STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325076	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Healthcare and Rehab Center	1400 West 21st Street Clovis, NM 88101

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on an interview, record review, and facility policy review, the facility failed to ensure the resident's right to participate in the care planning process for two of two residents (Resident (R) 32 and R48) reviewed for care plans out of a total sample of 23. This failure placed the residents at risk for unmet care needs due to a lack of resident involvement in their care. Findings Include: 1. Review of R32's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R32 was admitted to the facility on [DATE] with diagnoses that included bipolar disease. It was recorded R32 was her own representative. Review of R32's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/24 and located under the MDS tab of the EMR, revealed R32 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. Review of R32's Progress Note, dated 07/18/24 at 2:35 PM and located under the Progress Notes tab of the EMR, revealed a care plan meeting note. It was recorded neither R32 nor her family were in attendance. During an interview on 07/23/24 at 10:20 AM, R32 stated she had not participated in her care plan meeting but would like to attend. During an interview on 07/25/25 at 3:52 PM, the Social Service Director (SSD) stated care plan meetings were scheduled based on MDS assessments. The SSD stated families were notified by email or regular mail, and residents were provided a letter. The SSD stated there were no sign-in sheets for the care plan meetings, but care plan notes were used to document attendance. The SSD was asked to provide documentation that R32 had been invited and/or attended her care plan meeting. The SSD reviewed the documentation and stated she was unable to find any documentation of a letter inviting R32 to the care plan meeting or any information related to attendance in the care plan notes. During an interview on 07/26/24 at 10:00 AM, the SSD was asked to provide any documented evidence R32 had been invited to her care plan meetings. No information was provided before the end of the survey. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R48's Admission Record, located under the Profile tab of the EMR, revealed R48 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus. It was recorded that R48 was her own representative. Review of R48's MDS tab of the EMR revealed MDS assessments were completed for R48 with ARDs of 11/07/23, 02/07/24, 05/09/24, and 06/03/24. Review of R48's significant change MDS, with an ARD of 06/03/24 and located under the MDS tab of the EMR, revealed R48 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R48's Progress Note, dated 05/16/24 at 11:17 AM and located under the Progress Notes tab of the EMR, revealed a care plan meeting note that recorded R48 had been invited to her care plan meeting. It was recorded the SSD, Unit Manager, and Activities personnel had attended. During an interview on 07/23/24 at 10:20 AM, R48 stated, I know I am supposed to have a care plan meeting. R48 stated she had not had a care plan meeting since admitting to the facility. During an interview on 07/25/25 at 3:52 PM, the SSD stated care plan meetings were scheduled based on when MDS assessments were completed. The SSD was asked to provide documentation R48 had been invited to and/or attended her care plan meetings. The SSD provided a letter dated 02/02/24 for a care plan conference to be held on 02/08/24. During an interview on 07/26/24 at 10:00 AM, the SSD was asked to provide any documented evidence R48 was invited to her care plan meetings. No information was provided before the end of the survey. Review of the facility's policy titled, Person-Centered Care Planning, revised 10/24/22, revealed, . Person-centered care means to focus on the patient as the locus of control and support the patient in making their own choices and having control over their daily life. The patient has the right to: Participate in development and implementation of the person-centered care plan; request meetings and revisions to the person-centered care plan; be informed in advance of changes to the plan of care; and see the care plan, including the right to sign after significant changes to the plan of care .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450 Based on observation, interview, record review, and facility policy review, the facility failed to ensure restorative services were provided as ordered by the physician for five of eight residents (Residents (R) 47, R54, R46, R11, and R34) reviewed for restorative services out of a total sample of 23. This had the potential to cause avoidable decline in the residents' functional abilities. Findings include: 1. Review of R37's Face Sheet, located in the Profile tab of the electronic medical record (EMR,) revealed R37 was admitted to the facility on [DATE] with diagnoses including quadriplegia, contracture of the right and left hand, and obesity. Review of R37's Restorative Nursing Referral, dated 03/27/24 and located in the restorative nursing binder in therapy, revealed R37 was to receive exercises of passive range of motion (ROM) five times a week to the upper extremities by the Restorative Nursing Assistant, who was Certified Nursing Aide (CNA)1. Review of R37's Restorative Nursing Care Plan, dated 03/27/24 and located in the restorative nursing binder in therapy, revealed R37 was at risk for decline of range of motion, and the goal was to maintain or increase range of motion and prevent further contractures. It was recorded that R37 was to receive exercises five times a week and passive range of motion to all upper extremities. Review of R37's Physician Orders, dated 04/22/24 and located in the Orders tab of the EMR, revealed an order for Restorative Nursing Program (RNP) for passive range of motion to bilateral upper extremities five times a week. Review of R37's quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR and with an Admission Reference Date (ARD) of 06/12/24, revealed R37 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15, which indicated his cognition was intact. It was recorded R37 needed total assistance with Activities of Daily Living (ADL). It was recorded R37 had received 15 minutes of restorative services on one day out of the preceding seven day. Review of R37's Point of Care Response record, dated 07/01/24 through 07/25/24 and located in the restorative nursing binder in therapy, revealed R37 only received passive range of motion 11 out of 20 possible times. During an observation and interview on 07/23/24 at 11:53 AM in R37's room, R37 revealed he could not move his left arm or leg. Observation further revealed the fingers on his right hand were bent, and he could not open them. He stated he was supposed to get restorative services to prevent worsening, but he had not had any restorative done. During an interview on 07/25/24 at 4:14 PM, LPN3 confirmed that restorative services were only provided by CNA1 and not by the CNAs working on the floor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R54's Face Sheet, located in the Profile tab of the EMR tab, revealed R54 was admitted to the facility on [DATE] with diagnoses of schizophrenia, dementia, wandering, anxiety, and Alzheimer's disease. Review of the Restorative Nursing Referral, dated 06/25/24, revealed R54 was to have active range of motion to the upper body extremities, upper body 10-inch red digiflex 40 times, flexion to upper body 40 times, two-pound dumb bell curls times, hip circles, marches, and ankle pumps seven times a week. Review of R54's Physician Orders, located in the Orders tab in the EMR and dated07/01/24, revealed an order for restorative nursing to do active range of motion to the upper body extremities, upper body 10-inch red digiflex 40 times, flexion to upper body 40 times, two-pound dumb bell curls 40 times, hip circles, marches, and ankle pumps seven times a week. Review of R54's admission MDS, located in the MDS tab in the EMR and with an ARD of 07/01/24, revealed R54 had a BIMS score of 12, out of 15 which indicated the resident was cognitively intact. Review of the MDS further revealed she needed minimal assistance with ADLs. Review of R54's Restorative Care Plan, dated 07/01/24 