., the resident said the following: -Staff forgot to shave him/her with his/her bed bath yesterday; -All this facial hair made him/her itch; -His/Her nails were so long they break off. 8. Review of Resident #89's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Impairment on one side both upper and lower extremities; -Required substantial/maximal assistance from staff for personal hygiene; -Diagnosis of stroke. Review of the resident's care plan, dated 5/8/24, showed the resident had a deficit in ADL self-care and impaired functional mobility. Observation on 5/10/24 at 12:15 P.M. in the main dining room showed the following: -The resident sat in his/her wheelchair at the table; -The resident's fingernails on his/her left hand were long; -There was black debris under the fingernails on his/her right hand. Observation on 5/13/24 at 12:30 P.M. showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident sat in his/her wheelchair; -He/She had brown debris under his/her fingernails. During an interview on 5/10/24 at 12:15 P.M., the resident said his/her nails were dirty. During an interview on 5/10/24 at 1:48 P.M., CNA EEE said the following: -Staff should provide nail care and shaving two times a week with showers; -He/She didn't get Resident #89's nails trimmed and cleaned yesterday, it should have been done with his/her shower. During an interview on 5/10/24 at 12:37 P.M., Registered Nurse (RN) Q said CNA staff should trim and clean nails and shave residents on shower days and as needed. 9. Review of Resident #80's admission MDS, dated [DATE] showed the following: -Moderately impaired cognition; -Did not reject care; -Upper extremity impairment on one side; -Substantial to maximum assist with personal hygiene. Review of the resident's care plan, last revised 5/1/24, showed the following: -Deficit in ADL self care due to impaired functional mobility; -Provide set-up/cueing/assistance as needed with ADLs. Observation on 5/7/24 at 1:10 P.M. showed the resident sat in his/her wheelchair in his/her room eating lunch. The resident had whitish/gray facial hair on his/her face and neck. Observation on 5/9/24 at 10:16 A.M. showed the resident sat in his/her wheelchair just outside of his/her room. The resident had facial hair covering his/her face. Observation on 5/10/24 at 8:20 A.M. showed the resident sat in his/her wheelchair in the dining room. The resident had whitish/gray facial hair covering his/her face. During an interview on 5/7/24 at 1:10 P.M., the resident said he/she was not sure if staff helped him/her to shave. During an interview on 5/9/24 at 10:30 A.M., the resident's family member said the resident was very particular about his/her appearance. During an interview on 5/14/24 at 12:55 P.M., and 5/22/24 at 1:10 P.M., the DON said the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected the CNAs to clean and clip resident's nails during showers, but would prefer the nurse to use the clippers or put the resident on the podiatry list to be seen; she would also expect staff to provide nail care when needed, not necessarily with every shower; -She expected residents to receive a shower two times a week; -She expected staff to offer the shower again if the resident refused. If the resident refused more than once, the staff should talk to the charge nurse; -She expected staff to shave the residents who want to be shaved. 34003 36219 45563

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34003 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #72), a resident with identified history of ingesting non-food items such as Styrofoam, in a review of 35 sampled residents, was served food on Styrofoam. Additionally, the facility failed to ensure staff safely transferred one additional resident, (Resident #306), with a gait belt, when staff assisted and lifted the resident for transfer by placing their hands underneath the resident's arms during the transfer. The facility census was 149. Review of the facility policy for Gait Belt Use, dated 7/2015, showed: -Purpose: to provide control and balance of a resident that required physical assistance for transfers and gait; -Gait belts should be used with all residents that require physical lifting assistance for transfers and/or ambulation; -Wrap the gait belt around the resident's waist and pull the strap through the buckle to tighten; -Make sure you can slide your open (flat) hand between the belt and the resident; -Face the resident when assisting to standing potion and place both hands on the belt; -Once standing, assistant should position dominate hand on the gait belt at the center of the resident's back to assist with mobility. Review of the undated facility policy, Dining Servers: Guidelines for Safe Handling of Tableware, showed Dining Services staff will provide clean, well maintained tableware in a style and configuration comparable with the facilities dining services and in a manner that meets the individual needs of residents. 1. Review of Resident #306's face sheet showed he/she had diagnoses that included stroke with hemiplegia (paralysis on one side of the body), dysphagia (inability to swallow), diabetes and chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of the resident's care plan, dated 5/7/24, showed no care plan to direct staff on how the resident transferred or what equipment to use when transferring the resident. Observation on 5/09/24 at 11:11 A.M. showed the following: -Certified Nurse Aide (CNA) MM and CNA NN entered the resident's room. The resident sat in a wheelchair and CNA MM explained to the resident they were going to lay the resident down in the bed; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA MM removed a gait belt from around his/her waist, put it around the resident's waist and moved the resident in the wheelchair to the side of the bed; -CNA MM and CNA NN put one hand on the gait belt and one arm under the resident's arms; -The CNA's lifted the resident out of the wheelchair and as they lifted the resident, the resident's shoulders raised up; -Each CNA pulled on the resident's arm to help him/her stand; -The resident had no control on the right side of his/her body and his/her right foot drug the floor as the CNA's pivoted him/her from the chair to the bed; -The CNA's sat the resident on the side of the bed and CNA MM swung the resident's legs onto the bed while CNA NN guided the resident's upper body down to the bed. During an interview on 5/9/24 at 11:30 A.M., CNA MM said if a resident is a two person transfer with a gait belt, each person would put one hand on the gait belt and the other arm/hand under the resident's arm for stability. During an interview on 5/9/24 at 12:30 P.M., CNA NN said the following: -This was the first time he/she had worked with the resident; -He/She did not know how the resident transferred; -He/She should have had both hands on the gait belt to transfer the resident. During an interview on 5/9/24 at 11:45 A.M., Licensed Practical Nurse (LPN) Z said staff should always have their hands on the gait belt when transferring a resident, never under a resident's arms. During an interview on 4/14/24 at 12:52 P.M., the Director of Nursing (DON) said she would expect staff to have both hands on the gait belt when transferring a resident, and never under the resident's arms. 2. Review of Resident #72's face sheet showed the following: -He/She had a diagnosis of Alzheimer's disease (a form of dementia), cognitive communication deficit (difficulty communicating because of injury to the brain that controls the ability to think), unspecified dementia with behavioral disturbance, and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness); -He/She had a legal guardian; -He/She resided on the division unit (an Alzheimer's/dementia unit). Review of the resident's care plan showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem start date: 5/24/21 - The resident has the potential for nutritional deficits related to a recent hospital stay and a regular diet which consists of finger foods; -Approach start date: 5/24/21 - Assess the residents' ability to feed him/herself and provide assistance/supervision as needed; -Problem start date: 12/05/22 - The resident had ingested and/or has the intermittent desire to ingest non-food items (Styrofoam from dinner plates); -Goal target date: 7/29/23 - The resident will not ingest non-food items and/or experience injury from ingestion of non-food items; -Approach start date: 12/05/22: 1. The resident will be observed during meals for any attempts at ingesting non-food items; 3. The resident will not be served meals/drinks on/in Styrofoam plates/cups or be given plastic silverware. Review of the resident's quarterly Minimum Data Set (MDS), (a federally mandated assessment completed by facility staff), dated 8/27/23 and 2/26/24, showed the following: -The Brief Interview for Mental Status (BIMS) (identifies cognition) could not be conducted as the resident is rarely/never understood; -Severely impaired for both short- and long-term memory; -His/Her cognition skills for daily decision making regarding tasks of daily life were severely impaired and he/she never/rarely made decisions; -He/She had behaviors of inattention and disorganized thinking were continuously present and did not fluctuate; -He/She required help with setting up and cleaning up with eating, but could eat without assistance. Review of the resident's physician orders, dated May 2024, showed the following: -The resident's diet was regular and to serve finger foods; -The resident level of orientation was to his/herself. Observation on 5//7/24 at 12:30 P.M. showed the following: -The resident sat a table in the dining room eating; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff served the resident his/her drink in a Styrofoam cup. No staff member sat with the resident at his/her table. The resident bit down on a Styrofoam cup he/she was drinking from and staff put on gloves to get the Styrofoam out of his/her mouth. The resident clamped his/her teeth down together making it difficult for staff to retrieve Styrofoam from his/her mouth. LPN DD was able to retrieve a piece of Styrofoam about the size of a dime and the bite mark missing from the Styrofoam cup looked to be about one-half dollar in size. Review of the resident's progress note, dated 5/07/24 at 12:38 P.M., showed staff documented the following: -At lunch, the resident was observed taking a bite out of a Styrofoam cup; -LPN DD immediately attempted to remove the Styrofoam from the resident's mouth; -After comparing the missing piece from the cup, it was determined the resident did ingest some of the Styrofoam; -Call placed to nursing administration, the physician and the guardian. Review of the resident's physician orders, dated 5/07/24, showed a new order to monitor for any adverse reaction due to eating a piece of Styrofoam cup, include findings in progress notes every shift (start 5/07/24). Review of the resident's care plan, revised 5/08/24, showed no additional documentation added to the plan. Review of the facility's division care schedule, a document listing twenty four care areas in a grid format for ease of care for each resident on the unit dated 5/08/24, showed the following: -The care schedule is kept at the division nursing desk; -Keep the resident from wandering around the division dining area during meals because he/she will eat leftovers from other residents. Observation of the resident in the dining room on 5/09/24 at 12:57 P.M., showed staff served the resident grapes in a Styrofoam bowl. The resident ate the grapes from the bowl, no staff member sat with the resident or supervised the resident. Observation of the resident in the dining room on 5/13/24 at 12:30 P.M., showed the resident sat at a table eating his/her noon meal. Staff served the resident fruit in a Styrofoam bowl. The resident picked up the partially fruit filled bowl and used it to move his/her hair out of his/her eyes. While he/she held the Styrofoam bowl, he/she rubbed the bowl on his/her left cheek and then started licking the bowl with his/her tongue and moved the rim of the bowl to his/her mouth. No staff monitored the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's, undated, dietary restrictions chart, located in the division 200 servery, when? if on 5/7 before the 12:30 P.M. observation, please move this statement there showed the resident required finger foods and a special cup. (Found at the end of the survey after all of the meals had been served) During an interview on 5/23/24 at 9:17 A.M., the resident's guardian/family member, said the following: -Staff should never serve the resident food in Styrofoam, the resident had ingested a piece of Styrofoam when this had occurred; -He/She would have expected staff serve the resident food in something the resident could not bite through; -The resident would mistake Styrofoam for food because of his/her cognition. During an interview 5/13/24 at 3:07 P.M., Certified Medication Technician (CMT) FF said the following: -He/She did not believe any resident on the division should have been served any food on/in Styrofoam because it was unsafe, even if the dishwasher was not working; -He/She would go off of the dietary restrictions and instructions from the nurse when serving the resident his/her food; -He/She was unaware the resident had eaten a piece of Styrofoam earlier that week. During an interview on 5/07/24 at 12:37 P.M. and 5/22/24 at 9:26 A.M., LPN DD said the following: -The facility dishwasher had been broken for about one week and staff served the residents food in/on Styrofoam; -He/She was not aware the resident's care plan showed he/she was not supposed to be served food on/in Styrofoam; -He/She was not aware the resident had ingested Styrofoam before 5/07/24. During an interview on 5/13/24 at 2:39 P.M. and 5/14/23 at 10:55 A.M., LPN EE said the following: -After receiving report, he/she knew the resident needed to be served food in a plastic cup instead of Styrofoam; -He/She had asked the dietary manager earlier today (5/13/24) to serve the resident's fruit in a plastic cup; -All of the staff should be following the resident care plans; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The aides bring the food to the residents, but it was still the nurse's responsibility to ensure no Styrofoam was given to the resident; -On 5/13/24 and 5/14/24, he/she had instructed all of the aides at the beginning of the shift, there should be no food served in Styrofoam to the resident; -Staff served the resident fruit in a Styrofoam bowl during lunch on 5/13/24; -He/She did not know why the resident had no Styrofoam added to his/her care plan in December 2022. During an interview on 5/13/24 at 2:51 P.M., the dietary manager said the following: -He/She was unaware the resident was not supposed to be served food on Styrofoam; -Dietary staff members prepare fruit in the Styrofoam bowls and delivered it to the division; -If the resident was not supposed to have the Styrofoam, the division staff could empty the food in a plastic cup to be served to the resident. During an interview on 5/14/24 at 12:26, the dietician said he/she would expect a resident to not be served food on Styrofoam if the resident could not safely be served on Styrofoam. There were plastic items the dietary staff could use for food service. During an interview on 5/14/24 at 12:52 P.M., the Director of Nursing (DON), said the following: -She would not expect a resident to be served food on/in Styrofoam if the resident had taken a bite out of a Styrofoam cup the prior day; -She did not feel it was safe for division 200 to be served food on/in Styrofoam even with the dishwasher being out of service; -It was ultimately the division nurses responsibility to ensure the resident was not served food in/on Styrofoam; -Dietary should be notified by the nursing staff as to what a resident should be served food on/in if the resident could not be safely served food on/in Styrofoam. During a phone interview on 5/22/24 at 1:10 P.M., the administrator said the following: -She would not expect a resident to be served food on Styrofoam if they had taken a bite out of a Styrofoam cup the day before unless closely monitored; -She would expect staff to follow a resident's care plan; -She would not expect a resident to be served food on Styrofoam if their care plan from 12/2022 said the resident should not be served food on Styrofoam; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It would be resident specific if it is safe for division 200 to receive food served on/in Styrofoam; -Staff could wash dishes on division 200; they are using some regular dishes even with the dishwasher being broken; -Nursing and or dietary were responsible to ensure the resident would not receive food on/in Styrofoam. 47008 50851

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34003

Based on observation, interview, and record review, the facility failed to provide appropriate care of a urinary catheter (a tube inserted into the bladder to drain urine into a collection bag) for three residents (Resident #58, #20 and #11), in a review of 35 sampled residents. The facility census was 149.

Review of the facility policy, Catheter Care, revised 3/2021, showed the following:

Purpose:

-To keep indwelling catheter free of discharge and/or crusting which can cause infections;

-Attach bag to bed frame only;

-Never lift bag above bladder level (source of infection).

1. Review of Resident #58's continuity of care document (CCD) showed the resident had diagnoses that included personal history of UTIs, neuromuscular dysfunction of bladder (when the nerves and the muscles in the bladder don't communicate properly with the brain), and retention of urine (when the bladder does not completely empty of urine).

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 2/23/24, showed the following:

-Dependent on two or more staff for hygiene and toileting hygiene;

-Had indwelling catheter;

-Occasionally incontinent of bowel.

Review of the resident's care plan, revised 4/17/24, showed the following:

-The resident was at risk for contracting a multi-drug resistant organism (MDRO) due to an indwelling device that requires the use of personal protective equipment during high contact activities;

-The resident had potential for recurrent UTI's related to history of UTI's;

-If the resident was incontinent, provide peri care as soon as possible after incontinent episode, per facility policy, being sure to cleanse well and cleanse from front to back;

-Use principles of infection control and universal/standard precautions.

