STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365272	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview	3710 Olentangy River Road Columbus, OH 43214

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52007 Based on medical record review, staff interview, review of the Electronic Information Dissemination and Collection (EIDC) system, and review of the facility policy, the facility failed to report an injury of unknown origin to the State Survey Agency (SSA). This affected one resident (Resident #7) of two residents reviewed for abuse. The facility census was 120. Findings include: Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side, chronic kidney disease (CKD), epilepsy, chronic atrial fibrillation, mild cognitive impairment, and chronic pulmonary embolism. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/12/25, revealed Resident #7's cognition was unable to be assessed due to the resident being rarely/never understood. Further review revealed Resident #7 had impaired range of motion (ROM) on one side, utilized a wheelchair for mobility, was dependent on staff for personal hygiene and lower body dressing, and required substantial/maximum staff assistance for upper body dressing. Review of the plan of care, revised 03/25/24, revealed Resident #7 had a potential for impairment to skin integrity related to fragile skin, history of malignant neoplasm of the skin, impaired mobility, left hemiplegia, and anticoagulant use. Interventions included encourage long sleeves, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, and monitor for signs of bleeding. Review of a nursing progress note, dated 03/01/25 at 8:47 P.M., revealed that during medication pass, a big hematoma with bruise, painful to touch, was identified on Resident #7's right forearm. The facility assessed the resident and Resident #7 was sent to the emergency department (ED) for evaluation at the physician's direction. Review of the physician orders dated 03/10/2025 revealed an order to observe bruising to the right arm for worsening/improvement until resolved, observe hematoma to the right forearm on every shift until resolved, and monitor for signs and symptoms of bleeding related to use of anticoagulant medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EIDC system revealed no evidence of a facility submitted Self-Reported Incident (SRI) related to Resident #7's injury of unknown source, identified on 03/01/25, had been reported to the SSA. Interview on 04/30/35 at 2:50 P.M. with the Director of Nursing (DON) verified the hematoma discovered on Resident #7's forearm on 03/01/25 was not reported to the SSA as an injury of unknown origin. Review of the facility policy titled, Abuse, dated 04/13/23, revealed the facility would ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes were reported immediately to the SSA, but no later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52007 Based on medical record review, resident interview, staff interview and review of the facility policy, the facility failed to thoroughly investigate an injury of unknown origin. This affected one (#7) of two residents reviewed for abuse. The facility census was 120. Findings include: Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side, chronic kidney disease (CKD), epilepsy, chronic atrial fibrillation, mild cognitive impairment, and chronic pulmonary embolism. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/12/25, revealed Resident #7's cognition was unable to be assessed due to the resident being rarely/never understood. Further review revealed Resident #7 had impaired range of motion (ROM) on one side, utilized a wheelchair for mobility, was dependent on staff for personal hygiene and lower body dressing, and required substantial/maximum staff assistance for upper body dressing. Review of the plan of care, revised 03/25/24, revealed Resident #7 had a potential for impairment to skin integrity related to fragile skin, history of malignant neoplasm of the skin, impaired mobility, left hemiplegia, and anticoagulant use. Interventions included encourage long sleeves, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, and monitor for signs of bleeding. Review of a nursing progress note, dated 03/01/25 at 8:47 P.M., revealed that during medication pass, a big hematoma with bruise, painful to touch, was identified on Resident #7's right forearm. The facility assessed the resident and Resident #7 was sent to the emergency department (ED) for evaluation at the physician's direction. Interview on 04/30/25 at 11:41 A.M. with Nurse Manager (NM) #238 revealed that the ED after visit summary indicated Resident #7's hematoma was the result of a fall; however, NM #238 stated the resident's roommate verbalized Resident #7 got the hematoma from playing with her overbed table that evening. Interview on 05/01/25 at 10:18 A.M. with the Director of Nursing (DON) revealed the facility did not have evidence a facility investigation was conducted related to the injury of unknown source identified on Resident #7's right forearm, including staff interviews, witness statements, or assessments or interviews with like residents. The DON verified she did not conduct any staff or resident interviews and further confirmed no staff education was completed related to the incident. Interview on 05/01/25 at 11:26 A.M. with Resident #106, Resident #7's roommate, revealed on the night the injury was identified on Resident #7's forearm, staff did not ask her any questions related to the injury. Resident #106 revealed when staff came into the room to provide care for the resident, she informed staff that Resident #7 had been trying to get out of bed with the assistance of her bedside table. Resident #106 revealed that she did not see the injury occur. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, dated 04/13/23, revealed the facility conducted a timely, thorough, and objective investigation of any allegation of abuse. The facility's policy was to investigate all allegations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source. The investigation process included: identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents, family members, staff who worked closely with the alleged perpetrator and/or alleged victim) and providing complete and thorough documentation of the investigation. The results of the investigation were reported to the Administrator and a final report would be submitted to the State Survey Agency (SSA) no later than five working days after the discovery of the incident.