and located in the restorative binder in therapy, revealed a problem of being at risk for decreased muscle strength and the goal was for her to maintain or increase muscle strength. The interventions included resistance exercises using the referral information seven times a week. Review of the Point of Care Response history log, dated 07/01/2014 through 07/25/24 and located in the restorative book in therapy, revealed R54 received only restorative nursing services on 12 days out of a possible 25 days. During an interview on 07/23/24 at 10:48 AM, R54 revealed she was supposed to receive restorative services at least five times a week. R54 stated she had not received the therapy like it was ordered because the staff person that did the therapy had another job with the facility and had to drive a van and could not do her restorative services when she was out of the building. R54 further revealed there was no one else to do restorative when the staff person was gone. 3. Review of R46's Face Sheet, located in the Profile tab of the EMR, revealed R46 was admitted to the facility on [DATE] with diagnoses including spinal stenosis, hypertension, cervical disc disease, diabetes, heart failure, atrial fibrillation, pressure ulcer, and atherosclerotic disease. Review of R46's quarterly MDS, with an ARD of 04/29/24 and located in the MDS tab in the EMR, revealed R46 had a BIMS score of 14 out of 15, which indicated his cognition was intact. Review further revealed R46 needed moderate supervision assistance with ADLs. Review of R46's Physician's Orders, dated 05/19/24 and located in the Orders tab of the EMR, revealed an order for restorative nursing program for bilateral left extremity active range of motion and transfer training/standing five times a week. Review of R46's Restorative Nursing Referral, dated 05/20/24 and located in the restorative nursing binder in the therapy room, revealed R46 was to receive exercises with active range of motion to right and left lower extremities five times a week. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's Restorative Nursing Assistant Care Plan, dated 05/21/24 and located in the restorative binder in therapy, revealed R46 was at risk for decline in range of motion, muscle strength, contracture formation. Review further revealed the goals were to maintain or increase range of motion, muscle strength, improve function of extremities, and prevent contractures. Review of the interventions for physical and occupational restorative were to have bilateral lower extremities exercises five times a week. Review of the Point of Care Response history log, dated 07/01/24 through 07/25/24, R46 had received occupational restorative seven times for the month of July and physical restorative eight times. It was documented the resident had refused twice. 4. Review of R11's Face Sheet, located in the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses of kidney failure, obesity, anemia, osteoarthritis, muscle weakness, difficulty walking, atrial fibrillation, and abnormal gait. It was recorded R11 was out of the facility from 07/15/24 through 07/18/24. Review of R11's quarterly MDS, located in the MDS tab of the EMR and with an ARD of 06/27/24, revealed R11 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of the MDS further revealed R11 needed supervision with some ADLs. Review of R11's Physician Orders, dated 07/19/24 and located in the Orders tab of the EMR, revealed he was to resume restorative nursing with exercises three times a week for right and left lower extremity active range of motion. Review of R11's Restorative Nursing Referral, dated 07/12/24 and located in the restorative binder in the therapy room, revealed he was to have exercise three times a week for right and left lower extremity active range of motion. Review of R11's Restorative Nursing Assistant Care Plan, dated 07/12/24, revealed R11 was at risk for decline in muscle strength and range of motion. The care plan further revealed R11 was to have exercises three times a week for right and left lower extremities to maintain or increase range of motion and strength. Review of R11's Point of Care Response history log dated 07/01/24 through 07/25/24, revealed no documented evidence R11 received any restorative services. 5. Review of R34's Face Sheet, located in the Profile tab of the EMR, revealed R34 was admitted to the facility on [DATE] with diagnoses of schizophrenia, muscle weakness, contracture of the right and left hand, and segmental and somatic dysfunction. Review of R34's Restorative Nursing Referral, dated 01/03/24, revealed restorative was to apply hand carrots to both hands seven days a week for six hours a day. Review of R34's Physician's Order tab revealed no order for restorative services. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R34's quarterly MDS, with an ARD of 05/21/24 and located in the MDS tab of the EMR, revealed R34 a BIMS score of 12 out of 15, which indicated she was moderately impaired cognitively. Review of the MDS further revealed R34 was dependent on staff for her care needs. Review of the MDS revealed R34 had impairment on both upper and lower extremities and splinting was done on one day out of the seven day look back. Review of R34's Point of Care Response history, dated 06/28/24 through 07/26/24, revealed passive range of motion had only been provided once. There was no documented evidence hand carrots had been applied as per the referral. During an observation on 07/23/24 at 4:30 PM, R34 was sitting up in her wheelchair. Her right and left hands were noted to be contracted, and she did not have carrots in her hands. During an interview on 07/23/24 at 4:30 PM, R34 stated she was supposed to have carrots placed in her hands, but the staff did not apply them, R34 stated she had to place the carrots herself if she could get someone to get them out of the drawer for her. R34 revealed the carrots would slip out of her hands, and she could not get them back on. During an observation and interview on 07/24/24 at 3:47 PM, R34 was noted to not have hand carrots in place. R34 stated she had worn the carrots briefly on this day, but they had come off, and she did not put them back on. During observations on 07/25/24 at 7:42 AM and 10:42 AM, R34 did not have the carrots in place During an interview on 07/25/24 at 4:40 PM, the Occupational Therapy Assistant OTA stated R34 restorative services were supposed to apply R34's carrots to her hands. During an interview on 07/26/24 at 2:35 PM, the MDS Coordinator (MDSC) stated she did not play much of a part with restorative until recently when she started inputting the physician orders from the therapy to restorative referrals. The MDSC stated she would look at the documentation of what restorative had been done but did not physically monitor that restorative was being done. The MDSC stated she was aware that restorative was not being consistently done as ordered, and she had brought it to the attention of the team's management and told them the facility was going to get into trouble because restorative was not being offered. The MDSC revealed she became aware of the gaps in care when she was doing the MDS for the restorative portion. Continuing with the interview on 07/26/24 at 2:35 PM, the MDSC stated when she asked CNA1 about the gaps in documentation for restorative, CNA1 told her that she was busy and did not have time to do all the restorative due to having to drive the van all the time. The MDSC stated R34 did not even get on CNA1's case load. The MDSC revealed the reason R34 did not receive restorative like the referral had outlined was because the referral was entered incorrectly, and therefore, did not pull over in the system to alert the CNA1. During an interview on 07/25/24 at 4:30 PM, CNA1stated she could not complete all the restorative that needed to be done for the residents. CNA1 stated she had to be the transport driver for the residents to and from appointments and had to pick up new admissions. CNA1 stated when she had to drive the van, restorative services did not get done. CNA1 stated the facility's transport driver had left in September 2023, and they had not been replaced. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuing with the interview on 07/25/24 at 4:30 PM, CNA1 stated the lack of restorative for the residents could cause possible declines in their daily living, walking and ADLs. CNA1 stated the lack of restorative had the potential for the residents to be less independent. CNA1 confirmed that all restorative that was done was documented on the Point of Care Response history log, and if there was no documentation listed, then the restorative was not done. During an interview on 07/25/24 at 7:29 PM, the Administrator stated her expectations were if therapy recommended restorative, then restorative should have been done to maintain the resident's functional ability. The Administrator stated she thought there may have been one or two other CNAs that would do restorative when CNA1 was gone, but she was not sure. Review of the facility's policy titled, Restorative Nursing, revised 08/0723, revealed, . centers may provide restorative nursing programs for patients who: are admitted with restorative needs but are not candidates for formalized rehabilitation therapy; have restorative needs arise during the course of a longer stay; will benefit from restorative programs in conjunction with formalized rehabilitation therapy . to promote the patient's ability to adapt and adjust to living as independently and safely as possible. To help the patient attain and maintain optimal physical, mental, and psychosocial functioning. Restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. A licensed nurse must supervise the activities in a restorative nursing program .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observation, interview, record review, and facility policy review, the facility failed to provide an ongoing program of activities to meet the needs and interests of five of six residents (Resident (R) 43, R38, R47, R22, and R42) reviewed for activities out of a total sample of 23. This failure had the potential to cause diminished quality of life for all residents who resided on the dementia care unit. Findings include: Review of R43's quarterly Minimum Data Set (MDS), located under the MDS tab of the electronic medical record (EMR) and with an Assessment Reference Date (ARD) of 05/27/24, revealed R43 was admitted to the facility on [DATE]; had diagnoses of schizophrenia, dementia with other behavioral disturbances, and cognitive communication deficit; and was coded as being severely impaired for cognitive skills for daily decision making. Review of R43's Care Plan, revised 06/06/24 and located under the Care Plan tab of the EMR, recorded it was important for R43 to have the opportunity to engage in daily routines that were meaningful relative to her preferences and with assistance such as bingo, ball toss, art/crafts, painting, relaxing outside, pet visits, music activities, nail painting and activities involving food and drinks. Interventions included encouraging and assisting with the activities, to verbally invite to activities, and providing a monthly activity calendar. Review of R38's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 05/09/24, revealed R38 was admitted to the facility on [DATE]; had diagnoses of dementia with other behavioral disturbances, schizophrenia, Alzheimer's disease, and violent behaviors; and had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated R38 was severely cognitively impaired. Review of R38's Recreational Quarterly Evaluation, located under the Progress note tab of the EMR and dated 05/09/24, revealed R38 participated in activities with snacks and food and pet visits and was active in both group/independent activities. Review of R47's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 04/24/24, revealed R47 was admitted to the facility on [DATE], had diagnoses of dementia and anxiety, and had a BIMS score of five out of 15, which indicated R38 was severely cognitively impaired. Review of R47's Care Plan, revised 04/25/24 and located under the Care Plan tab of the EMR, recorded R47 was at risk for limited and/or meaningful engagement related to cognitive impairment and exit seeking behaviors. Interventions included encouraging and assisting her to participate/attend activities such as arts/crafts, painting, relaxing outside, and active activities. Review of R22's significant change MDS, located under the MDS tab of the EMR and with an ARD of 06/14/24, revealed R22 was admitted to the facility on [DATE]; had diagnoses of post-traumatic stress disorder, major depressive disorder, psychosis, anxiety disorder, and dementia; and had a BIMS score of six out of 15, which indicated R22 was severely cognitively impaired. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R22's Care Plan, revised 06/2024 and located under the Care Plan tab of the EMR, recorded R22 was at risk for limited and/or meaningful engagement related to cognitive impairment/emotional behaviors. Interventions included encouraging and assisting her to participate/attend activities of interest and to encourage and facilitate the resident's activity preferences such as bingo, arts/crafts, games, pet visits, church services, and socials. The care plan recorded R22 . participates/observes in most activities . Review of R42's significant change MDS, located under the MDS tab of the EMR and with an ARD of 06/30/24, revealed R42 was readmitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, hepatic encephalopathy, mild neurocognitive disorder, major depressive disorder, post-traumatic stress disorder, history of falling, and dementia with agitation; and had a BIMS score of five out of 15, which indicated R42was severely cognitively impaired. Review of R42' Care Plan, revised 06/25/24 and located under the Care Plan tab of the EMR, recorded it was important that R42 have the opportunity to engage in daily routines that were meaningful relative to his preferences such as relaxing, taking naps, listening to music (Jazz; Country), talking on the phone, watching TV (Baywatch, Game Shows), praying, and reading. It was recorded that R42 enjoyed being outdoors, playing Bingo, and having pet visits. Interventions included to encourage and assist him to participate/attend activities. During intermittent observations on 07/23/24 from 10:30 AM through 2:21 PM, R43, R38, R47, and R22 were observed repeatedly walking up and down the halls of the dementia care unit and into and out of the dining room/common area and resident rooms. R42 was observed either sitting in his room or in the common area or lying in bed. R43, R22 and R38 attempted to open the locked door on the unit several times. No activities were observed occurring on the dementia care unit. During an observation on 07/23/24 at 2:22 PM, R47 kept repeatedly removing her shoes and socks. Certified Nurse Aide (CNA) 2 stated it was the fourth time she had to put R47's shoes back on her. During an interview on 07/23/24 at 3:49 PM, CNA2 was asked about the residents walking around and the lack of activities. CNA2 stated there were no activities conducted or offered to the residents on 07/23/24 because the facility did not have an Activity Aide for the unit. During observations on 07/23/24 at 4:00 PM and 4:13 PM, R38 approached CNA2 and asked her what time breakfast was. Each time, CNA2 told R38 that they would be serving dinner soon. R38 replied she was hungry, and each time, CNA2 told her to go to her room to lay down and relax, and she would get her when the food cart arrived. On 07/24/24, intermittent observations were conducted on the dementia care unit from 9:15 AM to 4:30 PM. During the observations, the residents were observed walking around the unit and occasionally attempting to push the doors open. No activities were observed occurring on the dementia care unit. During an observation on 07/24/24 at 10:58 AM, R38 repeatedly pushed on the locked door asking, Where should I go? She then walked into the dining room and stated she guessed she would go out the window. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/24/24 at 2:30 PM, R43 and R22 were assisted off the unit to a birthday party in the main dining room on the 200 unit and returned to the dementia care unit at 3:00 PM. This was the only activity offered to R22 and R43 that day. During an interview on 07/24/24 at 3:10 PM, CNA2 stated there had been an employee who provided activities on the dementia care unit a couple of days a week for about three weeks in June, and the residents really enjoyed it and participated in the activities. She stated the employee stopped doing the activities and went to be a night shift CNA, and they had not had any activities on the unit since she left. CNA2 stated all the residents participated in most of the activities, and the residents were more occupied and exhibited less behaviors when they had activities on the unit. She stated occasionally they would take R43 and R22 off the unit for birthday parties and for Bingo on Fridays. CNA2 stated they did not take R47 and R38 off the unit to participate in any activities because they would refuse to return to the unit. During an interview on 07/24/24 at 4:19 PM, Licensed Practical Nurse (LPN) 2 stated the residents were more occupied and they had fewer behaviors when they were involved in activities throughout the day. On 07/25/24, intermittent observations were conducted on the dementia care unit from 8:39 AM through 11:05 AM. R42 was observed in bed during each observation. R38, R47, R43 and R22 were again observed walking around the unit. No activities were observed occurring on the dementia care unit. On 07/25/24 at 6:14 PM, the Activity Director (AD) confirmed that there were not any activities provided on the dementia care unit during the days of the survey. She stated there had been an Activity Aide who worked on the dementia care unit up until October 2023. The AD stated they had not conducted activities on the dementia care unit since January 2024, except for a couple of weeks in June 2024, when there had been an Activity Aide. The AD stated the Activity Aide had also been responsible for transportation and central supply duties as well and was frequently pulled to work as a CNA. She stated the Activity Aide now worked as a CNA on the night shift. During an interview on 07/25/24 at 8:03 PM, the Administrator stated they did not have any staff to provide activities on the dementia care unit. She stated there was someone lined up for the position; however, she did not know how long it would take to get the employee through the hiring process. Review of the facility's policy titled, Recreation Services Policies and Procedures reviewed 08/07/23, recorded it was the policy of the facility to . provide an ongoing person-centered recreation program that incorporates the individual's interests, hobbies, and cultural preferences which are integrated to maintaining and improving a resident's/patient's physical, mental, and psychological well-being and independence .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observation, interview, record review, and facility policy review, the facility failed to: 1. Ensure the environment was free of accident hazards when water temperatures were not maintained at a safe temperature level for six of 20 residents (Resident (R) 31, R23, R43, R22, R18, and R41) residing on the dementia care unit. 0n 07/19/24, water temperatures at the hand washing sinks on the dementia care unit were recorded to be 123.4 degrees Fahrenheit (F). Water temperatures were adjusted but no monitoring occurred. On 07/24/24, water temperatures in two resident bathrooms were noted to be 122 degrees F and 125 degrees F. The water temperatures were not adjusted after water was measured to be in excess of 120-degree F. The failure to maintain water temperatures at a safe level had the potential to cause serious burns or injuries for the residents, and 2. Provide supervision to prevent accidents related to falls for one of three residents (R42) reviewed for falls out of total sample of 23. The facility failed to assess R42 after falls and failed to attempt to identify and implement interventions to prevent future falls and/or injury. This had the potential to cause R42 to sustain additional falls and injury. The facility's failure to ensure the environment was free of accident hazards by not maintaining safe water temperatures placed residents at continued risk of serious injury, harm, or impairment. Immediate Jeopardy at S483.25(d) - Accidents, at a Scope and Severity of a J, was identified on 07/24/24 and was determined to exist on 07/19/24 when hot water temperatures in excess of 120-degree F were first noted on the dementia care unit, and resident rooms were not monitored for safe water temperatures. The Administrator and Director of Nursing (DON) were informed on 07/25/24 at 4:28 PM. The facility provided an acceptable removal plan on 07/25/24 at 8:15 PM. The survey team validated implementation of the removal plan through observations of water temperatures, review of education documentation, and by interview with staff and the professional plumber. Immediate Jeopardy was removed on 07/26/24 at 3:17 PM. After removal of the Immediate Jeopardy, the deficiency remained at an E scope and severity for a pattern of potential harm. Findings include: 1. Water Temperatures a. Review of R31's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/21/24 and located under the MDS tab of the electronic medical record (EMR) revealed R31 was admitted to the facility on [DATE] and had severely impaired cognition. It was recorded R31was able to walk independently. Review of R31's Diagnosis tab of the EMR revealed R31 had diagnoses that included diabetes mellitus, dementia, and depression. R31 resided on the dementia care unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R28's quarterly MDS, with an ARD of 03/21/24 and located under the MDS tab of the EMR, revealed R28 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated he was moderately cognitively impaired. It was recorded R28 utilized a wheelchair for mobility. Review of R31's Diagnosis tab of the EMR revealed R28 had diagnoses that included hemiplegia and depression. R28 resided on the dementia care unit. During an observation on 07/24/24 at 1:15 PM, the water temperature at the bathroom sink utilized by R31 and R28 was checked with the Maintenance (MD) using his thermometer. The water temperature was 122 degrees F. On 07/24/24 at 3:10 PM, Certified Nurse Aide (CNA) 1 stated R31 could turn the water on independently and R28 needed assistance with turning the water on. b. Review of R43's quarterly MDS, with an ARD of 05/27/24 and located under the MDS tab of the EMR, revealed R43 was admitted to the facility on [DATE] and was severely impaired in cognitive skills for daily decision making and was independent with walking. Review of R43's Diagnosis tab of the EMR revealed R43 had diagnoses that included schizophrenia, dementia with other behavioral disturbances, and cognitive communication deficit. Review of R22's significant change MDS, with an ARD of 06/14/24 and located under the MDS tab of the EMR, revealed R22 was readmitted to the facility on [DATE] and had a BIMS score of six out of 15, which indicated R22 was severely cognitively impaired. It was recorded R22required supervision with walking. Review of R22's Diagnosis tab of the EMR revealed R22 had diagnoses that included post-traumatic stress disorder, major depressive disorder, psychosis, anxiety disorder, and dementia. R22 was observed ambulating independently on 07/23/24 and 07/24/24. Review of R18's annual MDS, with an ARD of 04/06/24 and located under the MDS tab of the EMR, revealed R18 was admitted to the facility on [DATE] and was severely impaired in cognitive skills for daily decision making. It was recorded R18 walked independently. Review of R18's Diagnosis tab of the EMR revealed R18 had diagnoses that included Alzheimer's disease and depression. Review of R41's quarterly MDS, with an ARD of 05/16/24 and located under the MDS tab of the EMR, revealed R41 was admitted to the facility on [DATE] and was severely impaired in cognitive skills for daily decision making. It was recorded R41 was unable to walk. Review of R41's Diagnosis tab of the EMR revealed R41 had diagnoses that included Alzheimer's disease and dementia. During an observation on 07/24/24 at 1:23 PM, the water temperature at the bathroom sink used by R43, R22, R18 and R41 was checked with the MD using the facility thermometer, and it was noted to be 125 degrees F. On 07/24/24 at 3:10 PM CNA1 stated R43 could turn the water on independently, and she felt the resident could ensure the water was not too hot. CNA1 stated R22 could only turn the water on with help. She stated R18 and R41 did not turn the water on independently but potentially could. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Review of temperature monitoring logs, provided by the facility, revealed water temperatures were taken on 10 days during the previous three months. There was no documentation that water temperatures were taken in any resident room. It was recorded that on 07/19/24, the hot water temperatures in the North Hall Sink and South Hall Sink were 123.4 F. There was no documentation that water temperatures were tested in any resident rooms after the water was noted to be 123.4 F on 07/19/24 or that any monitoring occurred. During an interview on 07/25/24 at 8:25 AM, the MD stated he could not find a policy related to hot water temperatures, but he had been informed the water temperatures should be maintained between 110 F and 120 F. The MD stated on 07/19/24, he did adjust the hot water temperature and checked the temperature at the sinks in residents' bathrooms close to the North and South Hall sinks, but he did not document those results. The MD confirmed he did not check the hot water temperature in resident rooms unless the hot water temperatures at the hand sinks on the North and/or South halls exceeded 120 F. The MD stated that he had not monitored the resident room water temperatures after 07/19/24 until checking with the surveyor on 07/24/24. On 07/25/24 at 10:51 AM, the MD was asked to recheck the water temperatures at the bathroom sinks for R32, R28, R43, R22, R18, and R41. The MD obtained the water tempertures and reported they were 119 degrees F. He stated he did not adjust the hot water temperatures on 07/24/24 after the temperatures obtained were more than 120 F. The MD stated he adjusted the hot water on this date, 07/25/24, right after he learned of the surveyor's request to recheck them. During an interview on 07/26/24 at 3:17 PM, the plumber who came to service the water heaters stated the hot water heater servicing the dementia care unit needed a new mixing valve. He stated the hot water temperatures were steady at 110 degrees F for now. Review of the facility's policy titled, Preventive Maintenance Policies and Procedures PM202 Hot Water Temperatures: Inspection, with a revision date of 01/08/24, revealed the policy was to test water temperatures daily. The policy recorded, . Conduct test in at least three locations . These locations should be the closest, median, and farthest points from the source . If the temperature does not meet State or Local regulations, the facility will investigate and adjust the mixing valve . 2.Falls Review of R42's significant change MDS, with an ARD of 06/30/24 and located in the MDS tab of the EMR, revealed R42 was admitted to the facility on [DATE] and had a BIMS score of five out of 15, which indicated he had severe cognitive impairment. It was recorded R42 had inattention and disorganized thinking; had functional limitation in range of motion to both lower extremities; required substantial/maximal assistance with dressing, personal hygiene, lying down, and transfers; did not walk; and was always incontinent. It was recorded R42 had falls with injuries since the prior assessment. Review of R42's Diagnosis tab of the EMR revealed R42 had diagnoses that included alcoholic cirrhosis of the liver, encephalopathy, vascular dementia with agitation, major depressive disorder, hepatic encephalopathy, post-traumatic stress disorder, chronic migraine, paranoid schizophrenia, cognitive communication deficit, muscle weakness, abnormalities of gait and mobility, and a history of falling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R42's Care Plan, dated 05/05/23 and located under the Care Plan tab of the EMR, revealed a problem related to being at risk for falls due to cognitive loss, lack of safety awareness, history of falling, bilateral primary osteoarthritis of knee, and sleep apnea. Interventions included a bed in low position and fall mats with a created date of 07/02/24; to provide safe place for the resident to lie on the floor with a created date of 07/02/24; to assist to organize belongings for a clutter-free environment in resident's room; and to encourage to attend activities. Review of R42's Progress Notes tab of the EMR and/or Incident Reports, provided by the facility revealed the following: A progress note, dated 06/05/24 and timed 3:08 PM, recorded the writer heard a loud noise then R42 called out, I fell down. Upon entering the room, R42 was sitting on the floor at the side of his bed. According to the note, the resident was not injured. A paper Fall incident report, dated 06/08/24 and timed 11:36 PM, recorded two nurse aides found the resident on the floor. The note recorded the fall had not been witnessed. R42 stated he needed to use the toilet, was walking across the room, and when he was in the doorway, he lost his balance and fell beside his toilet. According to the report, R42 had no visual injuries but stated he hit his head. A progress note, dated 06/09/24 and timed 2:17 AM, recorded two nurse aides found the resident on the floor. The note recorded the incident was not witnessed, and the resident claimed he hit his head and denied pain. A social service progress note, dated 06/20/24 and timed 11:24 PM, recorded the Social Service Director (SSD) was visiting another resident in the dementia care unit when the SSD heard R42 calling from his room. The SSD observed R42 lying on the floor outside of his bathroom. According to the note, the resident stated it was because he had a migraine. The SSD wrote she informed the south nurse and the nurse aide regarding the resident being on the floor. Review of the EMR revealed there was no nursing documentation related to this fall. A nursing note, dated 06/29/24 and timed 10:33 AM, recorded while the nurse was assisting with care, she noted a very large bruise to the left buttocks. The nurse wrote, . the bruise covers left buttocks and smaller bruise noted to left hip .Also, small spot noted to top of head with a small amount of blood noted . A nursing note, dated 06/29/24 and timed 5:46 PM, recorded clarification to the previous note and stated the area on the top of R42's head was soft, but the resident would not allow the nurse to touch it. The medical record was reviewed in its entirety and was silent for an investigation into how the injuries occurred or any additional interventions to prevent further injuries. A nursing progress note, dated 6/29/24 and timed 9:15 PM, recorded the resident fell on the floor in his room and hit his head. His pants and briefs were around his ankles. R42 stated he needed to use the bathroom. The note recorded he had a recent change in condition and was no longer aware of safety risks and the decline in physical abilities to do things. R42's EMR was reviewed in its entirety and was silent for further assessment of this fall or of additional interventions put in place to prevent further falls or injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 07/13/24 and timed 8:14 PM, recorded the nurse aides reported that R42 had a small bruise and hematoma to the left side of his head. It was recorded that the writer had noted a large bruise on R42's forehead and the top of his head when she arrived on shift. She wrote there was no documentation of the bruise on the right side of the forehead and the top of his head. She wrote, . not sure how this resident ended up with these bruises. He was on the floor crawling around most of the night but stated he thinks he must have hit his head on the floor when he climbed out of bed but is not totally sure. The EMR was reviewed in its entirety and was silent for an assessment of how R42 could have obtained the hematoma and bruises. A nursing progress note, dated 07/20/24 and timed 6:31 AM, recorded upon receiving report from the night nurse, the night shift CNAs voiced to this nurse that R42 had a lot of bruising to right side of face. The nurse wrote upon entering the room, bruising was noted to the right side of his face, nose, eye, forehead, cheek, and the top of his head. It was recorded, . The bruising is red and purple in color. Resident is unable to tell me what happened at this time. Bruising also noted to bilateral knees and bilateral arms . The fall incident report, dated 07/20/24 and timed 6:31 AM, stated upon arriving to the evening shift it was noted the resident had swelling around the right eye and forehead. The note recorded the day nurse said he had been on the floor throughout the day but did not know what happened. The note recorded the swelling and