Observation on 5/8/24 at 8:25 P.M., showed the following:

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Certified nurse aide (CNA) UU, walked into the resident's room, donned gloves, picked up trash (candy wrappers, used plastic ware and Styrofoam cups) from the room and held the trash can with his/her gloved hands. With soiled gloves, he/she grabbed a graduate container (container used to measure a volume of liquid) from the resident's bathroom and emptied the resident's urine filled catheter bag by removing the drainage tube from the holder, (touching the drainage tube with his/her soiled gloves), and emptied the collection bag into the graduate container. With soiled gloves, CNA UU then touched the drainage tube and placed it back in the holder. Observation of CNA VV on 5/9/24 at 12:00 P.M. showed the following: -CNA VV put on gloves upon entering the resident's room, grabbed the trash (candy wrappers, Styrofoam cups) from around the room and bedside table and placed them in the trash can and cleaned spilled soda from the resident's bedside table; -Without doffing his/her soiled gloves, hand sanitizing or washing his/her hands with soap and water and donning new gloves, CNA VV went into the bathroom and wet some washcloths (one with soap and one with water); -With the soapy washcloths and soiled gloves, CNA VV wiped down the right side of the resident's leg, wiped down the left side of the resident's leg, then with the same wash cloth, cleaned the catheter tube from the insertion site down the tube; -Still wearing the same soiled gloves, CNA VV repeated another swipe down the catheter tubing with the soiled wet washcloth; -CNA VV did not perform proper catheter care. 2. Review of Resident #20's significant change MDS), dated [DATE], showed the following: -Indwelling catheter; -Diagnoses of heart failure, diabetes, and dementia; -UTI in the last 30 days; -Hospice care. Review of the resident's care plan, dated 4/17/24, showed the following: -Resident requires an indwelling urinary catheter related to retention; -Position bag below the level of bladder; -Resident has deficit in activities of daily living (ADL) self-care and impaired functional mobility. Observation in the resident's room on 5/9/24 at 2:25 P.M., showed the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident sat in his/her Broda chair (a type of chair that provides the ability to tilt and recline) with a urinary bedside drainage bag hanging on the lower bar under the Broda chair; -CNA CCC and CNA ZZ entered the resident's room and applied gowns and gloves; -CNA CCC removed the bedside drainage bag from the lower bar under the Broda chair and held it above the level of the resident's bladder; -The urine in the tubing was cloudy yellow with mucous, and as CNA CCC held the bag at that level, urine backed up in the catheter tubing. 3. Review of Resident #11's quarterly MDS, dated [DATE], showed the following: -Required substantial to maximal assistance with toileting and personal hygiene; -Indwelling catheter; -Diagnoses of cancer, neurogenic bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), septicemia (blood poisoning by bacteria), and diabetes; -Dependent on staff for chair/bed to chair transfer. Review of the resident's care plan, dated 5/8/24, showed the following: -Resident has a potential for recurrent UTIs related to history of UTI; -Resident requires an indwelling urinary catheter related to urinary retention/neurogenic bladder; -Position bag below level of bladder; -Provide catheter care every shift and as needed; -Weight bear as tolerated, two person mechanical lift transfer. Observation on 5/8/24 at 10:20 A.M., in the resident's room, showed the following: -CNA EEE and CNA ZZ entered the resident's room; -The resident lay in bed; -CNA EEE and CNA ZZ hooked the resident up to the mechanical lift; -CNA EEE hooked the resident's urine collection bag on a loop of the sling (above the level of the resident's bladder); -The urine in the tubing was yellow with mucous and had a strong smell; -CNA EEE and CNA ZZ transferred the resident to his/her wheelchair; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA EEE removed the urinary collection bag from the loop of the sling and placed it under the resident's wheelchair. During an interview on 5/10/24 at 1:48 P.M., CNA EEE said the following: -Catheter bags should be off the floor; -The catheter bag should always be below the level of the bladder. During an interview on 5/28/24 at 9:00 A.M., LPN W said the following: -The catheter bag should be below the level of the bladder at all times; -The catheter bag should be off the floor at all times. During an interview on 5/10/24 at 12:37 P.M., Registered Nurse (RN) Q said the BSDB should be kept off the floor and below the level of the bladder. During an interview on 5/14/24 at 12:53 P.M. the Director of Nursing said the following: -She would expect the catheter drainage bag to be off the floor; -She would expect the catheter drainage bag to be below the level of the bladder at all times. 36219 45563

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 34003 Based on observation, interview, and record review, facility staff failed to provide food in a form as ordered by the physician, monitor weights, notify the physician of the refusal of nutritional supplements and weights for two residents with significant weight loss, (Resident #59 and #305), in a review of 35 sampled residents. The facility census was 149. Review of the facility policy for Weight Monitoring, dated 11/2018, showed: -Purpose: to obtain accurate weight of each resident and maintain control of weight changes; -Residents are weighed on admission, weekly for the first four weeks and monthly thereafter, unless otherwise ordered by nursing order or the attending physician; -Residents are weighed upon admission and on a weekly basis for the first four weeks to establish a baseline weight; -Any resident with a weight gain/loss of five pounds will be re-weighed within 24 hours; -Weight reports will be monitored by the Charge Nurses, Registered Dietician (RD)/Dining Services Director and Director of Nursing. The weight management committee will meet monthly to discuss residents with fluctuation; -Significant weight loss is defined as residents with weight loss of five percent (%) or more in the last 30 days, seven and one-half % or more in the last three months or 10% or more in the last six months; -Residents with unplanned weight loss/gain will be weighed weekly or as ordered by the physician. A weight change follow-up event will be completed by the Charge Nurse in the electronic health record (EHR); -The charge nurse is responsible to immediately notify the attending physician, registered dietitian and resident representative of weight loss/gain; -Any significant weight loss or gain is to be noted in the progress notes section in the EHR, as to the reason why the resident has weight loss or gain with any interventions. 1. Review of Resident #59's significant change Minimum Data Set (MDS), (a federally mandated assessment instrument completed by facility staff), dated 10/25/23, showed the following: -Cognitively intact; -Swallowing disorders (holding food, coughing/choking and difficulty/pain with swallowing); (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Weight of 158 pounds (lbs); -Mechanically altered diet while a resident; -No weight loss/gain; -Set up only for eating. Review of the resident's weight record for 2024 showed the following: -February weight of 148.4 pounds; -March weight of 43 pounds (5.59 % loss for one month). Review of the resident's April 2024 physician order sheets (POS) showed and order for a mechanical soft diet (12/8/22). Review of the resident's weight record showed staff documented the resident's weight as 135 lbs on 4/12/24. Review of the resident's progress note, dated 4/15/24, and authored by the Registered Dietician (RD), showed the following: -Current body weight 135 lbs, 3/8/24 weight 143 lbs, 1/7/24 weight 153.4 lbs, weight 10/1/23 158 lbs. Weight down 8 lbs/5.6% for one month, 18 lbs/12% for three months and 23 lbs/14.6% for six months. Weight loss is significant at one, three and six months. Body Mass Index (BMI)=23.91 indicating adequate weight/height. On mechanical soft diet. By mouth intakes variable, refuses Glucerna (nutritional supplement) so will try to change to Ensure Clear (nutritional supplement) two times daily to provide 500 kcal and 18 grams protein if consumed. Often refuses care. Eats all meals in bed. On hospice for comfort and support. Resident may continue to lose weight if intake remains poor. Encourage food/fluid intakes as tolerated. Monitor weight, by mouth intakes and skin. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -No swallowing disorders; -Weight of 135 pounds; -Mechanically altered diet; -Set up only for meals; -No weight loss/gain. Review of the resident's April 2024 POS showed a new order for Ensure clear two times daily, scheduled for 7:15 A.M. -11:15 A.M. and 3:15 P.M. -6:45 P.M. (order date of 4/15/24). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, last revised 4/16/24 showed the following: -Weight loss; -Monitor need for changing diet consistency to increase ease of eating; -Monitor/record weight weekly for four weeks then monthly (4/16/24); -Upper dentures; -Provide bedtime snack; -Mechanical soft diet; -Assess ability to feed self. Provide assistance/supervision as needed; -Monitor for signs/symptoms of dysphagia (difficulty swallowing), coughing and choking with liquid and/or meal intake; -Ensure Plus (nutritional shake) two times daily. Review of the resident's April 2024 POS showed a new order for weekly weights times four weeks (4/19/24 to 5/17/24). Review of the resident's weight record showed the following: -No documentation to show staff obtained the resident's weight on 4/16/24; no documentation the resident refused; -No documentation to show staff obtained the resident's weight on 4/19/24; no documentation the resident refused; -Staff documented on 4/21/24 that the resident's weight was not taken (no documentation of a reason why); -No documentation to show staff obtained the resident's weight on 4/26/24; no documentation the resident refused. Review of the resident's medication administration record (MAR) dated 4/2024 showed the following: -Resident refused supplements 21 out of the 29 times they were scheduled; -Weights were documented as not taken on 4/21 and 4/28, with no reason why documented. Review of the resident's progress notes from 4/1/24 to 4/30/24, showed no documentation the resident's physician was notified of weight loss, concerns with obtaining weekly weights or supplemental refusals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's POS, dated 5/2024, showed the following: -Mechanical soft diet (12/8/22); -Ensure clear two times daily, scheduled for 7:15 A.M. -11:15 A.M. and 3:15 P.M. -6:45 P.M. (order date of 4/15/24); -Weekly weights times four weeks (4/19/24 to 5/17/24). Review of the resident's May 2024 MAR, from 5/1/24 to 5/6/24, showed one weight attempted on 5/5/24 and the resident refused. Review of the resident's progress notes from 5/1/24 to 5/6/24, showed no documentation staff notified the physician of the resident's refusal to obtain his/her weight. Review of the resident's weight record on 5/7/24 showed no documentation to show staff obtained the resident's weight on 5/3/24 and no documentation about the resident refusing to have his/her weight obtained on 5/5/24. During an interview on 5/7/24 at 12:21 P.M., the resident said staff did not bring desserts with trays and that he/she had to beg for them. Review of the lunch dietary spreadsheet, dated 5/8/24, showed staff was to prepare and serve minestrone soup, #8 ground Italian meat and cheese on hoagie bun, shredded lettuce, diced tomatoes, chopped steamed broccoli and a peach half for a mechanical soft diet order. Observation and interview on 5/8/24 at 1:53 P.M., showed the resident lay in bed with the head of the bed elevated. A Styrofoam plate sat on his/her lap and contained an Italian sub sandwich made up of ham, roast beef, salami and cheese. The meat was not cut up, mechanical soft or ground. The plate also contained a pickle, lettuce, an onion and a tomato (none were cut up or diced) and a cup of chocolate pudding. No peach half was served. The resident said he/she could not chew the food. Review of the supper dietary spreadsheet, dated 5/8/24, showed staff was to prepare and serve #8 diced tomato salad, #8 ground Salisbury steak with mushroom gravy, white rice, Normandy vegetables and canned ambrosia fruit salad for a mechanical soft diet order. Observation and interview on 5/8/24 at 8:14 P.M., showed the resident was in bed with the head elevated and his/her food on a Styrofoam plate which included a formed Salisbury steak (not ground with minimal gravy) and cooked broccoli/carrot vegetable mix and rice. There was no dessert (ambrosia fruit salad), however staff retrieved ice cream for the resident after he/she requested it. He/She had taken a few bites of the steak. The resident said he/she could not eat it as he/she had trouble swallowing the food. Review of the lunch dietary spreadsheet, dated 5/9/24, showed staff was to prepare and serve a green salad/dressing, #8 ground sole with tarter sauce, #8 mashed potatoes, Tuscany vegetables and canned fruit for a mechanical soft diet order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 5/9/24 at 1:07 P.M. showed the resident in bed and his/her lunch tray in front of him/her. The tray contained a large, whole (not cut or ground) piece of breaded fish (no tarter sauce), a large, whole (not cut) potato wedges (not mashed potatoes), mixed vegetables with greens, coleslaw and no canned fruit (dessert). The resident said he/she could not eat the fish (tapping it with a fork) and requested a cheeseburger. Staff (Nurse Aide in Training (NAT) T) brought a cheeseburger, whole and not ground, for the resident and exited the room. Review of the diet sheet (posted in the 600 unit servery) dated, 5/10/24 at 8:25 A.M., showed the resident took his/her meals in his/her room and his/her diet was listed as mechanical soft. Review of the resident's MAR, dated 5/2024, showed the following: -The resident refused Ensure Clear (ordered two times daily) 14 times from 5/1/24 to 5/13/24 out of the 26 times it was scheduled; -On 5/12/24, staff documented the resident was not weighed due to condition. Review of the resident's progress notes for May 2024 (through 5/14/24) showed no documentation staff notified the physician of the resident's refusal to obtain his/her weight or consume the ordered nutritional supplement. During an interview on 5/10/24 at 8:22 A.M., Dietary Aide G said the following: -He/She helped plate trays in the 600 unit servery; -They refer to the dietary sheet for diet orders which are updated and printed weekly; -He/She double checked the diet sheet (which sat atop the serving table on each end) to ensure it was correct; -The certified nurse aides (CNA's) stand at the servery door, report the resident name and diet order, and they in turn plate the food and the CNA's deliver the trays. During an interview on 5/9/24 at 3:12 P.M., Nurse Aide in Training (NAT) T said the following: -He/She worked regularly on the resident's unit; -He/She knew residents diets (regular, mechanical soft diet, puree); -Staff serving the resident meals should be aware of the resident's diet; -A mechanical diet should have ground meat; -He/She was not aware that the resident was on a mechanical soft diet; -The resident had said he/she did not like the ground meat; -Staff should cut up meat and other food if chunks were too big; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA's served meal trays to residents after telling the servery staff who they needed a tray for and what their diet was; -The servery staff would hand them the meal tray and they would deliver it to the resident either in the dining room or in their room. During an interview on 5/14/24 at 9:55 A.M. Certified Nurse Aide (CNA) II said the following: -He/She believed the resident was on a regular, NCS (no concentrated sweets) as he/she was a diabetic; -He/She was not aware that the resident was on a mechanical soft diet; -If a resident refused their ordered diet, he/she would expect staff to inform him/her; -Staff had not reported to him/her of the resident's refusal to eat his/her ordered diet. 2. Review of Resident #305's undated face sheet showed the following: -The resident admitted to the facility on [DATE]; -Diagnoses included dementia with anxiety, depression, and vitamin deficiency. Review of the resident's progress notes, dated 4/23/24 at 6:15 P.M., showed the resident refused most of his/her meal. He/She left the dining room early at dinner. The resident was yelling out for help as he/she did not know where his/her room was. Staff assisted the resident to his/her room and instructed the resident to wait for assistance to get into bed. Review of the resident's April 2024 POS showed the following: -Regular diet; -Weekly weights on Sundays; -May follow recommendations made by the RD. Review of the resident's weight record, dated 4/23/24, showed the resident weighed 192.2 pounds. Review of the resident's intake record for April 2024 showed the resident ate 26-50 percent (%) of his/her food at breakfast and lunch on 4/24/24. Review of the resident's progress notes, dated 4/24/24 at 4:03 P.M., showed the RD completed an initial nutrition assessment. The resident's current body weight was 192.2 pounds on 4/23/24. The resident was on a regular diet. His/Her oral intake was fair. The resident reported his/her appetite was good, and he/she liked most foods. Staff to encourage food/fluids intake and to monitor the resident's weight and intake. Review of the resident's intake record for April 2024 showed the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/25/24, the resident ate 1-25% at breakfast and lunch; -On 4/26/24, the resident ate 1-25% at lunch. Review of the resident's weight record showed no documentation staff obtained a weekly weight as ordered on 4/28/24 (or during the week of 4/28/24 through 5/4/24). Review of the resident's intake record for April 2024 showed the following: -On 4/28/24, staff documented the resident did not eat at lunch; -On 4/29/24, the resident ate 1-25% at breakfast and lunch; -On 5/1/24, the resident ate 1-25% at breakfast and lunch; -No documentation of the resident's meal intakes after 5/1/24. (The RD recommended on 4/24 for staff to monitor the resident's intake.) Review of the resident's admission MDS, dated [DATE], showed the following: -Cognition moderately impaired; -Moderate depression; -Supervision required for eating. -Weight 192 pounds; -No weight loss or gain. Review of the resident's weight record, dated 5/7/24, showed the resident weighed 180.8 pounds (11.4 pound weight loss, 5.9% loss in two weeks). Observation on 5/7/24 at 12:28 P.M. showed staff began to serve the lunch meal out of kitchenette, bringing meals out one meal at a time. The resident received his/her tray at 12:28 P.M. At 12:30 P.M., the resident left the dining room without eating his/her lunch meal. Staff was not in the dining room at this time and did not observe the resident leave. During an interview on 5/7/24 at 2:50 P.M., the resident said he/she did not remember why he/she did not eat lunch. He/She did not eat very much anymore. Review of the resident's progress notes, date 5/8/24 at 10:55 A.M., showed the RD completed a weight note. The resident's current body weight on 5/7/24 was 180.8 pounds. The resident's weight was 192.2 pounds on 4/23/24; weight down 11 pounds in one month, which was significant. The resident was on a regular diet. His/Her intake was generally good. The resident said he/she had a good appetite and ate most of what was on his/her plate. Recommend nutritional supplement every day to provide 350 kilocalories (kcal) and 13 grams (g) of protein. Staff to encourage food/fluid intakes and monitor weight and intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/8/24 at 12:36 P.M. showed staff began to serve the lunch meal. Observation on 5/8/24 at 12:59 P.M. showed the following: -The resident left the dining room after only eating a few bites of his/her meal; -Staff was not in the dining room during this time; -No staff observed the resident leave. Review of the resident's care plan, dated 5/8/24, showed the following: -The resident experienced weight loss; -Encourage oral intake of food and fluids; -Monitor need for changing diet consistency to increase ease of eating; -Monitor/record weight weekly for four weeks, then monthly. Notify the physician and family of significant weight change; -Offer available substitutes if resident has problems with the food being served. Review of the resident's May 2024 POS showed an order dated 5/8/24 for nutritional supplement every day with morning medication pass. Review of the resident's MAR, dated May 2024, showed the following: -On 5/9/24, the resident did not receive the nutritional supplement; the administration box said NONE (other days had percentages); -On 5/10/24, the resident did not receive the nutritional supplement; the administration box said NONE. Review of the resident's MAR, dated May 2024, showed the resident did not receive the ordered nutritional supplement on 5/13/24; the administration box said NONE. Review of the resident's weight record, on 5/14/24, showed no documentation staff had obtained the resident's weight on Sunday (per physician order), 5/12/24, and had not obtained a weight since 5/7/24. During an interview on 5/14/24 at 9:55 A.M., CNA II said the following: -Staff weigh the residents once a week on Sunday; -Oral intake comes up on the computer charting system for the CNA to complete for 10 days after admission; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident did not eat his/her meal, he/she would report this to the charge nurse; -CNAs do not give nutritional supplements, only Certified Medication Technicians (CMTs). During interview on 5/14/24 at 12:45 P.M., CNA OO said the following: -Weights that needed to be obtained were placed (written) on the daily assignment sheet (by the nurse) at the nurses station for the CNA to obtain; -If a weight was needed, it was red in the computer charting system; -If a weight was not done the previous week, the CNA could not see it wasn't completed; -Weights are supposed to be documented in the computer. During an interview on 5/14/24 at 9:40 A.M., CMT LL said the following: -CMTs were responsible to give nutritional supplements if a nutritional supplement was ordered; -He/She asks residents (in general) if they wanted the nutritional supplement during the morning medication pass; -If a resident said they did not want a nutritional supplement, he/she would not give the resident one; -If a resident said they wanted a nutritional supplement, he/she would give them one after he/she completed the medication pass; -If a resident refused to take a nutritional supplement, he/she would notify the charge nurse; -If a resident received a nutritional supplement but did not drink it, he/she would notify the charge nurse. During an interview on 5/10/24 at 11:28 A.M., and 5/14/24 at 10:00 A.M., Licensed Practical Nurse (LPN) Z said the following: -Staff did not have to document meal intakes; -CMTs gave nutritional supplements if a nutritional supplement was ordered. During interview on 5/14/24 at 10:08 A.M., the Director of Nursing (DON) said the following: -Nursing administration entered new admission orders into the computer charting system; -Weight orders were put in with admission orders, and tasked to the CNAs for documentation; -Nurses would not see if the CNA completed the task; (obtaining weights as ordered); (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oral intake was recorded for seven days after admission; -CMTs were responsible for monitoring nutritional supplements. During an interview on 5/14/24 at 12:22 P.M., the RD said the following: -She would expect diet orders to be followed; -She would not expect a resident with an order for a mechanical soft diet to be served a regular diet; -A resident on a mechanical soft diet should not be served fish, potato wedges, Salisbury steak or Italian hoagies unless it was ground; -If a resident refused an ordered diet, he/she would expect staff to take the tray to the nurse, ensuring she was made aware and could then notify the physician; -CNA's and servers should be aware of diet orders. They should also refer to the list; -She could not say if Resident #59 being served the wrong diet was directly related to the weight loss as the resident's eating was variable; -They could speak with hospice regarding comfort foods for Resident #59; -Staff entered a standard order for weekly weights for the first four weeks and then monthly thereafter into the computer system on admission; -She looked at oral intakes but she also liked to observe the residents during meal times; (there was no documentation in the RD's notes to indicate observations had been made of either resident); -She met with the interdisciplinary team and gave her suggestions; -CMTs made him/her aware if a resident did not take their supplements. During an interview on 5/22/24 at 1:10 P.M., the Administrator said the following: -She would expect staff to follow orders; -Nursing who care for the residents should be aware of their diet orders (regular vs mechanical soft); -If a diet was refused he/she would expect staff to notify the family and physician; -The physician would be the one to decide if the diet was changed. 50851

