STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295082	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardnerville Health & Rehabilitation Center	1573 South Muller Pkwy Gardnerville, NV 89410

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review and document review, the facility failed to ensure informed consents were obtained prior to administering two psychotropic medications for 1 of 13 sampled residents (Resident #288). Findings include: The facility policy titled Psychotropic Drugs, updated 08/2022, documented psychotropic drugs included anti-depressants and anti-anxiety agents. Resident #288 Resident #288 was admitted to the facility on [DATE], with diagnoses including unspecified dementia unspecified severity, obstructive sleep apnea, and anxiety disorder unspecified. The physician's orders for Resident #288 dated 06/18/2024, documented the following: -Amitriptyline Hydrochloride (HCl) oral tablet 25 milligrams (mg), give 25 mg by mouth one time a day for restlessness related to anxiety. -Buspirone HCl oral tablet 30 mg, give 30 mg by mouth two times a day for restlessness related to anxiety. The June 2024 medication administration record (MAR) for Resident #288 dated 06/25/2024, documented the following: -Amitriptyline HCl was administered from 06/18/2024 through 06/24/2024. -Buspirone HCl oral tablet 30 mg was administered from 06/18/2024 through 06/24/2024. Resident #288's clinical record contained signed Psychotropic Drugs Disclosure and Consents for Amitriptyline and Buspirone. The forms were signed and dated 06/24/2024. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/2024 at 3:12 PM, the Director of Nursing (DON) verbalized informed consents were required for any psychotropic drugs including those for depression and anxiety. The DON explained informed consents must be completed within 48 hours of admission. The DON confirmed Resident #288 was taking Amitriptyline, an anti-anxiety agent and Buspirone, an anti-depressant; both Amitriptyline and Buspirone required informed consents. On 06/26/2024 at 11:48 AM, the DON confirmed the Psychotropic Drugs Disclosure and Consents forms for Amitriptyline and Buspirone were completed on 06/24/2024. The DON verbalized the medications were administered prior to obtaining the informed consent documentation. The facility policy titled Informed Consent for Psychotropic Drugs, updated 09/2017, documented when the physician ordered the use of anti-depressant or anti-anxiety drugs, the center would obtain informed consent from the resident. An informed consent was expected to be obtained before the drug prescribed was administered.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 2 of 13 sampled residents (Resident #3 and #13). Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including other cord compression, muscle weakness generalized, and contracture of muscle unspecified site. A physician's order dated 09/28/2019, documented Resident #3 required bilateral bed rails to increase safety and independence with bed mobility. Resident #3's care plan revised 10/10/2023, documented the resident had bilateral quarter size bed rails as it related to bed mobility and repositioning. An intervention documented the resident and the resident's family would understand the use of bed rails was for bed mobility and repositioning only. Resident #3's last quarterly MDS assessment dated [DATE], section P0100 (Restraints and Alarms - Physical Restraints) documented bed rails were used daily as restraints. On 06/24/2024 at 2:55 PM, Resident #3 was in their room seated in a wheelchair. Quarter size bed rails were in the up position on the upper left and right sides of Resident #3's bed. On 06/24/2024 at 2:55 PM, Resident #3 verbalized the resident used bed rails to move in bed and the resident did not feel restrained by the bed rails as the bed rails assisted with mobility. On 06/25/24 at 1:12 PM, a Certified Nursing Assistant (CNA) verbalized Resident #3 used bed rails to reposition while in bed, and the bed rails did not restrict the resident's movement. On 06/25/2024 at 1:33 PM, a Licensed Practical Nurse (LPN) verbalized Resident #3 used bed rails for mobility and confirmed the bed rails did not restrain the resident. On 06/25/2024 at 3:41 PM, the MDS Coordinator, Registered Nurse, (MDS Coordinator) defined restraints as anything impeding the resident's movement. The MDS Coordinator verbalized Resident #3 had bed rails because bed rails gave the resident confidence and assisted the resident with transferring in and out of bed. The MDS Coordinator verbalized the bed rails were not used as a restraint for Resident #3 but confirmed the bed rails were coded in the MDS assessment as a restraint. The facility policy titled Devices vs (Versus) Restraints, updated 07/2024, documented devices were evaluated individually for the effect they have on the resident. Unless half side rails (bed rails) prevent the resident from getting out of bed, half side rails were not restraints. