STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265810	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Adams Street	1024 Adams Street Jefferson City, MO 65101

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on interview and record review, facility staff failed to check the Employee Disqualification List ((EDL) a list of individuals who have been determined to have abused or neglected a resident or misappropriated funds or property belonging to a resident) and/or criminal background check (CBC), prior to hire in accordance with their facility policy for eight employee (Certified Nurse Aide (CNA) I, Licensed Practical Nurse (LPN) J, receptionist K, Social Services Director, Certified Medication Technician (CMT) L, housekeeper N, Nurse Aide (NA) B, and Food Service Manager) out of ten sampled employees. Facility staff failed to develop an abuse and neglect policy that directed staff to check the NA registry for all employees, prior to hire, for seven employees (CNA I, LPN J, Receptionist K, Social services director, CMT L, housekeeper N, and NA B) out of 10 employees. The facility census was 53. 1. Review of the Facility's Background Screening Investigations, dated March 2019, showed the director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment. Review of the Facility's Credentialing of Nursing Service Personnel, dated May 2019, showed: -Nursing personnel requiring a license/certification are not permitted to perform direct resident care services until all licensing/background checks have been completed; -Upon obtaining the applicants informed consent to conducting a license/certification/background investigation, the director of nursing services, or designee, will: -Contact the facility's authorized vendor/service organization to perform a background check in accordance with current state law and facility policy; -A copy of all documents obtained during the verification and background check are filed in the employee's personnel file. Such records are filed in accordance with current federal and state law and facility policy to protect the confidentiality of information. 2. Review of CNA I's personnel record showed the employee hire date of 12/27/23. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of LPN J's personnel record showed the employee with a hire date of 05/22/24. The personnel record did not contain documentation staff completed a EDL check prior to his/her hire date. 4. Review of Receptionist K's personnel record showed the employee with a hire date of 04/23/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 5. Review of Social Services Director's personnel record showed the employee with a hire date of 10/29/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 6. Review of CMT L's personnel record showed the employee with a hire date of 06/12/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 7. Review of Housekeeping N's personnel record showed the employee with a hire date of 02/08/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 8. Review of NA B's personnel record showed the employee with a hire date of 06/03/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 9. Review of Food Service Manager's personnel record showed the employee with a hire date of 07/10/24. The personnel record did not contain documentation staff completed a CBC or EDL check prior to his/her hire date. 10. During an interview on 12/03/24 at 2:50 P.M., the Business Office Manager (BOM) said he/she is responsible for doing EDL and CBC checks for new employees. He/She said six months ago his/her processes changed. He/She said the facility was shorthanded and employees were pushed through the hiring process without back ground screenings prior to hire. He/She said he/she was initiating the paperwork during their orientation. He/She said new employee screenings are supposed to be initiated before the employee steps foot in the building. He/She said the employees are in the building before the checks come back. He/She said he/she is not sure where the missing background checks are. He/She said he/she does do yearly chart audits. He/She said he/she does background screenings when missing background checks are found during those audits. During an interview on 12/03/24 at 3:17 P.M., the Director of Nursing (DON) said EDL and CBC checks should be done prior to hire. He/She said it is the responsibility of the BOM to ensure those checks are completed. He/She said those checks are important because they keep residents safe from people who have been committed of abuse and neglect. He/She said he/she was not aware the BOM was not running background checks on new employees prior to hiring them. During an interview on 12/03/24 at 4:10 P.M., the administrator said the BOM is responsible for checking background screenings. He/She said it is his/her expectation that the CBC and EDL checkes are completed prior to hire. He/She said he/she was not aware the BOM wasn't conducting background screenings prior to hire. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Review of the facility's policies showed staff did not provide a policy to direct staff to check the NA registry on all employees prior to hire. 12. Review of CNA I's personnel record showed the employee with a hire date of 12/27/23. The personnel record did not contain documentation staff completed a NA Registry check prior to his/her hire date. 13. Review of LPN J's personnel record showed the employee with a hire date of 05/22/24. The personnel record did not contain documentation staff completed a NA Registry check prior to LPN J's hire date. 14. Review of Receptionist K's personnel record showed the employee with a hire date of 04/23/24. The personnel record did not contain documentation staff completed a NA Registry check prior to Receptionist K's hire date. 15. Review of Social Services Director's personnel record showed the employee with a hire date of 10/29/24. The personnel record did not contain documentation staff completed a NA Registry check prior to Social Services Director's hire date. 16. Review of CMT L's personnel record showed the employee with a hire date of 06/12/24. The personnel record did not contain documentation staff completed a NA Registry check prior to CMT L's hire date. 17. Review of Housekeeping N's personnel record showed the employee with a hire date of 02/08/24. The personnel record did not contain documentation staff completed a NA Registry check prior to Housekeeping N's hire date. 18. Review of NA B's personnel record showed the employee with a hire date of 06/03/24. The personnel record did not contain documentation staff completed a NA Registry check prior [NAME] B's hire date. 19. During an interview on 12/03/24 at 2:50 P.M., the BOM said he/she is responsible for running the NA registry checks. He/She said he/she is aware he/she was supposed to run the NA registry checks prior to hire. He/She said he/she was not sure why the staff members did not have the NA Registry checks done prior to hire. He/She said he/she thought the NA registry was only ran to check if an employee was certified. He/She said he/she was not aware it was to check for federal indicators (a marker given by the federal government to individuals who have committed abuse and/or neglect) against the staff member. During an interview on 12/03/24 at 3:17 P.M., the DON said NA registry checks should be done prior to hire. He/She said the BOM is in charge of ensuring all checks are done prior to hire. He/She said he/she knows that it is important to have them done prior so that residents are not exposed to any employees who may cause them harm. He/She was not aware that the NA registry checks were not being done prior to hire. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/03/24 at 4:10 P.M., the Administrator said the BOM is responsible for checking the NA registry prior to hire on all employees. He/She said he/she was not aware the facility's policy did not direct staff to check all employees prior to hire. He/She said it is his/her expectation that staff check all employees prior to hire. He/She said he/she had instructed the BOM to do checks on all staff prior to hire and he/she was not aware that the BOM was not doing the checks.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39644 Based on interview and record review, facility staff failed to notify the Ombudsman (a resident advocate) for four residents (Resident #25, #34, #38, and #54) out of four sampled resident who transfered to the hospital. The facility's census was 53. 1. Review of the facility policies showed the facility did not have a policy for Ombudsman notification. 