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 49528 Based on observation, interview and record review, the facility failed to ensure three additional residents (Resident # 39, #51, #109), who received insulin injections, were free from significant medication errors. Staff failed to prime (remove the air from the needle and cartridge) the Humalog Kwik pen (prefilled pen of fast acting insulin (medication injected under the skin used to treat diabetes)) needle as instructed by the manufacturer prior to administration of the medication, resulting in administration of less, or more than the ordered dose of Humalog. Staff failed to hold the needle against the resident's skin for the manufacturer's suggested time after the administration of the medication. The facility census was 149. Review of the facility policy, Insulin Administration, dated 05/2021, showed the following: -Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used only on the correct individual; -Insulin pen needles are also intended only for a single person; -Explain the procedure to the resident; -Provide privacy; -Wash hands; -Put on gloves; -Check the label on the pen and make sure it is the correct ordered insulin for the resident; -Check the expiration date; -Remove the pen cap and cleanse the rubber stopper with an alcohol wipe. Attach pen needle to device. Do not use a syringe to draw insulin out of the pen; -Select an approved site for insulin administration; -Cleanse the area with an alcohol wipe; -Prime the pen immediately before injection. Priming is dialing up two units of insulin and pressing the button on the pen to shoot some insulin into the air. You should see a drop of insulin at the end of the needle. More than one prime may be required for a new pen; -Dial up the dose on the pen as indicated on the order. Verify that insulin is being given at the correct time in relation to meals; -Administer insulin to cleansed area using a subcutaneous method. The inserted needle should remain in the tissue for 10 seconds after the pen gets back down to zero to ensure proper absorption; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dispose of needle in a sharps container. Please note that needles are one time use only; -Cover resident and ensure his/her comfort. Place call light within reach; -Document dose given on eMAR. Review of the Humalog Kwik pen package insert showed the following in part: -Humalog Kwik Pen was a disposable single-patient-use prefilled pen containing 300 units of Humalog insulin. Each turn (click) of the dose knob dialed one unit of insulin. You could give from one to 60 units in a single injection; -Pull the pen cap off, wipe the rubber seal with alcohol swab, check the liquid in the pen and ensure the liquid is clear. Select a new needle, remove the paper tab from the outer needle shield, push the capped needle straight onto the pen and twist the needle on until tight. Pull off the outer needle shield and remove the inner needle shield; -Prime. If you do not prime before each injection you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle; -Turn the dose knob and select the number of units you need to inject and administer the medication; -Choose your injection site. Humalog is injected subcutaneously (under the skin) in your stomach area, buttocks, upper legs, upper arms; -Wipe skin with an alcohol swab and let the skin dry before you inject your dose; -Insert the needle into the skin. Push the dose knob all the way in; -Continue to hold the dose knob in and slowly count to five before removing the needle. 1. Review of Resident #51's May 2024 Physician Order Sheets (POS) showed the following: -Diagnosis of type 2 diabetes mellitus; -Humalog Kwik Pen Insulin (insulin Lispro) 100 units/milliliter (ml) subcutaneous (sub-q) (tissue just below the skin) inject 30 units with lunch; -Accucheck (blood glucose test) four times daily and at bedtime; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Humalog KwikPen Insulin (insulin Lispro) insulin pen, 100 units/ml; amount per sliding scale (a dose amount to be determined based on the accucheck); if blood sugar is 150 to 200 give two units, if blood sugar is 201 to 250 give four units, if blood sugar is 251 to 300 give six units, if blood sugar is 301 to 350 give seven units, if blood sugar is 351 to 400 give 10 units, if blood sugar is greater than 400 give 12 units subcutaneous. Observation on 5/9/24 at 11:45 A.M. showed the following: -Licensed Practical Nurse (LPN) W obtained the resident's blood sugar level with results of 289 milligrams per deciliter (mg/dL) and determined Humalog sliding scale Insulin dose was to be six units; -LPN W obtained the resident's Humalog flex pen from the top medication cart drawer, removed the lid, cleansed the tip with an alcohol pad and attached a new sterile needle; -LPN W did not prime the insulin pen; -LPN W dialed 36 units of Humalog insulin (Humalog 30 units scheduled and six units sliding scale) and administered the medication in the resident's subcutaneous tissue of the abdomen; -LPN W did not hold the dose knob in for five seconds before removing the needle. 2. Review of Resident # 39's May 2024 POS showed the following: -Diagnosis of type 2 diabetes mellitus; -Humalog Kwik Pen Insulin (insulin Lispro) 100 u/ml sub-q, inject 16 units with lunch; -Accucheck four times daily; -Humalog KwikPen Insulin (insulin Lispro) insulin pen; 100 u/ml; amount per sliding scale; if blood sugar is 200 to 250 give two units, if blood sugar is 251 to 300 give four units, if blood sugar is 301 to 350 give six units, if blood sugar is 351 to 400 give eight units, if blood sugar is greater than 400 give nine units subcutaneous. Observation on 5/9//24 at 12:03 P.M showed the following; -LPN W obtained the resident's blood glucose level with a blood glucose reading of 187 mg/dL and determined that sliding scale insulin was not needed; -LPN W obtained the resident's Humalog Kwik pen from the top medication cart drawer, removed the lid, cleaned the tip with an alcohol pad and attached a new sterile needle; -LPN W did not prime the insulin pen; -LPN W dialed up 16 units of Humalog insulin and administered the medication in the resident's subcutaneous tissue of the abdomen; -LPN W did not hold the dose knob in for five seconds before removing the needle. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the Resident #109's May 2024 POS showed the following: -Diagnosis of type 2 diabetes with hyperglycemia (elevated blood sugar); -Accucheck before meals and at bedtime; -Humalog Kwik Pen Insulin (insulin Lispro) 100 u/ml sub-q, inject eight units with lunch; -Humalog KwikPen Insulin (insulin Lispro) insulin pen, 100 units/ml; amount per sliding scale (a dose amount to be determined based on the amount of sugar in the blood); if blood sugar is 70 to 140 give zero units, if blood sugar is 141 to 180 give three units, if blood sugar is 181 to 220 give six units, if blood sugar is 221 to 260 give nine units, if blood sugar is 261 to 300 give 12 units, if blood sugar is 301 to 350 give 15 units if blood sugar is greater than 350 call MD. Observation on 5/9/24 at 12:10 P.M. showed the following: -LPN W obtained the resident's blood sugar level with results of 195 mg/dL and determined Humalog insulin sliding scale dose was to be six units; -LPN W obtained the resident's Humalog Kwik pen from the medication cart, cleaned the tip with an alcohol pad and attached a new sterile needle; -LPN W did not prime the insulin pen; -LPN W dialed up 14 units of Humalog insulin (Humalog eight units scheduled and six units sliding scale), cleansed the site and administered the medication in the subcutaneous tissue of the abdomen; -LPN W did not hold the dose knob in for five seconds before removing the needle. During an interview on 5/28/24 at 09:00 A.M. LPN W said the following: -Insulin pens should be primed; -Insulin pen should be held in place on the residents skin for five to six seconds according to manufacturer's recommendations. During an interview on 05/14/24 at 1:00 P.M., the Director of Nursing said the following: -She expected staff to prime insulin needles; -She expected staff to hold following administration; -She expected staff to administer insulin in accordance with facility policy, physician orders, and manufacturer guidelines. During an interview on 5/22/24 at 1:10 P.M., the administrator said she would expect nursing staff to prime and administer insulin pens as recommended by the manufacturers recommendations.

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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** 49528 Based on observation, interview and record review, the facility failed to use disposal methods for controlled medications that involved a secure and safe method to prevent diversion and/or accidental exposure. The facility failed to keep discontinued/outdated Schedule II medications (narcotic medications with a high potential for abuse) stored in containers or cabinets and under double lock in the medication room. The facility failed to ensure staff kept medications locked up or secured when staff left medications unattended and not within sight on the medication cart and at the nursing desk and left the medication cart unlocked. The facility census was 149. Review of the facility's policy, Disposal of drugs, revised 12/2020 showed the following: -Medications not authorized for release to a resident by the physician at discharge and any expired medications must be destroyed on site by two professionals. Record of disposal shall be retained by the facility for at least seven years in the resident's chart. The policy did not address how staff were to dispose of drugs. Review of the facility's policy, Storage of drugs, revised 05/2013 showed the following: -Schedule II drugs are stored in containers or cabinets under double lock in the medication room. Only the charge nurse or medication nurse has access to the narcotics keys. The key to the narcotic compartment or cabinet is not the same as the medication room or medication cart key. - No discontinued, outdated, or deteriorated drugs or medications are stored in the facility over thirty days; -Compartment and areas containing drugs are locked when not in use or when left unattended. Such areas include drawers, cabinets, rooms, refrigerators, carts and boxes. Review of the facility's policy, returns/refusals revised 03/2017 showed the following: -All drugs which are discontinued or remain after a resident expires, or is discharged , shall be returned to the issuing pharmacy or destroyed; -No controlled drugs may be returned to the pharmacy, but must be destroyed on site, by two licensed nurses or a pharmacist and a licensed nurse by the end of shift; -Medications in the facility which are beyond their date of expiration shall be removed and destroyed by two nurses/Certified Medication Technicians (CMT's) and indicated on the resident's medication destruction record; -The policy did not address how drugs were to be disposed of. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Observation on 5/9/24 at 3:00 P.M. in the locked medication room at the 500 hall nurses' station, showed a small, opened sharps container on the counter that was three fourths full of medication tablets; water was not visible (the medications were not under double lock in the medication room as the policy instructed). During an interview on 5/9/24 at 3:00 P.M. Licensed Practical Nurse (LPN) V said the small biohazard container on the counter contained controlled medications to be destroyed. The process for destruction of controlled medications was to have two nurses put the medications in a small biohazard container with a small amount of water, fill out the medication destruction log, fill out the destruction log in Mediprocity (part of the electronic medical records for pharmacy) and when the small sharps container is full, it is put in the biohazard to be picked up. The small sharps container contains the controlled medications. 2. Observation on 5/10/24 at 1:00 P.M. in the locked medication room at the 100 hall nurses' station showed a small sharps container on the counter that was half full of medication tablets; there was no water visible in the container. The medications were not under double lock in the medication room as the policy required. During an interview on 5/10/24 at 1:00 P.M. Registered Nurse (RN) Q said to destroy controlled medications, it takes two nurses that put medications in the small sharps container with a small amount of water, fill out the medication destruction log on paper and in Mediprocity (a secure messaging system) and when the sharps container is full, it goes to the biohazard to be picked up. During an interview on 5/13/24, at 11:55 A.M., LPN R to destroy controlled medications two nurses pop the medications out of the medication cards and put in the small sharps container with water to dissolve; the medications are signed out as destroyed on the medication destruction log and in Mediprocity and when the container is full, it goes to the biohazard to be picked up. During an interview on 5/14/24 at 1:00 P.M., the Director of Nursing said the following: -To destroy medications two nurses pop out the medications and put them in the sharps containers; -Small sharps container are used for controlled medications; -The nurses fill out the paper destruction log and one in Mediprocity; -Water or some sort of liquid is added to the sharps containers to dissolve the tablets and when the container is full, it will be sent with the biohazard company. 3. Review of Resident #84's Physician Orders, dated 5/08/24, showed the following: -Macrobid (antibiotic) 100 milligrams (MG), give one capsule two times daily for urinary tract infection (UTI), start 5/08/24; -Florastor (probiotic) 250 mg. capsule, give one capsule two times daily for UTI, start date 5/08/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #135's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/07/24, showed the following: -Diagnoses included Alzheimer's disease (the most common type of dementia) and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities); -The resident had severe cognitive impairment. Observation on 5/08/24 at 8:14 P.M., showed the following: - medication card containing 14 Macrobid 100 mg capsules sat on the nurses desk unattended; -Medication card containing 20 Florastor 250 MG capsules sat on the nurses desk unattended; -No staff was in sight; -Resident #135 sat at the nurses' desk, on the opposite side as the medications, rolling ace wrap bandages. During an interview on 5/08/24 at 8:17 P.M., LPN AA said the medications were delivered from the pharmacy. He/She had signed for the medications, but had not had the opportunity to lock them up. He/She was responsible for the medications. Medications were not supposed to be left on the nurses desk unattended. During an interview on 5/08/24 at 8:19 P.M., the Administrator said medications are expected to be locked in a medication cart and not left on the nurses' desk. Medications should not be left unattended on a nurses' desk with a resident sitting on the other side of the desk. 4. Review of Resident #800's face sheet showed his/her diagnoses included chronic diastolic (congestive) heart failure (a condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), essential hypertension (high blood pressure), pulmonary hypertension (a type of high blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and pain. Review of the resident's physician orders, dated May 2024 showed the following: -Amlodipine (anti hypertensive) 10 mg give one tablet a day; -Carvedilol (heart failure) 12.5 mg give one tablet twice daily; -Citalopram (anti depressant) 20 mg give one tablet a day; -Gabapentin (pain) 100 mg capsule, give 200 mg three times a day. Observation on 5/10/24 at 11:25 A.M., showed the following: -A medication cart sat in the hallway near the resident's room; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The medication cart was unlocked and unattended; -The following medications sat on top of the unattended, unlocked medication cart: -A medication card containing eight amlodipine 10 mg. tablets; -A medication card containing 18 carvedilol 12.5 mg. tablets; -A medication card containing seven citalopram 20 mg. tablets; -A medication card containing 14 capsules of gabapentin 100 mg; -LPN BB sat in the resident's room; the medication cart was not in sight; -Two staff members and one visitor walked by the unattended, unlocked medication cart. During an interview on 5/10/24 at 11:29 A.M., LPN BB said the medication cart should not be left unlocked and unattended in the hallway. The medications which were on top of the cart should not have been left unattended and should have been put up before going to the resident's room to administer medication. 5. Observation on 5/9/24 from 10:17 A.M. to 10:19 A.M. in the hallway outside room [ROOM NUMBER] showed the following: -An unlocked medication cart sat in the hallway outside room [ROOM NUMBER]; -LPN XX stood in the resident's room with his/her back to the door and to the medication cart; -LPN XX administered the resident's medications and gave him/her a drink of water; -The medication cart was not in line of sight of LPN XX; -The top drawer of the medication cart was open approximately two inches; -An opened bottle of polyethylene glycol (laxative) sat on top of the cart; -A resident propelled past the opened medication cart in his/her power chair; -An activity staff member pushed another resident in a wheelchair down the hallway and past the cart. During an interview on 5/9/24 at 10:19 A.M. LPN XX said the following: -He/She usually locks the medication cart when he/she enters a resident's room; -He/She didn't lock the medication cart today, he/she did not know why; -He/She usually tried to park the medication cart closer to the resident's room; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The medication cart contains multiple residents' medications. During an interview on 5/14/24 at 12:52 P.M., the Director of Nursing (DON) said all medication carts needed to be locked if they were unattended. She expected all medications to be locked in the medication carts and expected no medications to be left out of a medication cart unattended. During an interview on 5/22/24 at 1:10 P.M. , the Administrator said the following: -She would not expect medications to be left on top of a medication cart sitting in 100 hallway unattended; -She would not expect that same medication cart to be left unlocked in 100 hallway when two staff members and one visitor passed by and staff were out of sight of the cart; -She would expect the medication cart to be locked if unattended on division 200 when resident was standing right next to the cart.

