STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50207 Based on record review and interview, the facility failed to ensure residents, resident representatives, and Ombudsman received a written notice of transfer as soon as practicable for 1 (R #52) of 1 (R #52) residents sampled for being discharged . This deficient practice could likely result in the Ombudsman not knowing the reason for transfer or location to which the resident was discharged . The findings are: A. Record review of R #52's administration progress note, dated 02/17/24, revealed R #52 was admitted to a hospital on 02/17/24. B. Record review of R #52's Discharge Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility staff), dated 02/17/24, revealed the resident had an unplanned discharge to a short term general hospital. C. On 03/29/24 at 11:23 am during an interview with the DON she confirmed they did not have documentation to show the staff notified the Ombudsman of the resident's transfer from facility.

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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(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 Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 50207 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility staff) was accurate for 2 (R #25 and R #51) of 2 (R #25 and R #51) residents reviewed for MDS accuracy. This deficient practice could likely result in the facility not having an accurate assessment of resident's care needs. The findings are: R #25 A. Record review of the quarterly MDS for R #25, dated 02/24/24, identified R #25 took an anticoagulant (medication that slows down the process of making blood clots). B. Record review of the Electronic Health Record (EHR) for R #25 revealed the record did not contain an order for an anticoagulant since the resident was admitted to the facility on [DATE]. C. On 03/29/24 at 10:24 am, during an interview with the MDS Coordinator, she stated the MDS for R #25 indicated the resident took an anticoagulant. The MDS Coordinator stated this was an error. She stated R #25 did not have a physician's order R #25 to take an anticoagulant since the resident was admitted to the facility. R #51 D. Record review of psychiatric physician notes for R #51, dated 10/04/23, indicated the resident had a diagnosis of schizoaffective disorder. E. Record review of the current care plan for R #51, dated 02/22/24, indicated the resident took a psychotropic medication (a drug that acts on the mind). F. Record review of the quarterly MDS for R #51, dated 02/23/24, revealed the record did not identify that R #51 had a psychotic disorder (a group of serious illnesses that affect the mind). G. On 03/29/24 at 9:55 AM during an interview with Minimum Data Set Coordinator, she stated if there was an inaccurate diagnosis, she would consult with the physician for confirmation, and then she would correct the MDS. She stated she was unaware R #51 had a diagnosis of schizoaffective disorder (psychiatric health diagnosis).

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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. 50207 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and implemented within 21 days of readmission for 1 (R #52) of 1 (R #52) residents reviewed for care plans. This deficient practice could likely result in the facility not providing appropriate care and treatment to meet the needs of the residents. The findings are: A. Record review of R #52's care plan, dated 03/22/24, revealed staff marked all items listed as resolved or cancelled. B. On 03/29/24 at 10:24 am, the Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility staff) Coordinator stated she did not know why staff marked all items in R #52's care plan as resolved or cancelled. The MDS Coordinator stated all items in a care plan should still be effective since they were still pertinent to the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on record review, observation, and interviews, the facility failed to provide services that meet professional standards when staff failed to: 1. Update diagnosis for the use of a medication ordered for R #47. 