2. Review of Resident #25's medical record showed the resident transferred to the hospital on 10/15/24 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital. 3. Review of Resident #34's medical record showed the resident transferred to the hospital on 10/31/24 and readmitted to the facility on [DATE]. The medical record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital. 4. Review of Resident #38's medical record showed the resident discharged to the hospital on 08/12/24 and readmitted to the facility on [DATE]. The record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital. 5. Review of Resident 54's medical record showed the resident discharged to the hospital on 11/07/24 and readmitted to the facility on [DATE]. The record did not contain documentation staff notified the Ombudsman of the resident's transfer to the hospital. 6. During an interview on 12/04/24 at 10:10 A.M., the Social Services Director said he/she was not aware of the process for Ombudsman notification of transfered and discharged residents. He/She said he/she does not handle this task. During an interview on 12/04/24 at 4:00 P.M., the Administrator said the Ombudsman notification should be sent monthly and she was the one who did that task but hasn't had time to do it.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	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** 39644 Based on interview and record review, facility staff failed to provide written information to the resident and/or the resident's representative of the facility's bed hold policy at the time of transfer to the hospital for four residents (Resident #25, #34, #38, and #54) out of 14 sampled residents. The facility's census was 53. 1. Review of the facility's Bed Holds policy, dated March 2022, showed the facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of the bed-hold policy. 2. Review of Resident #25's medical record showed the resident discharged from the facility on 10/15/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 3. Review of Resident #34's medical record showed the resident discharged from the facility on 10/31/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 4. Review of Resident #38's medical record showed the resident discharged from the facility on 08/12/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 5. Review of Resident 54's medical record showed the resident discharged from the facility on 11/07/24 and readmitted to the facility on [DATE]. The record did not contain written documentation staff notified the resident or the resident's responsible party of the facility's bed-hold policy. 6. During an interview on 12//24 at 10:15 A.M., the Social Services Director (SSD) said he/she knows this is supposed to be done, but to their knowledge the charge nurse does it. The SSD said the nurse would give it to him/her to upload. The SSD said he/she has not completed any bed holds for any residents upon transfer or discharge. During an interview on 12/24 at 11:03 A.M., the Administrator said We are supposed to do bed holds, but it is not happening. The facility found that the last SSD had not been doing this, and the new SSD needs to be trained.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on record review, and interview, facility staff failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet resident's needs for three residents (Resident #20, #49, and #56) out of 14 sampled residents.The facility census was 53. 1. Review of the facility's Comprehensive Care Plans policy, September 2022, showed: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment; -The comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, assessment. 2. Review of Resident #20's admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted on [DATE]; -Cognitivly impaired; -Diagnoses of Cancer, Cerebrovascular accident (CVA), Transient Ischemic attack (TIA), or Stroke; -Care Area Triggers: Delirium, cognitive loss/dementia, communication, urinary incontinence/indwelling catheter, behavioral symptoms, falls, dental care, pressure ulcer, psychotropic drug use, and pain, Review of the resident's medical record showed the record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's delirium, cognitive loss/dementia, communication, urinary incontinence/indwelling catheter, behavioral symptoms, dental care, pressure ulcer, psychotropic drug use, and pain. During an interview on 12/04/24 at 8:52 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed 21 days after admission, but unsure why this residents comprehensive was not completed. 3. Review of Resident #49's admission MDS, dated [DATE], showed staff assessed the resident as follows: -admitted on [DATE]; (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Moderate cognitive impairment; -Diagnoses: Renal failure, Thyroid disorder, Dementia, and Parkinson's; -Care Area Triggers: Delirium, Cognitive loss, communication, activities of daily living (ADL) care, urinary incontinence/indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain. Review of the resident's medical record showed the record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's communication deficits, ADL care, urinary catheter, psychosocial well-being, mood and behavioral symptoms, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain. During an interview on 12/04/24 at 8:53 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed 21 days after admission, but he/she must have just overlooked it. 4. Review of Resident #56's discharge MDS, dated [DATE], showed staff assessed the resident as follows: -admitted on [DATE] from an acute hospital; -discharged [DATE] to an acute hospital with return anticipated; -Moderate cognitive impairment; -Diagnoses: Obstructive uropathy (blocked urine flow), Diabetes Mellitus, Right hip dislocation, -Care Area Triggers: Cognitive loss, visual function, activities of daily living (ADL) care, urinary incontinence/indwelling catheter, psychosocial well-being, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, and pain, Review of the resident's medical record showed staff documented the resident returned to the facility on [DATE]. The record did not contain documentation of a comprehensive person-centered care plan for the resident, to provide directions for the resident's visual deficits, ADL care, urinary catheter, psychosocial well-being, falls, dental care, and pain. During an interview on 12/04/24 at 8:54 A.M., the MDS/Care Plan Coordinator said the resident's comprehensive care plan should have been completed in October, and he/she must have just overlooked it. 5. During an interview on 12/04/24 at 3:50 P.M., the Director of Nursing (DON) said the MDS coordinator is responsible for the completion of care plans. The DON said he/she and MDS review all the care plans together. The DON said she does not have a good reason for the care plans not being done or updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 4:50 P.M., the Administrator said comprehensive care plans are compeleted by MDS coordinator. The administrator said he/she does not have a reason why any of the care plans have not been done or updated, but the DON should monitor that they are. 39644 50422

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to safely transfer two residents (Resident #14 and #52) of two sampled residents via mechanical lift, in a manner to prevent accidents. The facility's census was 53. 1. Review of the facility's policy titled, Using a Mechanical Lift Machine, dated July 2017, showed staff were directed as follows: -At least two nursing assistants are needed to safely move a resident with a mechanical lift; -Staff must be trained and demonstrate competency using the specific machines or devices used in the facility; -Gently support the resident as he or she is moved, but do not support any weight; -The policy did not contain direction for position of the base legs during the transfer. 2. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/14/24 showed staff assessed the resident as severe cognitive impairment and dependent on staff for transfers from chair to bed/bed to chair. Review of the resident's care plan, dated 10/30/24, showed two staff are to assist the resident with the mechanical lift for transfers. Observation on 12/03/24 at 10:12 A.M., showed Certified Nursing Aide (CNA) E and Nuring Assistant (NA) B attached the resident's sling to the mechanical lift. NA B raised the resident from his/her wheelchair with the legs in the opened position of the mechanical lift, while CNA E removed the wheelchair from behind the resident. CNA E left the room to gather additional supplies, leaving the resident suspended in the sling without two staff support for three minutes. CNA E returned to the resident's room, closed the legs of the mechanical lift, pushed the lift to the resident's bed, and lowered the resident to the bed. During an interview on 12/03/24 at 10:35 A.M., CNA E said two staff should perform mechanical lift transfers, with one person controlling the lift and the other to guide the resident in the sling to ensure safety and prevent falls or the machine tipping over. The CNA said he/she should have lowered the resident back to the chair prior to leaving the room, for safety, and since only one staff was left with him/her in the room. The CNA said he/she was taught the legs of the mechanical lift should be closed when pushing the resident with the lift for better maneuvering, and to keep staff from tripping over each other. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 10:47 A.M., NA B said two staff should perform mechanical lift transfers, with one person controlling the lift and the other to guide the resident in the sling. The NA said the legs of the mechanical lift should be opened when pushing the resident with the lift for balance and resident safety. The NA said the resident could have fallen while left dangling in the air, but he/she was unsure of what to do since he/she was left alone with the resident. 3. Review of Resident #52's significant change MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and dependent on staff for transfers from chair to bed/bed to chair. Review of the resident's care plan, dated 12/02/24, showed two staff are to assist the resident with the mechanical lift for transfers. Observation on 12/01/24 at 12:07 P.M., showed CNA E widened the legs of the mechanical lift to accommodate the resident's wheelchair. CNA E and CNA F attached the resident's sling to the mechanical lift. CNA E raised the resident from the wheelchair in the sling using the mechanical lift, while CNA F removed the chair from behind the resident. CNA E closed the legs of the lift, pushed the lift to the resident's bed, and lowered the resident to the bed. During an interview on 12/03/24 at 10:35 A.M., CNA E said he/she was taught the legs of the mechanical lift should be closed when pushing the resident with the lift for better maneuvering, and to keep staff from tripping over each other. Observation on 12/02/24 at 8:11 A.M., showed NA C widened the legs of the mechanical lift to accommodate the resident's wheelchair. NA C and NA D attached the resident's sling to the lift. NA D raised the resident from the wheelchair in the sling using the mechanical lift, while NA C removed the chair from behind the resident. NA D closed the legs of the lift, pushed the lift to the resident's bed, and lowered the resident to the bed. During an interview on 12/02/24 at 2:39 P.M., NA C said two staff should always perform mechanical lift transfers, with one person who locks the wheel/controls the lift and the other person to guide the resident in the sling while in the air. The NA said the legs of the mechanical lift should be opened when pushing the resident with the lift for balance and safety. The NA said when he/she realized that NA D was pushing the resident in the lift with the legs closed, it was too late for him/her to intervene. During an interview on 12/04/24 at 10:55 A.M., the Director of Nursing (DON) said NA C and NA D have received training on how to transfer a resident with a mechanical lift. 4. During an interview on 12/04/24 at 3:42 P.M., the DON said two staff are required to transfer a resident via a mechanical lift to ensure resident safety and prevent falls, and one person should always guide the resident in the sling. The DON said it is not appropriate or safe to leave a resident suspended in the sling in the air. He/She said the legs of the mechanical lift should be opened to ensure stability of the lift when pushing a resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Based on observation, interview, and record review, facility staff failed to accurately assess the use of side rails for three residents (Resident #2, #49, and #52), and failed to complete an entrapment risk assessment for five residents (Resident #1, #2, #49, #52, and #106), out of 14 sampled residents. The facility census was 53. 1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments. Review of the facility's Proper use of Side Rails Policy, dated 09/2022, showed: -Examples of bedrails include, but are not limited to side rails, bed side rails, safety rails, grab bars, and assist bars; -The resident assessment must assess the resident's risk from using bed rails such as entrapment; -The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself; -A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or a change in the type of bed/mattress/rail. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/27/24, showed staff assessed the resident as: -readmitted on [DATE]; -Severe cognitive impairment; -Impairment on one side of upper extremity (shoulder, elbow, wrist, hand); -Required substantial/moderate assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed, and dependent for transfers from bed to chair. Review of the resident's side rail use assessment, dated 10/29/24, showed staff documented the resident used grab bars to assist with cares and to turn side to side. Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails/grab bars. Observation on 12/03/24 at 8:33 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Required partial/moderate assist from staff to roll left and right; -Required substantial/maximum assist from staff from sitting to lying in bed and for lying to sitting on side of bed, and dependent of staff for transfers from bed to chair. Review of the resident's side rail use assessment, dated 09/22/24, showed staff documented the resident did not use side rails or assistive devices such as grab bars. Review of the resident's medical record showed the record did not contain an entrapment risk assessment. Observation on 12/01/24 at 2:04 P.M., showed the resident in bed with bilateral hand rails in upright position. Observation on 12/02/24 at 1:33 P.M., showed the resident in bed with bilateral u-bars in upright position. Observation on 12/03/24 at 10:25 A.M., showed the resident in bed with bilateral u-bars in upright position. During an interview on 12/04/24 at 3:13 P.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect, but knows resident uses u-bars. The charge nurses are responsible to complete the assessment. 4. Review of Resident #49's Admission MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -Required partial/moderate assist from staff to roll left and right and from sitting to lying and lying to sitting on side of bed; -Required dependent assist from staff for transfers from bed to chair. Review of the resident's side rail use assessment dated [DATE], showed staff documented the resident did not use side rails or assistive devices such as grab bars. Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails. Observation on 12/01/24 at 2:28 P.M., showed the resident in bed with bilateral grab bars in upright position. Observation on 12/02/24 at 1:28 P.M., showed the resident in bed with bilateral grab bars in upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/04/24 at 09:08 A.M., showed the resident in bed with bilateral grab bars in upright position. During an interview on 12/04/24 at 3:13 P.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect, but knows resident uses grab bars. 5. Review of Resident #52's admission MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -Impairment on one side of upper extremity (shoulder, elbow, wrist, hand); -Required substantial/maximum assist from staff to roll left and right, sitting to lying in bed, dependent for lying to sitting on side of bed and transfers from bed to chair. Review of the resident's side rail use assessment dated [DATE], showed staff documented the resident did not use side rails or assistive devices such as grab bars. Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails/grab bars. Observation on 12/01/24 at 12:07 P.M., showed the resident held the grab bar on each side of the bed when assisted by staff to roll left and right during care. Observation on 12/02/24 at 8:11 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position. During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said the resident's side rail use assessment was incorrect. The charge nurses are responsible to complete the side rail use assessment. 6. Review of Resident #106's admission MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Required partial/moderate assist from staff to roll left and right, sitting to lying in bed, lying to sitting on side of bed, and substantial/maximum assist with transfers from bed to chair. Review of the resident's side rail use assessment, dated 11/18/24, showed staff documented the resident used half side rails per family request. Review of the resident's medical record showed the record did not contain an entrapment risk assessment for use of side rails. Observation on 12/01/24 at 11:00 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/03/24 at 8:30 A.M., showed the resident in bed with grab bars to both sides of the bed in the upright position. During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said he/she could not find documentation that the maintenance staff completed the bed safety measurements. 