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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 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.

34003

Based on observation, interview, and record review, the facility failed to ensure meals were served to meet the needs of the residents when staff failed to prepare and serve all items listed on the menu, failed to serve food items for each diet type according to the menu, and failed to serve the correct serving sizes per the menu. The facility census was 149.

1. Review of the diet spreadsheet menu for the lunch meal on 5/8/24 showed the following:

-Staff was to serve fruit garnish (2 ounces) to residents with a regular, finger foods, low sodium, and no concentrated sweets (NCS) diet;

-Staff was to serve a peach half (2 ounces) to residents with a mechanical soft diet;

-Staff was to serve pureed peach (2 ounces) and pureed tomato (2 ounces) to residents with a pureed diet.

Review of the resident diet roster for the 500/600 division, obtained on 5/7/24 from the dietary manager, showed the following:

-Eleven residents were on a mechanical soft diet;

-One resident was on a pureed diet with one additional resident who could receive pureed items upon request.

Observation on 5/8/24 from 12:30 P.M. to 1:37 P.M., in the 500/600 division servery, showed no fruit garnish, peach half, pureed tomato, or pureed peach arrived in the food items delivered from the kitchen nor did staff serve any of these items to residents during the lunch meal service.

During an interview on 5/9/24 at 8:44 A.M., Dietary Aide H said he/she was unaware the fruit garnish, peach half, pureed tomato, or pureed peach were to be served during the lunch meal and confirmed he/she did not prepare these items. He/She referred to the weekly at-a-glance menu rather than the diet spreadsheet menu and must have missed these items.

Review of the weekly at-a-glance menu showed fruit garnish was listed for the lunch meal on 5/8/24. The peach half, pureed tomato, and pureed peach were not listed on the weekly menu.

During an interview on 5/9/24 at 12:37 P.M., Dietary Aide I said he/she went to the kitchen to pick up food items to serve in his/her respective servery. If the kitchen staff did not prepare a food item for a meal, he/she only served what was prepared.

During an interview on 5/8/24 at 4:11 P.M., the dietary manager said she expected staff to follow, prepare, and serve all items listed on the diet spreadsheet menu.

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

2. Review of the diet spreadsheet menu for the lunch meal on 5/8/24 showed staff was to serve sugar-free chocolate pudding to residents with a no concentrated sweets (NCS) diet and low-sodium soup to residents on a low sodium (LS) diet.

Review of the facility-wide resident diet order report, obtained on 5/7/24 from the dietary manager, showed 32 residents had a physician's order for a NCS diet and seven residents had a physician's order for a LS diet.

Review of the resident diet roster for the 500/600 division, obtained on 5/7/24 from the dietary manager, showed the following:

-Fifteen residents were on a NCS diet;

-One resident was on a LS diet.

Observation 5/8/24 from 12:30 P.M. to 1:37 P.M., during the lunch meal service in the 500/600 division servery, showed the following:

-The facility's dietitian and Dietary Aide G served minestrone soup to residents. No soup identified as low-sodium was served to residents;

-Various staff aides obtained individual bowls of pre-portioned pudding from the servery's cooler and served the pudding to residents. None of the bowls were marked or indicated as being sugar-free pudding.

During an interview on 5/8/24 at 1:39 P.M., the facility's dietitian said the food items served from the 500/600 division servery were delivered from the kitchen. She confirmed no sugar-free pudding or low-sodium soup food items were brought from the kitchen nor were these items served to residents during the 5/8/24 lunch meal service.

During an interview on 5/9/24 at 8:44 A.M., Dietary Aide H confirmed he/she scooped regular chocolate pudding into individual bowls that was served in the main dining room and all the facility's serveries for the lunch meal service on 5/8/24. He/She was unaware residents with a NCS diet were to receive sugar-free pudding for the meal. He/She didn't think the facility even had sugar-free pudding and confirmed this by looking for the item in the dry storage room with negative findings.

During an interview on 5/9/24 at 8:48 A.M., [NAME] A said he/she prepared regular minestrone soup for the 5/8/24 lunch meal service and did not prepare a separate low-sodium soup. The soup was served in the main dining room and all the facility division serveries. He/She did not add salt to the pre-packaged soup and usually only made a low-sodium option if it there was a cream-based soup on the menu.

Review of the recipe for minestrone soup showed the sodium content was 239 milligrams per six-ounce serving.

During an interview on 5/24/24 at 3:37 P.M., the facility's corporate dietitian said the following:

-She expected staff to follow the diet spreadsheet menu and residents' physician diet orders;

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a low-sodium food item, such as low-sodium soup, was indicated on the spreadsheet menu to be served to residents with a low-sodium diet, she expected staff to prepare and serve that item to those residents; -A resident with a low-sodium diet order should consume under 2,500-3,000 milligrams of sodium daily (total for all food items); -Diet rosters that listed residents and their associated orders were available for staff to utilize; -Staff serving food to residents were responsible to ensure residents were served the correct diet order; -She expected staff who brought residents' food trays from the servery to double-check that the residents were receiving the correct food for their diet type. During an interview on 5/8/24 at 4:11 P.M., the dietary manager said she expected staff to follow the diet spreadsheet menu and resident's physician diet orders. 3. Record review of the facility's undated policy, Portion Variations, showed the following: -The menu diet spreadsheets will indicate specific portions to be served at each meal to meet the dietary reference intakes and specific state and federal guidelines if required; -Residents requiring portion variations will be served according to the information listed on their diet sheet or diet spreadsheet; -Information on the meal card will be used to guide serving sizes that are different from the diet spreadsheet. Review of the diet spreadsheet menu for the lunch meal on 5/8/24 showed staff was to serve 4 ounces of chocolate pudding to residents on regular, mechanical soft, pureed and low sodium diets. Observation on 5/8/24 at 10:49 A.M. showed Dietary Aide H used a 3-ounce scoop to serve chocolate pudding into individual bowls for the lunch meal. Observation 5/8/24 from 12:30 P.M. to 1:37 P.M., during the lunch meal service, at the 500/600 division servery, showed staff served the individual bowls of pre-portioned (3 ounces) pudding to residents. During an interview on 5/9/24 at 8:44 A.M., Dietary Aide H confirmed he/she used a 3-ounce scoop to serve pudding into bowls for the lunch meal. He/She normally used that size scoop for serving pudding and was unaware the diet spreadsheet menu indicated the pudding was to be served at a 4-ounce portion size. During an interview on 5/8/24 at 4:11 P.M., the dietary manager said she expected staff to serve correct portion sizes by following the diet spreadsheet menu. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36219 44665

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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 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. 34003 Based on observation, interview and record review, the facility failed to prepare and serve food at a safe and appetizing temperature and to conserve the flavor of food items. The facility census was 149. 1. Review of the facility's undated policy, Monitoring Food Temperatures for Meal Service, showed the following: -Food temperatures will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures; -The temperature for each food item will be recorded on the Food Temperature Log. Foods that required corrective action (such as reheating), will have the new temperature recorded with a circle around it next to the original temperature; -If the serving/holding temperature of a hot food is not at 135 degrees Fahrenheit (F) or higher when checked prior to meal service, the item will be reheated to at least 165 degrees F for a minimum of 15 seconds; -If the serving/holding temperature of a cold food item or beverage is not at 41 degrees F or below (for less than four hours in duration) when checked prior to meal service, the item will be chilled on ice or in the freezer until it reaches 41 degrees F or less before service; -Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater to promote palatability for the resident; -Any complaint regarding food temperatures by residents will be documented on the food temperature log. Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120 degrees F. The investigation is recommended to be completed within 72 hours of the complaint; -All room trays are sent to the room with a tray ID. The ID will list the resident's name, diet, room number. Review of the following recipes and manufacturer label showed the following: -Pureed broccoli salad, hold or serve cold food at or below 41 degrees F; -Mechanical soft broccoli salad, hold or serve cold food at or below 40 degrees F; -Pureed Italian club on hoagie roll, hold or serve cold food at or below 41 degrees F; -Turkey on hoagie roll, hold or serve cold food at or below 40 degrees F; (continued on next page)

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-Mayonnaise, refrigerate after opening.

Review of the 500/600 servery binder temperature log, for the lunch meal on 5/8/24, showed the following entries:

-Entree, 40 degrees F;

-Starch, 38 degrees F;

-No temperature entries recorded for cold item, mechanical entree, puree entree, puree starch, and vegetable.

Observation 5/8/24 from 12:30 P.M. to 1:37 P.M., in the 500/600 division servery, showed staff served pureed broccoli salad, mechanical soft broccoli salad, pureed Italian club on hoagie roll, French fries, and turkey on hoagie roll (with mayonnaise) to residents in the associated dining rooms and halls during the lunch meal service. Mayonnaise, located in individual condiment cups, sat on a cart and was not on ice.

Observation on 5/8/24 at 1:42 P.M. of the lunch meal test tray obtained after all residents had been served on the 500/600 division, showed the following (temperatures of food items obtained using a calibrated probe-style thermometer):

-The temperature of the pureed broccoli salad was 51.4 degrees F; it tasted warm and was not cool to taste;

-The temperature of the mechanical soft broccoli salad was 53.1 degrees F; it tasted warm and was not cool to taste;

-The temperature of the pureed Italian club was 59.2 degrees F; it tasted lukewarm and was not cool to taste;

-The temperature of the turkey on hoagie roll was 52.7 degrees F and tasted warm;

-The temperature of the mayonnaise was 78.3 degrees F and tasted lukewarm;

-The temperature of the French fries (alternate food item) was 95.4 degrees F and were very cool to taste.

During an interview on 5/9/24 at 12:37 P.M., Dietary Aide I said the following:

-Hot food items should be 160 to 170 degrees F at the steam table and close to that temperature when residents receive their food;

-Cold foods should be at least 40 degrees F or below and should be held on ice.

During an interview on 5/8/24 at 4:11 P.M., the dietary manager said the following:

-She expected hot foods to be served hot and cold foods to be served cold;

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hot food items should be held at 140 degrees F and served at 130 degrees F on the halls; -Cold food items should be held and served at or below 40 degrees F; -Each servery had a temperature log book for staff to record temperatures of food items at each meal. 2. Review of the diet spreadsheet menu, for the lunch meal on 5/8/24, showed staff were to serve a mechanical soft ground Italian meat and cheese on hoagie sandwich to residents on a mechanical soft diet. Review of the weekly at-a-glance menu, for the lunch meal on 5/8/24, showed cheeseburgers were an alternate daily food item available to residents. Review of the recipe for mechanical soft ground Italian meat and cheese on hoagie bun showed the following preparation instructions: 1. Slice buns in half lengthwise; 2. Spread each roll half with Italian dressing (one teaspoon) and mayonnaise (one teaspoon); 3. Measured desired number of servings of meat into food processor. Grind to appropriate consistency. If needed, add gravy or broth to moisten meat; 4. Place a #10 scoop of meat on bun along with half slice of cheese. Top with second half of bun and slice sandwich in half. Observation on 5/8/24 at 1:42 P.M. of the lunch meal test tray obtained after all residents had been served on the 500/600 division, showed the following: -No mayonnaise was spread on the bun for the mechanical soft ground Italian meat and cheese on hoagie bun. The meat mixture tasted overwhelmingly of mayonnaise; -The French fries (alternate food item) tasted very dry and bland; -The cheeseburger lacked flavor. During an interview on 5/9/24 at 8:44 A.M., Dietary Aide H said the following: -He/She prepared the meat for the mechanical soft ground Italian meat and cheese on hoagie sandwich by adding mayonnaise, rather than broth, to the ground meat mixture when he/she processed the meat in the food processor; -He/She did not refer to a recipe but thought mayonnaise was an appropriate item to use in moistening the mechanical soft meat. During an interview on 5/8/24 at 4:11 P.M., the dietary manager said the following: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Food served to residents should taste good; -Staff should follow recipes for food items and recipes should be readily available to staff; -Recipes were kept in a binder in the food preparation area and, if a recipe was not in the book, staff should ask her for the food item's recipe; -She started working for the facility approximately eight weeks ago and had not yet conducted a test tray to evaluate food taste or temperature. 36219 44665

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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.

44665

Based on observation, interview, and record review, the facility failed to ensure residents, including those with a physician's order for a mechanical soft diet, received food items with the proper texture to allow for foods to be easily swallowed. The facility census was 149.

1. Review of the facility policy, Admission Diet Orders, effective June 2021, showed the following:

-Purpose: To ensure each resident has a diet order prescribed by the physician and documented in the medical health record. The safest diet for each resident will be ordered;

-All diet orders will be reviewed upon admission by the charge nurse to assure that they conform to the language of the facility offered diets;

-If there is a particular dysphagia diet that is not offered by the facility, the diet should be downgraded to a diet used in the community until a speech therapist can evaluate the resident;

-A speech therapist consult should be initiated for all residents on texture modified diets for the evaluation of the appropriate diet for safe consumption by the resident;

-Samples of appropriate diet modifications: minced and moist - pureed, soft and bite size - pureed, easy to chew - mechanical soft;

-The diet recommended by the speech therapist should be brought to the attention of nursing, approved by the physician, and entered into the electronic health record.

Review of the facility's Diet Manual, 2024 edition, showed the following:

-Summary of Diets: Mechanical Soft Diet - This consistency modified diet is for individuals with limited or difficulty in chewing regular textured foods. The diet follows the Regular Diet planned and provides foods that can be more successfully and easily chewed. The diet consists of food of nearly regular textures but eliminates very hard, sticky, crunchy or hard to chew foods. Foods should be moist and fork tender.

Review of the facility-wide resident diet order report, obtained on 5/7/24 from the dietary manager, showed the following:

-24 residents had a physician's order for a mechanical soft diet;

-133 residents had a physician's order for a regular texture (including those with finger foods) diet.

