STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355065	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 27221 Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician of a change in condition for 1 of 1 sampled resident (Resident #67) reviewed who experienced low blood sugars. Failure to notify the physician of blood sugar results below the ordered parameters may result in complications to the resident and prevent the physician from evaluating/prescribing an appropriate treatment plan. Findings include: Review of the facility policy titled Notification of Change occurred on 05/02/24. This policy, revised 12/04/23, stated, . A facility must immediately . consult with the resident's physician . when there is . A significant change in the resident's physical . status . Review of Resident #67's medical record occurred on all days of survey. Diagnoses included type 2 diabetes. Medications included, . NovoLOG [Insulin] . Inject as per sliding scale: if 0 - 60 = call [sic] provider . The current care plan stated, . MEDICATIONS AND BLOOD SUGAR MONITORING PER ORDER TIMING AND DOSING MAY VERY DUE TO RESIDENT BRITTLE DIABETIC STATUS NOTFIY [sic] S/S [signs/symptoms] OF . HYPOGYCEMIA TO PROVIDER . Review of the February-March 2024 Blood Sugars Log showed the following: * 02/23/24, 54 milligrams per deciliter (mg/dL) * 04/14/24, 53 mg/dL A progress note, dated 04/14/24 at 7:48 a.m., stated, . 0630 [6:30 a.m.] - Resident had episode of hypoglycemia in the 50s, OJ [orange juice] x [times] 2 and 1 tube of glutose > [greater than] BS [blood sugar] 113 at 0730 [7:30 a.m.] . Review of the medical record showed the facility failed to notify Resident #67's physician of the low blood sugar readings. During an interview on 05/01/24 at 1:30 p.m., an administrative nurse (#1) confirmed facility staff failed to notify Resident #67's physician of the two low blood sugar readings.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 39687 Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the use of a wheelchair lap belt as a possible restraint for 1 of 4 sampled residents (Resident #52) observed with a wheelchair lap belt. Failure to assess the wheelchair lap belt as a possible restraint, monitor the use, and evaluate the need for continued use, placed Resident #52 at risk for an unnecessary restraint and injury related to its use. Findings include: Review of the facility policy titled Restraints occurred on 05/02/24. This policy, revised 12/05/23, stated, . Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint . and a Physical Device and/or Restraint Evaluation and review is completed. There will be documentation in the medical record of the resident's response to . and ongoing re-evaluation of the need for the restraint. Observation on 04/30/24 at 11:15 a.m., showed Resident #52 seated in a wheelchair with a lap belt in place. Review of Resident #52's medical record occurred on all days of survey and included diagnosis of CVA (bleeding in the brain), hemiplegia (paralysis of one side of the body), aphasia (disorder that affects a person's ability to communicate) and apraxia (difficulty with skilled movements). A physician's order, dated 12/13/21, stated, Use of lap belt/wheel chair tilt when in wheel chair. Risk and benefits discussed with [family member]. The current care plan stated, Use lap belt when in custom wheel chair. Resident unable to remove belt, is aware that it is present but unable to physically click/unclick it. The record lacked evidence of ongoing assessment and evaluation since 12/13/22 regarding the use of the wheelchair lap belt as a possible restraint, monitoring and evaluation of the continued indication for use. During an interview on 05/02/24 at 10:45 a.m., an administrative nurse (#1) agreed the medical record lacked a current or recent evaluation of the lap belt.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 25 sampled residents (Resident #12, #25, and #40). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2023, page N-7, stated, . N0415: High-Risk Drug Classes: Use and Indication (cont.) . N0415D 1. Hypnotic: Check if a hypnotic medication was taken by the resident at any time during the 7-day look-back period . - Review of Resident #12's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed Item N0415D coded as the resident received a hypnotic medication within the 7-day look back period. The medical record lacked documentation that Resident #12 received a hypnotic during the look-back period. - Review of Resident #25's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed Item N0415D coded as the resident received a hypnotic medication within the 7-day look back period. The medical record lacked documentation that Resident #25 received a hypnotic during the look-back period. - Review of Resident #40's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed Item N0415D coded as the resident received a hypnotic medication within the 7-day look back period. The medical record lacked documentation that Resident #40 received a hypnotic during the look-back period. During an interview on the afternoon of 05/02/24, an administrative staff member (#1) confirmed she expected the MDS to be coded accurately. 27221