7. During an interview on 12/04/24 at 8:50 A.M., the MDS/Care plan Coordinator said nurses do the side rail and entrapment assessment and maintenance does the measurements of the side rails monthly. He/She said he/she is unsure if the resident is supposed to be in the bed during entrapment measurements. During an interview on 12/04/24 at 9:00 A.M., Maintenance said he/she does entrapment measurements monthly. He/She said he/she measures without the resident in the bed. He/She agrees that the gaps between side rail and mattress would be different measurements with the resident laying in the bed. He/She said that he/she is unsure if he has read anything that stated that the resident needed to be in the bed for the measurements. During an interview on 12/04/24 at 3:08 P.M., Licensed Practical Nurse (LPN) J said bed rail assessments are done upon admission and quarterly. He/She said he/she is not sure who completes them quarterly. During an interview on 12/04/24 at 4:00 P.M., the Director of Nursing (DON) said maintenance and nursing get together and make sure that the side rail assessment and entrapment measurements are done. He/She said the side rail assessment is part of the admission process or it is completed if a family member asks for side rails. He/She said it is the admitting nurses responsible to complete the side rail assessment. He/She said maintenance is responsible for doing entrapment measurements, but he/she is unsure how often or if the resident should be in the bed during the measurements. During an interview on 12/04/24 at 4:25 P.M., the Administrator said that side rail assessment is done quarterly by a nurse. He/She said maintenance does entrapment measurements monthly or with change of a new bed. He/She assumes the resident should be in the bed during measurements since that's what the diagram shows. He/She said the DON and ADON is responsible for monitoring to ensure assessments are being done. 39644 Surveyor: [NAME], [NAME] 50422

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39440 Based on interview and record review, facility staff failed to provide the services of a Registered Nurse (RN) for at least eight consecutive hours per day, seven days per week. The facility's census was 53. 1. Review of the facility's Nursing Services Registered Nurse Policy, dated October 2022, showed it is the intent of the facility to comply with RN staffing requirements, and the facility will utilize the services of a Registered Nurse for at least eight consecutive hours per day, seven days per week. 2. Review of the facility's time-keeping records for consecutive hours worked by an RN for August 2024, showed: -Saturday, 08/17/24: 7.55 hours; -Sunday, 08/18/24: 7.9 hours. Review of the facility's time-keeping records for consecutive hours worked by an RN for September 2024, showed: -Sunday, 09/01/24: 7.83 hours; -Saturday, 09/07/24: 7.6 hours; -Sunday, 09/08/24: seven hours; -Sunday, 09/29/24: did not show a RN in the building. Review of the facility's time-keeping records for consecutive hours worked by an RN for October 2024, showed: -Saturday, 10/05/24: 4.87 hours; -Saturday, 10/19/24: 6.83 hours; -Saturday, 10/26/24: 6.52 hours. During an interview on 12/04/24 at 3:36 P.M., the Director of Nursing (DON) said his/her expectation is for staff to provide eight consecutive hours of RN coverage every day including the weekends, and he/she usually fills in if there is no RN scheduled or if someone called in. The DON said some of the days with less than eight hours of RN coverage on the weekends were likely due to a lunch break, and he/she did not have an explanation for why there was no RN coverage on 09/29/24. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/24 at 4:09 P.M., the administrator said there should be an RN at the facility for eight consecutive hours per day, seven days per week. The administrator said he/she realized that there were days where the facility staff did not meet the eight consecutive hours requirement for RN coverage, and he/she did not have an explanation for why there was no RN coverage on 09/29/24.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39440 Reviewed AT Based on observation, interview, and record review, facility staff failed to post the required nurse staffing information on a daily basis, which included the facility name, current date, resident census, total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. Facility staff failed to keep the required daily staffing records for 18 months. The facility's census was 53. 1.Review of the facility's policy titled, Nurse Staffing Posting, dated September 2022, showed: -The facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents; -It is the policy of the facility to make nurse staffing information readily available in a readable format to resident and visitors at any given time; -The facility will post the Nurse Staffing sheet at the beginning of each shift; -A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current; -The information shall reflect staff absences on that shift due to call-outs and illness, and after the start of each shift, actual hours will be updated to reflect such; - Nursing schedules and posting information will be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater. Review of the facility's records showed the facility did not retain nurse staff posting for: -January 2024; -February 2024; -03/01/24 through 03/14/24; -April 2024; -05/01/24, 05/04/24, 05/05/24, 05/09/24 through 05/15/24, 05/17/24 through 05/21/24, and 05/23/24 through 05/29/24; -06/03/24, 06/06/24 through 06/14/24, 06/18/24 through 06/20/24, 06/25/24, 06/27/24, and 06/28/24; -07/06/24, 07/07/24, and 07/12/24 through 07/31/24; (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	-08/01/24 through 08/15/24, and 08/20/24 through 08/26/24; -09/13/24 through 09/15/24, 09/18/24, and 09/23/24; -10/02/24, 10/07/24, and 10/28/24. 2. Observation on Sunday, 12/01/24 at 9:20 A.M., showed the daily nurse staff posting, dated Friday, 11/22/24. 3. During an interview on 12/04/24 at 10:47 A.M., the Director of Nursing (DON) said the postings should be retained for 18 months. He/She said he/she started working at the facility in April and did not know the process for retaining the staff posting sheets prior to that or why the sheets from January through March were missing. The DON said he/she was not sure why the sheets from 07/01/24 through 07/31/24 were missing either. The DON said at one point, he/she, the administrator, and Assistant Director of Nursing (ADON) shared the responsibility to post the daily Nurse Staffing sheet, but currently, the administrator is responsible to post it on weekdays, and the ADON prepares the ones for Saturday and Sunday ahead of time and directs the weekend charge nurse to post on the weekends. During an interview on 12/04/24 at 10:50 A.M., the ADON said he/she prepares and prints the Nurse Staffing sheets with hall assignments on Fridays for the weekends, and gives the sheets to the charge nurse to post on the weekends. During an interview on 12/04/24 at 4:09 P.M., the administrator said the ADON ensures the daily staff posting is printed, and the charge nurse posts it at the beginning of the shift, but he/she was not sure anyone updates the posting with call-outs or illnesses. The administrator said the daily postings for January through April were not being completed because the facility only had an interim DON and did not have enough staff to keep up with it. The administrator said he/she did not know why the Nurse Staffing sheets were not posted daily from 11/23/24 through 11/30/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50422 Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5% out of 27 opportunities observed, seven errors occurred, resulting in a 25.93% error rate, which affected two residents (Resident #16, and #36). The facility census was 53. 1. Review of the Facility's Administering Medications policy, dated 12/2012, showed: -Medications must be administered in accordance with the orders including any required time frame; -Individual administering the medication must check to verify right time; -The Expiration/beyond use date on the medication label must be checked prior to administering, when opening a multi-dose container, the date opened shall be recorded on the container; Review of the Facility's Medication Errors policy, dated 04/2017, showed: -A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles or the professional providing services; -Example of medication error includes wrong time and/or failure to follow manufacturer instructions and/or accepted professional standards. 