Review of the diet spreadsheet menu, for the lunch meal on 5/8/24, showed staff was to serve chopped steamed broccoli to residents on a mechanical soft diet.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the weekly at-a-glance menu, for the lunch meal on 5/8/24, showed a cheeseburger was a daily alternate food item available to residents. During an interview on 5/9/24 at 8:44 A.M., Dietary Aide H said he/she made mechanical soft broccoli salad for the lunch meal on 5/8/24. He/She had [NAME] A steam the broccoli so it wasn't so hard then he/she added mayonnaise and cheese to it to make the salad. Observation 5/8/24 from 12:30 P.M. to 1:37 P.M., during the lunch meal service, at the 500/600 division servery, showed staff served mechanical soft broccoli salad (instead of chopped steamed broccoli) to residents with a mechanical soft diet. Observation on 5/8/24 at 1:42 P.M. of the lunch meal test tray obtained after all residents had been served on the 500/600 division, showed the following: -Mechanical soft broccoli salad - numerous edges of the broccoli pieces were hard and the softness was in between cooked and raw broccoli. The salad contained large-sized chunks of broccoli measuring approximately one-quarter inch, and was difficult to chew and swallow; -French fries (alternate item) had hard edges that were difficult to chew; -The bottom bun of the cheeseburger was very hard and tough especially around the edges and was difficult to chew. 2. Observation on 5/9/24 at 12:45 P.M. in the 100 hall dining room showed the following: -Resident #11 sat at the dining room table; -Staff served the resident fried fish; -The crust on the fish was dark brown and appeared crispy; -The resident attempted to cut the fish with the plastic fork and could not; -The resident took his/her fork, poked it into the piece of fish and held the piece of fish up; -The resident said he/she couldn't cut the fish, it was too tough. Observation on 5/9/24 at 12:50 P.M. in the 100 hall dining room showed the following: -Resident #47 sat at the dining room table; -Staff served the resident fried fish; -The crust on the fish was dark brown and appeared crispy; -The resident tried to cut his/her fish and could not; -The resident said he/she was trying to cut his/her fish but the fish was too hard to cut. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/9/24 at 12:51 P.M. in the 100 hall dining room showed the following: -Resident #20 sat at the dining room table; -The Restorative Aide served the resident a plate of fried fish; -The Restorative Aide attempted to cut the fish into bite sized pieces; it took the RA several minutes to cut up the fish; -The RA dipped a piece of fish into the tartar sauce and gave the resident a bite; -The resident had no teeth; -The resident chewed and chewed for several minutes and eventually swallowed the fish. During an interview on 5/9/24 at 2:02 P.M. Resident #20 said he/she couldn't eat the regular piece of fish so staff gave him/her softer fish as he/she had no teeth. Observation on 5/9/24 at 1:00 P.M. of a test tray showed the outer breading was crunchy and the fish was hard to chew. During an interview on 5/8/24 at 4:11 P.M., the dietary manager said food served to residents should be prepared at the correct texture and should not be tough or difficult to chew.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265792	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in accordance with professional standards for food service safety. Staff failed to label, date, and seal opened food items. Staff failed to store food items per manufacturer's label instructions, store food items off the floor, and store food items in an area separate from resident medications and related items. Staff failed to discard food items that were expired or showed visible signs of deterioration. Staff failed to properly clean ice machines, properly store ice scoops, and ensure an air gap was present at each ice machine drain. Staff failed to ensure food and beverage containers and utensils were in good condition and were handled, dried and stored in a sanitary manner. Staff failed to ensure food service equipment and surfaces were appropriately cleaned and trash cans remained covered when not in use. Staff failed to practice proper hygienic practices when preparing and serving food to residents, including employing proper hair restraint usage, hand hygiene techniques, consumption and storage of personal food and drink items in food preparation areas, thermometer probe cleaning, and handling of ready-to-eat food items. Staff failed to monitor the dishwashing machine for appropriate parameters to ensure dishes were properly cleaned and sanitized. The facility census was 149. 1. Review of the undated facility policy, Labeling/Dating Foods (Date Marking), showed the following: -All foods stored will be properly labeled according to the following guidelines; -Date marking for dry storage foods items: -Once a case is opened, the individual food items from the case are dated with the date the item was received into the facility and placed in/on the proper storage unit utilizing the first in - first out method of rotation; -Expiration dates on commercially prepared, dry storage food items will be followed; -Date marking for refrigerated storage food items; -Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage location utilizing the first in - first out method of rotation; -Once opened, all ready to eat, potentially hazardous food will be re-dated with the opened date; -Date marking for freezer storage items; -Frozen food packages removed from the case will be dated with the date the item was received into the facility and will be stored using the first in - first out method of rotation; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date; -Prepared food or opened food items should be discarded when the food item is older than the expiration date. Review of the undated facility policy, Safe Food Handling Guidelines for Resident Representative and/or Family Members and Guests, showed the following: -Resident family members, resident representatives and guests are always welcome to bring food into the facility for their loved one(s). When doing so, the following guidance should apply to ensure food safety strategies are adhered to; -If some or all of any perishable food is not eaten immediately, please inform staff so they can properly label, date and store the food for your loved one until they are ready to eat it; -Please do not encourage residents to store food in their rooms. Please inform the staff and we will be happy to label, date, and store the food for your loved one until they are ready to eat it. Observation on [DATE] at 1:52 P.M., in the 100 servery, showed the following: -A bag of cereal located in the bottom cabinet under a preparation counter was loosely sealed with plastic wrap and several pieces of cereal were on the bottom surface of the cabinet; -Two metal pans of food, with plastic wrap covering them, sat by each other and were undated. The left pan contained a yellow-colored food substance and was not marked to identify the contents. The right pan contained orange fruit and was labeled with a marker 'Mech.' Observation on [DATE] at 2:58 P.M., in the kitchen walk-in freezer, showed a box of frozen dinner rolls and a box of frozen breadsticks did not have the inner plastic sealed, were open to air, and the box flaps of each box were loosely folded over. During an interview on [DATE] at 4:11 P.M., the dietary manager said she expected food items to be sealed, labeled, and dated. 2. Observation on [DATE] at 1:52 P.M., in the 100 servery refrigerator, showed an opened 46-ounce bottle of nectar thick orange juice with a date of ,d+[DATE] written on the label. The label read 'discard if not used within 10 days of opening.' Observation on [DATE] at 3:13 P.M., of the kitchen's dry food storage room, showed an open, unrefrigerated 11-pound container of vanilla icing with an open date of ,d+[DATE]. The label read 'Once icing container has been opened, the icing can be stored covered at room temperature for one week. After this time period, store covered in the cooler.' Observation on [DATE] at 3:35 P.M., of the shelf under the kitchen steam table, showed the following: -An opened bottle of lemon juice; the label read 'Refrigerate after opening; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An opened bottle of soy sauce; the label read 'Refrigerate after opening for quality'. Observation on [DATE] at 10:39 A.M., of the shelf above the wooden counter in the kitchen outside the dishwashing room, showed an opened bottle of lemon juice. The label read 'Refrigerate after opening'. During an interview on [DATE] at 4:11 P.M., the dietary manager said she expected food items to be stored per manufacturer's label instructions. 3. Observation on [DATE] at 2:43 P.M., in the 500 division medication room, showed a box containing oatmeal pies and one box of nutritional shakes sat on the floor near the refrigerator. During an interview on [DATE] at 2:45 P.M., Licensed Practical Nurse (LPN) N said the oatmeal pies belonged to a resident. Observation on [DATE] at 8:13 A.M., in the kitchen walk-in freezer, showed a 20-pound unopened box of frozen vegetables sat directly on the floor and was not elevated on a shelf or other means off the floor. During an interview on [DATE] at 4:11 P.M., the dietary manager said she expected food to be stored off of the floor. 4. Observation on [DATE] at 2:43 P.M., in the 500 division medication room, showed several undated and unlabeled (with the owner's name/initials) opened bottles of beverages in the refrigerator that sat next to containers that held residents' refrigerated medications. A sign on the refrigerator door indicated that no food was to be stored in the refrigerator. During an interview on [DATE] at 2:45 P.M., LPN N said the beverages in the refrigerator belonged to a resident. During an interview on [DATE] at 1:38 P.M., the director of nursing said resident food items stored in medication rooms should be stored and labeled appropriately, and not stored in a refrigerator where medication and related items are stored. 5. Observation on [DATE] 2:23 P.M., in the 600 division living room cabinets, showed an unopened 10-ounce bottle of orange juice had a manufacturer's expiration date of [DATE]. Observation on [DATE] at 1:52 P.M., in the 100 division servery refrigerator, showed a 4-ounce carton of vanilla nutritional shake with a manufacturer's use by date of [DATE]. Observation on [DATE] at 2:58 P.M., in the kitchen walk-in freezer, showed two clear bags of frozen mixed vegetables had an excess accumulation of frost visible through the bags and on the food contents. During an interview on [DATE] at 4:11 P.M., the dietary manager said food items that are expired or showed signs of deterioration should be discarded. 6. Review of the undated facility policy, Ice Handling and Cleaning, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Ice will be stored and served to residents in a sanitary manner; -Ice will be handled, transported, and stored in such a manner as to be protected against contamination; -Approved containers and utensils will be provided for storing and serving ice in a sanitary manner; -Ice scoops will be kept clean and will be stored and handled in a sanitary, protected manner so that the handle does not make contact with the ice. Scoops will be cleaned/sanitized daily; -Ice machine will be wiped down daily with sanitizer; -Ice machine will be emptied quarterly and thoroughly cleaned with an approved sanitizer to remove any settlement or mineral buildup in the ice discharge area and floor of the machine; -Ice storage bins shall be drained through an air gap. Observation on [DATE] at 1:52 P.M., in the 100 servery, showed the ice machine drain was connected to a 1-inch clear reinforced flexible hose that was connected directly to the nearby sink drain with a gray pipe connector and pipe clamps and contained no air gap. Observation on [DATE] at 12:40 P.M., in the 300 servery, showed the ice machine drain was connected to a 1-inch dark gray colored flexible hose that was inserted approximately 1 inch below the flood rim level of the floor drain located in front of the machine. There was no air gap present at the ice machine drain. Observation on [DATE] at 12:54 P.M., in the 700 servery, showed the interior portion of the ice machine had dried white drips with black specks with a moderate accumulation of encrusted white debris on the interior portion of the door. Observation on [DATE]., in the ,d+[DATE] division, showed the following: -At 2:37 P.M., CNA M entered the servery and carried a cup with a straw and lid; -He/She did not wash his/her hands, opened the ice machine and used a clear disposable cup to scoop ice from the machine into his/her cup; -He/She left the disposable cup in the ice machine, closed the door, and left the servery. Observation on [DATE] at 8:26 A.M., of the service hall ice machine located near the kitchen, showed the following: -Various bits of trash, including cup lids and straws, and a white dried accumulation of debris covered the surface of the floor under the machine; -The interior portion contained various bits of brown wet and dried debris and visible staining above the finished ice reservoir; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The exterior was stained in several areas with dried white drips that ran down the surface of the machine; -Two 1-inch drain pipes were located at a floor drain in front of the machine; -One drain pipe extended several inches below the flood rim level of the drain and contained no air gap; -The second drain pipe, located near a discarded drinking straw, was just above the flood rim level of the drain and contained a limited air gap. During an interview on [DATE] at 3:14 P.M., the director of environmental services said he expected the ice machine drains to contain an appropriate air gap. He was unaware of the ice machine drains found during the survey that did not contain air gaps or adequate air gaps. During an interview on [DATE] at 4:11 P.M., the dietary manager said the following: -She expected ice machines to be clean and for dietary staff to wipe the inside and outside of the ice machines one to three times per week; -The ice machine service company sanitized the machine during their routine visits; -The ice machines should have an appropriate air gap at the drain and this was the responsibility of maintenance staff; -Staff should have clean hands, use a handled ice scoop when obtaining ice from ice machines, and store the scoop sanitarily. 7. Review of the undated facility policy, Dining Servers: Guidelines for Safe Handling of Tableware, showed the following: -All staff assigned to assisting in the dining room will wash their hands before passing foods/fluids to residents; -Glasses and cups are handled as to avoid bare hand contact with the rim; -Plates are handled by the rim with no bare hand contact with the food contact area; -If anyone assisting in the dining room contaminates their hands, they will re-wash their hands before resuming passing foods/fluids to residents; -If any risk of touching the food contact or mouth contact area of a utensil exists, a washed and gloved hand will be used to handle the tableware. Observation on [DATE] at 1:52 P.M., in the 100 servery refrigerator, showed a one-third full clear plastic beverage pitcher that contained a brown-colored liquid. The pitcher was visibly scratched, stained, and worn across the entire plastic surface and was cloudy and no longer clear. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 2:25 P.M., in the ,d+[DATE] servery cabinets, showed two blue scoops stored inside a clear container of thickener powder. Observation on [DATE] at 3:30 P.M., on the shelf below the steam table in the kitchen, showed a clear scoop stored inside a container of brown sugar. Observation on [DATE] at 3:07 P.M., in the kitchen clean dish and utensil storage area, showed moist light orange drips on the clean scoops and rubber scrapers. Various large mixing bowls and fluted clear dishes were not inverted. Observation on [DATE] at 8:31 A.M., in the kitchen clean dish storage area, showed a rolling blue cart of clean plates was not covered and the plates were not inverted. Another cart of plates sat near the wooden counter and the plastic cover that was over the plates was torn with moist splatters of brown debris by the top section of plates. Observation on [DATE] at 11:25 A.M., in the kitchen, showed Dietary Aide J and [NAME] A used paper napkins and cloth towels to dry silverware that was obtained from a dishwashing tray of wet silverware. Observation on [DATE] at 10:49 A.M., in the kitchen food preparation area, showed Dietary Aide H used his/her gloved hands to touch the inside eating surface of bowls as he/she scooped pudding into the bowls for the lunch meal service. Observation on [DATE] at 12:44 P.M., in the ,d+[DATE] servery, showed the following: -CNA P used his/her gloved hands to fill beverage pitchers at the sink; -He/She turned off the faucet handles, put the lids on the pitchers, and carried the pitchers by supporting and touching his/her gloved hands on the pouring spout of the pitchers; -He/She filled drinking glasses on a cart from the pitchers and used his/her gloved hands to touch and pick up the glasses by the inside drinking surface rim of the glasses to arrange the glasses on the cart. During an interview on [DATE] at 12:37 P.M., Dietary Aide I said staff should handle dishware, silverware, and beverage ware by the non-eating and drinking surfaces of those items. During an interview on [DATE] at 4:11 P.M., the dietary manager said the following: -Foodware,beverageware, and utensils should be cleaned and sanitized properly. These items should be in good condition and stored clean, dry, and in a protected manner such as covered or inverted; -She expected scoops not to be stored within food items or in bulk bins; -Staff should handle foodware and beverageware items by non-food and beverage contact surfaces. 8. Review of the undated facility policy, Cleaning Rotation, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Equipment and utensils will be cleaned according to the following guidelines or manufacturer's instructions; -Items cleaned after each use: can opener; -Items cleaned daily: stove top, grill, toaster, microwave oven, steam table, exterior of large appliances; -Items cleaned weekly: ovens; -Items cleaned monthly: ice machines, walls. Observation on [DATE] at 1:14 P.M., of the counter-mounted water dispenser and ice storage unit in the main dining room, showed the following: -Both portions of the unit were marked with tags that read 'Out of Service;' -Below the cabinet where the unit was located, an unlocked door opened to the lower cabinet area where dried brown and black splatters and wipe marks were visible across the surface of the cabinet's interior bottom and side portions; -The cabinet's bottom interior portion was cracked and warped in several areas across the white surface and did not provide a smooth and easily cleanable/wipeable surface. Observation on [DATE] at 1:52 P.M., in the 100 servery, showed the following: -The floor was very sticky and dried shoe prints were visible across the surface of the floor; -Bits of brown food debris were on the floor and various dried brown splatters were visible on the walls near the two doors of the servery; -Various bits of food debris, Styrofoam cups and lids were on the floor behind the refrigerator; -Brown sticky drips were across the front exterior surface of the refrigerator and ice machine; -Bits of food debris were underneath the microwave; -Food crumbs and a heavy accumulation of brown and black debris buildup were on the toaster; -Dried smears and drips of debris were across the metal surface of the cereal dispensing unit; -Red moist debris and an excess accumulation of ice were in the freezer compartment. Observation on [DATE] at 2:07 P.M., of the counter-mounted water dispenser and ice storage unit in the 200 division dining room, showed a pink plastic tub with a moderate accumulation of moist brown and tan chunks of debris was located below the counter under the unit's drain. Dried brown splatters were on the interior surface of the drain and interior cabinet area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 2:25 P.M., in the ,d+[DATE] servery, showed the following: -A moderate accumulation of dust and buildup was on a box fan that faced the steam tables and sat on a folding wooden tray stand with fabric straps that was covered in dried brown and white debris across the surfaces of the wood and fabric straps; -The steam table and clear shield had various dried smears and drips across their surface and the shield was visibly cloudy and greasy; -The shelf below the steam table was splattered with dried brown debris and had bits of food debris and trash on the metal surface. The metal surface was missing paint in an approximate 2-foot by 3-foot area; -The metal trash can lid edges was smeared with dried food debris. Observation on [DATE] at 1:21 P.M., in the ,d+[DATE] servery, showed a box fan with a moderate accumulation of dust and buildup sat running on a folding wooden tray stand (visibly soiled with dried brown and white debris). The fan blew directly toward the steam table of uncovered food items as staff served residents' food during the lunch meal service. Observation on [DATE] at 3:10 P.M., in the kitchen walk-in cooler, showed a metal conduit, that ran the length of the cooler ceiling, had black and white crusty debris accumulated across its surface. Observation on [DATE] at 3:35 P.M., in the kitchen, showed the following: -A moderate accumulation of yellow grease was on the range hood suppression nozzles located above the flat griddle; -A moderate accumulation of light brown residue was on one of four light covers above the flat griddle. One of four bulbs was not working on the left side of the range hood; -The floor in front of the deep fryers and tilt skillet was very slippery and there was a black buildup of residue on the nearby floor under the steam table, ovens, fryers, and tilt skillet. Bits of food and trash debris were on the floor under these units; -A thick accumulation of brown greasy debris was on the sides of the deep fryers; -The oven handles were greasy to the touch and an excessive amount of grease accumulation from the deep fryer grease collection channel was on the top right portion of the oven door; -An excessive accumulation of thick, black encrusted debris coated the interior surfaces of the top and bottom convection oven compartments. Observation on [DATE] at 10:49 A.M., in the kitchen, showed a can opener sat on the top shelf above the clean dish storage area. The blade of the can opener was heavily soiled with a brown moist substance that resembled chocolate pudding. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 8:31 A.M., in the kitchen, showed the can opener at the end of the food preparation counter contained a small hair and dark black moist debris on the blade's surface. During an interview on [DATE] at 4:11 P.M., the dietary manager said the following: -She expected surfaces and equipment to be clean; -She had worked at the facility for approximately eight weeks; -She would like all equipment to be cleaned in the kitchen a least daily and for deep cleaning to occur one to two times per month; -In the serveries, dietary staff were to clean the steam tables, toasters, refrigerators, microwaves, etc. 9. Observations on [DATE] at 11:22 A.M. and at 12:01 P.M., in the kitchen, showed a trash can (located between the convection oven and steamer) contained discarded plastic and food waste items. The trash can was approximately 90% full, sat uncovered, and no staff were actively using the trash can. Observation on [DATE] at 12:47 P.M., in the 300 servery, showed a trash can approximately 50% full of trash was uncovered. Staff were not actively using the trash can and no staff were in the servery or nearby area. During an interview on [DATE] at 4:11 P.M., the dietary manager said she expected trash cans to be covered when not in use. There was no lid for the trash can located in the kitchen between the convection oven and steamer. 10. Review of the undated facility policy, Hair Restraints, showed the following: -Hair restraints shall be worn by all dining services staff when in food production, dishwashing areas, or when serving food from the steam table; -Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Review of the undated facility policy, Proper Hand Washing Procedure and Proper Use of Gloves, showed the following: -All employees will use proper hand washing procedures and glove usage in accordance with state and federal sanitation guidelines; -All employees will wash hands upon entering the kitchen from any other location, after all breaks, and between all tasks; -Employees will wash hands before and after handling foods, after touching any part of the uniform, face, or hair, and before and after working with an individual resident; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Gloves are to be used whenever direct food contact is required with the following exception: bare hand contact is allowed with foods that are not in a ready to eat form that will be cooked or baked; -Hands are washed before donning gloves and after removing gloves; -Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; or if the gloves become contaminated by the touching the face, hair, uniform, or other non-food contact surfaces, such as door handles and equipment; -Staff should be reminded that gloves become contaminated just as hands do, and should be changed often. When in doubt, remove gloves and wash hands again; -When gloves must be changed, they are removed, hand washing procedure is followed, and a new pair of gloves is applied. Gloves are never placed on dirty hands; the procedure is always, wash, glove, remove, rewash, and re-glove. Review of the facility's undated policy, Monitoring Food Temperatures for Meal Service, showed the following: -Food temperatures will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures; -Proper procedures are followed to ensure food temperatures are accurately and safely obtained according to safe food handling practices: -Thermometers are washed, rinsed, sanitized before and after each meal use. An alcohol swab may be used to sanitize between uses while taking temperatures during the same meal or if contamination of the thermometer occurs. Observation on [DATE] at 12:14 P.M., in the kitchen, showed Dietary Aide E was in the food serving area for the lunch meal service. Dietary Aide E did not wash his/her hands, and put on gloves. He/She cut up a resident's sandwich by touching his/her gloved hands on the bread of the sandwich. Observation on [DATE] at 8:38 A.M., in the 700 servery, showed Dietary Aide I used his/her bare hands to grab pieces of toast from the toaster and place them on the steam table in a pan for serving to residents at the breakfast meal service. Observation on [DATE] from 9:01 A.M. to 9:13 A.M., in the ,d+[DATE] servery, showed the following: -Dietary Aide G used his/her gloved hands to serve food from the steam table onto residents' plates; -He/She adjusted his/her glasses multiple times, touched the eating surfaces of plates as he/she grabbed the plates, served food items by grabbing handles of serving utensils, grabbed pieces of toast with his/her gloved hands to place on residents' plates, and grabbed the handle of a cart and moved it around in the servery; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She did not wash his/her hands in between tasks or after touching contaminated items. Observation on [DATE] at 10:26 A.M., in the kitchen, showed Dietary Aide J used his/her bare hands to adjust his/her hair restraint and touched his/her face area. He/She touched pans of food for the lunch meal service and placed them on pans of ice by handling them with his/her bare hands. He/She did not wash his/her hands after touching his/her face or adjusting his/her hair restraint. Observation on [DATE] at 10:58 A.M., in the kitchen, showed a daycare staff walked into the kitchen past the food preparation area where Dietary Aide H scooped pudding into bowls for the lunch meal service. The daycare staff walked into the dry storage room (located in the kitchen and beyond the food preparation area) and obtained plates from a box and did not wear a hair restraint. During an interview on [DATE] at 10:58 A.M., the daycare staff said he/she knew he/she was supposed to wear a hair restraint in the kitchen but needed plates to serve lunch in the daycare portion of the facility. Observation on [DATE] at 12:36 P.M., in the ,d+[DATE] servery, showed the following: -The dietitian washed her hands at the sink, put a glove on her left hand, opened and obtained an alcohol pad from the cabinet, donned a glove on her right hand, and obtained a pen to record temperatures of food items in the log book; -She took temperatures of food items, located on the steam table, with a prob-style thermometer and used the alcohol pad to wipe the thermometer probe in between food items; -The alcohol pad became increasingly soiled with food after she wiped the probe; -She did not obtain a new alcohol pad and continued to take temperatures of food items, wiping the probe after insertion into each food item. Observation on [DATE] at 12:12 P.M., in the ,d+[DATE] servery, showed Dietary Aide G dropped a packet of wrapped disposable silverware onto the floor. He/She picked up the silverware with his/her gloved hands, did not remove his/her gloves or wash his/her hands, and grabbed clean plates from a nearby cabinet and took the plates to the adjacent dining room for the lunch meal service. Observation on [DATE] at 12:30 P.M., in the ,d+[DATE] servery, showed Dietary Aide G washed his/her hands at the sink and turned off the faucet handle with his/her clean hands, dried his/her hands with a paper towel, and went to the steam table to arrange food items for serving at the lunch meal service. Observation on [DATE] at 1:02 P.M., in the ,d+[DATE] servery, showed the dietitian plated residents' food for the lunch meal service. She used the same tongs to serve fresh vegetables (onion slices, tomatoes, lettuce leaves for sandwiches) as she did for serving hot items (chicken tenders and French fries), going back and forth serving items onto plates from the two containers of food as items were needed on those plates. During an interview on [DATE] at 12:37 P.M., Dietary Aide I said the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff should wear a hairnet when serving food items in the serveries; -Staff should wash their hands after changing gloves, after touching unclean surfaces, prior to touching food items and clean dishes, and when entering a servery; -Staff should not touch ready-to-eat food items with their bare hands or with soiled gloves. -The 700 division servery had two sinks. He/She considered the smaller sink to be the handwashing sink and the larger sink to be used for food and beverage preparation; -The smaller sink did not have soap or paper towels so staff tended to wash their hands at the larger sink used for food and beverage preparation. During an interview on [DATE] at 4:11 P.M., the dietary manager said the following: -Food items should be stored, prepared, and served under safe and sanitary conditions; -Staff should not touch ready-to-eat food items with their bare hands or while wearing unclean gloves; -Staff should serve ready-to-eat food items with tongs and should have separate tongs for each item on the steam table; -Staff should not use the same tongs to serve items such as lettuce and tomatoes and then use the same tongs to serve French fries and chicken tenders; -Staff should wear a hair restraint when preparing and serving food items; -Staff should wash their hands after performing dirty tasks, such as picking up dropped items from the floor, when entering the kitchen or a servery, prior to conducting clean tasks, and when changing gloves. Changing one's gloves did not substitute the need for hand washing. 11. Observation on [DATE] at 12:24 P.M., in the kitchen, showed the following: -Dietary Aide E was in the food serving area during the lunch meal service; -He/She held a pickle spear in his/her hand and took a bite of the pickle. Observation on [DATE] at 10:33 A.M., in the kitchen, showed various staff beverages such as bottles of tea and soda and a Styrofoam cup with a lid and straw sat on the shelf above the food preparation area. Dietary Aide H prepared pureed food items for the lunch meal service at the food preparation area. During an interview on [DATE] at 4:11 P.M., the dietary manager said staff should not eat or drink in food preparation or serving areas. Staff should store and consume their personal food and drink items in the dietary manager's office or in the staff breakroom. 12. Review of the undated facility policy, Dishwashing: Machine, showed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All dishwashing machines should be operated according to manufacturer recommendations. Tableware, utensils, and pots and pans should be cleaned and sanitized in either a high-temperature dishwashing machine that uses hot water, or a chemical-sanitizing dishwashing machine that uses a chemical sanitizing solution; -Check the dials to ensure the wash and rinse cycles are achieving proper temperature per manufacturer guidelines. Observation on [DATE] at 3:23 P.M., of the kitchen (loaner) dishwashing machine, showed the following: -The label on the front of the dishwashing machine read: -Wash temperature - minimum 120 degrees F, recommended 140 degrees F; -Rinse temperature - minimum 120 degrees F, recommended 140 degrees F; -Required - 50 parts per million (PPM) available chlorine. Review on [DATE] at 10:45 A.M., of the Low Temperature Sanitizing Dish Machine log sheet, located on a clipboard above the dishwashing machine, showed the following: -A PPM of 200 was recorded for the A.M. and P.M. columns for [DATE] through [DATE]; -No data was recorded for [DATE] and [DATE]; -No acceptable chemical parameter ranges were indicated on the form; -No temperature parameters were indicated or temperature levels were recorded on the form. Observation on [DATE] at 11:03 A.M., of the chemical test strip bottles provided by the dietary manager, showed chlorine test strips bottle, a color scale was indicated on the label from light purple (10 PPM) to a dark purple (200 PPM). During interviews on [DATE] at 11:43 A.M. and [DATE] at 2:36 P.M., the dietary manager said the following: -The facility's old dishwashing machine had been having issues off and on for the past few months; -Repairs were made to the machine but after it

