STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285252	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Manor Nursing Home	933 Grant Street Imperial, NE 69033

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49766 Licensure Reference 175 NAC 1-005.01(G) Based on record reviews and interview, the facility failed to report to the State Agency and submit an investigation within 5 working days of an elopement for 1 (Resident 26) of 1 sampled resident. The facility identified a census of 32. Findings are: A record review of a facility policy Reporting Alleged Violations with a date of 2/22/2023 revealed alleged violations must be reported to the administrator of the facility and to the State Survey Agency in accordance with state law. The policy did not include a timeframe. A record review of Resident 26's Progress Notes with a date of 1/27/2024, written by Registered Nurse (RN) - E revealed Resident 26 had eloped out the front door of the facility after breakfast. Staff were able to catch up to Resident 26 and redirect. Resident 26 attempted to leave the facility again about an hour later. An interview on 10/10/2024 at 11:00 AM with the Administrator confirmed a report to the State Agency within 5 working days regarding Resident 26's elopement had not completed.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference 175 NAC 12-006.09(c)(ii) Based on interviews and record review, the facility failed to complete a significant change in status Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) within the required 14 days assessment within 14 days of the determination of a significant change for 1 (Resident 11) of 1 sampled resident. The facility identified a census of 32. Findings are: A record review of the Long-Term Care Facility Resident Assessment Instrument Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities), Chapter 2.6 revealed, A significant change of status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program. The record also revealed that the Assessment Reference Date (ARD) of an SCSA must be no later than, the 14th calendar day after determination that significant change in resident's status occurred. A record review of Resident 11's face sheet revealed the resident was admitted to the facility on [DATE]. A record review of Resident 11's active physician's orders revealed an order dated 6/5/24 stating, Admit to hospice services. A record review of Resident 11's Minimum Data Set (MDS) assessment, a data tool used by nursing homes to report resident information to the federal government, dated 7/4/24, indicated the type of assessment was, significant change in status (SCSA). Section O of the record also revealed resident was receiving hospice care. An interview on 10/09/24 at 1:46 PM with the MDS Coordinator revealed that the facility followed the RAI Manual's guidelines when completing and submitting MDS assessments. The MDS coordinator confirmed that the SCSA for Resident 11 was completed beyond the required 14-day timeframe set forth by the RAI Manual.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 51560 Based on observation, interview and record review; the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASRR) was completed prior to admission for one (Resident 15) of one sampled resident. The facility identified a census of 32. Findings are: Record review of Residents 15's face sheet revealed a diagnosis of schizoaffective disorder (a chronic mental illness that combines symptoms of schizophrenia and a mood disorder, such as bipolar disorder or depression) dated the day of admission 12/15/21. Record review of Resident 15's PASSR dated 12/15/21 on page two under section three where the form asks if the Resident has a suspected mental illness, the facility answered the question no and the Resident had a diagnosis of schizoaffective disorder. On page four of the PASRR form where the facility would write in any suspicion of a mental illness, this was also marked no. Record review of Resident 15's care plan dated 9/26/24 revealed an additional diagnosis of psychotic disturbance, mood disturbance, and schizoaffective disorder. Record review of Resident 15's physicians orders revealed Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 37.5 MG (Venlafaxine HCl) for depression, prescribed on 2/11/23. Quetiapine Fumarate Tablet Give 50 mg by mouth in the evening related to schizoaffective disorder, prescribed on 2/25/22, this was decreased to 25 mg on 2/10/23. Interview with Social Service Director (SSD) on 10/8/24 at 12:48 PM confirmed if a resident admits from home the facility is responsible for completing the PASRR. The SSD also confirmed that the diagnosis of schizoaffective disorder should have triggered a level two PASRR. The additional diagnosis of psychotic disturbance and mood disturbance along with psychotropic medications also failed to prompt the facility to complete a new PASRR.