2. Review of the Resident #16's physician's order sheets (POS), dated December 2024, showed the directed staff to adminster: -Fiasp (Rapid-acting insulin) inject 25 units subcutaneously (SQ) (under the skin)with meals; -Fiasp inject per sliding scale for a blood sugar of 301-350 inject five units SQ; -Tresiba (Long-acting insulin) inject 65 units SQ with meals. Observation on 12/02/24 at 10:22 A.M., showed Certified Medication Tech (CMT) O prepared and administered Fiasp 30 units and Tresiba 65 units SQ to the resident. The resident's Fiasp and Tresiba insulin pens did not contain an open or beyond use date. During an interview on 12/02/24 at 10:31 A.M., Certified Medication Technician (CMT) O said insulins pens are supposed to be dated when opened. He/She said whoever opens the insulin pen is responsible for making sure resident name and open date is on the pen. He/She said he/she thinks insulin expires after 30 days of being open, but he/she usually has to ask the nurse for sure. He/She said if insulin pens are not dated and he/she has questions about when they were opened or doubts, he/she will go talk with the charge nurse or converse with the other CMT's to see when they were opened. He/She the risk of not dating insulin pens is not knowing how long it's been opened, and it could affect the overall effectiveness of the insulin. He/She said that residents normally going through about one insulin pen a week, so they usually don't expire. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #36's POS, dated December 2024, showed staff are directed to administer medications between 0600-1100 A.M.: -ProFe (treat low iron) 391.3 (180 fe) milligrams (mg) daily in the morning between 0700-1100 A.M.; -Pioglitazone (treat diabetes) 30mg one time a day between 0600-1100 A.M.; -Metoprolol Succinate (treat high blood pressure) 25 mg in the morning between 0700-1100 A.M.; -Furosemide (diuretic) 20mg one time a day between 0600-1100 A.M.; -Glimepiride (treat diabetes) 2mg in the morning between 0700-1100 A.M. Observation on 12/02/24 at 12:10 A.M., showed CMT O administered Profe, Pioglitazone, Metoprolol, Furosemide, and Glimepiride to the resident. One hour and 10 minutes after the allotted timeframe. During an interview on 12/02/24 at 12:15 A.M., CMT O said he/she normally gives the resident his/her morning medications during breakfast but said the resident left the dining room before he/she could give them to the resident and then he/she forgot to go back later. He/She said when he/she gives medications late he/she usually puts a progress note in chart and then watches the other medication to make sure they are not given to close together. 4. During an interview on 12/02/24 at 4:03 P.M., License Practical Nurse (LPN) G said if a CMT has a medication error he/she would expect them to report it to charge nurse. He/She said if he/she is notified about a medication error then the physician would be contacted along with the Director of Nursing (DON), resident family, and possible pharmacy to see if anything needed to be done. He/she said there should be a progress note in the chart under risk management for a medication error and there are steps to follow. He/She agreed that administering medications late and given undated insulin is a medication error. He/She said he/she was not informed about any medication errors today. During an interview on 12/04/24 at 3:53 P.M., the DON said when a medication error occurs that it needs to be reported to the charge nurse, DON, notify family, physician and obtain any orders. He/She said administering undated insulin and administering medications late are considered medication errors to him/her because it violates the nine rights of administration. He/She expects a progress note to be in the chart. During an interview on 12/04/24 at 4:25 P.M., the Administrator said when a medication error occurs the charge nurse should be notified along with the doctor and family member. He/She said administering undated insulin and administering medications late would be considered a medication error. He/She expects there to be a progress note in the chart.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50422 Based on observation, interview, and record review, facility staff failed to store medications in a safe and effective manner when staff failed to properly label, and/or discard expired insulin medications from two of two sampled medication carts. The facility census was 53. 1. Review of the facility's policy titled, Administering Medications, dated ,d+[DATE], showed the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. 2. Observation on [DATE] at 9:26 A.M., showed the ,d+[DATE] hall medication cart contained two Lantus insulin Pens opened and undated. During an interview on [DATE] at 9:30 A.M., Certified Medication Technician (CMT) P said insulin pens are usually only good for 28 days. He/She said the person opening the insulin pen is responsible for putting the open date on the pen. He/She said the risk of not having an open date is you don't know when it expires, and insulin may not be effective if it is expired. 3. Observation on [DATE] at 9:49 A.M., showed the ,d+[DATE] hall medication cart contained: -Six Lantus insulin pens opened and undated; -Three Novolog insulin pens opened and undated; -One Novolin insulin pen opened and undated; -One Glargine insulin pen opened and undated; -One Aspart insulin pen opened and undated; -One Fiasp insulin pen opened and undated; -One Tresiba insulin pen opened and undated. 4. During an interview on [DATE] at 09:55 A.M., CMT Q said there is no explanation why the insulin pens are not dated. He/She said he/she always works, and the residents take their insulin so frequently they go through one pen a week or less. He/She said insulin pens usually expire 28 days after opening. He/She said the person opening the insulin is responsible for dating the pen with the open date. He/She said the risk of not dating the pens is the insulin may not be effective if you do not know when it expires. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:06 P.M., Licensed Practical Nurse (LPN) J said whoever opens the insulin pens should be dating it with the open date. He/She thinks insulin pens are good for 60 days after opening. He/She said the risk for not dating insulin pens when opened is you don't know when it expires, and the insulin may not be effective. During an interview on [DATE] at 3:53 P.M., the Director of Nursing (DON) said insulin pens should be labeled with the pharmacy label and open date when opened. He/She said the person opening the pen is responsible for putting the open date on the pen. He/She said most insulin pens are good for 28 days after opening. He/She said if insulin pens are not dated then you don't know how long it has been opened and risk the insulin losses effectiveness. He/She said the Assistant Director of Nursing (ADON) and the DON should be monitoring if insulin pens are being dated. He/She said he/she was not aware there were several insulin pens opened with no dates on them. During an interview on [DATE] at 4:25 P.M., the administrator said insulin pens should be dated when opened. He/She said whoever opens the insulin pen is responsible for dating it. He/She is unsure when insulin pens expire. He/She said the ADON and DON should be monitoring the pens. He/She is unsure of the risks of having opened and undated insulin pens.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 45564 Based on observation, interview and record review, the facility staff failed to provide each resident with a nourishing, palatable, well-balanced diet to meet their daily nutritional and special dietary needs, when staff failed to follow recipes. The facility census was 53. 1. Review of the facility's Standardized Recipes policy, revised April 2007, showed staff were directed to use only tested , standardized recipes to prepare foods. Review showed standardized recipes will be adjusted to the number of portions required for a meal. Review of the facility's standardized recipe for 52 servings of shepherd's pie showed staff were directed to include 16 pounds of ground beef, one and one-eighth of a #10 (approximately seven pounds) can of tomatoes and one gallon plus one cup of potatoes. Review showed the recipe also included peas and carrots. Review showed a three inch by three inch wide long portion was equal to one serving. Observation on 12/02/24 at 11:36 A.M., showed dietary staff served the residents a #8 scoop (four ounces) of shepherd's pie for the noon meal. Observation showed the shepherd's pie contained more potatoes than ground beef and did not contain tomatoes. Observation showed the shepherd's pie was runny in consistency. During an interview on 12/02/24 at 11:42 A.M., the Dietary Supervisor (DS) said staff used about eight pounds of beef and forgot to add tomatoes. The DS said staff used enough peas, carrots and potatoes for 52 servings. The DS said he/she reduced the amount of beef so there would not be a lot of left overs which would go to waste. During an interview on 12/02/24 at 11:47 A.M., the Registered Dietician (RD) said he/she would expect staff to follow the standardized recipes. The RD said he/she was not aware staff only used half of the beef called for in the recipe. The RD said shepherd's pie should be firm and served as a three inch by three inch wide long portion, not a four ounce scoop. The RD said he/she did not know if a four ounce scoop was the same as a three inch by three inch wide long portion .