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34524 Resident #13 Resident #13 was admitted to the facility 09/11/2021, with diagnoses including Parkinsonism and unspecified dementia, unspecified severity, with other behavioral disturbance. On 06/25/2024 at 10:39 AM, an LPN verbalized Resident #13 received an anticoagulant for a Deep Vein Thrombosis (DVT). The LPN confirmed the resident did not have a diagnosis of DVT, for which the medication was given to treat. A Nurse Practioner Progress Note dated 07/24/2023, documented Resident #13 had a left lower DVT of superficial and common femoral vein. A physician's order dated 07/26/2023, documented Eliquis, 5 milligram (mg) tablet. Give 5 mg by mouth two times a day for DVT. Resident #13's June Medication Administration Record (MAR) documented Eliquis 5 mg tablet was administered twice daily from 06/01/2024-06/25/2024. Resident #13's clinical record lacked documented evidence of a diagnosis of DVT in the active diagnosis list. Resident #13's last quarterly MDS assessment dated [DATE], section I - Active Diagnosis lacked documented evidence the resident was diagnosed with a DVT. On 06/25/2024 at 1:42 PM, the MDS Coordinator verbalized Resident #13 was receiving an anticoagulant for DVT, however the MDS did not reflect a diagnosis of DVT. The MDS Coordinator confirmed the MDS Coordinater should have updated the MDS to reflect a diagnosis of DVT. The Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 (RAI Manual) version 1.18.11, dated October 2023, documented comprehensive assessments included the completion of MDS, as well as care planning. Comprehensive Assessments were completed upon admission and when a significant change in a resident's status has occurred.

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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** 34524 Based on interview, clinical record review, and document review the facility failed to develop a care plan for a resident with a Deep Vein Thrombosis (DVT) (Resident #13) and a resident with insomnia (Resident #20) for 2 of 13 sampled residents. Findings include: Resident #13 Resident #13 was admitted to the facility 09/11/2021, with diagnoses including Parkinsonism and unspecified dementia, unspecified severity, with other, behavioral disturbance. On 06/25/2024 at 10:39 AM a Licensed Practical Nurse (LPN) verbalized Resident #13 received an anticoagulant for a DVT. The LPN confirmed the resident did not have a care plan for DVT. A Nurse Practitoner Progress Note dated 07/24/2023, documented Resident #13 had a left lower DVT of superficial and common femoral vein. A physician's order dated 07/26/2023, documented Eliquis, 5 milligram (mg) tablet. Give 5 mg by mouth two times a day for DVT. Resident #13's June Medication Administration Record (MAR) documented Eliquis 5 mg tablet was administered twice daily from 06/01/2024-06/25/2024. On 06/25/2024 at 1:42 PM, the Minimum Data Set Coordinator, Registered Nurse (MDS Coordinator) verbalized the MDS Coordinator had initiated a care plan for DVT on 06/25/2024. The MDS Coordinator confirmed Resident #13 was confirmed to have a DVT on 07/24/2023, and the resident did not have a care plan in place for DVT until 06/25/2024. The care plan would have included interventions such as elevate legs, maintain sufficient tissue perfusion, monitor for color changes of the affected leg, and monitor and assess anticoagulant therapy with the goal to prevent the dislodgment of the blood clot. Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including anxiety (unspecified) and cellulitis of left lower limb. On 06/25/2024 at 10:29 AM, an LPN verbalized Resident #20 received Trazadone for insomnia. A physician's order dated 03/12/2024, documented Trazodone Hydrochloride oral tablet 50 mg. Give one tablet by mouth one time a day for insomnia. Resident #20's June Medication Administration Record (MAR) documented Trazodone 50 mg tablet was administered once daily from 06/01/2024-06/25/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20's Comprehensive Care Plan lacked a care plan for insomnia. On 06/25/2024 at 1:55 PM, the Director or Nursing (DON) verbalized care plans should be created upon admission and updated within 48-72 hours as problems or interventions were added. On 06/26/2024 at 9:16 AM, the Director of Nursing (DON) verbalized Resident #20 received Trazodone for insomnia every night. The DON confirmed Resident #20 did not have a care plan for insomnia and should have. The Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 (RAI Manual) version 1.18.11, dated October 2023, documented comprehensive assessments included the completion of MDS, as well as care planning. Comprehensive Assessments were completed upon admission and when a significant change in a resident's status has occurred.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34524 Based on interview, clinical record review, and document review, the facility failed to meet professional standards for accurate recording per the Nevada Nurse Practice Act for a Registered Nurse (RN) when the Minimum Data Set Coordinator, Registered Nurse (MDS Coordinator) backdated a resident's care plan for deep vein thrombosis (DVT) by 11 months (Resident #13). Findings include: Resident #13 Resident #13 was admitted to the facility 09/11/2021, with diagnoses including Parkinsonism and unspecified dementia, unspecified severity, with other, behavioral disturbance. On 06/25/2024 at 10:39 AM a Licensed Practical Nurse (LPN) verbalized Resident #13 received an anticoagulant for DVT. The LPN confirmed the resident's Comprehensive Care Plan lacked a care plan for DVT or the anticoagulant. On 06/25/2024 at 10:40 AM, Resident #13's Comprehensive Care Plan lacked documented evidence of a care plan