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49766 Licensure Reference 175 NAC 12-006.09(F)(i) Based on record review and interview, the facility failed to develop a baseline care plan (a written strategy for how nursing home staff will help a resident receive the care they need) with the required information for 1 (Resident 30) of 1 sampled resident. The facility identified a census of 32. Findings are: A record review of a facility policy Baseline Care Plan with a date implemented of 10/7/2022 indicated baseline care plans would, at minimum, include initial goals, physician's orders, dietary order, therapy services, and social services. A record review of an Admission Record indicated the facility admitted Resident 30 on 3/29/2024 with diagnoses of Chronic Obstructive Pulmonary Disease and dementia. A record review of Resident 30's Interim Care Plan with a date of 3/29/2024 revealed no evidence of physician's orders, dietary orders, or social services. An interview on 10/8/2024 at 12:40 PM with the Minimum Data Set (MDS) Coordinator confirmed the required information was not included on Resident 30's baseline care plan and should have been included.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49766 Licensure Reference 175 NAC 12-006.09(I)(i)(3) Based on observations, interviews, and record reviews; the facility failed to implement interventions to prevent elopement for 1 resident (Resident 26), ensure fall interventions were in place for 2 residents (Resident 3 and 22), and ensure a call light was within reach for 1 resident (Resident 15). The sample size was 4 out of 4 residents. The facility identified a census of 32. Findings are: A. A record review of a facility policy Elopements and Wandering Residents with a date of 5/9/2023 indicated the facility's approach to monitoring and management of residents at risk for elopement included implementing interventions to reduce the hazard and risk of elopement. A record review of an Admission Record indicated the facility admitted Resident 26 on 12/28/2023 with diagnoses of dementia with agitation and anxiety. A record review of Resident 26's significant change Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning,) with a date of 9/18/2024 indicated Resident 26 had a Brief Interview for Mental Status (BIMS) of 2/15, which indicated severe cognitive impairment. It also revealed Resident 26 had behaviors of having delusions and wandering into unsafe spaces. A record review of Resident 26's Progress Notes with a date of 1/27/2024, written by Registered Nurse (RN) - E revealed Resident 26 had eloped out the front door of the facility after breakfast. Staff were able to catch up to Resident 26 and redirect. Resident 26 attempted to leave the facility again about an hour later. A record review of Resident 26's Care Plan with a date initiated of 12/29/2024 indicated Resident 26 was an elopement risk with history of attempts to leave the facility unattended and wandered throughout the facility. Interventions included the following: - Document if wandering behavior and attempted diversional interventions with an initial date of implementation of 12/29/2023. - Monitor for fatigue and weight loss with a date initiated of 1/18/2024. - Provide structured activities toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes with a date of implementation of 1/18/2024. - Resident able to sit in front entry way with frequent visual checks by staff with a date of implementation of 6/5/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident has Wander Guard with a date of implementation of 12/29/2023. An interview on 10/10/2024 at 10:15 AM with RN-E confirmed Resident 26 had eloped through the front door and an hour later had exited through a rear door on 1/27/2024. RN-E confirmed no new interventions were implemented after Resident 26's elopements. B. A record review of the facility's policy Fall Prevention Program with a date of 6/28/2024 indicated the facility would implement interventions to decrease the risk of resident's falling. A record review of an Admission Record indicated the facility admitted Resident 3 on 8/1/2023 with diagnoses of dementia, weakness, and history of falls. A record review of Resident 3's quarterly MDS, with