STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275103	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. 47752 Based on observations, interviews, and record reviews, the facility failed to ensure resident MDS assessments contained accurate information for 6 (#s 17, 37, 44, 48, 50, and 54) of 25 sampled residents. Findings include: During an observation and interview on 5/20/24 at 10:14 a.m. resident #37 was lying in bed. Resident #37 had metal bars attached to her bed. Resident #37 stated she used the bars on the bed to help position herself while in bed, and they do not restrict her from moving. Review of resident #37's Quarterly MDS, with an ARD of 4/8/24, showed resident #37 was coded for restraints used daily, under the bedrails section. During an observation and interview on 5/19/24 at 1:50 p.m., resident #44 was sitting in his room. Resident #44 had metal bars attached to his bed. Resident #44 stated the bars on his bed do not interfere with him getting in or out of bed. Resident #44 stated the bars helped him get in and out of bed and helped him move around in bed. Resident #44 stated he did not feel restricted. Review of resident #44's Admission MDS, with an ARD of 4/8/24, showed resident #44 was coded for restraints used daily, under the bedrail section. During an observation on 5/18/24 at 4:08 p.m., resident #50 was sitting in his wheelchair in the doorway to his room. Resident #50 had metal bars attached to his bed. Resident #50 was severely cognitively impaired and could not respond to the surveyor's questions. A call was placed to NF1 on 5/19/24 at 10:55 a.m., 5/20/24 at 10:16 a.m., and 12:37 p.m. No call back was received prior to the end of the survey. During an interview on 5/18/24 at 4:16 p.m., staff member E stated resident #50s bedrails were to help with repositioning and mobility, and they did not stop resident #50 from getting up if he wanted to. Review of resident #50's 5-Day MDS, with an ARD of 5/9/24, showed resident #50 was coded for restraints used daily, under the bedrail section. (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 5/19/26 at 12:16 p.m., staff member D stated she had only been doing MDS assessments for about six months, and the last time she had done MDS assessments was about ten years ago. Staff member D stated, I was under the assumption that even mobility bars are restraints. I am not sure what constitutes a restraint. 47785 Review of resident #54's MDS assessment, with an ARD of 5/7/24, showed the use of restraints, daily, coded under the bedrail section. During an interview on 5/18/24 at 2:33 p.m., staff member P stated she was unaware of any restraints being used for resident #54. Resident #54 does have bedrails that are used for help with mobility to assist her getting in and out of bed. Review of resident #54's physician's orders on 5/18/24 showed no orders for bedrails. 50245 Review of resident #17's MDS assessment, with an ARD of 3/18/24, showed the use of restraints daily under the bedrail section. During an observation on 5/18/24 at 3:05 p.m., resident #17 had bedrails attached to the bed and stated the bed rails were used to assist her when she was getting in and out of bed. Review of resident #17's physician orders showed no orders for bedrails. Review of resident #48's MDS assessment, with an ARD of 4/12/24, showed the use of restraints daily under the bedrail section. During an observation and interview on 5/18/24 at 2:16 p.m., resident #48 had bedrails attached to her bed and stated her bed rails were to assist her in turning, and did not prevent her from getting out of bed. Resident #48 was able to turn independently in bed and sit up in bed without staff assistance. Review of the Resident Assessment Instrument Manual, with a revision date of 10/2023, showed: . Definition of Physical Restraints- Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752 Based on observations, interviews, and record reviews, the facility failed to complete baseline care plans timely for 8 (#s 44, 50, 53, 54, 58, 59, 61, and 221) of 25 sampled residents. This deficient practice had the potential for resident's needs to be unmet by staff. Findings include: Review of resident #44's baseline care plan showed an admitted [DATE]. The baseline care plan was created on 3/27/24 and completed and locked on 4/2/24. Four days after the 48-hour time frame. Review of resident #50's electronic medical record showed an admitted [DATE]. Resident #50's baseline care plan was created on 3/21/24, 43 days after admission, and it was completed and locked on 4/1/24; 52 days after the 48-hour time frame. Review of resident #58's electronic medical record showed an admitted [DATE]. Resident #58's baseline care plan was created on 5/9/24, two days after admission, and it was completed and locked on 5/14/24; seven days after the 48-hour time frame. Review of resident #61's electronic medical record showed an admitted [DATE]. Resident #61's baseline care plan was created on 3/3/24, two days after admission and was completed and locked on 4/2/24. 