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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. 46477 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards for 1 of 1 sampled resident (Resident #316) with intravenous (IV) administrations. Failure of staff to label, date, and time the IV solution bags may result in medication errors and adverse reactions. Findings include: Review of the facility's policy titled Medication: Intravenous Administration occurred on 05/02/24. This policy, dated 03/29/24, stated, . All IV solution containers will be labeled with the resident's name . time of preparation . Review of Resident #316's medical record occurred on all days of survey. A current physician's order stated, Administer LR [lactated ringers] 100 cc [cubic centimeters]/hr [hour] for 10 hours daily (Total: 1000 cc per 24 hrs [hours]). Observation from 04/29/24 to 04/30/24 showed an IV solution bag of lactated ringer's (an electrolyte solution) not labeled with the resident's name, date, and time. During an interview on 05/02/24 at 2:45 p.m., an administrative nurse (#1) confirmed staff did not follow facility policy regarding labeling the IV bag. 2. Based on observation, record review, and staff interview, the facility failed to follow professional standards 1 of 1 sampled resident (Resident #77) with a tube feeding. Failure to label enteral tube feedings can lead to an outdated product. Findings include: Review of the facility policy titled Tube (Enteral) Feeding occurred on 05/02/24. This policy, revised 02/02/24, stated, System Type- Closed: Change feeding administration set with each new bottle . label the formula container with resident's name, date, time and nurse's initials . Review of Resident #77's medical record occurred on all days of the survey. A physician's order, dated 06/20/23, stated, Enteral feeding via pump, continuous at 47 milliliters [ml] for 21 hours/day via gastrostomy tube [G-tube]. Turn feeding off one hour before each meal three times a day [TID] . change and label tubing for every new feeding bag change. Observation on 04/30/24 at 3:13 p.m., showed a nurse (#21) entered Resident #77's room to give medications via the feeing tube. The resident's enteral tube feeding container was attached to the feeding pump which ran at 47 ml /hour. The formula container was not labeled with the resident's name, date, time, and nurse's initials. The nurse (#21) stated she did not know when the formula was started and verified the container lacked labeling. During an interview on the afternoon of 04/30/24, an administrative nurse (#20) stated she expected staff to follow the physician's orders regarding labeling of tube feedings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 supplemental resident (#414) with a recent surgical incision. Failure to follow the physician's order related to the incision may have contributed to the resident's increased pain and discomfort. Findings include: Review of Resident $414's medical record occurred on all days of survey. A physician's order, dated 04/17/24, stated, Incisions to chest: Cleanse with normal saline (NS), apply gauze with ACE [compression] wrap until steri strips are removed . put ON in the morning and OFF at night until 05/06/24. Observation on 04/30/24 at 10:31 a.m., showed a nurse (#21) entered Resident #414 room to perform a dressing change to the resident's surgical site. Resident #414 complained of pain from the surgical site. Observation showed the ACE wrap around the resident's chest incision site twisted. The resident stated the ACE wrap caused her chest incisions to hurt more, rating the pain as a nine out of 10 on the pain scale. The resident stated staff did not remove the ACE wrap last evening and it was on all night. During an interview on the morning of 04/30/24, an administrative nurse (#20) confirmed she expected staff to follow the physician's orders. 39685