bruising became extremely worse. The EMR was reviewed in its entirety and was silent for an assessment of how he potentially obtained the hematoma and bruises. A nursing note, dated 07/21/24 and timed 5:00 PM, recorded the resident was found lying on floor mat with his feet facing towards this bed and his head towards the roommates' bed near the wall. It was recorded R42 already had bruising to the right side of his face, and he stated he was trying to pull the call light out of the wall so it could call 911 because he had a migraine headache. During an observation on 07/23/24 at 10:32 AM, R42 was seen sitting on the floor in his room, holding onto the wall close to the bathroom and across the room from his bed. Staff were immediately notified and Licensed Practical Nurse (LPN) 2 and Certified Nurse Aide (CNA) 2 came down to the room with the gait belt. They lifted him up into the wheelchair with the gait belt and asked him if he wanted to go to the common area or to bed or in room and he stated no to all the questions. CNA2 stated he had been in bed prior to finding him on the floor. The bed was low, and the fall mat was beside the bed; however, the call light was not in reach as it was clipped to the wall and not within reach of his bed. LPN2 verified the call light was not in reach. LPN2 and CNA2 stated R42 typically did not use the call light by his bed and would attempt to go into the bathroom to pull the bathroom call light. They left the room leaving the resident in his room in a wheelchair by the window. CNA2 and LPN2 both stated R42 frequently got out of bed and attempted to walk or crawl around on the floor. R42 was noted to have fading bruise to his right eye, right side of his face, and the top of his forehead. During an interview on 07/25/24 at 2:30 PM, the DON was interviewed about R42's incidents. When ask if R42 had any interventions added to his care plan after the falls, the DON stated he was moved from the 200 unit to the last room on the dementia care unit, furthest way from the nursing station; had floor mats and low bed put in place on 06/04/24; and had some blood draws/laboratory completed on 06/12/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continuing with the interview on 07/25/24 at 2:30 PM, the nursing progress notes dated 06/20/24 and timed 11:24 PM; 06/29/24 and timed 9:15 PM; 06/29/14 and timed 10:33 AM; 07/13/24 and timed 8:14 PM; 07/20/24 and timed 6:31 AM; 07/21/24 and timed 5:00 PM were reviewed with the DON. The DON was unable to provide any additional documentation to show assessments were completed to determine the cause of R42's bruising or that any additional interventions were put in place to prevent further falls and/or injuries. The DON stated that she and her staff discussed moving him to a private room closer to the nursing station earlier that week; however, they had not moved him. During an interview on 07/26/24 at 10:58 AM, the Social Worker from R42's hospice company stated she had been providing services for the resident since he was admitted to hospice on 06/24/24. She stated she was very concerned about the bruising the resident had. She stated the staff tell her he crawls around on the floor. She stated that on 07/02/24 at 3:00 PM she had a meeting with the facility social worker and a Registered Nurse, and during the meeting they discussed the falls and injuries. The hospice social worker stated she was told they would move R42 to a room closer to the nursing station.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 22411 Based on interview and facility policy review, the facility failed to post the actual hours worked for the licensed and unlicensed nursing staff, including Registered Nurses, Licensed Nurses, and Nursing Assistants. This had the potential to affect 59 of 59 residents who resided at the facility and any visitors to the facility. This had the potential to cause residents and staff to be uninformed of the facility's staffing data. Findings include: During observations on 07/23/24 at 9:00 AM, 07/23/24 at 12:31 PM, 07/24/24 at 1:55 PM, and 07/25/24 at 7:59 AM, no nurse staffing information was noted to be prominently displayed and accessible for patients, visitors, and staff to review. During an interview on 07/25/25 at 8:50 PM, the Administrator was asked where the nurse staffing information was posted. The Administrator pointed to a bulletin board and stated, This is where we usually hang them, but the Velcro won't stick to the wall. The Administrator pointed to a box beside the business office door and confirmed the staffing sheets were in the box but were not posted so they could be seen. During an interview on 07/25/24 at 10:32 AM, the Director of Nursing (DON) stated the night shift was responsible for completing the staffing sheets. She stated there was an area where they were to be posted, but they would not stay attached to the glass case. The DON stated the staffing sheets were kept in a drawer in her office. Review of the facility's policy titled, Posting Staffing, dated 08/07/2,3 revealed, . In accordance with federal and state regulations, Centers will post the census, shift hours, number of staff, and total actual hours worked by licensed and unlicensed nursing staff who are directly responsible for patient care for each shift and on a daily basis .

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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. 03115 Based on observations, interviews, and documentation review, the facility failed to ensure food was stored and served in a sanitary manner. This had the potential to result in the spread of infections and food born illnesses for 59 of 59 residents residing in the facility. Findings include: 1. During an observation on 07/23/24 at 9:30 AM, the temperature of the walk-in refrigerator was 49 degrees Fahrenheit (F) on both the outside and inside thermometers. The refrigerator contained two large roasts; two large bags of lettuce; an open, partially used gallon container of mayonnaise; an open container of alfredo sauce; two large bags of cut up potatoes; two cases of margarine; and two boxes of angel food cake. The bags of lettuce did not have a use-by date on them because they had been removed from their original box. The lettuce in one of the bags was turning brown. On 07/23/24 at 10:13 AM, the refrigerator temperature remained at 49 degrees F. The Dietary Manager (DM) verified the temperature was 49 degrees F and stated they had been having problems with the refrigerator maintaining its' temperature for the past four months. The DM stated they had submitted a work order to have it fixed some time ago. She verified food was being stored in the refrigerator and stated she would expect the refrigerator temperature to be maintained between 35- and 40-degrees F. She stated there was only one other reach in the refrigerator, and it was not large enough to hold all the food. The temperature of food in the refrigerator was obtained using the facility thermometer. The potatoes were 44.4 degrees F, and the lettuce was 46.9 degrees F. The DM stated the food should have been held at 41 degrees F. Review of the facility's policy titled, Food Storage: Cold Foods, revised February 2023, recorded, . all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service . 2. During an observation on 07/23/24 at 9:40 AM and 9:47 AM, Cook1 was observed washing dishes in the low temperature dishwasher in the dish room. She was observed placing the soiled dishes on racks at the soiled end of the dishwasher, pushing the racks into the dishwasher, sticking her hands in a container with quaternary sanitizer, drying her hands with a paper towel, and then removing the clean dishes from the racks and placing them on a cart. At 9:47 AM, Cook1 was asked how she cleaned or sanitized her hands between touching the dirty dishes and touching the clean dishes. She stated she always sticks them in the container of sanitizing solution and then dries them off. During an interview on 07/25/24 at 10:18 AM, the District Manager of Health Care Service Group, the company contracted to provide the dietary services, was informed of how Cook1 sanitized her hands between the clean and dirty end of the dish washer. Cook1 was present and again verified this was the way she cleaned her hands. On 07/25/24 at 12:11 PM, the District Manager of Health Care Service Group stated it was not an approved way for Cook1 to clean her hands and stated she should be washing her hands between the soiled and clean end of the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 07/25/24 at 8:05 PM, the Administrator stated she would expect Cook1 to wash her hands between handling soiled and clean dishes. Review of the facility's policy titled, Food and Nutrition Services Policies and Procedures Hand Washing, revised 06/15/18, revealed hand washing was to be performed after contacting any soiled equipment or utensils. Review of the manufacturer's instructions on the Oasis 146 Multi-Quat Sanitizer, used by the facility as a sanitizer in the kitchen, revealed it was a surface disinfectant, and the instructions did not address or recommend using the product to sanitize hands. Review of the Safety Data Sheet for Oasis 146 Multi-Quat Sanitizer revealed, . only use for the purposes on the product sheet . Under handling it was recorded, . wash hands thoroughly after handling . 