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on observation, interview and record review, the facility failed to follow appropriate infection control and prevention procedures while providing care to 12 residents, (Resident #11, 58, 59, 74, 77, 78, 87, 89, 120, 121, 309 and 606), in a review of 35 sampled residents. Staff failed to use appropriate hand washing and gloving techniques while providing care, failed to wear appropriate personal protective equipment (PPE), failed to utilize enhanced barrier precautions (EBP) during care and failed to ensure proper infection control was utilized for respiratory care supplies. The facility census was 149. Review of the facility policy, Enhanced Barrier Precautions (EBP), revised 3/2024, showed the following: -Purpose was to reduce the spread of multi-drug resistant organisms (MDRO); -EBP was indicated for residents with any of the following: Infection or colonization with a Centers for Disease Control (CDC)-targeted MDRO when contact precautions do not otherwise apply; or, wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; -Procedure: -Residents with colonization of MDRO and/or with indwelling medical devices (central lines (an intravenous line placed in a large vein like the neck or near the heart to administer medications or draw blood), gastrostomy tubes (G-tubes) (surgically inserted tube that provides direct access to the stomach for nutrition, hydration or medicine), foley catheters (flexible tube inserted into the bladder to drain urine)) will be placed on EBP; -Signage will be placed outside of their rooms to alert staff that personal protective equipment (PPE) is needed; -PPE including gowns and gloves, will be available immediately outside of the resident room; -PPE should be worn during high-contact resident care activities: dressing, bathing/showering, transferring (not needed when transferring in common areas), providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing, chronic wound examples include pressure injuries, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers (a wound on the leg or ankle caused by abnormal or damaged veins); -Trash can will be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room; -Private room is not required; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident may participate in communal activities and dining. Review of the facility policy, Gloves, revised 6/21, showed the following: -Purpose: To prevent the spread of infection and disease to residents and employees, to protect wounds from contamination, to protect hands from potentially infectious matter, and to prevent exposure to blood borne pathogens; -Procedure: Gloves are to be used when touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin, when employee's hands have any cuts, scrapes, wounds, dermatitis, etc, when cleaning up spills or splashes of body fluids, when it is likely that hands will come into contact with blood, body fluids, or other potentially infectious material, whenever in doubt; -When gloves are indicated, disposable single-use gloves are to be worn; -After use, remove gloves in the following manner: using one hand, pull the cuff down over the opposite hand turning the glove inside out, discard the glove into the waste can inside the resident's room, with the un-gloved hand, pull the cuff down over the opposite hand turning the glove inside out; again, discard in waste can in resident's room; -Wash hands after removing gloves, gloves do not replace hand washing; -Reminder: do not wear gloves in the hallway; dispose of in resident's room. Review of the facility policy, Hand Washing, revised 1/21, showed the following: -Purpose: to provide guidelines to employees for proper and appropriate hand washing techniques that will aid in the prevention of the transmission of infections; -Procedure: Check for adequate paper towels before starting the handwashing procedure, wet hands with water, apply two squirts of soap, using friction, rub hands together, cleaning under nails and between fingers thoroughly, wash up to your wrist as well, do this for at least 20 seconds, rinse hands well without touching the inside of the sink or the faucet (these are always considered soiled), leave water running, dry hands well, when finished, turn off faucet with a clean paper towel, discarded the towel in an appropriate trash container; -When to wash hands (at a minimum): when reporting to work and before going home, before eating and drinking, before and after using the toilet, after sneezing, coughing, or blowing your nose, after touching your hair, face, etc., after smoking cigarettes, before and after each resident contact, after touching a resident or handling his or her belongings, whenever hands are obviously soiled, after contact with any body fluids, after handling any contaminated items (lines, soiled diapers, garbage, etc.), after caring for residents with active clostridium difficile (a type of bacteria that can cause colitis (a serious inflammation of the colon)), before and after caring for residents with active Coronavirus Disease 2019 (COVID-19) (infectious disease) infection; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Procedure for using alcohol based hand rub (ABHR): the hands should be free of dirt and organic material, apply enough alcohol-based hand sanitizer to cover the entire surface of the hands and fingers, or a drop about the size of a nickel, rub the solution vigorously until dry, the ABHR may be used routinely for hand hygiene, unless hands are visible soiled; then soap-and-water handwashing is required, always wash hands with soap and water after blood or body fluid exposure; -When to use alcohol hand sanitizer: Only when visible soil is absent, after contact with residents' intact skin (as in taking a pulse, blood pressure or repositioning a resident). Review of the facility policy, Continuous Positive Airway Pressure (CPAP) (machine that uses mild air pressure to keep breathing airways open while you sleep)/Bi-Level Respiratory Care (non-invasive ventilation that helps one breathe) revised 7/2021 showed the following: Purpose: -Obstructive sleep apnea is a sleep disorder that occurs when the airway is obstructed or blocked and as a result, no air moves into or out of the lungs; -The obstruction may be due to a variety of factors including loss of muscle control over the tongue which may cause the tongue to fall back against the airway and/or the collapse of the soft palate over the airway; 4. Cleaning: a. DAILY: Wash mask with warm washcloth or CPAP mask wipes; NOTE: masks/cannula should be stored in mesh or comparable ventilated bag when not in use; Review of the policy did not include any direction to staff regarding storage of nebulizer masks when not in use. Review of the facility's Catheter Care Policy, revised 3/2021, showed the following: -Purpose: To keep indwelling catheter free of discharge and/or crusting which can cause infections; -Observation and Reporting: 4. Check tubing for positioning. Coil on bed; 5. Attach the urine collection bag to the bed frame only; 6. Never lift the bag above bladder level (source of infection); -No documentation showing were the urinary collection bag should be attached on a wheelchair, or that the bag should no be sitting on the floor or dragged on the floor when placed under a wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #78's continuity of care document (CCD) showed he/she had diagnoses that included malignant neoplasm of lungs and brain (cancer), difficulty in walking, functional diarrhea and lower extremity contracture (tightening or shortening of muscle, tendons, skin or other tissue that can limit movement in a joint or body part) of right foot and right ankle. Review of the resident's Significant Change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/14/24, showed the following: -Dependent on staff for transfers and toileting; -Always incontinent of bowel and bladder. Review of the resident's care plan, revised 4/12/24 showed the following: -Incontinent of bowel and bladder; -Resident is at risk for skin breakdown related to limited mobility and incontinence; -Assess resident for presence of risk factors; treat, reduce, and eliminate risk factors to extent possible; -Provide incontinence care after each incontinent episode. Observation on 5/8/24 at 9:06 P.M. showed the following: -Certified Nurse Aide (CNA) RR and CNA SS came into the resident's room with a mechanical lift to provide incontinence care and get the resident ready for bed; staff donned gloves but did not use hand sanitizer or wash hands with soap and water prior to donning gloves; -Licensed Practical Nurse (LPN) TT came in to assist, donned gloves, but did not use hand sanitizer or wash hands with soap and water prior to donning gloves; -CNA RR used a disposable wipe to wipe down one side of the inner leg, folded the cloth, wiped down the other side of the inner leg, folded the cloth, wiped down the center genitalia from front to back and repeated with a clean disposable wipe; -LPN TT dried the front peri area with a washcloth and assessed the resident's skin; -CNA RR cleaned the resident's buttock of dried feces with disposable wipes; -LPN TT took a wash cloth to the bathroom sink to get it wet and then cleaned the resident's buttocks with the wet wash cloth; -LPN TT used a towel to dry the resident's buttock and doffed gloves; he/she did not wash hands with soap and water and donned new gloves, opened the new package of briefs, removed a clean brief, handed it to CNA SS, grabbed a tube of zinc cream and gave it to CNA SS to apply to the resident's buttock; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA SS applied cream to the resident's buttock and with soiled gloves, helped CNA RR put a clean brief on the resident; he/she then doffed gloves, placed dirty linens in a clear bag, tied it up then washed hands; -CNA RR doffed gloves, washed hands, donned new gloves and a put a new gown on the resident, doffed gloves and washed hands; -LPN TT doffed gloves and left the resident's room without hand washing or hand sanitizing. During an interview on 5/8/24 at 8:50 P.M., LPN TT said handwashing should be done before and after care. 2. Review of Resident #58's CCD showed he/she had diagnoses that included urinary tract infection (UTI), personal history of urinary tract infections, neuromuscular dysfunction of bladder (when the brain, spinal cord or nerves that control bladder function are damaged), and retention of urine (difficulty completely emptying the bladder). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Dependent on two or more staff for transfers, hygiene, dressing, showering/bathing, and toileting hygiene; -Has an indwelling catheter; -Occasionally incontinent of bowel. Review of the resident's care plan, revised 4/17/24 showed the following: -The resident was at risk for contracting a multi-drug resistant organism (MDRO) due to an indwelling device that requires the use of personal protective equipment during high contact activities; -The resident is on Enhanced Barrier Precautions (EBP); -Staff must perform hand hygiene before and after providing care; -Staff to wear gloves and gowns when providing high contact activities; -The resident had potential for recurrent UTI's related to history of UTI's; -Ensure meticulous personal hygiene, especially after elimination, keep perineal area clean and dry, use a front to back wiping technique; -If the resident was incontinent, provide peri care as soon as possible after incontinent episode, per facility policy, being sure to cleanse well and cleanse from front to back; -Use principles of infection control and universal/standard precautions. Review of the resident's physician order sheet (POS), dated 4/17/24, showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gloves and gowns for all high contact tasks; -Wear eye protection if splash anticipated. Observation of the area outside the resident's room and of CNA UU on 5/8/24 at 8:25 P.M. showed the following: -A precaution sign outside the resident's room that instructed everyone must clean hands before entering and after leaving the room and wear gloves and gown for high contact resident care activities, additional personal protective equipment may be required for standard precautions; -Personal Protective Equipment (PPE), including gowns, gloves, trash bags and hand sanitizer was outside the resident's room; -CNA UU walked into the resident's EBP room without gowning or washing hands with soap and water or sanitizing hands. He/She donned gloves, grabbed the graduate container (a container to measure the amount of liquids) from the resident's bathroom and emptied the resident's urine from the urine collection catheter bag into the graduate container, emptied the urine into the toilet, rinsed the graduate container out with water from the bathroom sink and dumped it into the toilet. CNA UU did not wear goggles or a face shield. CNA UU doffed gloves, and without washing his/her hands with soap and water or using hand sanitizer, touched the resident's candy from the bedside table with his/her bare hands and handed it to the resident; -He/She exited the room without hand sanitizing or hand washing and walked down the hallway to the clean utility room, got a roll of trash bags, took the trash bags back into the resident's room (without gowning or hand sanitizing or hand washing), donned gloves, emptied the trash, doffed gloves and left the room without hand sanitizing or washing hands. During an interview on 5/8/24 at 8:25 P.M., CNA UU said the following: -He/She was not sure what the precaution sign and PPE was for on the door; -The hand sanitizer on the wall in the hallway was always empty; -He/She didn't even notice there were supplies on the door. During an interview on 5/8/24, at 8:50 P.M., LPN TT said the following: -The PPE and EBP is for resident's that are more susceptible to infections and germs such as residents with a g-tube, compromised skin/wounds, catheters, etc; -Staff should gown and glove when entering the room and remove them before leaving the room; -Staff should wash hands before and after care and/or use the hand sanitizer that is on the door with the PPE supplies. 3. Review of Resident #74's annual MDS, dated [DATE], showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent on staff for mobility, toileting hygiene and dressing; -Always incontinent of bowel. Review of the resident's care plan, revised 4/24/24, showed the following: -The resident was incontinent of bowel and/or bladder and needed assist with toileting; -The staff would provide incontinence care; -The staff would monitor the resident for incontinent episodes and provide peri care after each episode; -The resident had a deficit in activities of daily living (ADL) self-care and impaired functional mobility related to weakness; -The staff needed to provide assistance with ADL's. Observation on 5/08/24 at 7:55 P.M., showed the following: -CNA GG propelled the resident to his/her room; -CNA GG and Certified Medication Technician (CMT) HH entered the resident's room and donned gloves without washing their hands with soap and water or using hand sanitizer; -CNA GG and CMT HH used a mechanical lift to transfer the resident from his/her wheelchair to his/her bed; -The resident lay in his/her bed on his/her back; -CNA GG took off the resident's pants and with CMT HH's assistance, rolled the resident to his/her left side; -CNA GG took down the resident's brief and pushed it through his/her legs; -When CMT HH removed the resident's brief, the resident had been incontinent of feces; -CMT HH used wipes to complete perineal care for the resident. Without changing gloves and washing hands with soap and water, CMT HH applied a barrier cream to the resident's buttock. With soiled gloves, he/she then used his/her left hand on the resident's left side and pulled a clean brief up between the resident's legs. CNA GG helped to roll the resident to his/her back; -CNA GG used wipes to clean feces from inside of the resident's legs. Without changing gloves and washing hands with soap and water, CNA GG pulled the clean brief up and fastened the brief, pulled down the resident's gown and covered the resident up with his/her sheet and blanket. (continued on next page)