for DVT. A Nurse Practitioner Progress Note dated 07/24/2023, documented Resident #13 had a left lower DVT of superficial and common femoral vein. A physician's order dated 07/26/2023, documented Eliquis, 5 milligram (mg) tablet. Give 5 mg by mouth two times a day for DVT. Resident #13's June Medication Administration Record (MAR) documented Eliquis 5 mg tablet was administered twice daily from 06/01/2024-06/25/2024. On 06/25/2024 at 1:40 PM, Resident #13's Comprehensive Care Plan documented the resident had a diagnosis of left lower leg DVT. The care plan date of initiation was 07/21/2023. On 06/25/2024 at 1:42 PM, the MDS Coordinator verbalized the MDS Coordinator had added a care plan for DVT on 06/25/2024. The MDS Coordinator confirmed Resident #13 was confirmed to have a DVT on 07/24/2023, and the resident did not have a care plan in place for DVT until 06/25/2024. The MDS Coordinator explained the MDS Coordinator had documented the initiation date of the care plan as 07/24/2023, because there was a progress note in the resident's clinical record documenting the resident had a DVT on 07/24/2023. On 06/25/2024 at 1:55 PM, the Director of Nursing (DON) verbalized it was not acceptable to back date a resident's care plan. The DON explained the care plan should be created upon admission and updated within 48-72 hours as problems or interventions were added. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON confirmed Resident #13's Comprehensive Care Plan was updated to include a care plan for DVT on 06/25/2024. The DON confirmed the care plan documented the care plan was initiated on 07/24/2023, however the DVT care plan initiation date was incorrect as the care plan was not created until 06/25/2024. The DON provided an audited copy of the Comprehensive Care Plan which documented the DVT care plan was created on 06/25/2024. The Nurse Practice Act Nevada Administrative Code (NAC) 632.890 Unprofessional Conduct documented the Board would consider the following acts by a licensee as unprofessional: Inaccurate recording, falsifying or otherwise altering or destroying records.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on record review, interview, and document review, the facility failed to ensure nursing staff were trained and certified to perform Cardio-Pulmonary Resuscitation (CPR) in the event of a resident cardiac arrest for 2 of 5 sampled licensed nurses (Licensed Practical Nurse (LPN)1 and LPN2). The deficient practice could result in a negative outcome for a resident in cardiac arrest while awaiting the arrival of emergency medical personnel. Findings include: LPN1 LPN1 was hired on [DATE]. LPN2 LPN2 was hired on [DATE]. LPN1 and LPN2's personnel records lacked documented evidence of current CPR certifications. On [DATE], the Business Office Manager (BOM) confirmed responsibility for personnel record review conducted during the survey process. On [DATE] at 10:54 AM, during an interview for review of personnel records, the BOM verbalized being unsure about the policy for CPR training, including who was required to be certified and how often training was required. The BOM confirmed the personnel records for LPN1 and LPN2 lacked documented evidence of current CPR certifications. The facility policy titled Cardiopulmonary Resuscitation (CPR), updated ,d+[DATE], documented licensed nurses employed by the facility were required to have current CPR certification.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure a resident was not administered a pain medication outside physician parameters resulting in a resident receiving acetaminophen unnecessarily for 1 of 13 sampled residents (Resident #288). Findings include: Resident #288 Resident #288 was admitted to the facility on [DATE], with diagnoses including encephalopathy unspecified, hypothyroidism unspecified, and hypertension. A physician's order dated 06/18/2024, documented acetaminophen oral tablet. Give 650 milligrams (mg) by mouth every six hours as need for one to four moderate pain. Resident #288's care plan documented the resident had identified pain interfering with sleep, rehabilitation activities, and day to day activities related to migraines and headaches. An intervention revised on 06/25/2024, documented to administer analgesia as per orders. The June 2024 medication administration record (MAR) for Resident #288 dated 06/25/2024, documented the acetaminophen was administered on the following occasions when pain levels were higher than ordered parameters: -On 06/18/2024 at 3:20 PM, pain was 8 -On 06/18/2024 at 10:46 PM, pain was 7 -On 06/19/2024 at 8:56 PM, pain was 7 -On 06/22/2024 at 4:28 PM, pain was 5 -On 06/22/2024 at 11:13 PM, pain was 8 -On 06/23/2024 at 7:45 AM, pain was 7 -On 06/24/2024 at 9:15 AM, pain was 10 On 06/25/2024 at 1:43 PM, a Licensed Practical Nurse (LPN) confirmed Resident #288's physician's order for acetaminophen documented a pain level of one to four and the MAR documented acetaminophen was administered when pain was outside ordered parameters on the days and times documented above. The LPN confirmed the acetaminophen for those administrations did not follow the physician's order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/2024 at 3:12 PM, the Director of Nursing (DON) verbalized expectations for nurses administering medications included ensuring medications being administered matched the order on the MAR. The DON verbalized according to the MAR, physician's orders were not followed on the days and times documented above. The DON explained it was important for medication to be administered as ordered because it was within physician scope of practice to determine resident needs and to prescribe medications based on those needs. The DON could not confirm whether or not the medication was necessary. The facility policy titled Medication Administration, dated 01/2021, documented medications were administered as prescribed. The third step of medication preparation indicated prior to administration, authorized personnel were to review and confirm medication orders for each individual resident on the MAR.