a date of 8/12/2024, indicated Resident 3 had a BIMS score of 6/15, which indicated Resident 3 had severe cognitive impairment. It also indicated Resident 3 used a walker and wheelchair, required extensive assistance for transfers, and required moderate assistance for walking. It also indicated Resident 3 had one fall without injury since the last MDS completion. A record review of Resident 3's Care Plan, with a last revised date of 8/15/2024, indicated Resident 3 was at risk for fall due to history of falls and weakness. The care plan included an intervention of ensuring Resident 3's walker was always in reach. An observation on 10/8/2024 at 2:16 PM revealed Resident 3 had been sitting in their recliner. Resident 3's walker had been positioned across the room near the window and was not within Resident 3's reach. An observation on 10/9/2024 at 10:31 AM revealed Resident 3 had been sitting in their recliner. Their walker was positioned across the room near the window and was not within Resident 3's reach. An interview on 10/9/2024 at 10:41 AM with Nurse Aide (NA)-D confirmed Resident 3's walker was not within reach and NA-D was not aware of the care plan intervention of keeping the walker within Resident 3's reach. C. A record review of the facility's policy Fall Prevention Program with a date of 6/28/2024 indicated the facility would implement interventions to decrease the risk of resident's falling. A record review of an Admission Record indicated the facility admitted Resident 22 on 5/22/2023 with a diagnosis of spinal stenosis (a condition where the spine narrows causing pressure on the spinal cord and nerves) and macular degeneration (a disease that causes central vision loss). A record review of Resident 3's quarterly MDS, with a date of 8/29/2024, indicated Resident 3 had a BIMS of 3/15, which indicated Resident 3 had severe cognitive impairment. It also indicated Resident 3 required extensive assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 22's Care Plan, with a last revision date of 12/12/2023 revealed Resident 3 was at risk for falls. The care plan included an intervention to remind Resident 3 to use their call light when needing to transfer. An observation on 10/9/2024 at 9:27 AM revealed Resident 3 had been sitting in their wheelchair. Resident 3's call light was positioned on the floor behind the bed, inaccessible to Resident 3. An interview on 10/9/2024 at 9:28 AM with NA-C confirmed Resident 3's call light was inaccessible to Resident 3 and should have been within Resident 3's reach. 51560 D. Record review of Resident 15's Admission Record revealed the Resident admitted on [DATE] and subsequent diagnosis were listed: Hypotension, Unspecified Dementia, Anxiety, Cervical Disk Disorder with Myelopathy, Pain and Constipation. Record review of Resident 15's quarterly MDS dated [DATE] revealed under Section C a Brief Interview for Mental Status (BIMS, an interview to determine a residents cognition) a score 3 out of 10 indicating severe cognitive impairment. An observation of Resident 15 on 10/07/24 at 1:41 PM revealed Resident 15's call light was across the room attached to the wall with the cord draped over the call box, not within reach of the resident. An observation of Resident 15 on 10/08/24 at 7:50 AM revealed the Resident resting in bed with both shoes on, the call light across the room on wall. An observation of Resident 15 on 10/08/24 at 1:43 PM revealed Resident up in room with shoes on getting ready to go out to activities. Call light across the room on wall. An interview with Resident 15 on 10/08/24 at 1:43 PM revealed that staff do not leave the call light within reach and if the Resident needed to call for help, the Resident would get up and walk over to the wall. An interview with Nurse Aide (NA)-J at 9:30 AM on 10/09/24 revealed that call lights are detachable from wall down the 300 hall. They also have a cord if it will reach to the resident, or they also use a pendant (necklace). When asked what type of call light Resident 15 uses NA-J states Resident 15 has a pendant. No pendant was noted to be found with Resident 15 or in the room. NA-J confirmed that if a resident does not have a pendant and the cord will not reach them that they are supposed to be detached and placed by the resident. NA-J then removed the box from wall and set it next to Resident 15 on the bed. An interview with the MDS Coordinator at 9:58 AM on 10/09/24 revealed Resident 15 does not have order for pendant and should be utilizing either the cord or the box for a call light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/09/24 