3. During observations on 07/23/24 at 9:48 AM and on 07/25/24 at 10:25 AM, the tops of the containers containing sugar packets, sugar substitute packets, and tea were noted to be soiled with food crumbs and dried brown food spills. The wood cabinet doors on the three cabinets over the food preparation counters were soiled and had a sticky feel where staff touched to open the doors. The cabinets contained cups and bowls. On 07/25/24 at 10:25 AM the District Manager of Health Care Service Group verified these observations and stated they would turn in a work order to get the wood cabinet doors resurfaced. 4. During an observation on 07/23/24 at 10:15 AM, two unopened five-pound containers of cottage cheese with a use-by date of 07/12/24 were noted in the reach in refrigerator. The top of one of the containers was bulging up. The DM was present during the observation and verified the use-by date had passed. 5. During an observation on 07/23/24 at 10:15 AM, two-16 ounce opened and partially used containers of Knorr Vegetable Base, with the date of 01/03/24 marked on them, were noted in the reach in refrigerator. The DM stated it was the date the containers had been opened. She stated the product should have been used or discarded within six months of it being opened and verified it had been over six months since they were opened. 6. During an observation on 07/23/24 at 1:20 PM, the refrigerator/freezer on the dementia care unit was inspected with the assistance of Licensed Practical Nurse (LPN) 2. LPN2 stated the refrigerator was only used to store food brought in for the residents. The freezer contained a breakfast hot pocket with an expiration date of June 2024, 14 individual Mom frozen dinners with manufacturer use-by date of 06/27/24 marked on them, a Factor frozen dinner with a manufacturer use-by date of 07/05/23 marked on it, and an unopened three-pound package containing 12 hamburger patties with a manufacturer use-by date of 11/20/23. LPN 2 verified the food items were past their use-by dates. Review of the facility's policy titled, Food: Safe Handling of Foods from Visitors, revised February 2023, revealed that the refrigerator/freezer storage area should be monitored daily, and any foods stored greater than 7 days or that are past the use by dates were to be discarded.

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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. 15879 Based on observation, interview, record review, and review of facility policy, the facility failed to administer medications in a manner to prevent cross contamination for five of eight residents (Resident (R) 18, R43, R9, R42, and R5) residents observed receiving medications out of a total census of 59 and failed to complete wound care in a manner to prevent cross contamination for one of one resident (R11) reviewed for pressure ulcers out of a total sample of 23. The failure had the potential to cause residents to be exposed to pathogens and increased the risk of infection. Findings include: 1. During an observation of the medication administration pass on 07/25/24 at 7:06 AM, Licensed Practical Nurse (LPN) 1 completed a blood pressure check for R18, gave the resident her medication, and returned to the medication cart. LPN1 did not sanitize or wash her hands after resident contact. Continuing with the medication administration observation on 07/25/24 at 7:17 AM, LPN1 prepared the medications for R43, completed a blood pressure check, gave the resident her medication, and went back to the medication cart. Without sanitizing or washing her hands. LPN1 applied gloves, cleaned the blood pressure cuff, doffed her gloves, and washed her hands. Continuing with the medication administration observation on 07/25/24 at 7:30 AM, LPN1 administered medication to R9. LPN1 did not sanitize or wash her hands after resident contact. Continuing with the medication administration observation on 07/25/24 at 7:32 AM, LPN1 prepared medication for R42, completed a blood pressure check, administered his medications, and returned to the medication cart. LPN1 did not sanitize or wash her hand after resident contact. Continuing with the medication administration observation on 07/25/24 at 7:33 AM, LPN1 prepared medication for R5, including an inhaler which had to opened and set up for the resident. LPN1 administered R5's medications and returned to the medication cart. LPN1 did not sanitize or wash her hands. During an interview on 07/25/24 at 7:40 AM, LPN1 confirmed she did not perform hand hygiene between residents while completing the medication pass. She stated hand hygiene should be performed every couple of residents and if the hands are soiled. During an interview on 07/25/24 8:45 AM, the Director of Nursing (DON) stated hand sanitizer should be used after contact with each resident and then after three resident contacts, staff should wash their hands. The DON stated if liquids or injections were used, staff should wash their hands before and after contact. The DON stated good hand hygiene should be done to provide infection control and not cross contaminate or carry germs to another resident. Review of the facility's policy titled, Genesis Health Care Hand Hygiene Policy, revised 11/10/20, revealed the policy was for all personnel to adhere to hand hygiene practices. to in order to reduce the transmission of pathogenic microorganisms. The policy recorded, . perform hand hygiene before resident care, after resident care, and after contact with the resident's environment . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 07/26/24 at 9:55 AM, LPN3 was observed preparing to do a wound treatment for R11. LPN3 donned her gloves, cleaned the left heel with wound cleanser, doffed her gloves, and without performing hand hygiene, donned new gloves. LPN3 mixed Silvesorb and collagen together and applied it to the open wound with her gloved finger. Without changing her gloves or performing hand hygiene, LPN3 applied a clean dressing to the wound. LPN 3 then removed her gloves and washed her hands. Continuing with the observation on 07/26/24 at 10:10 AM, LPN3 donned gloves and removed the dressing on R11's right ankle. A small amount of light yellow and red fluid was noted on the dressing. LPN3 cleaned the wound with wound cleanser on a gauze, patted it dry, and doffed her gloves. Without performing hand hygiene, LPN3 donned new gloves, applied Silvasorb and collagen (wound treatments) to the right ankle wound, and without changing her gloves or performing hand hygiene, applied a foam dressing. LPN3 then doffed her gloves and washed her hands. During an interview on 07/26/24 at 10:30 AM, LPN3 confirmed she did not change her gloves or perform hand hygiene as per infection control standards. LPN3 confirmed this increased the risk of more infection for R11. Review of the facility's policy titled, Genesis Procedure: Wound Dressing: Aseptic, revised 12/01/21, revealed when performing wound dressings, clean gloves should be applied, and the old dressing removed and discarded. It was recorded that new gloves should be applied when the wound was cleansed and patted dry, and when a medication was to be applied to the wound, a sterile swab or applicator should be used, and a clean dressing should be applied. It was recorded that if the gloves become contaminated, they should be removed, and new gloves should be applied.