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review, and document review, the facility failed to ensure a psychotropic medication was prescribed to a resident with a diagnosed indication for use for 1 of 13 sampled residents (Resident #20). Findings include: Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including anxiety, unspecified and cellulitis of left lower limb. On 06/25/2024 at 10:29 AM, a Licensed Practical Nurse (LPN) verbalized Resident #20 received Trazadone for insomnia. The LPN confirmed the resident did not have a diagnosis of insomnia, for which the medication was to treat. A physician's order dated 03/12/2024, documented Trazodone Hydrochloride oral tablet 50 milligram (mg). Give one tablet by mouth one time a day for insomnia. Resident #20's June Medication Administration Record (MAR) documented Trazodone 50 mg tablet was administered once daily from 06/01/2024-06/25/2024. Resident #20's Comprehensive Care Plan lacked a care plan for insomnia. On 06/26/2024 at 9:16 AM, the Director of Nursing (DON) verbalized Resident #20 received Trazodone for insomnia every night. The DON confirmed Resident #20 did not have a diagnosis for insomnia and should have. The facility policy titled Psychotropic Drugs, updated 10/2022, documented the resident's physician would provide justification why the continued use of the drug and dose were clinically appropriate. The justification would include a diagnosis with a description of symptoms.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure the medication room and a medication cart did not contain expired COVID-19 testing supplies and narcotic medications were stored appropriately to prevent a resident's narcotic pain medication from going missing for 1 of 1 residents sampled for Facility Reported Incident (FRI) investigations (Resident #188). This deficient practice had the potential to result in residents tested with the expired products receiving inaccurate results, delays in residents receiving pain medication, and unauthorized individuals having access to narcotics without a prescription, leading to the misuse of prescription opioids. Findings include: Expired Testing Supplies On [DATE] at 11:13 AM, the facility's medication storage room contained a box of COVID-19 test kits with an expiration date of [DATE], documented on the side of each test kit box. The box contained 73 test kits. The Resident Care Manager confirmed the expiration date and confirmed the test kits were past the expiration date. On [DATE] at 11:36 AM, the bottom left drawer of the medication cart for the 200 hall contained a box of COVID-19 test kits with an expiration date of [DATE], documented on the package for each testing card. The box contained the supplies for 12 tests. The Licensed Practical Nurse (LPN) for the 200 hall confirmed the expiration date and confirmed the testing supplies were expired. On [DATE] at 1:15 PM, the Director of Nursing (DON) verbalized the DON completed an audit of the medication supply rooms and carts weekly to remove expired items. The DON verbalized the DON had not removed the COVID-19 test kits because the expiration date had been extended and the Administrator had documentation of the updated expiration dates. On [DATE] at 2:00 PM, the Administrator provided documentation of an extended expiration date for the COVID-19 testing supplies in the medication cart. The extended expiration date was [DATE]. The Administrator confirmed the COVID-19 testing supplies in the medication storage room and the medication cart were expired. The facility policy titled Medication Storage: Storage of Medication, dated ,d+[DATE], documented the facility would store medications and biologicals properly. Outdated supplies would be removed from stock and disposed of. Medication Storage (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #188 Resident #188 was admitted to the facility on [DATE], with diagnoses of encounter for other orthopedic aftercare, fusion of spine, cervical region, and encounter for surgical aftercare following surgery on the nervous system. A Physician Order, dated [DATE], documented Oxycodone Hydrochloride (HCl) oral tablet 20 milligrams (mg), give 20 mg by mouth every three hours as needed for pain management of breakthrough pain. FRI #NV00070378, dated [DATE], documented 38 tablets of Resident #188's Oxycodone 20 milligrams (mg) went missing between the hours of 11:00 AM and 4:00 PM on [DATE]. An incident timeline provided by the facility documented, the LPN working with Resident #188 and the medication cart containing the resident's Oxycodone medication had reported to the DON on [DATE], the resident's Oxycodone was missing from the