31 days after the 48-hour time frame. Review of resident #221's electronic medical record showed an admitted [DATE]. Resident #221's baseline care plan was created on 5/9/24, and it was completed on 5/14/24; three days after the 48-hour time frame. During an interview on 5/20/24 at 12:08 p.m., staff member H stated the admitting nurse was to initiate the baseline care plan. During an interview on 5/20/24 at 12:20 p.m., staff member B stated it was the responsibility of the admitting nurse to initiate the baseline care plan. Staff member B stated the expectation was to have the baseline care plan completed by the 48-hour time frame. Staff member B stated it was her responsibility to make sure baseline care plans were completed on time. 47785 Review of resident #53's electronic medical record showed an admitted [DATE]. The baseline care plan was initiated on 7/21/23, and not completed until 7/28/23, seven days after admission. Review of resident #54's electronic medical record shows an admitted [DATE]. The baseline care plan was initiated on 10/19/23, and not completed until 11/7/23, twenty days after admission. Review of resident #59's electronic medical record shows an admitted [DATE]. The baseline care plan was initiated on 2/29/24, and not completed until 3/17/24, seventeen days after admission. Review of a facility document titled, Baseline Care Plan, not dated, showed: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: The facility will develop and implement a baseline care plan for each resident . 1. The baseline care plan will: a. Be developed with in 48 hours of a resident's admission .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47752 Based on observations, interviews, and record reviews, the facility failed to complete comprehensive, person-centered care plans to include oxygen information for 4 (#s 5, 37, 58, and 61) of 25 sampled residents. Findings include: During an observation and interview on 5/19/24 at 10:25 a.m., resident #37 was in her room and had oxygen on via nasal cannula at two liters. Resident #37 stated she had to use oxygen all the time now and received two liters. Resident #37 stated she used a concentrator while she was in her room but had a portable oxygen tank for when she left her room. A review of resident #37's comprehensive care plan showed oxygen use at two liters via nasal cannula was initiated on 6/9/23. The care plan did not include if the oxygen was to be intermittent or continuous, if there was oxygen saturation monitoring, or the type of oxygen equipment used by the resident. During an observation and interview on 5/18/24 at 1:49 p.m., resident #58 was sitting on her bed with oxygen in place. On the bedside table was a BI-PAP machine. Resident #58 stated she was to use two to three liters of oxygen at all times and use the BI-PAP machine at night because of COPD and respitory failure. A review of resident #58's admission orders, dated 5/7/24, showed resident #58 was to use the BI-PAP machine at night and to bleed in three liters of oxygen. A review of resident #58's comprehensive care plan, with an initiation date of 5/17/24, showed: No person-centered interventions under respiratory care. Interventions showed: .Provide BIPAP per MD orders, . Provide oxygen as ordered . [sic] The care plan also did not include if the oxygen was to be intermittent or continuous, oxygen saturation monitoring, or the type of oxygen equipment used. During an observation and interview on 5/18/24 at 4:24 p.m., resident #61 was sitting in her room with oxygen on. Resident #61 stated she had to have oxygen on at all times and was on two liters. Review of resident #61's comprehensive care plan, dated 3/19/24 to current, showed no focus, goals, or interventions addressing the use of oxygen. Review of resident #61's admission orders dated, 3/1/24, showed the resident was to be on two liters of oxygen via nasal cannula. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/24 at 8:07 a.m., staff member I stated she knew resident #61 was on oxygen at two liters. Staff member I stated she was not sure how to access the care plan but if she had questions about a resident, she would ask the nurse. 47785 Review of resident #5's care plan showed he is to receive oxygen .per order . but failed to specify the amount to be administered or when the oxygen should be applied. A review of a facility document titled, Comprehensive Care Plans, undated, showed: Policy: It is the policy of this facility to develop and implement a comp, person-centered care plan for each resident .to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs . [sic] . 3. The comprehensive care plan will describe at minimum, the following: - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . A review of a facility policy titled, Oxygen Administration, undated, showed: . 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as but not limited to: - Type of oxygen delivery system, - When to administer, such as continuous or intermittent and/or discontinue, - Equipment setting for the prescribed flow rates, - Monitoring of SpO2 (oxygen saturation) levels .; and, - Monitoring for complications associated with the use of oxygen.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47752 Based on observation, interview, and record reviews, the facility failed to revise and update a resident's care plan to address a PICC line, for 1 (#50) of 25 sampled residents. Findings include: During an observation and interview on 5/18/24 at 4:08 p.m., resident #50 was sitting in his wheelchair in the doorway, dressed in a short sleeve shirt and pants. Resident #50 was unable to answer questions appropriately. A review of resident #50's 5-day MDS, with an ARD of 2/9/24, showed resident #50 was unable to answer BIMS questions (Brief Interview of Mental Status) and was considered severely cognitively impaired. A call was placed to NF1 on 5/19/24 at 10:55 a.m., 5/20/24 at 10:16 a.m., and 12:37 p.m., regarding resident #50's cognition, and the care the resident received at the facility. No call back was received prior to the end of the survey. Review of resident #50's comprehensive care plan showed: . Focus: The resident is on IV Medications .administered by PICC line to LUA. Date initiated 2/9/24, revised 2/12/24. Goals: The resident will not have any complications related to IV (intravenious) therapy through the review date. Date initiated: 2/9/24, Target date: 10/8/24. Interventions: - Observe for signs and symptoms of infiltration, - Flush PICC line with 10cc ., - Activase 2 mg IV administration each am to maintain PICC line patency . Review of resident #50's nursing notes, dated 2/13/24, showed, [Resident #50] pulled his PICC line out. Pressure dressing applied bleeding stopped . Review of a facility policy titled, Care Plan Revisions Upon Status Change, undated, showed: . 1. The comprehensive care plan will be reviewed, and revised as necessary .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 47785 Based on observation, interview, and record review, the facility failed to label oxygen tubing when it was changed for 2 (#s 3 and 5) of 25 sampled residents, and failed to follow the physician orders for prescribed oxygen amounts for 2 (#s 3 and 13) of 25 sampled residents. Findings include: 1. Review of resident #5's physician orders, dated 10/1/23 showed, Change oxygen tubing and storage bag every Sunday and prn. Label with date. During an observation on 5/18/24 at 2:15 p.m., it was noted there were no labels on the oxygen tubing or oxygen equipment for resident #5. 50245 2. During an interview and observation on 5/18/24 at 3:43 p.m., resident #3 stated, I'm on two liters (of oxygen). Resident #3's oxygen concentrator was set to one and a half lpm and had not been in the resident's nose during the interview. The nasal cannula tubing was dated 5/2. Review of resident #3's EHR showed the following physician's orders: Change oxygen tubing and storage bag every Sunday Please label with date, [sic] and Continuous oxygen at 2 liters via Nasal cannula. During an interview on 5/20/24 at 10:01 a.m., staff member L stated resident #3's physician order for oxygen was two lpm. During an observation on 5/20/24 at 10:22 a.m., resident #3's oxygen concentrator had been at one and a half lpm when first entering the room. Staff member L increased resident #3's oxygen concentrator to two lpm after the surveyor had asked about the lpm value on the oxygen concentrator. During an observation on 5/20/24 at 1:33 p.m., resident #3's oxygen concentrator was at one and a half liters per minute. Resident #3 was never observed to exit her bed during survey without staff present. Resident #3's Care Plan, initiated 5/30/23, showed: [Resident name] has little or no activity involvement r/t Anxiety, Immobility, Physical Limitations, and she wishes not to participate . [sic] Review of resident #3's Care Plan, revised 8/25/23, showed: Oxygen per MD order, O2 at 4 lpm per nasal prongs . Resident #3's physician order (two lpm of oxygen), Care Plan (four lpm of oxygen), and the observed oxygen being used (one and a half lpm on 5/20/24 at 10:22 a.m. and 1:33 p.m.) were all inconsistent. 