2. Follow physicians order regarding liquid consistencies for R #54 These deficient practices are likely to cause residents to aspirate if ordered liquid consistencies are not followed and residents are likely to receive the wrong use of medications if diagnosis are not updated. The findings are: R #47 A. Record review of R #47's face sheet reveals R#47 was admitted to the facility on [DATE] with a diagnosis of anxiety (feeling of worry or unease.) B. Record review of R #47's physician orders, dated 03/20/24, revealed an order for alprazolam oral tablet (a medication used to treat anxiety and panic disorder), 0.5 milligram (mg). Give one tablet via percutaneous endoscopic gastrostomy (PEG) tube (a tube placed in the abdomen to provide nutrition and medications) for the use of insomnia and anxiety. C. Record review of R #47's Medication Administration Record (MAR), dated 03/28/24, revealed alprazolam oral tablet, 0.5 mg. Give one tablet via PEG-Tube at bedtime for insomnia, anxiety. Medication was administered daily from 03/01/24 through 03/27/24. D. On 3/29/24 at 11:15 AM during an interview with Director of Nursing (DON) and the Minimum Data Set (MDS) Coordinator, they stated face sheet should be updated to include the diagnosis of insomnia as indicated on the physicians orders. R #54 E. Record review of R #54's diet order, dated 03/14/23, revealed an order for mechanical soft texture, mildly thick consistency (liquids that are thicker than water but still thin enough to flow through a straw.) F. Record review of R #54's dietary ticket, dated 03/25/24, revealed staff to serve the resident mildly thickened liquids. G. On 03/25/24 at 5:20 pm, during an observation in the dining room, the Administrator gave R #54 two cups of cranberry juice that were thin liquids. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 03/29/24 at 9:47 am during an interview, the Director of Nursing (DON) stated staff should serve R #54 thickened liquids. The DON stated the staff should have notified the physician if there was a change to receive an approval for a dietary update. The DON stated this was not done on that day.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 48960 Based on record review, observations, and interview the facility failed to: 1. Update the staffing sheets at the beginning of each shift or in a timely manner to reflect the staff working that day. This deficient practice could likely prevent the public as well at the 56 residents identified on the facility census list provided by the Administrator on 03/25/24 from having access to accurate, current, and previous staffing information. The findings are: A. Record review of the posted staffing sheet, on 03/25/24 at 3:49 PM, revealed the following: - Staff documented RN-1 LPN -1 CMA-1 CNA-5 for the day shift; - The data was not in a clear and readable format; -Staff did not update the document with the evening shift staff. B. On 03/26/24 at 8:03 AM, 12:20 PM, and 5:07 PM, record review of the posted staffing sheet remained the same as the staffing sheet on 03/25/24, and the evening shift was not filled out. The staffing post sheet was not updated to reflect the current date. C. On 03/27/24 at 8:00 AM, record review of the posted staff sheet revealed it was dated 03/26/24. D. On 03/28/24 at 3:30 PM, record review of the Posting Nurse Staffing Information and Report policy and procedure revealed the staff will post the following information daily, at the beginning of each shift, day, night and weekend shift. 1. Registered Nurses, 2. Licensed Vocational Nurses, 3. Certified Medication Aides, 4. Certified Nurse's Aides and Nursing Assistants. E. On 03/29/24 at 11:30 AM during an interview with Director of Nursing (DON) and the Administrator, they stated staff should complete the posted staffing sheet each day and post the staffing sheet daily at the beginning of the shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47899 Based on observation, interview, and record review, the facility failed to maintain records of controlled substances (drugs subject to strict government control because they may cause addiction) on each medication cart. This deficient practice could cause the likelihood of controlled substances being diverted (a medical and legal concept including the transfer of any illegal prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use). The findings are: A. On 03/24/24 at 4:05 pm, an observation of the 200 medication cart revealed staff did not sign the narcotic book [a book used to manually track inventories of prescribed medications, tracks the resident's prescription administration, and records when the facility received the medication for each schedule 2 controlled substance (medication with a high potential for abuse and/or addiction) from the pharmacy] to show they counted the