medication cart and the LPN had been unable to locate the medication. The LPN reported to the DON the LPN had left the keys to the medication cart on top of the cart earlier in the day. The facility was unable to locate the missing medication. On [DATE] at 10:21 AM, the DON verbalized the facility had been unable to locate Resident #188's Oxycodone and was unable to determine if the medication had been taken by staff, residents, or a visitor. The DON explained the medication could have been accessed by anyone during the time the medication cart keys were left on top of the cart. The DON verbalized the keys to a medication cart should not be stored on top of the cart to limit the access to medications only to those individuals authorized to have access. The facility policy titled Medication Storage: Controlled Medication Storage, dated ,d+[DATE], documented only authorized licensed nursing and pharmacy personnel would have access to controlled medications. The medication nurse would maintain possession of the key to controlled medication storage areas. FRI #NV00070378

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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. 31739 Based on observation, interview and document review, the facility failed to ensure an ice machine's cleanliness was maintained, food was discarded per facility policy, and hand hygiene was performed during trayline observation. This deficient practice had the potential to affect the entire facility census. Findings include: Ice Machine On 06/24/2024 at 8:14 AM, the ice machine in the kitchen had a hard, white, flaky substance around the outside and inside of the door of the machine. An ice machine task sheet, posted on the side of the ice machine, documented routine maintenance was completed on 06/04/2024, and included door gasket cleaning. The task sheet documented a contracted maintenance company would complete a six month deep clean on the ice machine. On 06/24/2024 at 8:16 AM, the Nutrition Services Supervisor confirmed the ice machine had a hard, white, flaky substance around the door, and believed the cleaning of the door was completed during the deep cleaning of the ice machine by the contractor. On 06/24/2024 at 8:26 AM, the Nutrition Services Supervisor verbalized not having been able to locate the contractor's cleaning log or when the next deep cleaning was scheduled. The facility policy titled, Cleaning Ice Making Machine, published 07/2009, documented monthly cleanings of the ice machine were to be followed and all cleanings were to be documented. Discarding of Food On 06/24/2024 at 8:35 AM, in the walk-in refrigerator was a cardboard case containing seven unopened, and one opened, one-quart cartons of heavy cream. The expiration dates on each one-quart carton, and the used-by date on the outside of the case, was 06/16/2024. On 06/24/2024 at 8:36 AM, the Nutrition Services Supervisor confirmed the quarts of heavy cream located in the walk-in refrigerator should have been removed and discarded as they were past the expiration and used-by dates. The facility policy titled, Food Storage Guidelines, published 02/2018, documented to follow the used-by dates for the storage of heavy cream. Hand Hygiene (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/25/2024 at 12:05 PM, during the lunch trayline observation, a [NAME] entered trayline from the kitchen prep area behind trayline, donning a pair of blue latex gloves. The [NAME] did not don new gloves or wash hands prior to entering trayline. The [NAME] used the right hand with the blue glove and grabbed a handful of shredded cheese from a plastic bag on trayline and placed the cheese on a slice of bread in a pan on the stove. On 06/25/2024 at 12:08 PM, the [NAME] walked off trayline to the kitchen prep area with the same blue gloves and grabbed a large knife and a small red cutting board. The [NAME] reentered trayline without washing hands and donning new gloves. On 06/25/2024 at 12:09 PM, the Nutrition Services Supervisor verbalized the kitchen prep area, located behind trayline, was not considered part of trayline and staff were to wash hands and don new gloves each time prior to entering trayline. The Nutrition Services Supervisor confirmed having observed the [NAME] enter trayline without washing hands or donning new gloves. On 06/25/2024 at 12:10 PM, the [NAME] confirmed having exited trayline to the kitchen prep area to obtain a knife and cutting board and reentered trayline without washing hands and donning new gloves. The [NAME] verbalized having known to wash hands and don new gloves prior to reentering trayline but had forgotten to do so. The facility policy titled, Handwashing, updated 03/2016, documented appropriate handwashing procedures were to be followed before preparing or handling food, and before and after glove use. Employees were to wash hands with warm water and soap and dry with disposable towels.