at 2:49 PM with the Director of Nursing (DON) confirmed that call lights are expected to be near wherever the resident is located for instance if they were in their recliner, we would have it next to recliner. Or we also keep it in one place so residents won't forget where it is located The DON confirmed that the call light for Resident 15 should not be left on the wall while in bed and should be by resident, within reach. Record review of the facility Fall Prevention Policy implemented 6/28/24 revealed the call light and frequently used itmes are to be within reach. Record review of the facility Call Light Policy last revised 6/28/24 revealed staff will ensure the call light is within reach of residents and secured, if needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC 12-006.09(H)(vi)(3)(g) Based on observations, interviews, and record review; the facility failed to ensure that nasal cannula tubing was stored in a sanitary condition and failed to ensure oxygen settings were set at the prescribed rate for 2 (Resident 8 and 30) of 2 sampled residents. The facility identified a census of 32. Findings are: A. A record review of a facility policy Oxygen Administration with a date implemented of 5/31/2023 indicated oxygen delivery devices are to be kept covered in plastic bags when not in use and oxygen is to be administered under orders of a physician. A record review on an Admission Record indicated the facility admitted Resident 30 on 3/29/2024 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD.) A record review of Resident 30's Order Summary with a date of 10/8/2024 revealed an order for oxygen at 2 Liters Per Minute (LPM) at bedtime and as needed. An observation on 10/8/2024 at 11:50 AM revealed Resident 30's oxygen tubing had been wrapped through the handle of the oxygen concentrator with the nasal cannula resting on the floor. An interview on 10/8/2024 at 11:58 AM with Registered Nurse (RN) - B confirmed the nasal cannula was on the floor and should have been stored in a bag. An observation on 10/8/2024 at 2:00 PM revealed Resident 30's oxygen concentrator was set at 4 LPM. An interview on 10/8/2024 at 2:05 PM with Licensed Practical Nurse (LPN) - I confirmed Resident 30's oxygen concentrator was set at 4 LPM and should have been set at 2 LPM. 51560 B. Record review of Resident 8's Face sheet revealed the resident admitted on [DATE] with the following diagnosis: COPD, Unspecified, Essential Hypertension, Obstructive Sleep Apnea, Shortness of Breath, Chronic Systolic Heart Failure, Hypoxemia. Record review of Resident 8's Physicians Orders dated 2/27/22 revealed oxygen at 2 liters per nasal cannula to keep oxygen saturations greater than 90%. Check oxygen saturations every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/08/24 at 01:30 PM of Resident 8 sitting in electric recliner in room with head elevated to the highest postion. Continuous Positive Airway Pressure (CPAP) device in place on Resident's face with oxygen attached to the device. No sound was audible from CPAP machine and it was discovered to be unplugged. Resident was not receiving oxygen. Resident cued to turn machine on after plugging it in and the oxygen concentrator was noted to be at .5 liters. An interview on 10/8/24 at 2:07 PM with Registered Nurse (RN)- B revealed that the person on the medication cart should be monitoring the oxygen machine and oxygen saturations. RN-B accompanied the surveryor to room to look at oxygen concentrator dial and confirmed that the order is for 2 liters and the concentrator is on .5 liters. Record review of the facility Oxygen Administration Policy dated 5-31-23 under number 4; The care plan shall identify equipment setting for prescibed flow rates and monitoringand c. monitoring of SpO2 and equipment setting for the prescribed flow rates.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49766 Licensure Reference 175 NAC 12- 006.09(H) Based on record reviews and interview, the facility failed to have a stop date for an antibiotic for 1 (Resident 3) of 5 sampled residents. The facility identified a census of 32. Findings are: A record review of the facility's policy Antibiotic Stewardship Program with a last review/revised date of 10/8/2024 revealed all prescriptions for antibiotics shall specify the dose, duration, and indication for use. Antibiotic orders obtained upon admission to the facility shall be reviewed for appropriateness. A record review of an Admission Record revealed the facility admitted Resident 3 on 8/1/2023. A record review of Resident 3's Order Summary with a date of 10/9/2024 revealed an order for Doxycycline (an antibiotic) once a day for chronic knee infection. The order had a beginning date of 8/1/2023 and no evidence of a stop date. An interview on 10/9/2024 at 1:00 PM with the Infection Preventionist (IP) confirmed Resident 3's antibiotic had no stop date and no attempts to discontinue the antibiotic had been made.