medication blister pill cards (single dose pack that have the medication name, pill information, and expiration dates and allows one to count the number of pills remaining) and compared them to the residents' medication sheets for numerous dates between 3/11/24 to 03/19/24. B. On 03/25/24 at 4:06 pm during an interview with Certified Medication Aide (CMA) #1 stated there were missing signatures from the narcotic book. She stated they counted the narcotics at the beginning of each shift before they took the keys to the medication cart, and they counted the narcotics at the end of each shift before they gave the keys to the medication cart to the oncoming nurse. C. On 03/25/24 at 4:45 pm during an interview with the Director of Nursing (DON), she stated the nursing staff should sign the narcotic book when they come onto and go off of each shift. She stated this was to ensure the narcotic count was correct before on-coming shift nurse took the keys for the narcotic box from the off-going shift nurse.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 47899 Based on record review and interview, the facility failed to ensure they monitored for side effects of medication for 2 (R #56 and R #111) of 2 (R #56 and R #111) residents reviewed for unnecessary medications. If the facility is not adequately monitoring for the side effects of the medications prescribed to their residents then residents are likely to be at risk of adverse outcomes. The findings are: R #56 A. Record review of R #56's current physician's orders revealed an order, dated 02/08/24, for clopidogrel bisulfate oral tablet (prevents platelets in the blood from sticking together to form an unwanted blood clot that could block an artery), 75 milligram (MG). Give 75 MG via G-tube (gastro intestinal tube inserted directly into the stomach to provide nutrion) one time a day related to stroke (a brain lesion in which a cluster of brain cells die when they do not get enough blood.) B. Record review of R #56's electronic Treatment Administration Records (ETAR) revealed the following: - February, 2024: Staff did not document they monitored the resident's enoxaparin sodium, an anticoagulant. - March, 2024: Staff did not document they monitored the resident's enoxaparin sodium, an anticoagulant. R # 111 C. Record review of R #111's physicians orders revealed the following: 1. Physician order, dated 03/13/24, for enoxaparin sodium injection solution pre-filled syringe (blood thinner), 40 MG/0.4 Milliliters (ML). Inject 40 MG subcutaneously (into the fat under the skin), one time a day related to acute embolism (blockage in the artery or vein) and thrombosis (the formation or presence of a blood clot in a blood vessel) of the right femoral vein (large vein in the right thigh) for 30 days. 2. Physicians order, dated 03/26/24, for insulin lispro-aabc injection solution (a fast-acting insulin and used by people with diabetes to help keep blood sugar levels under control) 100 unit/ML, subcutaneously every 12 hours as needed for diabetes mellitus (DM) related to type 2 DM with hyperglycemia (high blood sugar). Inject as per sliding scale: If blood glucose measures 300 to 500 then administer 10 units; If blood glucose measures 501 to 600 then give 0 units of insulin and notify the provider. D. Record review of R #111's electronic Treatment Administration Record (ETAR), dated Febraury 2024, revealed the following: 1. Staff did not document they monitored the resident's enoxaparin sodium, an anticoagulant. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Staff did not document they monitored the resident's hyperglycemia (high blood sugar) or hypoglycemia (blood sugar to low) for the insulin lispro. E. Record review of R #111's electronic Treatment Administration Record (ETAR), dated 03/2024, revealed the following: 1. Staff did not document they monitored the resident's enoxaparin sodium, an anticoagulant. 2. Staff did not document they monitored the resident's hyperglycemia (high blood sugar) or hypoglycemia (blood sugar to low) for the insulin lispro. F. On 03/29/24 at 9:49 am during an interview, the Director of Nursing (DON) stated staff should monitor residents on insulin (used to control blood sugars) or anticoaglants (blood thinners.) The DON said staff should document they monitored the resident in the ETAR. She stated staff did not document in R #111's ETAR for anticoagulants, hyperglycemia, and hypoglycemia. The DON stated staff did not monitor R #56 for an anticoagulant.