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a staff member performed hand hygiene between contact with residents and environmental surfaces, a glucometer was sanitized correctly between residents, clean laundry was stored and handled in a sanitary manner and was not placed on a floor cleaner to finish drying, and a fan was not blowing air from the dirty laundry side of the laundry room to the clean laundry side of the laundry room. This deficient practice had the potential to result in the spread of infection and illness to residents throughout the facility due to lack of appropriate infection control practices. Findings include: Hand Hygiene On 06/20/2024 at 9:16 AM, the Activities Director (AD) entered a resident room and leaned down to speak with the resident in the bed nearest the door. The AD touched the resident's hand and the resident's bedding. The AD then left the resident's room and walked down the hallway toward the nurse's station. The AD placed both hands on the counter of the nurse's station and then walked to a resident sitting in a chair across from the nurse's station and greeted the resident by touching the AD's open palm to the resident's open palm. The AD did not perform any hand hygiene in between the activities. On 06/24/2024 at 9:21 AM, the AD confirmed the AD had not performed hand hygiene and should have performed hand hygiene after contact with a resident. On 06/24/2024 at 2:00 PM, the Infection Preventionist (IP) verbalized hand hygiene would be completed before and after contact with residents. On 06/26/2024 at 10:53 AM, the IP verbalized the IP had not provided education to the AD on hand hygiene because the IP only provided infection control education to nursing staff. On 06/26/2024 at 10:54 AM, the Director of Nursing (DON) verbalized all staff received training on hand hygiene at the time of hire. On 06/26/2024 at 10:55 AM, the IP verbalized it was important to perform hand hygiene in between resident contact to prevent the spread of disease and decrease the risk of preventable infections. The facility training titled Handwashing, undated, documented healthcare worker and other frontline worker could pick up infectious organisms by touching residents, as well as contaminated furniture or equipment. They can then carry these organisms to the other residents they come in contact with, who may in turn contract an infection. The facility policy titled Handwashing/Hand Hygiene, updated 03/2018, documented hand hygiene was the primary means to prevent the spread of infections. Hand hygiene would be completed before and after contact with residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Glucometer On 06/25/2024 at 11:28 AM, a Licensed Practical Nurse (LPN) verbalized the LPN had performed finger stick blood glucose testing for two residents earlier in the morning. The LPN verbalized the LPN used the same blood glucose meter (glucometer) for both residents. The LPN explained the LPN used a 70 percent isopropyl alcohol prep pad to clean the glucometer between residents. On 06/25/2024 at 1:22 PM the DON confirmed the glucometer would be used for multiple residents and explained the glucometer would be cleansed with a Sani-Cloth (germicidal disposable wipe) between residents. On 06/26/2024 at 10:56 AM, the DON and IP explained Sani-Cloths were available in all medication carts. The DON verbalized the glucometer would be wiped with the Sani-Cloth and remain wet for two minutes. The DON confirmed the facility would follow the manufacturer's instructions for appropriate cleaning of the glucometer and explained the purpose of using the appropriate products to sanitize the glucometer was to prevent the spread of blood borne pathogens. The facility policy titled Disinfecting Glucometer and PT/INR Machine, updated 02/2017, documented the glucometer would be disinfected per manufacturer's instructions. The manufacturer's instructions titled Assure Prism multi-Blood Glucose Monitoring System User Instruction Manual, revised 04/2021, documented to minimize the risk of transmission of blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended. The meter would be cleaned and disinfected after use on each patient. The Blood Glucose Monitoring System could only be used for testing multiple residents when the manufacturer's disinfection procedures were followed. The following had been validated for disinfecting the meter: - Clorox Healthcare Bleach Germicidal Wipes. - Dispatch Hospital Cleaner Disinfectant Towels with Bleach. - CaviWipes1 - and PDI Super Sani-Cloth Germicidal Disposable Wipes. Two disposable wipes would be needed for each cleaning and disinfecting procedure. One wipe would be used to wipe the entire surface of the meter three times horizontally and three times vertically. The second wipe would be used to wipe the entire surface of the meter three times horizontally and three times vertically. The exteriors would remain wet for the corresponding contact time for each disinfectant. Laundry On 06/26/2024 at 9:33 AM, during a tour of the laundry room the following was observed: - a fan was blowing air from the dirty side of the laundry room to the clean side and directly onto laundry being removed from the washing machine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- the clean side of the laundry room had three industrial floor cleaners (floor cleaner) stored behind and next to the dryers. - a blanket for resident use was lying on top of the larger floor cleaner. - the wire racks storing linens for resident use did not have solid bottom shelves. On 06/26/2024 at 9:35 AM, the Housekeeper1 confirmed the fan was on and blowing air from the side of the room where the dirty laundry was brought into the laundry room onto the area where the clean laundry was removed from the washing machine and placed into the dryer. The