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45564 Based on interview and record review, the facility staff failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate qualifications, when the facility did not employ a qualified dietitian or other clinically qualified nutrition professional full-time. The facility census was 53. 1. Review of the facility Food Services Manager policy, updated 9/28/22, showed the director of food and nutrition services must at a minimum meet one of the following qualifications: -A certified dietary manger (CDM); -A certified food service manager; -Has two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management. During an interview on 12/02/24 at 10:26 A.M., the Dietary Supervisor (DS) said he/she did not have any dietary manager training. The DS said he/she had worked in hotels and restaurants prior to starting at the facility. The DS said he/she was aware of the Certified Dietary Manager requirement and the administrator was working to get him/her certified. The DS said he/she had a food handlers card but he/she had never received any formal food service training. The DS said he/she started as a cook about six months ago and assumed the DS position about two months ago. During an interview on 12/04/24 at 11:05 A.M., the Human Resources (HR) Manager said the DS was hired as a cook on 07/10/24 and assumed the DS role on 09/03/24. The HR manager said he/she was aware the DS did not have previous experience in a nursing facility. The HR manager said he/she was aware of the CDM requirement but did not know the certification was required upon hire. The HR manager said the DS was in his/her 90-day probation period. The HR manager said he/she did not know if the DS was enrolled in any training. During an interview on 12/04/24 at 2:30 P.M., the administrator said he/she was responsible for ensuring the dietary manager had proper training and qualifications. The administrator said he/she thought the dietary manager could complete training after hired to the position and did not realize the dietary manager had to have dietary manager qualifications when hired. The administrator said the DS was enrolled in a food service manager course through the facility food service vendor but had not received a course date yet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45564 Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use. Facility staff failed to store ice scoops in a manner to prevent contamination and failed cover resident meals in a manner to prevent contamination. Facility staff failed to maintain the ice machine drain air gap. The census was 53. 1. Review of the facility's Food Receiving and Sorage policy, revised July 2014, showed: -Food in desiganted dry storage areas shall be kept off the floor at least 18 inches; -All foods stored in the refrigerator or freezer will be covered, labeled and dated with a use by date; -Other opened containers must be dated and sealed or covered during storage; -Dry foods that are stored in bins will be removed from original packaging, labeled and dated. 2. Observation on 12/01/24 at 9:29 A.M., showed the kitchen refrigerator #1 door contained a sign which read Record open and use by dates on all open items. Follow use by manufacturer's date or seven days. Observation showed the refrigerator contained: -One container of parmesan cheese opened and undated; -One container with chopped garlic open to the air, opened and undated; -An unlabeled and undated container with a yellow substance; -Bottles of Caesar and Italian dressing, opened and undated; -A bottle of ketchup, opened and undated; -A metal container of lettuce leaves open to the air and undated; -A container of chopped onions open to the air and undated; -Two cartons of grape juice, opened and undated; -Two cartons of orange juice, opened and undated; -One 64oz bottle of apple juice, opened and undated; -One gallon bottle of enchilada sauce, opened and undated; -One bottle of salsa, opened and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 12/01/2024 at 9:33 A.M., showed the kitchen refrigerator #2 contained food debris on the bottom shelf and two opened pieces of ham wrapped in plastic, which were dated 11/21. 4. Observation on 12/01/24 at 9:45 A.M., showed the kitchen freezer #1 contained: -Abox of pizza dough open to the air and undated; -A box of dinner rolls open to the air and undated; -A bag of breadsticks open to the air and undated; -A bag of hashbrown patties open to the air and undated; -A bag of cubed potatoes open to the air and undated; -A bag of french fries open to the air and undated. 5. Observation on 12/01/24 at 9:47 A.M., showed the kitchen freezer #2 door contained a sign which read Label and date before putting items in fridge or freezer. Observation showed the freezer contained: -A box of square cod patties with frost, open and undated; -A box of unbreaded raw beef steaks, open and undated; -A box of fajita flavored chicken strips, open and undated; -A box of cookie dough, open and undated; -A box of pork loin steak fritters, open and undated. 6. Observation on 12/01/24 at 9:50 A.M , showed the dry storage room contained: -A package of egg noodles open to the air; -A package of spaghetti noodles, open and undated; -A box of parboiled rice, on the floor, open and undated; -A bag of oatmeal on the floor, open and undated; -A salt storage container which contained an aluminum bowl. Observation on 12/02/24 at 10:44 A.M., showed the dry goods storage area contained a bulk storage bin which contained flour. Observation showed a metal bowl was stored in the bin with the flour. 7. Observation on 12/01/24 at 9:55 A.M., showed under the cooks prep table contained a box of pancake mix with a scoop inside. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Observation on 12/02/24 at 10:31 A.M., showed the shelves behind the serving line contained: -A bin of frosted flakes, undated; -A bin of puffed [NAME] cereal, dated 9/30; -A bin of fruit loops, undated. During an interview on 12/01/24 at 9:55 A.M., The Dietary Manager (DM) said all dietary staff were responsible to label and date items when opened, and prior to storing. The DM said he/she was responsible to double check and ensure opened items were resealed and labeled/dated. The DM said scoops should not be left inside containers to prevent risk of bacteria growth. During an interview on 12/02/24 at 12:19 P.M., the Registered Dietician (RD) said food labeling/dating, and kitchen cleanliness have been issues lately and he/she was working with staff to resolve. 10. Observation on 12/01/14 at 12:45 P.M., showed staff served the noon meal. Observation showed the cooler uncovered contained ice with the ice-scoop inside. 11. Observation on 12/02/24 at 11:49 A.M., showed an unidentified staff member prepared drinks for residents in the dining room and placed the ice scoop into an uncovered cooler which contained ice after after each drink. 12. Observation on 12/02/24 at 11:59 A.M., showed shower Aide T used the ice scoop to remove ice from the cooler and placed the ice scoop back into the cooler with ice. During an interview on 12/02/24 at 11:59 A.M., Shower Aide T said he/she helped with lunch everyday. He/She said the ice scoop should go back in the scoop holder and should not be stored in the ice. 13. Observation on 12/02/24 at 12:11 P.M., showed Nurse Aide (NA) D used a ice scoop to remove ice from the dining room cooler and placed the ice scoop back into the cooler with ice. Observation showed NA D served the drink to a resident. NA D then removed the scoop from the ice, prepared another resident drink, and returned the scoop to the ice bin. During an interview on 12/02/24 at 12:12 P.M., NA D said the ice scoop should probably not go in cooler but he/she was not sure where it should go. NA D said he/she helped with lunch daily. 14. Observation on 12/02/24 at 12:11 P.M., showed Housekeeper N removed the ice scoop from the ice, placed ice in a cup and returned the scoop to the ice. During an interview on 12/02/24 at 12:15 P.M., Housekeeper N said the ice scoop should go back in the container next to the cooler. Housekeeper N said the ice scoop should not be stored in the ice. 15. Observation on 12/03/24 at 8:09 A.M., showed an unidentified staff member prepared drinks for residents in the dining room and placed the ice scoop into an uncovered cooler which contained ice after after each drink. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/24 at 1:00 P.M., the DM said dietary staff were responsible for ensuring the ice scoop was not stored in the ice. 16. Observation on 12/02/24 at 12:15 P.M., showed staff delivered two metal carts to the hallway near the nurse's station. Observation showed the meal plates were covered with plastic lids which contained a hole in the center, which exposed the food. Observation showed the cart remained in the hallway as staff delivered the meal trays to residents. Observation on 12/03/24 at 12:25 P.M., showed an open metal cart which contained five resident hall trays sat in the main hallway on the 100-hall side of the nurse's station. Observation showed the meal plates were covered with plastic covers, which contained a hole in the center. Observation showed five resident trays contained small cups of pudding and potato salad which were not covered. Observation showed the cart was not attended by staff. During an interview on 12/02/24 at 12:19 P.M., the Registered Dietician (RD) said the hall trays were being covered with lids for cold items and the lids should not have a hole in them. During an interview on 12/04/24 at 1:00 P.M., the DM said the servers were responsible for ensuring food was covered before being placed on delivery carts. The DM said the plate covers should not have holes. The DM said he/she was not aware meal carts were being left in the hall with uncovered food items. 17. Observation on 12/02/24 10:33 A.M., showed the ice machine drain ran to an open floor drain, sat below the finished floor level and did not contain an air gap. During an interview on 12/04/24 at 1:00 P.M., the DM said he/she was not familiar with the ice machine air gap requirement. During an interview on 12/04/24 at 11:30 A.M., the plant supervisor said he/she had never looked at the ice machine drain so he/she didn't realize there was not an air gap. During an interview on 12/04/24 at 2:30 P.M., the administrator said the DM and dietary staff were responsible for food storage. The administrator said dietary and nursing staff were responsible for ensuring food was covered when being delivered to resident rooms. The administrator said anyone serving drinks or using the ice scoop was responsible for not storing the scoop in the ice. The administrator said the DM and Plant Supervisor were responsible for the ice machine air gap. The administrator said the RD has been working with newer kitchen staff on ome of the issues noted.