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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** 47899 Based on observation and interviews the facility failed to: 1. Ensure opened and accessed (has been used) insulin flex pens (an injectable diabetes medicine that helps control blood sugar levels. This medication helps the pancreas produce insulin more efficiently) were dated as to when they were initially opened by nursing staff. 2. Ensure all expired supplies were not kept with unexpired supplies. These deficient practices are likely to result in all 56 residents, identified on the census list provided by the Executive Director (ED) on [DATE], receiving expired medication that may have lost their potency or effectiveness. The findings are: Findings for Insulin Pens A. On [DATE] at 3:42 pm, an observation of medication cart 100 revealed the following: - A Basagler flex pen (a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours), 100 unit/milliliter (ML) was ,d+[DATE] full and belonged to R #7. The insulin pen did not have an open date written on it. - An Ozempic prefilled syringe (a prescription drug for type 2 diabetes that lowers blood sugar and heart risks) 2 MG/3 milliliter (ML) was almost empty. The syringe did not have an open date written on it. B. On [DATE] at 3:46 pm during an interview with LPN #2, she confirmed staff did not write an open date on either medications, and both medications were used. C. On [DATE] at 10:05 am during an interview with the Director of Nursing (DON), she confirmed staff should write the dates on all insulin pens. Findings for expired supplies D On [DATE] at 3:42 pm, an observation of the 100-medication cart revealed the following: 1. Assure Dose, level 1, normal dose (a glucose control test used to check the meter and strips work optimally to deliver accurate and precise results) was opened and did not have an open by date. The test expired within 90 days of opening. 2. Assure Dose, level 2, normal dose was opened did not have an open by date. The test expired within 90 days of opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. On [DATE] at 3:33 pm LPN #2 stated staff should have dated the two open bottles of Assure Dose, the glucose control testing, with an open date.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 50207 Based on observation, interview and record review, the facility failed to ensure a resident received dental services for 1 (R #46) of 1 (R #46) residents reviewed for dental care. This deficient practice could likely result in residents experiencing tooth decay, tooth pain, and difficulty chewing. The findings are: A. During an interview with R #46 on 03/26/24 at 10:07 am, she stated her top dentures have been missing, and she told the facility's administrator but could not remember when she told her. B. During an observation on 03/26/24 at 10:01 am, R #46 had several missing teeth and did not wearing dentures. C. Record review of R #46's care plan, revised on 10/09/23, stated the resident had upper and lower dentuers and was at risk for difficulty chewing, malnutrition, and dehydration. D. Record review of R #46's electronic health record revealed a dental note, dated 12/12/23, which stated a follow-up appointment was needed for upper mouth dentures. E. On 03/29/24 at 10:46 am during an interview, the Social Services Director (SSD) stated the resident should have went to a follow-up appointment from the 12/12/23 dental appointment.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48960 Based on observation, record review, and interview, the facility failed to ensure that 1 (R #40) of 3 (R #40, R #46 and R #48) residents reviewed for food and drink were provided food and drink prepared in a form designed to meet the residents needs. This deficient practice is likely to negatively impact a resident not eating or having trouble with swallowing during mealtimes. The findings are: R#40 A. Record review of R #40's medical record revealed the resident had a diagnosis of dysphagia (difficulty with swallowing foods or liquids). B. On 03/25/24 at 5:00 PM, during an observation of the Dining Room, R#40 sipped his drink through a straw and had difficulty swallowing. The Occupational Therapy Director (OTD) noticed the consistency of the drink and added more thickener (a powder substance that thickens the consistency of liquids in order to prevent choking and it is recommended for residents who have difficulty with swallowing) to the drink. C. On 03/25/24 at 5:20 PM during an interview with the OTD, she stated R #40 had an order for extremely thick, pudding like drink consistency. D. Record review of R #40's meal ticket slip, dated 03/26/24, revealed a liquid consistency of extremely thick, pudding like. E. Record review of R #40's physician orders, dated March 2024, revealed the record did not include an order for thickened liquids. F. Record review of R #40's care plan, dated 03/24/24, revealed the plan did not address the consistency of the resident's drinks during meals. G. On 03/26/24 at 12:00 PM observation during lunch, the Minimum Data Set Director (MDS) served a drink to R #40 that appeared watery. R #40 drank the liquid through a straw and began to cough. The MDS Director checked R #40's meal ticket and added the thickener to R #40's drink. H. On 03/29/24 at 9:30 AM during an interview with the MDS director, she stated the care plan and orders needed to coordinate with the meal ticket.