3. During an observation on 5/20/24 at 9:43 am., resident #13's oxygen concentrator was set to three lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #13's EHR showed a physician's order for oxygen was two lpm. Review of a facility policy titled, Oxygen Administration, undated, showed: . 1. Oxygen is administered under orders of a physician .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50245 Based on observation, interview, and record review the facility failed to serve meals at a palatable temperature for 7 (#s 2, 14, 19, 24, 47, 49, and 218) of 25 sampled residents, for those who received room trays. Findings include: During an interview on 5/18/24 at 2:39 p.m., resident #49 stated the food was terrible, tasteless, and the hot food was lukewarm when he ate in his room. During an interview on 5/18/24 at 2:49 p.m., resident #19 stated she ate in her room and the hot food was often cold. Resident #19 stated the pork chops were tough and dry as well. During an interview on 5/18/24 at 3:24 p.m., resident #47 stated the hot food was warm and the pork chops were very tough. During an interview on 5/18/24 at 3:52 p.m., resident #2 stated he believed his food was never hot because his room was located at the end of the hallway which was served last. During an interview on 5/20/24 at 9:58 a.m., staff member L stated she had heard complaints from residents about the cold food served to residents in the rooms. During an interview on 5/20/24 at 10:48 a.m., NF3 stated resident #49 had told her the food was tasteless multiple times. During an observation in the dining room on 5/20/24 at 12:10 p.m., the food was moved from the steam table onto a tray which was then placed in a thermal insulated food cart. The plates had insulated dome covers, but did not contain an insulated base underneath the plates. The bowls did not have a lid, insulated cover, or insulated sleeve to keep the food warm while transferring the food. The food that was served for lunch was as follows: a ham sandwich (with one slice of ham), tomato soup, potato chips, a fruit cup, and a bowl of white bean soup (substitutions served for therapeutic diets were mashed potatoes and pureed meat). The white bean soup appeared as if it was chili in a very thick broth. During an observation and interview on 5/20/24 at 12:20 p.m., staff member I transferred the food cart to one wing of the facility to serve the food. Resident #14 was the first resident to be served on this wing. Resident #14's white bean soup was 100.5 degrees Fahrenheit. When asked, staff member I stated the soup bowl did not feel warm to the touch. Staff member I stated, I wouldn't eat it honestly. During an observation and interview on 5/20/24 at 12:20 p.m., staff member I took the temperature of resident #218's tomato soup which measured 88.5 degrees Fahrenheit. Resident #218's mashed potatoes and ground meat measured 101.8 and 86.0 degrees Fahrenheit. During an interview on 5/20/24 at 12:45 p.m., resident #24 stated, I have never had a warm bowl of anything. The food sits down the hall (in the cart) for half an hour. Resident #24's room was located at the end of the hallway. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/20/24 at 12:47 p.m., resident #24's soup temperature was 101.3 degrees Fahrenheit. During an interview on 5/20/24 at 12:54 p.m., staff member M stated she tries to keep the temperatures of soups between 140 and 160 degrees Fahrenheit. Staff member M stated the temperature of the tomato soup should be 150 degrees Fahrenheit. Staff member M stated beef should be held at least at a temperature of 155 degrees Fahrenheit. During an interview on 5/20/24 at 1:58 p.m., staff member N stated the plates were warmed but not the bowls. Staff member N stated the facility would occasionally do a couple of test trays, but she did not know if the food was cold by the time it reached