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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** 39440 Based on observation, interview, and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness. Facility staff failed to ensure the two-step purified protein derivative (PPD) (skin test for Tuberculosis (TB)) was completed for six employees (Certified Nurse aide (CNA) I, Licensed practical nurse (LPN) J, Receptionist K, transporter M, Housekeeper N, and nurse aide (NA) B) out of ten sampled employees. Staff failed to perform hand hygiene and/or wash hands to prevent the spread of infection during perineal care for four residents (Resident #9, #14, #38, and #52) of four sampled residents. Failed to implement the Enhanced Barrier Precautions (EBP) policy when they did not educate, or alert staff of residents who required EBP, and failed to place appropriate personal protective equipment (PPE) in close proximity for three (Resident #14, #38, and #52) of three sampled residents. The facility census was 53. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and Oversight (QSO) 17-30, dated 06/02/17 and revised on 07/06/18, showed: The bacterium Legionella can cause a serious type of pneumonia called Legionnaire's Disease in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Develops and implements a water management program that considers the ASHRAE industry standard and the CDC toolkit; -Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Risk Management Plan for Legionella Control, reviewed 10/08/24, showed the plan contained a policy template which was not modified to reflect the facility's water system. Review showed the plan did not contain: -Facility specific policies related to water management; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A description of the facility's water system; -Facility specific areas identified as at risk for Legionella growth; -Control measures to include acceptable ranges; -Corrective actions to take if control measures are out of range. Review of Appendix B of the Legionella control plan showed the Appendix contained 30 questions which provided a description of the facility water system. The Appendix did not contain information related to areas identified as risk areas. The Appendix did not contain information related to control measures or corrective actions. During an interview on 12/04/24 at 10:55 A.M., the Housekeeping supervisor said his/her staff flushes toilets and runs water in vacant rooms every couple of days. The housekeeping supervisor said the Plant Supervisor brought up the need to run the water periodically but the Plant Supervisor never provided guidance on four shower rooms which were being used for storage. The housekeeping supervisor said he/she did not know the last time the unused showers were flushed. During an interview on 12/04/24 at 11:30 A.M., the Plant Supervisor said he/she read the Legionella control plan briefly when he/she started work at the facility. The Plant Supervisor said he/she was not familiar with what should be included in the Legionella control plan. The Plant Supervisor said he/she did not know if the plan identified specific risk areas of the facility water system. The Plant Supervisor said he/she believed the four showers and two bathtubs which were not being used would probably be high risk areas. The Plant Supervisor said he/she did not know if the plan addressed low use areas. The Plant Supervisor said he/she had spoken with housekeeping about flushing low use resident room sinks and toilets. During an interview on 12/04/24 at 1:45 P.M., the administrator said maintenance staff were responsible for implementing the Legionella control plan. The administrator said he/she had reviewed the plan but was not very knowledgeable of the contents. The administrator said Appendix B contained facility specifics. The administrator said Appendix B did not contain facility specific risk areas, control measures or corrective actions. 2. Review of the Facility's Employee Screening for Tuberculosis, dated 12/2016, showed: -Each newly hired employee will be screened for TB infection and disease after an employment offer has been made prior to the employee's duty assignment; -The initial TB testing will be a two-step Tuberculin skin test (TST); -If the reaction to the first skin test is negative, the facility will administer a second skin test not before 7 days and no later than 21 days after the first test. The employee may begin duty assignments after the first skin test (if negative) unless prohibited by state regulation. Review of the Center for Disease Control and Prevention's, Clinical Testing Guidance for TB: TB Skin Tests, dated May 14, 2024, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two-Step testing; -If the first skin test is negative, a second TB skin test should be done one to three weeks later; -The skin test reaction should be read between 48-72 hours after administration by a health care worker trained to read TB skin results. 3. Review of CNA I's employee file showed a hire date of 12/27/23. Review showed the employees file did not contain documentation the first or second step PPD as completed. 4. Review of LPN J's employee file showed a hire date of 05/22/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed. 5. Review of Receptionist K's employee file showed a hire date of 04/23/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed. 6. Review of Transporter M's employee file showed a hire date of 05/15/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed. 7. Review of Housekeeper N's employee file showed a hire date of 02/08/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed. 8. Review of NA B's employee file showed a hire date of 06/03/24. Review showed the employee's file did not contain documentation the first or second step PPD as completed. 9. During an interview on 12/02/24 at 2:50 P.M., the business office manager (BOM) said the director of nursing (DON) and the assistant director of nursing (ADON) are responsible for ensuring the two-step TB's are completed on all new hires. He/She said at new employee orientation he/she has the new employees file out the TB documentation and then either the DON or ADON will administer the first step. He/She said it is the DON's job to keep track of the documentation and ensure the employee completes the TB testing. He/She said all employees should have the first step TB done and read before they come in contact with the residents. He/She is not sure why there are staff members who did not get the two step TB's completed timely. During an interview on 12/02/24 at 3:17 P.M., the DON said all new employees need a two-step TB. He/She said the first step should be given and read before staff come in contact with residents. The second step should be done one to three weeks after the first step is completed. He/She said TB's should be read 48-72 hours after administration. He/She said TB's are started at new employee orientation by either the ADON, Charge nurse, or himself/her/self. He/She is responsible for ensuring the TB's are completed timely. He/She tracks them on a spreadsheet. He/She said he/she is not sure why there are employees without two-step TB's completed. During an interview on 12/02/24 at 4:10 P.M., the administrator said the DON, with the help of the ADON, is responsible for ensuring two-step TB's are completed on all new hires. He/She said after conducting audits in September he/she was made aware that there were staff members who did not have a two-step TB. He/She said he/she thought they had all been fixed and was not sure why there were still staff members who were uncorrected. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of the facility's Hand Hygiene policy, dated May 2021 showed: -Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating and after using the restroom; -The use of gloves does not replace hand hygiene. If your task require gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 11. Review of Resident #9's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated , showed staff assessed the resident as follows: -Cognitively impaired; -Required substantial/maximum assist from staff with toileting, bathing, and personal hygiene. Observation on 12/01/24 at 3:10 P.M., showed NA A entered the resident's room to provide perineal care. NA A applied his/her gloves, removed the residents soiled brief and wiped the resident's perineal area front and back. With the same soiled gloves, NA A placed a clean brief, clean clothes, and covered the resident with their blanket. NA A removed the gloves and left the room without preforming hand hygiene. During an interview on 12/01/24 at 3:45 P.M., NA A said he/she forgot to change his/her gloves after they removed the dirty items. He/She said they are to wash hands before and after care. 12. Review of Resident #14's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Required substantial/maximum assist from staff with personal hygiene, and dependent with toileting. Observation on 12/03/24 at 10:13 A.M., showed CNA E entered the resident's room to provide care. CNA E applied his/her gloves and provided peri-care. CNA E changed his/her gloves, cleaned the bowel movement from the resident's buttock, changed gloves, placed a clean brief and disposable pad underneath the resident, removed gloves, and took the trash from the room. The CNA did not perform hand hygiene before or in between gloves changes during peri-care to prevent the spread of infection. During an interview on 12/03/24 at 10:35 A.M., CNA E said he/she should have sanitized or wash his/her hands prior to applying gloves, and after each glove change, but did not, because he/she was nervous and in a rush. 13. Review of Resident #38's Quarterly MDS, dated [DATE] showed staff assessed the resident as follows: -Moderate cognitive impairment; (continued on next page)