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 39685 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care and services for 1 of 1 sampled resident (Resident #417) observed during a PICC [peripherally inserted central catheter] line dressing change. Failure to follow physician's orders regarding dressing changes may result in delayed treatment and the resident experiencing adverse consequences. Findings include: Review of the facility policy titled Peripherally Inserted Central Catheter Line occurred on 05/02/24. This policy, revised 04/01/24, stated, . PROCEDURE: assess the catheter insertion site through the transparent semi-permeable dressing . assess for redness, swelling, drainage . DRESSING CHANGE: REMOVE THE OLD DRESSING . assess the site and skin for signs of inflammation, infection (redness, tenderness, drainage . and assess the arm for pain, warmth, swelling .). Using sterile technique . cleanse the area thoroughly with a chlorhexidine (antiseptic) . before redressing the site, use a sterile tape measure to measure the external length of the catheter from the hub to skin entry to ensure that the catheter hasn't migrated . apply the transparent semipermeable dressing . notify provider of concerns . Review of Resident #417's medical record occurred on all days of survey. Diagnoses included infection due to joint prosthesis. Current physician's orders identified, IV [intravenous] Dressing Change- PICC/Central Catheter: dressing change . transparent dressing change every week and PRN [as needed] . infection control . document for abnormal condition, site observation, (redness, swelling, etc .) . in progress notes, notify provider if external catheter length has changed from last measurement . Observation on 04/30/24 at 5:02 p.m., showed a nurse (#15) entered Resident #417's room to administer IV antibiotics through the resident's right arm PICC line, and observed the dressing missing. The site appeared reddened and slightly swollen. As the nurse proceeded to clean resident #417's PICC line, the resident reported his right arm felt sore and uncomfortable. The nurse failed to measure the catheter length, and applied the transparent dressing upside down to the site. A nurse supervisor (#16) entered Resident #417's room during the care. When asked what she would expect based on this observation, the nurse stated she would notify the primary care provider immediately. During an interview on 04/30/24 at 5:35 p.m., a nurse supervisor (#16) confirmed she expected staff to follow the physician's orders for PICC line care. During an interview on the morning of 04/30/24, an administrative nurse (#20) confirmed she expected staff to follow the physician's orders. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care and services for 1 of 1 sampled resident (Resident #58) with an observed bruise. Failure of staff to report signs of skin impairment to the licensed nurse may result in additional bruising if staff fail to identify risk factors that can be removed or modified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: Review of the facility's policy titled Skin Assessment Pressure Ulcer Prevention and Documentation occurred on 05/02/24. This policy, revised 04/26/24, stated, . A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. Observations showed the following: * 04/30/24 at 4:11 p.m., a certified nurse aide (CNA) (#8) transferred Resident #58 onto the toilet and placed a pillow behind the resident. The CNA (#8) pointed to a bruise on the resident's upper left shoulder and indicated the bruise resulted from the resident striking the pipe behind the toilet during a previous transfer. * 05/02/24 at 12:35 p.m., a medication aide (MA) (#10) looked at Resident #58's shoulder and stated, Oh, there is a bruise there. Like two-by-two inches. The bruise was brown in color with a dark brown rim. Review of Resident #58's medical record occurred on all days of survey. The current care plan stated, . The resident has potential impairment to skin integrity R/T [related to] use of antiplatelet therapy. High risk for skin injury - use extra caution during transfers . to prevent striking . against any . hard surface. The record lacked documentation related to the bruise. During an interview on 05/02/24 at 2:25 p.m., an administrative nurse (#1) confirmed she expected staff to document bruises on the skin assessment. 27221

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39685 Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to minimize the potential for the worsening of pressure ulcers for 1 of 4 sampled resident (Resident #98) with pressure ulcers. Failure to consistently implement dressings and pressure relief interventions on pressure ulcer may result in the worsening of Resident #98's current foot/heel pressure ulcer or the development of new pressure ulcers. Findings include: Review of Resident #98's medical record occurred on all days of survey. The quarterly Minimum Data Set, dated dated [DATE], identified Resident #98 at risk of pressure ulcers had one unhealed stage 3 pressure ulcer. A physician's order, dated 04/23/24, stated, Left heel derma saver boot or float on pillow at all times, every day and night shift for skin integrity. A physician's order, dated 04/25/24, stated, Left heel: Foam border pressure dressing (Mepilex, or equivalent) for prevention on every day shift, change 2 x/week [twice a week] and PRN [as needed] to ensure skin integrity related to pressure ulcer of left heel, stage 