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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. 03115 Based on observation, interview, and review of facility documents and policies, the facility failed to maintain the walk-in refrigerator to ensure it functioned properly and maintained a safe operating temperature. This had the potential to result in food-borne illness as the result of not holding food at a safe temperature level. This had the potential to affect 59 of 59 residents in the facility. Findings include: During an observation on 07/23/24 at 9:30 AM, the temperature of the walk-in refrigerator was 49 degrees Fahrenheit (F) on both the outside and inside thermometer. The refrigerator contained two large roasts; two large bags of lettuce; an open, partially used gallon container of mayonnaise; an open container of alfredo sauce; two large bags of cut up potatoes; two cases of margarine; and two boxes of angel food cake. On 07/23/24 at 10:13 AM, the refrigerator temperature remained at 49 degrees F. The Dietary Manager (DM) verified the temperature of 49 degrees F and stated they had been having problems with the refrigerator maintaining its' temperature for the past four months, and they had submitted a work order to have it fixed some time ago. She verified food was being stored in the refrigerator and stated she would expect the refrigerator temperature to be maintained between 35- and 40-degrees F. She stated they should not have had food in the refrigerator because it was not functioning properly to hold the food at safe temperature levels. She stated there was only one other reach in refrigerator, and it was not large enough to hold all the food. The temperature of food in the refrigerator was obtained using the facility thermometer. The potatoes were 44.4 degrees F, and the lettuce was 46.9 degrees F. She stated the food should have been held at 41 degrees F. A document titled, Direct Supply TELS Work Orders, dated 07/04/24, recorded, Walk in refrigerator not cold enough. According to the work order, it was submitted to the Maintenance Director by the DM and was marked as a high priority. Review of the facility's policy titled, Healthcare Services Group Inc Safety, revised September 2017, revealed it was policy for the kitchen and associated equipment to be properly maintained and for all kitchen equipment issues to be reported promptly the facility staff. Review of the facility's policy titled, Food Storage: Cold Foods, revised February 2023, recorded, . all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service . During an interview on 07/24/124 at 1:15 PM, the Maintenance Director acknowledged he received a work order for the refrigerator not being cold enough. He stated he was having problems getting vendors to come to the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain an environment free of flies. Flies were observed in resident rooms, dining rooms, hallways, and in the therapy room, landing on residents and their food. This had the potential to affect 59 of 59 residents who resided at the facility, and the potential to result in food borne illness and the spread of infection and diseases. Findings include: 1. Review of Resident (R) 29's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R29 was admitted to the facility on [DATE] with diagnoses including dementia. Review of R29's admission Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 06/14/24, revealed R29 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During a dining observation on 07/23/24 at 12:30 PM, where R29 was present, numerous flies were noted flying around the dining room while the residents were eating. During an observation and interview on 07/23/24 at 2:57 PM, R29 was wheeling himself back from the dining room. R29 asked the surveyor if the flies in the dining room had bothered her. R29 stated the flies were terrible, and it had been that way since he came here. R29 stated the flies were aggravating as hell. 2. Review of R46's Face Sheet, located under the Profile tab of the EMR, revealed R46 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis and atrial fibrillation. Review of R46's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 04/29/24, revealed R46 had a BIMS score of 14 out of 15, which indicated R46 was cognitively intact. During an observation and interview on 07/24/24 at 2:58 PM, flies were noted in R46's room. Flies landed on his foot and leg which had a sore on it. R46 stated he felt the facility should be cited because the flies were unhealthy and kept flying around his leg. During an observation on 07/26/24 at 3:48 PM, a fly was noted to land on R46's nose. He shook his head to remove the fly, and when R46 was asked about the fly being on his nose, he rolled his eyes. 3. Review of R37's Face Sheet, located under the Profile tab of the EMR, revealed R37 was admitted to the facility on [DATE] with diagnoses of quadriplegia, contracture of the right and left hands, and traumatic brain injury (TBI). Review of R37's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 06/10/24, revealed, R37 had a BIMS score of 14 out of 15, which indicated R37 was cognitively intact. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/24 at 3:42 PM, R37 stated there were lots of flies in the building but especially in his room. R37 stated he had more flies in his room because the smoking area door was open all the time. R37 stated the flies were annoying, especially when they landed on him. R37 stated he was not able move his arms enough to swat them away, and he had to shake his head to get the flies off of his face. R37 stated he had talked to the Maintenance Director (MD) about the flies, and he was supposed to put something up to blow them back out of the building, but the parts were not available yet. R37 stated it bugged him about the flies, and the flies were bad in the whole building. During an observation on 07/25/24 at 3:42 PM, flies were noted in R37's room, and some had landed on him. 4. During an interview and observation on 07/24/24 at 2:59 PM in the therapy room, while interviewing the Occupational Therapist Assistant (OTA), flies were noted flying around the OTA's head, and she had to swat them away. The OTA stated the flies were not too bad. During an interview on 07/25/24 at 2:11 PM, the MD stated the facility had a problem with flies. The MD stated it was hard to control the flies because they could not use pest spray in the building. He stated this was an agricultural community and they had flies year-round. The MD stated the facility had a contract with a pest control company, and they would come out every two weeks to spray outside. The MD stated R37 had complained to him a month ago about the flies, and he acted upon that complaint. The MD stated he had discovered that a fly curtain had been installed by the door where the residents that smoke go out; however, it was broken, and it had been broken for at least 10 months because that was how long he had been employed at the facility. The MD stated the former maintenance director had not repaired it. The MD stated he thought the fly problem was partly due to the fly curtain not being operable, and the flies would not be so bad if the fly curtain had been repaired. The MD stated the fly curtain would go over the door, and when the door was opened, a blower would begin and blow the flies downward and outward. The MD stated he had the part needed on order, and it should be there in a day or two. The MD stated he had bug lights ordered, and they would be at the facility Thursday. 03115 5. During an observation of the noon meal on 07/23/24 from 12/20 PM through 12:47 PM, three flies were observed flying around the dining/activity room on the dementia care unit. Fifteen residents were observed eating in the dining room, and Certified Nurse Aide (CNA) 2 had to keep shooing the flies off the residents and their food. CNA2 stated flies were a problem on the unit, especially at mealtimes. During an observation on 07/25/24 at 12:35 PM, flies were observed flying around the dining/activity room on the dementia care unit. The flies were landing on residents and their food. There were 14 residents in the dining room eating at the time of the observation. During an interview on 07/25/24 at 2:30 PM, the MD stated he would not like the flies landing on him. He stated it would be a nuisance, and he would not like it. The MD stated he could shoo the flies away, but some of the residents could not physically shoo them away. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/26/24 at 8:39 AM, the Director of Nursing (DON) stated they always had flies at the facility. The DON stated the facility tried to keep the doors closed, and the exterminator visited routinely. The DON stated the staff kept the residents clean, and the trash containers closed to deter the flies. The DON stated she knew the residents did not like the flies, and the residents had to constantly swish them away. The DON stated if a resident could not swish the flies away, a staff member would do it for them. Review of the facility's policy titled, Prevention Maintenance Policy and Procedures, Infection Control Practice, revised 01/08/24 revealed, . the Maintenance Department will support the facilities overall Infection Control . The purpose of the policy was recorded as, . to prevent infection spread from items or the environment to residents or staff . The policy further recorded, . facility will provide a pest free environment by contracting with a pest control vendor for appropriate services on a periodic basis whether weekly, monthly or as needed .