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 51560 Liscensure Reference Number 175 NAC 12-006.10 (D) Based on observation, interview, and record review; the facility failed to ensure that 1 (Resident 6) of 7 sampled residents received an extended-release medication per manufacturer directions. This resulted in a significant medication error. The facility identified a census of 32. Findings are: Record review of Resident 6's Minimum Data Set (MDS, a federally mandated assessment that helps determine a plan of care) dated 8/20/24, under Section C the Brief Mental Interview (BIMS) (an interview to determine a resident's cognition) a score of 7 out of 15 indicating the resident has moderate cognitive impairment. Section I indicates a diagnosis of non-Alzheimer's dementia and dysphagia (a swallowing disorder). Record Review of Resident 6's Medication Administration Record (MAR) revealed the following medications were ordered: -Magnesium 400 milligram (mg) orally every day for dietary supplement. -Vitamin B12 1000 micrograms (mcg) orally every day for dietary supplement -Zinc 50 mg orally every day for dietary supplement -Calcium + D3 600-400 mg orally every day for osteoporosis -Metoprolol Succinate extended-release 25 mg orally every day- for hypertension -Miralax 17 grams orally in 8 ounces of water for constipation -Sertraline 25 mg orally every day for depression -Vitamin D 1000 units gel capsule orally every day for osteoporosis -Metformin 500 mg give 2 tabs orally twice a day for diabetes -Voltaren gel 1% topically to right knee every 6 hours as needed for pain A medication administration observation of Registered Nurse (RN) E on 10/9/24 at 8:30 AM of prepping mediations for Resident 6 revealed RN- E placing all oral medications in a plastic envelope to be crushed. This included Metoprolol Succinate Extended-Release. RN-E mixed the crushed the medications with applesauce in a small cup and administered to Resident 6, Resident 6 swallowed all the medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN-E on 10/10/24 at 08:59 AM confirmed metoprolol ER should not be crushed and that there is no special order from doctor or instructions from pharmacy specifying that it was ok to crush metoprolol. Record Review of manufacturer recommendations for metoprolol extended release revealed metoprolol succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed. https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/019962s032lbl.pdf NDA 19-962 /S-032 Page 16 Interview with Director of Nursing (DON) on 10/10/24 at 09:18 AM revealed that the expectation for crushed medications is that there are some medications that cannot be crushed, however for some residents that refuse to swallow a whole pill they will continue to crush. The DON stated the Medical Director agreed that it is better for them to get it than for them not to get it however there is no documentation in the Resident 6's medical record to support that.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 43000 Licensure Reference Number 175 NAC ,d+[DATE].11(E) Based on observations, interviews and record review, the facility failed to ensure that outdated food items were not available for use, failed to ensure clean and sanitary surfaces were maintained throughout the kitchen, and failed to do proper hand hygiene to prevent cross contamination and prevent the spread of foodborne illness. The facility also failed to use pasteurized eggs when serving over-easy eggs to prevent foodborne illness and failed to follow package directions while preparing stuffing. This had the potential to affect all 32 residents served food out of the kitchen. Findings are: During the initial kitchen tour on [DATE] from 10:30 AM to 11:24 AM revealed the following concerns: A cart with pots and pans on the bottom shelf had dust and food particles on it. Two shelves above the serving area had seven plastic canisters with cereal, no dates on the canisters. Dust, grime and food particles were also on this shelf that could fall into food being prepped in this area. The shelves below this prep area had bowls and plate covers' with old food particles on shelf. The oven had dried fried food substances