Housekeeper1 confirmed the floor cleaners were stored on the clean side of the laundry room. On 06/26/2024 at 9:36 AM, the Housekeeper2 verbalized the Housekeeper2 had placed the blanket on top of the floor cleaner to continue drying as the blanket had still been damp when removed from the dryer. The Housekeeper2 then removed the blanket from the floor cleaner and placed it on the wire rack used for storing linen for resident use. On 06/26/2024 at 9:38 AM, the Housekeeper1 confirmed the three wire racks used for storage of linen for resident use did not have a solid bottom on the bottom racks. On 06/26/2024 at 11:00 AM, the IP and the DON verbalized neither the IP nor the DON oversaw the infection control practices of the laundry room as the services were provided by employees of a contracted agency. The DON verbalized the DON was not sure if linen could be placed on a floor cleaner to continue drying. The facility policy titled Soiled Laundry and Bedding, published 05/2015, documented soiled laundry/bedding would be handled in a manner to prevent microbial contamination of the air and persons handling the linen. The American Journal of Infection Control article titled Keeping health care linens clean: Underrecognized hazards and critical control points to avoid contamination of laundered health care textiles, published 07/18/2022, documented infection preventionists played a central role in guiding healthcare textile management practices. The bottom shelf of wire racks should be solid or lined with an impervious barrier; alternatively, items on the bottom shelf could be placed in impervious containers.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure 4 of 15 residents reviewed for vaccinations were offered a pneumonia vaccine upon admission (Residents #239, #88, #89, and #288) and 1 of 15 residents reviewed for vaccinations and residing in the facility during the 2023 to 2024 influenza (flu) season was offered a flu vaccine (Resident #33). This deficient practice had the potential for residents to become ill with a preventable illness due to lack of vaccinations. Findings include: Resident #239 Resident #239 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, type two diabetes mellitus without complications, and heart failure, unspecified. The clinical record for Resident #239 lacked documentation the resident was screened for or offered a pneumonia vaccine. Resident #33 Resident #33 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications, morbid (severe) obesity due to excess calories, and personal history of COVID-19. The clinical record for Resident #33 lacked documentation the resident was screened for or offered a flu vaccine. Resident #88 Resident #88 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus without complications, hyperlipidemia, unspecified, and essential (primary) hypertension. The clinical record for Resident #88 lacked documentation the resident was screened for or offered a pneumonia vaccine. Resident #89 Resident #89 was admitted to the facility on [DATE], with diagnoses including unspecified atrial fibrillation, chronic kidney disease, stage three unspecified, and essential (primary) hypertension. The clinical record for Resident #89 lacked documentation the resident was screened for or offered a pneumonia vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #288 Resident #288 was admitted to the facility on [DATE], with diagnoses including encephalopathy, unspecified, COVID-19, and essential (primary) hypertension. The clinical record for Resident #288 lacked documentation the resident was screened for or offered a pneumonia vaccine. On 06/26/2024 at 10:59 AM, the Infection Preventionist (IP) confirmed the residents had not been offered vaccinations because vaccinations were only offered during the vaccine clinics provided by the contracted pharmacy. The IP explained the vaccine clinics were conducted quarterly and it was possible for a resident to be admitted and discharged without being offered a pneumonia or flu vaccine. The IP verbalized it was important to offer flu and pneumonia vaccines to residents in the facility as the population tended to be older and more susceptible to illness due to comorbidities affecting the immune system. The facility policy titled Pneumococcal Vaccination of Residents, updated 03/2022, documented the Centers for Disease Control (CDC) recommended vaccinating persons at high risk for serious complications from pneumococcal pneumonia, including those [AGE] years and older. Each resident's vaccination status was determined upon admission. Informed consent would be obtained prior to immunization and vaccination refusals and reasons why were documented. The facility policy titled Resident and Employee Influenza Vaccine, updated 09/2017, documented current and newly admitted residents were offered the influenza vaccine from October of each year through the end of March the following year. Informed consent would be obtained, and vaccination refusal and reasons why were documented.