and was served at the end of the hall. References: Culinary experts recommend the following soup temperatures for quality: -Hot Clear Soups: serve near boiling 210 degrees Fahrenheit -Hot Cream or Thick Soups: serve between 190 to 200 degrees Fahrenheit -Cold Soups: heated, then cooled and served at 40 degrees Fahrenheit or lower Food Safety Training and Certification. (2020). National Soup Month and Food Safety. Retrieved from Food Safety Training and Certification: https://foodsafetytrainingcertification.com/food-safety-news/national-soup-month-and-food-safe-cooling/#:~:text=Soup%20Safe%20Cooking%20Temperature&text=Hot%20Clear%20Soups%3A%20serve%20near,4%C2%B0C)%20or%20lower

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 50245 Based on observation, interview, and record review, the facility failed to ensure the food served to 1 (#219) of 25 sampled residents followed the dietician's recommendations. Findings include: During an observation and interview on 5/20/24 at 12:50 p.m., the food served to resident #219 consisted of a ham sandwich with two slices of bread and one slice of ham, potato chips, a bowl of white bean soup with three packages of saltine crackers, and a fruit cup. Resident #219 stated his blood sugar had been significantly higher since he has been at the facility. Resident #219 stated he felt he had needed more insulin due to his diet, and the increase in carbohydrates in the food he was served. Review of resident #219's lunch order, on 5/20/24, showed the dietary order, Regular-Carbohydrate Controlled. During an interview on 5/20/24 at 4:45 p.m, staff member O stated the carbohydrate-controlled meal served for lunch on 5/20/24 should have consisted of: One slice of bread with deli meat, a pickle spear if they were serving it, soup like everyone else, and fruit. Staff member O stated two ounces of meat was supposed to be on the sandwich to ensure residents were receiving enough protein in their diets. Staff member O referenced, Three ounces (of meat) is a deck of cards. Record review of resident #219's blood sugar readings for the date of 5/20/24, showed: - 8:12 a.m. blood sugar was 195 mg/dL - 12:04 p.m. blood sugar was 266 mg/dL - 5:37 p.m. blood sugar was 218 mg/dL Review of resident #219's EHR showed his blood sugar averaged 228 mg/dL from the dates 5/10/24 to 5/20/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation, interview, and record review, the facility failed to ensure sanitary conditions and storage were maintained in the kitchen, which could affect all residents who eat food made by, or stored in, the kitchen facility. Findings include: During an observation on 5/18/24 at 12:17 p.m., staff member Q was mopping the kitchen floor without a hairnet on. Staff member Q was located behind the taped black line on the floor signifying hairnets were required. During an observation on 5/18/24 at 12:18 p.m., The following food was found directly on the floor: two boxes of hamburger buns, two boxes of grape juice, and two boxes of Folgers coffee. Sixteen other boxes were stacked on top of the food boxes, located on the floor. During an observation of the inside of the ice machine on 5/18/24 at 12:22 p.m., the plastic surface that serves as a barrier, preventing the ice from falling out of the machine, was dirty and had a tan and slight pink film on it. During an observation and interview on 5/18/24 at 12:34 p.m., two packages of tortilla shells showed: best by: 13/21/23. Staff member R stated, I don't know, when asked what the throw away date would be for the tortilla shells. Staff member R stated she was a little unsure but thought each item was dated with a sharpie marker when it came into the facility. No received date was documented on the package of tortilla shells. During an observation on 5/18/24 at 12:41 p.m., there were five bags of bread on a shelf that had no received date. During an observation on 5/18/24 at 12:42 p.m., four boxes of food were located on the floor of the freezer: [NAME] hawaiian bread, blended vegetables, green chile tamales and california vegetable blend. During an observation on 5/18/24 at 12:53 p.m., a fan in the kitchen was plugged in and the blades and front cover had a layer of dirt noted. The fan was pointed towards the dish pit. The debris located on the fan was able to be removed and cleaned. During an observation on 5/20/24 at 9:10 a.m., staff member N was past the black taped line on the floor in the kitchen without a hairnet. Staff member N came to the door to put a hairnet on when the surveyor entered the kitchen area. (continued on next page)