on the top of the stove and the front of the oven. The backsplash had brown oily substance on it and other yellow/brown splatters. There were two plastic containers of oil and soybean oil that were open with no dates. A sanitizer dispenser above the prep sink with a sign that reads out of order. A bucket of sanitizer on the prep sink shelf with four wet rags lying the sink shelf. Seven containers used to store greater than 10 pounds of flour, sugar, powdered sugar, oatmeal and rice in them, were found on the floor below the prep sink and prep counter. One container with breadcrumbs had a soiled blue bag on it. None of these canisters had dates and all of the canister outer surfaces were covered with dried food particles and dust. Foil lined trays stored on the bottom shelf of the prep cart containing one undated box of baking soda with an expiration date of [DATE], one open bag of granola with no date, one open bag of baking powder with no date, an undated open bag of vanilla pudding, and a pint sized plastic container of oregano leaves with an expiration date of [DATE]. All trays were soiled with old food particles, a sticky substance and other dark liquids. An upright refrigerator with one carton of cottage cheese with an expiration date of [DATE], that was available for use. The area near the office had 1 box of sweet potatoes stored on the floor with regular potatoes stacked on top of it. (continued on next page)

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	285252	A. Building B. Wing	10/10/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The walk in refrigerator had leaves and old food particles on the floor. The cartons of eggs did not have a P on them, indicating they were pasteurized. The walk in freezer had no less that six boxes of steak fries/pork/Brussel sprouts and sherbet stored on the floor. There was also one bag of hot dogs open and unsealed with no date, one bag of stir fry open and unsealed with no date, one bag of chicken breasts in a Ziploc bag with no date. The large dry storage room with shelf storage contained four boxes of baking soda with expiration dates of [DATE], one open and unsealed bag of egg noodles with no date, one bag of spaghetti rolled up but open and no date, one bag of penne noodles open and unsealed with no date. One open bag of rice crispy cereal with no date, one open bag of tortilla chips with no date and two bags expired on [DATE]. A 35 pound bag of powdered sugar that was open and unsealed with no date. Two boxes of corn and one box of cherry pie filling stored on the floor. An interview on [DATE] at 11:15 AM with the Dietary Supervisor (DS) confirmed the cleanliness concerns and outdated food items in the kitchen. An interview with on [DATE] at 10:35 AM with Dietary Aide (DA)-M revealed that the DA was uncertain if the dishwasher sanitized the dishes by chemical or hot water. Interview also revealed that they had a 3 compartment sink: the first one was used with dish soap to wash the dishes, the second one had water to rinse and the third sink they filled to the crate line and put some chemicals in, not measured because it is really strong. An observation on [DATE] at 10:38 AM revealed Cook-K obtaining a green bucket half full with the sanitizer solution. No test strips seen or observed being used to test sanitizer solution. An interview on [DATE] at 10:32 AM with DA-L about sanitizing solution revealed DA-L verbalized that the solution is changed after every meal. When asked how the solution is tested to ensure adequate sanitization of surfaces is occurring, DA-L was unsure. When asked how the cook obtained sanitizer solution, the cook verbalized that it comes from the wall mount and the cook adds water because it is too strong. DA-L confirmed that (gender) does not test the solution. An interview with the DS at 9:36 AM on [DATE] confirmed the chemicals for the dishwasher are not tested as they ran out of test strips a week ago. Interview also confirmed the sanitizer solution for cleaning surfaces test strips are out as well. An observation on [DATE] at 8:45 AM revealed Resident 1 and Resident 29 were both served over easy eggs and 100% was eaten. An interview with the DS on [DATE] at 9:35 AM confirmed that there were no pasteurized eggs available and that the cooks were instructed to only use those for hard fried eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on [DATE] for meal prep from 10:07 AM to 10:53 AM of DA-L preparing lunch revealed DA-L removed foil from turkey pans and placed in trash. DA-L completed hand hygiene for 5 seconds under