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	265792	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/08/24 at 8:23 P.M., CMT HH said he/she should change his/her gloves when perineal care was completed. He/She washed his/her hands as soon as possible after perineal care was finished. He/She did not take his/her gloves off because he/she was not thinking. During an interview on 5/08/24 at 9:11 P.M., CNA GG said he/she was supposed to change his/her gloves when they were exposed to (feces) or when doing perineal care between the front and the back of a resident. He/She did not change his/her gloves when they became soiled with (feces) because he/she was moving too fast and not paying attention. He/She knew the reason for changing gloves was to prevent the transfer of germs. 4. Review of Resident #606's face sheet showed he/she had diagnoses that included hematuria (blood in urine) and benign prostatic hyperplasia (BPH) (a condition in which the prostate gland is enlarged). Review of the resident's physician orders, dated May 2024, showed the following: -Diagnosis for use of indwelling catheter: Urinary retention (inability of the bladder to completely empty) with a start date of 5/09/24; -Insert 16 french (size of tube diameter) urinary catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body) with 30 cubic centimeter (cc) balloon; to be changed per Centers for Disease Control and Prevention (CDC) guidelines; -Catheter was inserted on 5/9/24 with a start date of 5/9/24. Review of the resident's care plan, dated 5/9/24, showed staff was to ensure tubing or any part of the drainage system did not touch the floor. Observation on 5/13/24 at 11:12 A.M., 12:12 P.M., and 2:25 P.M., showed the resident sat in the common area in his/her wheelchair and his/her catheter bag sat directly on the floor underneath his/her wheelchair. Observation on 5/13/24 at 2:32 P.M. showed CMT FF pushed the resident down the hallway and his/her catheter bag dragged the floor underneath his/her wheelchair. During an interview on 5/13/24 at 2:30 P.M., CMT FF said the catheter bag should not be touching the floor. The catheter bag should be kept up off the floor to prevent infection. During an interview on 5/13/24 at 2:39 P.M., LPN EE said a catheter bag should not be touching the floor. A catheter bag should be kept off the floor to prevent infection. 5. Review of Resident #89's quarterly MDS, dated [DATE], showed the following: -Dependent on staff for toileting; -Indwelling catheter; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of stroke, neurogenic bladder (a urinary tract condition that occurs when the bladder doesn't empty properly due to a neurological condition or spinal cord injury), obstructive uropathy (urinary tract disorder that occurs when urine flow is blocked and causes the urine to back up into the kidneys) and diabetes. Review of the resident's care plan, dated 5/8/24, showed the following: -The resident requires an indwelling urinary catheter related to obstructive and reflux uropathy and retention; -Do not allow tubing or any part of the drainage system to touch the floor. Observation of the resident's room on 5/9/24 at 10:28 A.M., showed the following: -The resident lay in bed; -The resident's urinary collection bag sat directly on the carpeted floor; -The resident's urine was pink tinged with mucous and sediment in the tubing (normal urine is usually clear or cloudy, with a pale yellow to amber color and should not contain sediment). During an interview on 5/9/24 at 10:28 A.M., the resident said he/she has had urinary tract infections (UTIs) in the past. 6. Review of Resident #309's face sheet showed his/her diagnoses included fractured left and right femur. Review of the resident's care plan for Infection, dated 5/4/24, showed: -Resident is at risk for contracting an MDRO due to wounds that require the use of PPE during high contact activities; -Goal: resident risk for contracting an MDRO will be decreased; -Interventions: resident is on EBP; staff must perform hand hygiene before and after providing care and staff are to wear gloves and gowns when providing high contact activities. Resident can participate in communal and dining as long as excretions and secretions are contained. Discontinue EBP once wounds are healed or indwelling device is discontinued. Observation of the area outside the resident's room and of staff on 5/8/24 at 7:37 P.M. showed the following: -A sign on the door for EBP indicating that a gown and gloves should be worn; -A storage container with disposable gowns hung over the door; -CNA BBB entered the resident's room and the resident told the aide that he/she was uncomfortable and wanted to be repositioned; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA BBB washed his/her hands and donned a pair of gloves but did not put on a gown; -He/She then removed the pillows from the resident's head, fluffed the pillows and put the pillows back under the resident's head. Then removed the pillows from under the resident's legs and placed one pillow on the right side and then the left side; -He/She removed his/her gloves and washed his/her hands and left the room; -The resident had incisions to both hips and there were no dressing to the incisions on either hip. During an interview on 5/8/24 at 7:50 P.M., CNA BBB said the following: -He/She was not aware of what EBP meant; he/she was told that it had to do with residents who had an indwelling catheter or a wound; -He/She was not aware that a gown had to be worn when taking care of the resident. 7. Review of Resident #120's admission MDS, dated [DATE], showed the following: -Dependent upon staff for toileting and hygiene; -Continent of bowel and bladder; -Diagnoses of cancer and arthritis. Observation of staff on 05/08/24 at 8:23 P.M. showed: -LPN Z and CNA AAA entered the resident's room to change the dressing to the resident's wound on his/her coccyx (tailbone); -LPN Z and CNA AAA washed their hands and applied gloves; -LPN Z brought in a dressing in a package and a tube of medication and placed them on the sheet at the foot of the bed (used no barrier); -LPN Z rolled the resident to the right side and removed the resident's brief, the resident had been incontinent of urine; -LPN Z took a wipe and wiped each buttock with one wipe, then, with the same soiled gloves, took a clean wipe and patted the pressure ulcer that was on the resident's coccyx; -LPN Z removed his/her gloves, and without washing his/her hands with soap and water, went to the treatment cart that was outside of the resident's door and took several dressing supplies and a bottle of wound cleanser out of the cart and brought them back into the resident's room placing them on top of the wound dressing package; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Without washing his/her hands with soap and water, LPN Z put on a pair of gloves, took several of the gauze dressings, sprayed the wound cleanser directly on the pressure ulcer and dabbed the wound with the gauze dressings; -With soiled gloves, he/she removed the dressing from the package, placed the dressing on top of the opened package, opened the tube of ointment and put a quarter size amount of ointment on the dressing and placed the dressing on the pressure ulcer on the resident's coccyx; -Wearing the same gloves, LPN Z picked up the tube of ointment and left the room; -LPN Z returned to the room wearing the same soiled gloves, and he/she and CNA AAA removed the resident's blouse and helped place a gown on the resident. During an interview on 5/8/24 at 8:15 P.M., LPN Z said the following: -Gloves should be changed when visibly soiled or going from dirty to clean tasks and before and after wound care; -He/She should have changed his/her gloves when he/she had cleaned the wound and before he/she applied the new dressing; -Dressing supplies should have been put on a clean field, the sheets on the resident's bed would not have been a clean field. 8. Review of Resident #77's quarterly MDS, dated [DATE], showed the following: -Dependent on staff for toileting hygiene; -Continence: blank; -Diagnoses of cancer and diabetes. Review of the resident's care plan, dated 4/29/24, showed the following: -Resident requires an indwelling urinary catheter related to urinary retention; -Resident is at risk for skin breakdown related to decreased mobility and incontinence; -Provide incontinence care after each incontinent episode; -Provide assist with ADLs as indicated. Observation in the resident's room on 5/8/24 at 8:20 P.M. showed the following: -The resident lay awake in bed; -CNA DDD and LPN W entered the resident's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA DDD and LPN W applied gowns and gloves; -With gloved hands, LPN W unfastened the resident's brief and provided front pericare; -The resident was having a bowel movement which LPN W provided care for; there was visible feces on the disposable wipe; -Without changing gloves or washing his/her hands with soap and water, LPN W assisted CNA DDD with applying a clean brief with the soiled gloves; -With the same soiled gloved hands, LPN W folded the blanket at the end of the bed; -LPN W removed his/her gown and gloves and washed his/her hands; -CNA DDD and LPN W exited the room. Observation in the resident's room on 5/8/24 at 8:40 P.M. showed the following: -CNA DDD and LPN W entered the resident's room; -CNA DDD and LPN W applied gowns and gloves; -The resident was incontinent of a medium soft bowel movement; -CNA DDD and LPN W rolled the resident to his/her right side; -LPN W provided rectal pericare; -With the same gloved hands, LPN W picked up a package of wipes and pulled a clean brief out of the package; -With the same gloved hands, LPN W tucked the soiled brief under the resident's hips and placed a clean brief under the resident's hips; -With the same gloved hands, LPN W applied barrier cream to the resident's buttocks; -LPN W removed his/her gloves and without washing his/her hands with soap and water or using hand sanitizer, LPN W applied clean gloves; -LPN W administered a Dulcolax (laxative) suppository into the resident's rectum; -LPN W removed his/her gloves, and without washing his/her hands with soap and water or using hand sanitizer, applied clean gloves; -LPN W and CNA DDD rolled the resident side to side in bed and CNA DDD removed the soiled brief; -LPN W fastened the tabs on the new brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/24 at 9:00 A.M., LPN W said the following: -Hands should be washed before cares, before and after gloving; -Hands should be washed prior to applying gloves; -Hands should be washed or hand sanitizer use with each glove change; -Gloves should be changed and hand hygiene completed after touching soiled items or performing pericare prior to touching clean items. 9. Review of Resident #121's physician's orders, dated May 2024, showed the following: -Ipratropium-Albuterol solution (inhaled lung medication) 0.5 milligrams (mg)-3 mg/3 milliliter (ml) one vial inhalation: inhale contents of one vial via nebulizer (machine used to administer nebulized medications) every six hours as needed for shortness of breath/cough (start date 1/26/24); -No order regarding the storage of the nebulizer mask when not in use. Review of the resident's care plan, dated 5/1/24, showed no documentation regarding the use of as needed nebulizer treatments. Observation in the resident's room on 5/7/24 at 4:23 P.M. showed the resident's nebulizer mask lay directly on the bedside table and not in a bag. Observation in the resident's room on 5/13/24 at 11:22 A.M. showed the following: -The resident sat in his/her power chair doing bead work; -The resident's nebulizer mask lay directly on the bedside table and not in a bag. 10. Review of Resident #11's care plan, dated 5/8/24, showed the following: -The resident requires a CPAP mask; -Wash mask, tubing, head gear, humidifier chamber with warm soapy water and air dry. Observation in the resident's room on 5/8/24 at 10:00 A.M., showed the resident's CPAP mask lay directly on the bedside table, and was not stored in a bag or container per policy. There was no visible mesh or comparable ventilated bag in the room to use for storage of the mask. Observation in the resident's room on 5/9/24 at 10:23 A.M. showed the resident's CPAP mask lay directly on the bedside table, and was not stored in a bag or container per policy. There was no visible mesh or comparable ventilated bag in the room to use for storage of the mask. Observation in the resident's room on 5/13/24 at 11:40 A.M. showed the resident's CPAP mask lay directly on the bedside table, and was not stored in a bag or container per policy. There was no visible mesh or comparable ventilated bag in the room to use for storage of the mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24 at 11:40 A.M., the resident said the following: -He/She wears his/her CPAP most nights; -Staff have to help him/her put on and take off the mask as he/she can't reach the machine or bedside table. During an interview on 5/13/24 at 11:45 A.M., CNA EEE said the following: -Sometimes he/she takes the CPAP off the resident when he/she comes in in the morning but sometimes the mask was already off; -He/She did not know anything about the mask being stored in something when not in use; -He/She has never seen the CPAP masks stored in a bag when not in use. During an interview on 5/13/24 at 12:50 P.M., LPN YY said the following: -There was no designated staff member responsible for the CPAP and nebulizer masks; -There were no orders to place the masks in a bag when not in use and he/she had not seen a bag for the masks used consistently; -Placing the mask in a bag would probably be a good idea. 11. Review of Resident #87's care plan, last revised 4/19/24, showed no documentation or instruction for storing the nebulizer system (mask, tubing and medication reservoir). Review of the resident's POS, dated 5/2024, showed the following: -Diagnoses included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe); -Ipratropium-albuterol solution for nebulizer 0.5 mg-3 mg (2.5 mg base)/3 ml: one vial per inhalation four times daily as needed (PRN); -No instructions for the storage of the nebulizer system. Observations of the resident's room showed the following: -On 5/7/24 at 12:17 P.M. the resident lay in his/her bed with the nebulizer mask on, attached to the nebulizer machine and administering a treatment; -On 5/7/24 at 3:35 P.M., the resident's nebulizer system lay on the over-the-bed table (unbagged) ; -On 5/8/24 at 12:54 P.M. and 8:00 P.M., the resident's nebulizer system lay on the over-the-bed table (unbagged); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 5/9/24 at 1:34 P.M., the resident's nebulizer system lay on the over-the-bed table (unbagged); -On 5/13/24 at 11:00 A.M., resident's nebulizer system lay on the over-the-bed table (unbagged); -On 5/14/24 at 10:30 A.M., the resident's nebulizer system lay on the over-the-bed table (unbagged). 12. Review of Resident #59's quarterly MDS, dated [DATE], showed the following: -Substantial to maximum assist with bed mobility and personal hygiene; -Did not address incontinence. Review of the resident's care plan, last rev