3. The current care plan identified, The resident has actual pressure ulcer development of left heel R/T [related to] immobility . Treatment and dressing changes per orders . dressings to left heel . derma saver boot to left heel or float at all times . Observations identified the following: * On 04/29/24 at 11:06 a.m., Resident #98 laid in bed without a heel boot or dressing on the left heel. Two certified nurse aides (CNA) (#8 and #19) entered the room to perform cares and stated the resident is to have a dressing and pressure reducing boot on at all times. The CNAs stated the dressing and heel boot have not been in place all morning. * On 04/30/24 at 09:40 a.m., Resident #98's left foot lacked a dressing or a boot. A CNA (#8) stated the dressing and boot had not been in place all morning. During an interview on the afternoon of 05/01/24, an administrative nurse (#20) stated she expected staff to provide Resident #98 with the pressure reducing devices and dressings as per the physician orders and the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39685 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/11/23. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 2 of 20 sampled residents (Resident #30 and #40) observed during transfers. Failure to ensure proper use of a mechanical sit-to-stand lift and/or wheelchair placed Resident #30 and #40 at risk for possible accidents with/without injury. Findings include: Review of the facility policy titled Safe Resident Handling Equipment occurred on 05/02/24. This undated policy stated, . check resident care plan or Kardex [certified nurse aide (CNA) instructions] prior to transfer for type and size of sling and amount of assistance required . position the harness around the upper body . arms outside the harness . adjust the foot pad as needed . EZ way seat strap if additional lower body support is needed . raises the resident slightly off the seated surface . slide the seat strap under the residents buttocks . Locks breaks of the . wheelchair. The resident should be encouraged to bear weight . - Review of Resident #30's medical record occurred on all days of survey. Diagnoses included cognitive deficits, self care performance deficits related to left sided paralysis of upper and lower extremities, and at risk for falls. The current care plan stated,. TRANSFER: sit to stand assist x [times] 1 large harness . Observation on 04/30/24 at 02:34 p.m., showed two CNA's (#18 and #19) transferred Resident #30 from the wheelchair to the toilet using the sit-to-stand lift. The CNAs attached a medium sized harness and seat strap to the lift, with the seat strap dangling mid-back, resulting in the resident hanging in the lift in a sitting position with the right arm raised to chin level. The CNAs stated the resident is care planned to use large harnesses/straps, but they only had medium sizes in the room. During an interview on 04/30/24 at 3:41 p.m., an administrative nurse (#17) confirmed she expected staff to use the appropriate size equipment when transferring a resident. - Review of Resident #40's medical record occurred on all days of survey. Diagnoses included cognitive deficits, weakness, and repeated falls. A fall assessment, dated 04/29/24, identified Resident #40 as a high risk for falls. The current care plan stated, . TRANSFER Assist x 1 with FWW [front wheeled walker] . Observation on 04/30/24 at 11:01 a.m. showed a CNA (#8) held onto the gait belt with one hand as she cued Resident #40 to stand from an unlocked wheelchair. The wheelchair rolled backwards as Resident #40 held onto his front wheeled walker and attempted to stand. The CNA (#8) failed to lock the brakes on the wheelchair prior to cuing the resident to stand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/24 at 2:25 p.m., an administrative nurse (#1) confirmed she expected staff to lock the brakes on a wheelchair prior to transferring a resident. 27221

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46964 Based on observation, review of facility policy, and staff interview, the facility failed to provide safe and secure storage of medications for 1 of 8 medication/treatment carts (Unit 2) observed during medication pass. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled Medication: Administration Including Scheduling and Medication Aides occurred on 05/02/24. This policy, revised 03/29/24, stated, . 