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure 4 of 15 residents reviewed for vaccinations were offered a COVID-19 vaccine upon admission (Residents #239, #88, #89, and #288) and 1 of 15 residents was offered an updated 2023 to 2024 COVID vaccine (Resident #30). This deficient practice had the potential for residents to become ill with a preventable illness due to lack of vaccinations. Findings include: Resident #239 Resident #239 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, type two diabetes mellitus without complications, and heart failure, unspecified. The clinical record for Resident #239 lacked documentation the resident was screened for or offered a COVID vaccination. Resident #88 Resident #88 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus without complications, hyperlipidemia, unspecified, and essential (primary) hypertension. The clinical record for Resident #88 lacked documentation the resident was screened for or offered a COVID vaccination. Resident #89 Resident #89 was admitted to the facility on [DATE], with diagnoses including unspecified atrial fibrillation, chronic kidney disease, stage three unspecified, and essential (primary) hypertension. The clinical record for Resident #89 lacked documentation the resident was screened for or offered a COVID vaccination. Resident #288 Resident #288 was admitted to the facility on [DATE], with diagnoses including encephalopathy, unspecified, COVID-19, and essential (primary) hypertension. The clinical record for Resident #288 lacked documentation the resident was screened for or offered a COVID vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 Resident #30 was admitted to the facility on [DATE], with diagnoses including multisystem inflammatory syndrome, dependence on renal dialysis, and end stage renal disease. The clinical record for Resident #30 lacked documentation the resident was screened for or offered an updated 2023 to 2024 COVID vaccine. On 06/26/2024 at 10:59 AM, the Infection Preventionist (IP) confirmed the residents had not been offered COVID vaccinations because vaccinations were only offered during the vaccine clinics provided by the contracted pharmacy. The IP explained the vaccine clinics were conducted quarterly and it was possible for a resident to be admitted and discharged without being offered a COVID-19 vaccine. The IP verbalized Resident #30 had not received an updated 2023-2024 COVID vaccine because the vaccine clinic had been scheduled at a time when the resident was out of the facility receiving dialysis. The IP verbalized it was important to offer COVID vaccines to residents in the facility as the population tended to be older and more susceptible to illness due to comorbidities affecting the immune system. The facility policy titled Prevention and Management of COVID-19 in Long Term Care, updated 09/06/2023, documented COVID-19 vaccination and recommended boosters would be offered to all residents per Centers for Disease Control and Prevention (CDC) and/or Food and Drug Administration (FDA) guidelines. All residents would be offered a Vaccine Information Statement and education on the vaccine offered. The facility would maintain documentation for all residents on COVID-19 vaccination, and recommended boosters. The information would be documented in the residents' medical record along with whether the resident consented to the vaccine or a reason for refusal.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41848 Based on observation and interview, the facility failed to ensure the laundry room was a safe and comfortable temperature. This deficient practice had the potential to result in staff experiencing adverse effects from working in unsafe temperatures while providing laundry services for residents of the facility. Findings include: On 06/26/2024 at 9:33 AM, during a tour of the laundry room, a fan was blowing air from the dirty side of the room to the clean side of the room. The Housekeeper confirmed the fan was in use to prevent the housekeeping staff from overheating as the room had not had air conditioning for the past year. On 06/26/2024 at 10:07 AM, the Administrator confirmed the laundry room was without air conditioning. On 06/26/2024 at 10:47 AM, the Maintenance Director verbalized the laundry room had been without out air conditioning off and on for the past year and the temperature should be maintained between 71- and 81-degrees Fahrenheit. On 06/26/2024 at 1:25 PM, the washing machine and dryers were not operating in the laundry room and the ambient temperature in the laundry room was 86-degrees Fahrenheit.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 50210 Based on personnel record review, interview and document review, the facility failed to ensure annual elder abuse training was completed 1 of 20 sampled employees (Housekeeper). Findings include: The Housekeeper was hired on 09/17/2019. Employee #20's personnel record documented elder abuse training completed 05/04/2023, but lacked documented evidence elder abuse training was completed in 2024. On 06/25/2024, the Business Office Manager (BOM) confirmed responsibility for personnel record review conducted during the survey process. On 06/26/2024 at 10:54 AM, during an interview for review of personnel records, the BOM verbalized all staff were required to complete elder abuse training upon hire and annually thereafter. The BOM explained being unsure about the expected timeframes for elder abuse training. The BOM confirmed Employee #20's personnel record lacked elder abuse training in 2024. The facility policy titled Abuse Training, updated 10/2022, documented center staff were trained on abuse prevention, reporting, and intervention upon hire, annually and periodically thereafter.