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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. 48960 Based on observation, interview, and record review, the facility failed to store and serve food under sanitary conditions in accordance with professional standards of food service safety when staff failed to monitor the internal temperature of food to ensure it is safe for consumption. This failure could likely affect all 56 residents in the facility (residents were identified by the resident matrix provided by the Administrator on 03/25/24) who eat food prepared in the kitchen. The findings are: A. Record review of the posted menu for lunch meal, dated 03/26/24, revealed staff to serve the following: 1. Breaded pork chop with onions, 2. Parslied buttered pasta, 3. Green beans, 4. Garlic toast, 5. Chocolate chip cake, 6. Beverage/Water. B. On 03/26/24 at 12:15 PM, observation of food temperatures taken by the dietary aide (DA) of the lunch meal trays revealed the pork chops measured 129 degrees ( ) Fahrenheit (F). C. Record Review of the U.S. Food and Drug Administration (FDA) Food Code, 2022 edition, revealed staff should serve hot foods at an internal temperature of 135 F or higher. D. On 03/26/24 at 1:30 PM during an interview with the Dietary Director (DD), he confirmed the food temperatures were not at an acceptable temperature. 50207

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47899 Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures when: 1. Staff did not sanitize hands before or after medication administration to 3 (R #4, 37, 41) of 6 (R #4, 24, 31, 37, 41, 49) residents . 2. Staff did not sanitize blood pressure cuff after using on each 5 (R #4, 24, 31, 37, 49) of 6 (R #4, 24, 31, 37, 41, 49) residents. 3. Oxygen cannula (tubing that is placed in the nostrials that delivers oxygen) on the floor for 1 (R #54) of 1 (R #54) residents. If the facility does not adhere to infection control practices, then residents are likely to be at risk of infection or disease. The findings are: Staff did not sterilize hands during medication pass. A. On 03/26/24 at 08:30 AM during observation of medication administration, Licensed Practical Nurse (LPN) #1 prepared medication for R #4. LPN #1 did not sanitize her hands before preparing the medication or entering residents' room. The LPN entered R #4's room, touched the resident on the arm while applying blood pressure cuff. LPN #1 exited the room and began to prepare R #37's medication. The LPN #1 did not sanitize her hands before entering R #37's room to administer medications. LPN # 1 touched R #37's arm while applying blood pressure cuff. LPN #1 left R #37 room and began preparing R #41's medication without sanitizing hands. LPN entered R #41's room to administer medications and touched R #41's arm to apply blood pressure cuff. LPN #1 left R #41's room without sanitizing hands and began working on the next medication for another resident. B. Record review of the facility's Medication Administration policy, no date, provided by (DON) Director of Nursing, directed staff to sanitize hand before and after medication administration. C. On 03/27/24 at 09:40 AM during an interview, the Assistant Director of Nursing (ADON) stated her expectation was for staff to follow the policies and procedures, which was to sanitize hands before and after medication administration. Staff did not sanitize blood pressure cuff after use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	03/29/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. On 03/26/24 at 8:30 AM during observation of medication administration, LPN #1 did not sanitize the blood pressure cuff after using on residents for 2 residents (R #4, # 37). LPN #1 entered R #4's room to administer medication, applied the blood pressure cuff on R #4's arm, and removed it after use. LPN #1 left R #4's room and put blood pressure cuff onto medication cart and began preparing medication for next resident. LPN #1 entered R #37's room to administer medication and applied the same blood pressure cuff on R #37's arm. The LPN did not sanitize the blood pressure cuff prior to applying it to R #37's arm. LPN #1 removed the blood pressure cuff from the resident's arm, left R #37's room, put blood pressure cuff onto medication cart, and began preparing medication for next resident. E. On 03/27/24 at 8:12 AM during observation of medication administration, LPN #2 did not sanitize blood pressure cuff after use on 3 residents (R# 24, 31, 49). LPN #2 