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	265810	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Adams Street	1024 Adams Street Jefferson City, MO 65101

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required substantial/maximal assist from staff with personal hygiene and toileting. Observation on 12/02/24 at 3:31 P.M., showed CNA R entered the resident's room to provide catheter care. CNA R washed hands, and applied gloves. CNA R cleaned the resident's catheter and peri area. With the same soiled gloves, the CNA rolled the resident and applied new brief underneath resident. CNA R changed his/her gloves, latched the resident's brief and adjusted the blankets. The CNA did not perform appropriate hand hygiene in between gloves changes during peri-care to prevent the spread of infection. During an interview on 12/02/24 at 3:45 P.M., CNA R said he/she should have washed hands between glove changes, but he/she was nervous. He/She said not washing hands between gloves changes is a risk for infection. 14. Review of Resident #52's significant change MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Required substantial/maximum assist from staff with personal hygiene, and dependent with toileting. Observation on 12/01/24 at 12:07 P.M., showed CNA E entered the resident's room to provide care and applied gloves. CNA E provided peri-care, changed gloves, and cleaned the bowel movement from the resident's buttock.With the same soiled gloves, CNA E open the dresser drawer and removed a clean brief, changed gloves, placed the brief underneath the resident, covered the resident, and took the trash from the room. CNA E did not perform appropriate hand hygiene before or in between gloves changes during peri-care to prevent the spread of infection. 15. During an interview on 12/04/24 at 3:36 P.M., the DON said staff should perform hand hygiene when they enter a resident's room and prior to putting gloves on. The DON said staff should perform hand hygiene after each glove change, wash hands between dirty and clean tasks, and prior to leaving the resident's room. The DON said staff may use hand sanitizer up to three times, then he/she should wash his/her hands with soap and water. During an interview on 12/04/24 at 4:30 P.M., the administrator said staff are expected to wash their hands when they enter the room and exit the room. Staff should hand sanitize between glove changes or wash hands if they are visibly soiled. Gloves should be changed between dirty task to clean task. 16. Review of the facility's Enhanced Barrier Precautions policy, dated September 2022 showed: -All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions; -Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident are activities that require the use of gown and gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order for enhances barrier precautions will be obtained for residents with any of the following: -Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO; -Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precaution do not apply. 17. Review of Resident #14's quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, and had one stage three (full thickness tissue loss) pressure ulcer. Observation on 12/01/24 at 11:48 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 12/02/24 at 9:57 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. LPN H and NA C performed incontinence care and wound care to the resident. NA C did not wear a gown when he/she performed incontinence care. The NA did not use appropriate PPE as an EBP during cares. During an interview on 12/02/24 at 10:16 A.M., NA C said he/she did not know what EBP was or that a gown was required when performing incontinence care with the resident. During an interview on 12/02/24 at 10:18 A.M., LPN H said extra PPE should be used with cares for residents with an open wound to protect the residents and staff from cross contamination. The LPN said the charge nurse notifies the NAs and CNAs during shift report of residents who require extra PPE, which requires the NAs/CNAs to wear at least a gown and gloves with incontinence care. The LPN said he/she should have ensured the NA wore a gown when he/she assisted him/her to provide incontinence care to the resident. Observation on 12/03/24 at 10:16 A.M., showed a sign on the resident's door to alert staff on the use of EBP. NA B and CNA E entered the resident's room and did not wear a gown when they transferred the resident via mechanical lift and performed incontinence care. During an interview on 12/03/24 at 10:35 A.M, CNA E said he/she should have worn a gown when he/she transferred the resident via mechanical lift and performed incontinence care since he/she was in contact with the resident's wound. The CNA said he/she was in a rush and forgot to go get a gown. During an interview on 12/03/24 at 10:47 A.M., NA B said he/she did not realize there was an EBP sign on the resident's room door, and he/she did not know to wear a gown when he/she transferred the resident via mechanical lift and performed incontinence care. 18. Review of Resident #38's Quarterly MDS, dated [DATE] showed staff assessed the resident as follows: -Moderate cognitive impairment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Indwelling catheter. Observation on 12/02/24 at 3:31 P.M., showed the CNA R entered the resident's room with EBP sign on resident's door, washed hands, and applied gloves. CNA R performed catheter care to resident, removed gloves, and sanitized hands. The CNA did not wear a a gown when he/she performed catheter care. During an interview on 12/02/24 at 3:45 P.M., CNA R said the EBP sign was just put on resident's door today. He/She said he/she was not informed about it at the beginning of his/her shift, but usually the sign means that the resident has a sickness. He/She said he/she is unsure why resident has one on the door today. 19. Review of Resident #52's significant change MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment, and had one unstageable (wound depth is undetermined due to being covered with necrotic tissue) pressure ulcer. Observation on 12/01/24 at 12:07 P.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. Observation on 12/02/24 at 9:39 A.M., showed the resident's room did not contain a sign to alert staff on the use of EBP or PPE in close proximity of the room. NA C did not wear a gown when he/she assisted LPN H to hold and reposition the resident's leg while LPN H performed wound care to the resident's leg. During an interview on 12/02/24 at 10:16 A.M., NA C said he/she did not know what EBP was or that a gown was required when he/she assisted to reposition the resident during wound care. During an interview on 12/02/24 at 10:18 A.M., LPN H said the NA did not need to wear a gown since the NA was not the one who performed the wound care to the resident. During an interview on 12/04/24 at 3:36 P.M., the DON said the NA should have worn gown and gloves to protect him/herself, whether he/she was directly involved with the wound care, or not. Observation on 12/02/24 at 1:11 P.M., showed a sign on the resident's door to alert staff on the use of EBP. LPN G and NA C entered the resident's room and did not wear a gown when they transferred the resident via mechanical lift and performed incontinence care. During an interview on 12/02/24 at 1:28 P.M., LPN G said he/she saw a sign on the resident's room door but he/she did not read it. The LPN said he/she had not received an in-service/training on EBP but would personally wear gloves and maybe a gown if he/she performed a treatment for a resident with an infected wound with drainage, or a urinary catheter. The LPN said he/she was not sure where to find extra PPE but he/she would ask staff or search for them if needed. During an interview on 12/04/24 at 3:36 P.M., the DON said he/she had not yet in-serviced all staff on the use of EBP but had begun packaging kits with extra PPE (gloves, gown, mask, and trash bags) for use on each hall. The DON said he/she recently had signs placed on doors for residents with a catheter or wound, that alert staff to wear at least a gown and gloves when they provide transfers, wound care, catheter care, incontinence care for that resident. The DON said not everyone is aware of where the extra PPE kits are stored. (continued on next page)

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