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	275103	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/20/24 at 9:15 a.m., staff member N stated the kitchen had received a delivery and this was why food boxes were located on the ground. Staff member N stated bread was left out for four to five days, but she had never dated it. Staff member N stated, (We) probably should (date the bread). Staff member N stated the fan in the kitchen was dirty, but she was going to throw it away. Staff member N stated the ice machine was cleaned monthly, but the maintenance department does it. Staff member N stated staff was expected to wear a hairnet past the taped black line on the floor. During an observation and interview on 5/20/24 at 9:18 a.m., staff member N stated dry goods were dated when they are placed on the shelf. One box of Spanish Rice was undated. Staff member N stated, I'll throw it away right now. During an observation on 5/20/24 at 12:02 p.m., staff member S went behind the black taped line in kitchen with no hairnet on.

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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. 47752 Based on observation, interview, and record review, the facility failed to adhere to infection control practices and PPE use during a COVID-19 outbreak, involving 2 (#11 and 217), for 25 sampled residents. Findings include: During an observation and interview on 5/18/24 at 11:55 a.m., facility staff were wearing N-95 masks. Staff member P stated the facility was in a COVID-19 outbreak. During an observation on 5/18/24 at 2:05 p.m., the door to resident #11 and #217's room was open to the hallway. Both resident #11 and resident #217 were COVID-19 Positive. Resident #11's bed was next to the door. Resident #11 was lying in bed, and was frequently coughing. During an observation and interview on 5/18/24 at 2:14 p.m., the door to resident #11 and #217's room was still open to the hallway. Staff member E stated, [Resident #11] does not like his door closed, so we leave it open. We just try to encourage other residents to put a mask on when they leave their rooms. Staff member E stated resident #s 11 and 217 had no safety risks that would require the door to be open. During an interview on 5/18/24 at 5:06 p.m., staff member C stated the COVID-19 outbreak started on 5/14/24. Staff member C stated, I fight with staff on a daily basis about hand hygiene, proper PPE use, and keeping the doors closed for those residents that do not have safety concerns. We have to keep resident #50's door open because of safety concerns. Staff member C stated resident #50 was a high fall risk and was impulsive. We try to encourage him to put a mask on, but there is only so much we can do. During an observation on 5/19/24 at 8:06 a.m., the door to resident #11's and 217's room was open. Resident #11 was lying in bed coughing. During an interview on 5/19/24 at 8:08 a.m., resident #11 stated he did not like to have his door shut but he would allow it to be closed. During an observation on 5/20/24 at 8:15 a.m., staff member L was passing breakfast trays to resident rooms. Staff member L donned PPE and walked into resident #s 11 and 217's room. Staff member L walked out of resident #s 11 and 217s room, still in full PPE, went to the breakfast cart, opened the doors, and retrieved resident #11s breakfast tray and took it into his room. Staff member L came back out of resident #11s room, in full PPE, went back to the breakfast cart and retrieved resident #217s breakfast tray. Staff member L put the tray on top of the breakfast cart, picked up the coffee carafe, and poured coffee into a cup. Staff member L picked up the tray off of the cart and went back into resident #217's room. Staff member L exited the room, still in full PPE and went back to the breakfast cart to pick up another tray. Staff member L did not doff the PPE or perform hand hygiene prior to exiting the room and going back to the breakfast cart. (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 5/20/24 at 8:20 a.m., staff member L stated hand hygiene was to be completed prior to entering a resident's room or putting on PPE. Staff member L stated PPE should be changed every time you leave a resident's room and should not be worn in the hallway or into other resident rooms. Staff member L stated, No one ever educated me on proper PPE use. Review of a facility document titled, Training-Enhanced precautions, handwashing and donning/doffing, dated May 8th,10th, and 13th, showed staff member L was in attendance and signed the training sign in sheet. Review of a facility policy titled, Handwashing/Hand Hygiene, undated, showed: . 