entered R #24's room to administer medications, applied the blood pressure cuff on R #24's arm, and removed it after use. LPN #2 left R #24's room and put blood pressure cuff onto medication cart and began preparing medication for R #31. LPN #2 entered R #31's room to administer medications and applied the same blood pressure cuff on R #31's arm. The LPN did not sanitize the blood pressure cuff prior to applying it to R #31's arm. LPN #2 removed the blood pressure cuff from the resident's arm, left R #31's room, put blood pressure cuff onto medication cart, and began preparing medication for R #49. LPN #2 entered R # 49's room and applied the same blood pressure cuff to R #49's arm. The LPN did not sanitize the blood pressure cuff prior to applying it to R #49's arm. LPN #2 removed the blood pressure cuff from the resident's arm, left R #49's room, put the blood pressure cuff onto the medication cart, and began preparing medication for the next resident. F. Review of CDC guidelines Guideline for Disinfection and Sterilization in Healthcare Facilities, dated 2008, Section 4.c., stated staff should ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis, such as after use on each patient or once daily or once weekly. G. On 03/27/24 at 09:40 AM during an interview, the ADON stated the expectation was for staff to follow the policies and to clean equipment in between patients. Oxygen cannula laying on the floor H. On 03/26/24 at 11:01am during an observation of R #54, he lay in his bed, and LPN #2 provided care. R #54's nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs) lay on the floor. CNA picked up the cannula and laid it across the R #54's roomate's bed. Then the CNA picked up the cannula and inserted the prongs into the R #54's nose. I. On 03/29/24 at 11:06 am, LPN #2 comfirmed staff should have changed the cannula to a new cannula. The LPN stated staff should not have place the cannula on R #54 after it had been on the floor and the other person's bed. 49827 50207

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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. 50207 Based on record review and interview, the facility failed to ensure staff offered COVID-19 (a highly infectious viral disease) vaccinations to 3 (R #7, R #50, and R #34) out of 5 (R #7, R #50, R #34, R #20, and R #46) residents reviewed for COVID-19 vaccines. This deficient practice could likely result in residents at risk for exposure to COVID-19 related infections. The findings are: R #7 A. Record review of R #7's Electronic Health Record (EHR) revealed staff did not offer the resident a COVID-19 vaccination. B. On 03/29/24 at 9:36 am during an interview with Director of Nursing (DON), she stated R #7 declined the vaccination, but she was unable to provide documentation of the declination. C. On 03/29/24 at 11:06 am during an interview, R #7 stated she did not decline the COVID-19 vaccination. She said she never said that. R #50 D. Record review of R #50's EHR revealed the resident received the first dose of the COVID-19 vaccine on 10/05/23. The EHR did not indicate R #50 received a second dose. E. During an interview on 03/29/24 at 9:36 am with the DON and the Infection Preventionist (IP), the DON stated R #50 did not receive the second dose of her COVID-19 vaccination. The Infection Preventionist (IP) stated staff should have administered the second dose about two months after the first dose. R #34 F. Record review of R # 34's EHR revealed the resident received a COVID-19 vaccine on 11/11/21. G. On 03/29/24 at 9:36 am during an interview with DON, she stated she was unable to provide documentation to show staff offered the COVID-19 vaccine to R #7 after the vaccine on 11/11/21.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 48960 Based on observation and interview, the facility failed to ensure kitchen equipment was in safe operating condition. This failure is likely to cause all residents to not receive meals as scheduled or served food at unappetizing temperatures. The findings are: A. On 03/26/24 at 12:15 PM during observation of the steam table, one section of the steam table did not function. The steam table light was not on, the well dial was set to high, but the water in the steam well was cool to touch. There was not steam in the water well. A pan of pork chops placed in the well measured 129 degrees ( ) Fahrenheit (F). B. On 03/25/24 at 1:30 PM, during an interview with the Dietary Director (DD), he confirmed the problems with the steam table.