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 36219

Based on interview and record review, the facility failed to provide the pneumococcal vaccine (a vaccine that can protect against pneumococcal disease) as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for three residents (Residents #26, #94 and #403), in a review of 35 sampled residents. The facility census was 149.

Review of the facility policy Pneumococcal Vaccination of Residents dated 2/2022 showed the following:

Purpose:

-To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP);

Policy:

-Upon admission, residents will be assessed for need of pneumococcal vaccination. ACIP recommends a single dose of PCV20 (Prevnar 20) for adults aged > [AGE] years who have not previously received the pneumococcal conjugate vaccine or whose vaccination history is unknown. For adults aged 19-[AGE] years with certain underlying medical conditions or risk factors* who have not previously received the pneumococcal conjugate vaccine or who vaccination history is unknown, ACIP recommends a single dose of PCV 20;

*The underlying medication conditions or risk factors warranting a dose of PCV20 in adults 19-[AGE] years old are: alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies;

Special situations:

-Adults who have previously received only PPSV23 (Pneumovax) may receive a dose of PCV20 > 1 year after their last PPSV23 dose. Shared clinical decision making between the resident and physician is recommended;

-Adults aged > [AGE] years who have previously received PCV13 (Prevnar 13) should receive a dose of PPSV23 > 1 year after their dose of PCV13 (or > 8 weeks after PCV13 dose if immunocompromised). It should also be at least 5 years since a prior dose of PPSV23, if applicable;

-Adults who have received PCV15 (Vaxneuvance) should receive a dose of PPSV23 > 1 year later (or > 8 weeks later if immunocompromised).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 9/22/23, showed the following: -Adults 19 through [AGE] years old with any of these conditions or risk factors: 1. Alcoholism or cigarette smoking; 2. Cerebrospinal fluid leak; 3. Chronic heart disease, including congestive heart failure and cardiomyopathies, excluding hypertension; 4. Chronic liver disease; 5. Chronic lung disease, including chronic obstructive pulmonary disease, emphysema, and asthma; 6. Cochlear implant; 7. Diabetes mellitus 8. Decreased immune function from disease or drugs (i.e., immunocompromising conditions); 9. Immunocompromising conditions include: a. Chronic renal failure or nephrotic syndrome; b. Congenital or acquired asplenia, or splenic dysfunction; c. Congenital or acquired immunodeficiency; d. Diseases or conditions treated with immunosuppressive drugs or radiation therapy; e. HIV infection; f. Sickle cell disease or other hemoglobinopathies; -Adults 19 through [AGE] years old who never received any Pneumococcal Vaccine, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. The minimum interval (8 weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adults 19 through [AGE] years old who only Received PPSV23, regardless of risk condition: 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination; 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete. -Adults 19 through [AGE] years old who only received PCV13, who have a risk condition (see above) other than an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13 for those with a cochlear implant or cerebrospinal fluid leak. The PPSV23 dose should be given at least 1 year after PCV13 for any of the other chronic health conditions. When PPSV23 is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have an immunocompromising condition: 1. Give 1 dose of PCV20 or PPSV23; 2. The PCV20 dose should be given at least 1 year after PCV13. When PCV20 is used, their vaccines are then complete; 3. The PPSV23 dose should be given at least 8 weeks after PCV13. When PPSV23 is used, they need another pneumococcal vaccine at least 5 years later. At that time, give either 1 dose of PCV20 or a second dose of PPSV23. When PCV20 is used, their vaccines will then be complete. When a second PPSV23 dose is used, no additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults 19 through [AGE] years old who have received PCV13 and 1 Dose of PPSV23 and who have an immunocompromising condition: 1. Give 1 dose of PCV20 or a second PPSV23 dose; 2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine. Their vaccines are then complete; 3. The second dose of PPSV23 should be given at least 8 weeks after PCV13 and 5 years after PPSV23. No additional pneumococcal vaccines are recommended until at least age [AGE] years; -Adults [AGE] years or older who have never received any pneumococcal vaccine and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of O'Fallon	7068 South Outer 364 O Fallon, MO 63368

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. The vaccines are then complete; Adults [AGE] years or older who have never received any pneumococcal vaccine and have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak: 1. Give 1 dose of PCV15 or PCV20; 2. When PCV15 is used, it should be followed by a dose of PPSV23 at least 8 weeks later. Their vaccines will then be complete; 3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete. -Adults [AGE] years or older who have only received the PPSV23 regardless of risk condition; 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination. 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they have already received it. Their vaccines are then complete. -Adult [AGE] years or older who have only received the PCV13 and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak; 1. Give 1 dose of PCV 20 or PPSV23, at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. -Adults [AGE] years or older who have only received the PCV13 and have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak; 1. Give 1 dose of PCV20 or PPSV23. Regardless of vaccine used, their vaccines are then complete; 2. The PCV20 dose should be given at least 1 year after PCV13. 3. The PPSV23 dose should be given at least 8 weeks after PCV13. -Adults [AGE] years and older who have received PCV13 at any age and PPSV23 before age 65 and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak; 1. Give 1 dose of PCV20 of PPSv23. Regardless of vaccine used, their vaccines are then complete. 2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine; 3. The PPSV23 dose should be given at least 5 years after the last PPSV23 dose. It should also be given at least 1 year after the PCV13 dose. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adults [AGE] years and older who have received PCV13 at any age and PPSV23 before age 65 who have an immunocompromising condition, cochlear implant or cerebrospinal fluid leak; 1. Give 1 dose of PCV20 or PPSV23. Regardless of vaccine used their vaccines are then complete; 2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine; 3. The PPSV23 dose should be given at least 5 years after the last PPSV23 dose. It should also be given at least 8 weeks after the PCV13 dose. -Adults [AGE] years or older who have received the PCV13 at any age and the PPSV23 after the age of 65; 1. Use shared clinical decision-making to decide whether to administer PCV20. 2. If so the dose of PCV20 should be administered at least 5 years after the last pneumococcal vaccine. -Adult [AGE] years or older who have only received PPSV23: 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination; 2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete. 1 Review of Resident #26's Continuity of Care Document (CCD) showed the following: -admitted [DATE]; -The resident was his/her own responsible party; -Diagnoses included 2019 nCov acute respiratory disease (COVID-19) (an infectious disease that can affect the upper and lower respiratory tract); -The resident was greater than [AGE] years of age. Review of the resident's Vaccination Consent Form, signed and dated 2/26/21, showed the resident wanted to receive the Pneumococcal Polysaccharide Vaccine (PPSV23). Review of the resident's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/10/24, showed the following: -Intact cognition; -The resident's pneumococcal vaccine was not up to date; -The resident was not offered the pneumococcal vaccine. (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 electronic health record (EHR) showed the following: -No documentation the resident had received any pneumococcal vaccine prior to admission; -No documentation the resident was offered, received or refused any pneumococcal vaccine; -The resident was not up to date on thepneumococcall vaccination per CDC recommendations. During an interview on 5/8/24 at 9:20 A.M., the resident said he/she believed his/her vaccines were up to date. -He/She could not recall the facility giving him/her the PPSV23; -He/She could not recall getting any pneumonia vaccination at the facility or outside the facility. 2. Review of Resident #94's CCD showed the following: -admitted [DATE]; -The resident had a responsible party to help with decision making; -Diagnoses included chronic respiratory failure; -The resident was greater than [AGE] years of age. Review of the resident's quarterly MDS, dated [DATE] showed the resident's pneumococcal vaccine was up to date. Review of the resident's vaccine history showed the following; -Resident previously had the PPSV23 on 10/18/2020; - No documentation the PCV15 was offered, administered or refused; - No documentation the PCV20 was offered, administered or refused; -The resident was not up to date per CDC recommendations. During an interview on 5/14/24 at 9:50 A.M., resident's responsible party/sister said the resident has never been offered the PCV20 vaccine and he/she would like for him to have the vaccine. 3. Review of Resident #403's face sheet showed the following: -He/She admitted to the facility on [DATE]; -He/She was less than [AGE] years of age; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had a diagnoses of diabetes and stroke; -He/She was his/her own person. Review of the resident's EHR immunization record showed the resident received PPSV23 outside the facility on 2/23/21. Review of the resident's vaccine consent form, dated 4/25/24, showed the following: -I would like to receive the pneumonia vaccine (Prevnar 20 or Pneumovax 23) based on CDC criteria: left blank; -I do not wish to receive the pneumonia vaccine: left blank; -Signed by the resident. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Pneumococcal vaccine not offered. Review of the resident's medical record showed no documentation facility staff offered or administered the PCV15 or PCV20 vaccine or that the resident refused the vaccines. During an interview on 5/14/24 at 12:55 P.M., the Director of Nursing (DON), said the following: -Medical Records was responsible for ensuring and checking that any new admissions and annual renewals are up to date for vaccines, filling out the consent form with the resident, and then passes the form on to the charge nurse to input the order; -She would expect the resident toreceivee the vaccine if they consented toreceivingg it; -She would expect resident vaccinations to be up to date according to the CDC guidelines. During an interview on 5/22/24 at 1:10 P.M., the Administrator said the following: -She would expect staff to offer pneumonia vaccine to all eligible residents according to CDC guidelines unless contraindicated; -She would expect staff to administer the pneumonia vaccine if a consent is signed requesting that vaccine. 45563

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 44665 Based on observation and interview, the facility failed to ensure equipment was maintained in good repair and safe operating condition so as not present a hazard to staff, residents, or visitors. The facility census was 149. Observation on 5/8/24 at 10:44 A.M., in the kitchen, showed the power cord of the food processor was frayed at the connection to the machine and was missing part of the cord's protective coating in an approximate one-inch long section. Observation on 5/7/24 at 12:54 P.M., in the 700 servery, showed the refrigerator compartment of a combination refrigerator/freezer unit was not working. The temperature on the unit read 105 degrees Fahrenheit. The door opened freely and felt warm inside the compartment. No food items were located in the compartment and there was no sign posted on the unit indicating the compartment was not working nor instructing staff, residents, or visitors to not put food items in the compartment for cooling. During an interview on 5/7/24 at 12:54 P.M., Dietary Aide I, confirmed the refrigerator compartment of the 700 servery combination refrigerator/freezer unit did not work. The unit was moved from a different part of the facility and the refrigerator portion had not worked for awhile. The bottom freezer portion still worked and was used for frozen food and ice storage. During an interview on 5/8/24 at 3:14 P.M., the director of environmental services said the following: -The refrigerator portion of the 700 servery combination refrigerator/freezer unit did not work and he made the decision not to repair it due to being told the parts were unavailable to fix it; -The dietary manager wanted the non-working refrigerator portion of the unit to be screwed shut; -He was unaware of the frayed cord on the food processor in the kitchen and he expected staff to report needed repairs to the maintenance department. During an interview on 5/8/24 at 4:11 P.M., the dietary manager said the following: -Equipment should be maintained in good repair and safe operating condition; -She was unaware of the frayed cord found on the food processor. She expected staff to let her know when an item needed repair so she could submit a work order to maintenance staff; -She was aware of the non-working refrigerator compartment in the servery and planned to have the maintenance staff screw the compartment shut. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 3:37 P.M., the administrator said she was unaware of the non-functioning refrigerator compartment in the 700 servery and of the frayed cord on the food processor in the kitchen. She expected staff to notify the maintenance staff of items needing attention so they could be repaired, replaced, or locked-out/tagged-out as needed.