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Review of a facility policy titled, Isolation-Categories of Transmission-Based Precautions, undated, showed: . Masks are worn when entering a room, . Gloves, gown, and goggles are worn . the gown will be worn prior to entering the room and removed before leaving the room . Review of a facility policy titled, Infection Prevention and Control Program, undated, showed: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, comfortable environment and to help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines. A request was made on 5/18/24, for a COVID-19 policy and procedure, and was not received prior to the end of the survey.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752 Based on interview and record review, the facility failed to address the extended duration of antibiotic use through the Antibiotic Stewardship Program for 3 (#s 4, 26, and 37) of 23 sampled residents. Findings include: Review of resident #37's physicians orders dated, 11/24/23, showed: Methenamine Hippurate 1 GM. Give one tablet by mouth two times a day for UTI prevention. Resident #37 had been taking this medication for 154 days. Review of resident #37's physicians orders dated 4/24/24 showed: Macrobid capsule 100 mg. Give 100 mg by mouth one time a day for UTI prevention. Resident #37 had been taking this medication for 20 days. No duration or stop date was present on the order. Resident #37 continued to receive both medications through the end of the survey. Review of resident #26's physicians orders dated, 1/5/22, showed: Macrobid capsule 100 mg. Give 100 mg by mouth two times a day for UTI prophylaxis for 10 days and Give 100 mg by mouth in the morning for UTI prophylaxis. Resident #26 had been taking this medication for 866 days. No duration or stop date was present on the order. Resident #26 continued to receive this medication though the end of the survey. During an interview on 5/20/24 at 2:32 p.m., staff member C stated she was aware of the extended use of antibiotics. Staff member C stated she had talked with the ordering providers about the medication use and could not get the medications discontinued. Staff member C stated the providers would not follow the recommendations from her or the medication regimen reviews. Staff member C stated, I know this does not follow national guidelines or the current standard of practice, but our providers had told me they are not going to change how they prescribe medications. During an interview on 5/21/24 at 11:10 a.m., NF2 stated he was aware of the medication use and per facility policy he had addressed the issue with the provider during the medication regimen reviews. NF2 stated, I am aware it was no longer standard practice to use antibiotics for UTI prophylaxis, but the providers would not discontinue the medications. Review of a facility policy titled, Antibiotic Stewardship, undated, showed: Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . . 4.Prescribers will provide complete antibiotic orders including the following elements: Drug name; Dose; Frequency of administration; Duration of treatment; -Start and stop date or -Number of days of therapy . [sic] 50245 Review of resident #4's EHR showed: Cefadroxil 500mg two times a day was prescribed for osteomyelitis. This medication was given for the months of February, March, April and May 2024, as shown in resident #4's EHR. Review of resident #4's Medication Regimen Review, dated from 4/1/24 to 4/30/24, showed no recommendations for medication changes within this timeframe. In the past, common treatment for osteomyelitis had been the standard timeline of 4-6 weeks. Although research is constantly changing regarding the duration of treatment for osteomyelitis, researchers suggest a longer timeframe that is 8-16 weeks. Other interventions that were shown to provide optimal outcomes for patients were surgical debridement, higher doses of medication, or changes in medication that have been shown to provide greater efficacy. Reference - [NAME]-[NAME], N. W., & [NAME], P. A. (2019). The History of Antibiotic Treatment of Osteomyelitis. Open Forum Infectious Diseases. - Spellberg, B., & [NAME], B. A. (2012). Systemic Antibiotic Therapy for Chronic Osteomyelitis in Adults. Clinical Infectious Diseases, 393-407.