5. Medications will be stored in a locked medication cart . Observation on the morning of 04/30/24 showed a nurse (#7) left Unit 2's medication/treatment cart to deliver medications to residents down the hallway. The cart remained unlocked, unattended, and not within the nurse's view. During an interview on the morning of 05/01/24, an administrative nurse (#1) confirmed she expected the medication cart to be locked when not being accessed to dispense medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46964 Based on observation, review of facility policies, review of professional reference, and staff interview, the facility failed to ensure food is prepared and stored in a clean and sanitary manner in 1 of 1 kitchen and 1 of 4 kitchenettes (Unit 2). Failure to ensure cleanliness of food preparation and storage areas has the potential to result in a foodborne illness to residents, visitors, and staff. Findings include: Review of the policy titled, Food -Supply Storage occurred on [DATE]. This policy, dated [DATE], stated, . Procedure. 9. Use By. dates are checked on a regular basis; foods/fluids that have expired. for use are discarded. Review of the policy titled, Date Marking occurred on [DATE]. This policy, dated [DATE], stated, . Procedure. 1. b. Observe for USE by date or USE or FREEZE by date. This is an expiration date. d. If the items are removed from the original container/package, individual items are labeled and dated with date. 2. a. Ensure that. foods opened. are clearly date-marked for: 1) The date/time the original container is opened. 3. a.Foods prepared. and held in refrigeration for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 4. A food item is discarded when: . c. The container or package does not bear a date or day. d. The. item is beyond the USE by date . Review of the policy titled, Food Handling occurred on [DATE]. This policy, dated [DATE], stated, . Policy: Food is handled in a manner that minimizes the risk of contamination. Leftovers. are handled properly to ensure food safety. Leftovers:. 4. Leftover. cold food items will be covered, labeled, dated (sic) and stored. 5. Leftover. cold foods are consumed or discarded within 7 days. The day of preparation shall be counted as day 1. 6. Items that do not have planned use within 72 hours should be dated, labeled. Review of the policy titled, Safe Handling of Personal Food, Outside Food occurred on [DATE]. This policy, dated [DATE], stated, . Procedure. 6. b. Food and beverages without manufacturer expiration date should be dated upon arrive (sic) in the facility and discarded 7 days after date marked. Personal Food Stored in Common Areas: . 3. a. labels, dates (sic) and covers all opened foods that are brought in for the resident. All food must have the resident name and room number clearly visible on the container/package. 4. Employees monitor common food storage areas, clean the equipment (sic) and remove unsafe foods. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355065	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 Food and Drug Administration (FDA) Food Code, Annex 3 page 100 states, . Preventing contamination from the premises . ,d+[DATE].11 Food Storage. ,d+[DATE].12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Chapter 4 Equipment . , d+[DATE].11 Characteristics . equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Inability to effectively wash, rinse and sanitize the surfaces. may lead to the buildup of pathogenic organisms transmissible through food. Observation of the kitchen occurred on [DATE] at 08:43 a.m. with dietary staff member (#6) and showed the following: - Main Kitchen: Floors and baseboards throughout the kitchen soiled with dust and debris. An opened box of two dozen moldy biscuits on a cart (next to ice machine in main kitchen). - Food prep sink drain visibly soiled with grease and food debris. - Dry Food Storage area: Soiled baseboards and floor and spiderwebs behind metal shelving. - Walk-in Cooler: Soiled floor, a plastic container of tuna with an open date of [DATE] (expired on [DATE]), and food storage racks under the fan covered with dust. - Walk-in Freezer: Soiled floor, an open bag of hot dogs dated [DATE] with an expiration date of [DATE], an unopened box of hot dogs with an expiration date of [DATE], and an undated package of beef roast with ice crystal build-up in a box. Observation of the kitchen occurred on [DATE] at 08:15 a.m. with dietary staff member (#6) and showed the following: -A double grease fryer covered with cookie sheets contained old oil and remnants of food particles. The dietary manager (#6) stated it hadn't been used in six months. -Limescale, rust, and dirt on the floor drain by the ice machine. Observation of the residents' food refrigerator in the kitchen showed the following: - Two containers of moldy raspberries and three containers of shriveled up blueberries. -Two unlabeled and undated containers of unknown food items. -A labeled container of food dated [DATE]. -A takeout out box of fried chicken dated [DATE]. -Two undated plastic containers of fruit. -A plastic container of taco meat dated [DATE] and an undated bag of wilted cilantro in a grocery bag. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of the kitchenette on Unit 2 occurred on the afternoon of [DATE], and the morning of [DATE], and showed the following: -Lime scale on the ice and water machine and coffee machine. During an interview on [DATE] at 10:00 a.m., administrative dietary staff member (#6) confirmed staff failed to discard expired foods from the resident refrigerator, failed to clean surfaces/floors in the main kitchen, and failed to clean the machines in the kitchenette on Unit 2.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39687 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/11/23. Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standards of infection control for 7 of 26 sampled residents (Resident #7, #23, #40, #58, #73, #80, and #83) observed during cares. Failure to follow infection control standards with use of personal protective equipment (PPE), during toileting, and colostomy care has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Personal Protective Equipment PPE including Putting on/Taking off, All Service Lines - Enterprise occurred on 05/02/24. This policy, revised 12/04/23, stated, Sequence for donning and Removing Personal Protective Equipment - CDC [Centers for Disease Control and Prevention]. The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions.1. Gown. Fasten in back of neck and waist. 2. Mask or Respirator [N95 mask]. Secure ties. Fit flexable band to nose bridge. fit snug to face and below chin. 3. Goggles or face shield. Place over face and eyes. 4. Gloves. Extend to cover wrist of isolation gown . USE OF PERSONAL PROTECTIVE EQUIPMENT The following observations occurred: * On 04/30/24 at 4:15 p.m., two certified nurses aides (CNAs) (#3, and #4) entered Resident #23's room without face shields and N95 masks. Staff had placed Resident #23 in droplet isolation on 04/28/24. * On 05/01/24 at 10:50 a.m., a CNA (#5) donned PPE before entering Resident #73's room. The CNA (#5) donned a gown without fastening the belt, double gloved, and put a N95 mask over his surgical mask. This prevented the N95 mask from contacting the skin. Staff placed Resident #73 in droplet isolation on 04/26/24. * On 05/01/24, a CNA (#6) collected the lunch tray from Resident #80's room wearing a gown, gloves, and surgical mask. The CNA (#6) failed to don an N95 mask and a face shield. Staff placed Resident #80 in droplet isolation on 04/26/24. During an interview on 05/02/24 at 2:45 p.m., an administrative nurse (#2) said she expected staff to follow the policies and procedures for donning and doffing PPE. TOILETING CARES (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observation on 04/30/24 at 10:44 a.m. showed two CNAs (#8 and #9) gloved and raised Resident #7 from the toilet with the stand lift. One CNA (#9) stated, He was straight cathed yesterday. He has been complaining of it burning [while urinating]. Yesterday and today. The CNA (#9) cleansed Resident #7's buttocks/rectal area, without performing cares to his frontal perineal area. The CNA (#9) failed to cleanse Resident #7's frontal perineal area. - Observation on 04/30/24 at 11:01 a.m. showed a CNA (#8) gloved, cued Resident #40 to stand after toileting, and cleansed the buttocks/rectal area. The CNA (#8) failed to cleanse Resident #40's frontal perineal area. During an interview on 05/02/24 at 2:25 p.m., an administrative nurse (#1) confirmed staff are expected to perform perineal cares for male residents' frontal perineal area. - Review of Resident #58's medical record occurred on all days of survey. The current care plan stated, . The resident has potential impairment to skin integrity R/T [related to] use of antiplatelet therapy. High risk for skin injury - use extra caution during transfers . to prevent striking . against any . hard surface. Observation on 04/30/24 at 4:11 p.m. showed a CNA (#8) gloved, transferred Resident #58 onto the toilet, grabbed a pillow from the bed, and placed it behind the resident with the pillow touching the inner ring of toilet seat and her buttocks. The CNA (#8) stated the bruise on the resident's left shoulder resulted from the resident striking the pipe behind the toilet during a previous transfer. After completing toileting cares, the CNA (#8) tossed the pillow back on the bed as she exited the room with Resident #58. The CNA (#8) failed to utilize a cushion with a cleanable surface to protect Resident #58's skin. COLOSTOMY CARE - Observation on 04/30/24 at 11:40 a.m., showed a CNA (#19) entered Resident #83's room to perform colostomy bag cares. The CNA removed the colostomy bag, full of stool, from the resident's abdomen, walked to the bathroom and emptied the stool in the toilet. The CNA filled the bag with water from the sink, emptied the contents in the toilet and with the same gloves, re-attached the colostomy bag to the resident. During an interview in the afternoon on 05/02/24, an administrative nurse (#17) confirmed she expected staff to perform hand hygiene during colostomy cares. 27221 39685