running water, applied new gloves and picked up turkey from pan and placed on a cutting board in a pan, removed string around turkey and sliced turkey with clean knife. Removed gloves and poured juice over the slices. Obtained sanitizer bag and wiped prep counter with rag. DA-L completed hand hygiene for 11 seconds under running water and applied new gloves then picked up the turkey and placed on a cutting board, removed string and threw in trash, sliced turkey, removed gloves, purred juice on turkey. Obtained foil. Placed pans in oven at 350 degrees. Observation of meal prep continued: DA-L obtained 2 pans and sprayed them with non-stick spray, then obtained a bag of stuffing, read the directions, dumped one bag of dry breadcrumbs in the large pan, then obtained 2 and ,d+[DATE] quarts of water per directions and poured over the dry crumbs. DA-L then poured , d+[DATE] of another bag of breadcrumbs into the small pan, no measurement. DA-L applied gloves without the benefit of hand hygiene and stirred the crumbs and water with gloved hands. DA-L removed gloves, obtained and undetermined amount of water and poured over the ,d+[DATE] pan of crumbs, applied clean gloves without the benefit of hand hygiene and stirred the mixture with gloved hands. DA-L then added a packet of seasoning to the large pan and part of the other package to the half pan. (no measurement completed) It is to note that the directions on the package said to boil the water and add the seasonings and bring to a boil prior to pouring over the breadcrumbs. DA-L then took and unmeasured amount of used butter from the refrigerator and placed in the microwave to melt. There was a line on the container that the butter was in that read 1 pound. The recipe called for 1 pound of butter per package. The butter was less than , d+[DATE] way to the 1 pound line and it was divided between the two pans of crumbs. Pans covered and placed in oven at 350 degrees. It is to note that when the dressing was served, it was very dry. An interview with the DS on [DATE] at 10:55 AM confirmed that the cook should have followed directions on the package, and that the DS would expect staff to do hand hygiene for ,d+[DATE] seconds, per facility policy. 51122 A record review of a facility policy titled, Hand Hygiene, last revised [DATE], revealed hand hygiene using soap and water or alcohol-based hand rub should be performed, between resident contacts, and after handling contaminated objects. The policy also stated, The use of gloves does not replace hand hygiene. On [DATE] between 12:14 and 12:54 PM, Dietary Aide (DA)-A was continually observed wearing the same pair of disposable gloves. During this time, DA-A: -delivered lunch plates to all residents in the dining room -walked from dining room across a hall to retrieve resident plates from the kitchen service window -carried lunch plates back to the dining room -removed and reapplied lids from multiple used resident cups -poured drinks into cups for multiple residents (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-retrieved sugar packets from the secondary kitchen area then delivered them to a resident in the dining room -touched their face with their gloved hand -delivered dessert plates to the residents in the dining room from a rolling cart -wrapped clean silverware in a napkin -retrieved a water pitcher from the secondary kitchen area. An interview with DA-A on [DATE] at 1:08 PM confirmed that they should have changed their gloves and performed hand hygiene during meal service between resident contacts and after touching contaminated objects.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49766 Based on record reviews and interview, the facility failed to submit data for the third quarter of 2024 for the Payroll Based Journal (PBJ, a collection of staffing information and a requirement of all long-term care facilities.) This had the potential to affect all resident residing within the facility. The facility identified a census of 32. Findings are: A record review of a facility policy Payroll Based Journal with a last reviewed/revised date of 8/31/2024 revealed the facility shall submit information as per Centers for Medicare and Medicaid Services (CMS) requirements and no later than the deadline specified for the specific quarter in which the data is to be reported. The policy states the deadline for submission for quarter three is August 14th. A record review of the PBJ report from CMS revealed the facility had failed to submit data for the third quarter (April 1 - June 30) in 2024. An interview on 10/10/24 at 08:20 AM with the Administrator confirmed the third quarter PBJ was not reported on time by the business manager as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49766 Licensure Reference 175 NAC 12-006.18(B) Licensure Reference 175 NAC 12-006.18(D) Based on observations, interview, and record reviews; the facility failed to don (put on) Personal Protective Equipment (PPE) of a gown during catheter cares and completed hand hygiene between glove use as required for 1 (Resident 26) of 1 sampled resident. The facility identified a census of 32. Findings are: A record review of Enhanced Barrier Precautions with a date of 5/3/2024 revealed initiation of enhanced barrier precaution will be implemented for those with indwelling medical devices (urinary catheters) during high-contact resident care activities of transferring, providing hygiene, changing briefs, or urinary device care. A record review of a facility policy Hand Hygiene with a date last revised of 6/12/2023 revealed if a task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. A record review of Resident 26's Care Plan with a date of 8/14/2024 revealed Resident 26 had a urinary tract infection, Methicillin-resistant Staphylococcus aureus (MRSA, an infection caused by a type of staph bacteria that's resistant to many antibiotics,) and had a urinary catheter. An intervention included to wear gowns and gloves during physical contact with the resident. An observation on 10/9/2024 at 12:16 PM revealed Nurse Aide (NA) - D had began to pull Resident 30's pants down to provide a brief change and peri-care. NA-D had not donned a gown before starting. An interview on 10/9/2024 at 12:18 PM with NA-D confirmed NA-D had not donned a gown and should have before beginning Resident 30's care. An observation on 10/9/2024 at 12:19 PM revealed NA-D had changed gloves without the benefit of performing hand hygiene prior to the application of new gloves. An observation on 10/9/2024 at 12:23 PM revealed NA-F, who had been assisting NA-D with Resident 30's care, had removed their gloves and applied new gloves without the benefit of hand hygiene prior to the application of the new pair of gloves. An interview on 10/9/2024 at 12:28 PM with NA-F confirmed NA-F did not perform hand hygiene between glove changes and should have. An interview on 10/9/2024 at 12:30 PM with NA-D confirmed NA-D did not perform hand hygiene between glove changes and should have.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49766 Licensure Reference 175 NAC 12-00604(B)(ii) Licensure Reference 175 NAC 12-006.04(B)(ii)(1) Based on record reviews and interview, the facility failed to ensure nurse aides had completed at least 12 hours of continuing education, including Dementia and Abuse training, as required for 4 (Nurse Aide G, F, D, and H) of 5 sampled employees. This had the potential to affect all 32 residents who reside within the facility. Findings are: A record review of the Imperial Manor Facility Assessment with a date of 8/5/2024, under Training and Education Section, indicated nurse aides must complete no less than 12 hours per year of continuing education, including Dementia and abuse. A record review of Nurse Aide (NA)-G's Relias Transcript with a date of 10/8/2024 revealed a hire date of 7/23/2021. It also revealed 0 hours of training for the year and no evidence of Dementia or abuse training. A record review of an undated list of in-services for NA-G revealed no in-services had been completed for the year and no evidence of Dementia or abuse training. A record review of NA-F's Relias Transcript, with a date of 10/8/2024, revealed a hire date of 7/10/2023 and a total training hours of 4.05. A record review of an undated list of in-services for NA-F revealed a total of 5 hours. NA-F had a total of 9.05 training hours for the year. A record review of NA-D's Relias Transcript, with a date of 10/8/2024, revealed a hire date of 11/23/2021 and a total of 8.3 training hours completed for the year. A record review of an undated list of in-services for NA-D revealed a total of 3 hours. NA-D had a total of 11. 3 training hours for the year. A record review of NA-H's Relias Transcript, with a date of 10/8/2024, revealed a hire date of 4/12/2021 and a total of 7.55 training hours completed. A record review of an undated list of in-services for NA-H revealed a total of 4 hours. NA-H had a total of 11. 55 training hours for the year. An interview on 10/9/2024 at 3:00 PM with the Administrator confirmed NA-D, NA-G, NA-F, and NA-H did not meet the required 12 hours of continuing education.