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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** 31404 Based on record review, staff interview, and policy review the facility failed to ensure residents receive care consistent with professional standards of practice when they failed to timely transcribe a new physician order for a pressure ulcer dressing change for Resident #105. This affected one (Resident #105) of four Residents reviewed for pressure ulcers. The facility census was 120. Findings include: Record review of Resident #105 revealed an admitted [DATE] with pertinent diagnoses of: sepsis, aphasia, type one diabetes mellitus, encephalopathy, cerebral infarction, chronic respiratory failure with hypoxia, hypertension, altered mental status, and personal history of other venous thrombosis and embolism. Review of the 02/17/25 quarterly Minimum Data Set (MDS) revealed Resident #105 is rarely or never understood and currently has a pressure ulcer. Review of the 04/23/25 wound assessment and care plan revealed the wound doctor came in and saw Resident #105 on the weekly wound rounds and wrote to change the order. The new order for left ischial tuberosity was to cleanse with normal saline, pat dry, apply collagen powder to wound bed, apply calcium alginate, and apply dry clean dressing every one day and as needed. Review of the physician order dated 04/23/25 revealed wound care order site left ischial tuberosity 1) cleanse with normal saline, 2) pat dry with gauze 3) apply collagen sheet to wound bed, then saline moistened gauze 4) cover with foam dressing every day shift for wound care. Review of the physician order dated 04/23/25 and timed at 10:15 A.M. revealed wound care order site: left ischial tuberosity: 1) cleanse wound with normal saline 2) pat dry with gauze 3) apply collagen sheet to wound bed, then calcium alginate to wound bed 4) cover with foam dressing every day shift for wound care and as needed for loosening or soilage. Interview with Licensed Practical Nurse (LPN) #335 on 04/30/25 at 11:25 A.M. verified she did not put the order in correctly on 04/23/25 to include applying the calcium alginate to the wound. LPN #335 verified the order was not corrected until 04/30/25. The wound area did not increase due to the order not being transcribed correctly. Review of the facility Medication, Treatment, and Physician Order Transcription policy dated 11/03/23 revealed orders are transcribed then noted by the licensed nurse. The licensed nurse noting the order is responsible for accurate transcription and initiation of orders.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on record review, interviews, and facility policy review, the facility failed to timely respond to monthly medication regimen reviews (MRR) for two Residents (#51 and #76) out of five residents (#10, #51, #57, #76 and #89) reviewed for unnecessary medications. The facility census was 120. Findings include: 1. Review of the medical record revealed Resident #51 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, insomnia, bipolar and hypoxia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was severely cognitively impaired. Required one person assistance with activities of daily living and transport with a wheelchair. Review of the medication administration record (MAR) for November 2024 and December 2024 revealed Resident # 51 was receiving Trazadone 50 milligrams (mg) at bedtime. Review of the monthly medication regimen reviews revealed on 11/29/24 the pharmacist documented Resident #51 had been using Trazadone 50 mg at bedtime and a trial dose reduction was recommended and instructions were provided to document in the progress notes if the therapy is required to prevent future depressive episodes. The response, dated 01/06/25 from Certified Nurse Practitioner (CNP) #402 confirmed Resident #51 had good response to current treatment and remains at a functional baseline, therefore a dose reduction was not approved due to a reduction was likely to impair the resident's function or cause psychiatric instability. 52012 2. Review of the medical record for Resident #76 revealed an admitted [DATE], diagnoses included chronic obstructive pulmonary disease, type II diabetes mellitus, sick sinus syndrome, bipolar disorder, major depressive disorder, emphysema, and anxiety. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was receiving scheduled antidepressant medications. Resident #76 also received antipsychotic and antianxiety medications with indications present. Review of the medication administration record (MAR) from December 2024 through January 6, 2025 revealed Duloxetine 60 milligrams (mg) was administered daily as ordered. Side effects of the medications, and side effects of the antipsychotic and antianxiety medications were also monitored every shift. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the monthly pharmacy medication regimen review conducted on 11/29/2024 the pharmacist recommended a trial dose reduction of the Duloxetine as Resident #76 had been receiving the medication since 04/09/24 after an acute manic episode. The pharmacy recommendation was reviewed and signed by the Nurse Practitioner (NP) #402 on 01/06/2025. The trial dose reduction was not accepted due to the resident having a good response to the current treatment and the benefits of the current treatment outweigh the risks of a change in treatment. Interview on 04/30/25 with the Director of Nursing (DON) at 4:00 P.M. confirmed the pharmacy reviews are conducted monthly. When recommendations are made a copy of the consultant pharmacist recommendation is given to the physician who ordered the medication. The DON verified their contract psychiatric services CNP #402 did not respond to the November recommendations until 01/06/25. The DON confirmed the December 2024 recommendations were reviewed on 12/29/24. Review of facility policy titled Medication Regimen Review, revised 07/22/2024 stated the physician will document in the medical record that any irregularities or recommendations identified by the pharmacist have been reviewed and what action was taken to address it by their next mandatory visit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, interview and policy review, the facility failed to ensure accurate physician order reconciliation was conducted following a hospital admission for one (Resident #82) of two residents reviewed for hospitalization s. The facility census was 120. Findings include: Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses of end-stage renal disease, type II diabetes mellitus, occlusion and stenosis of an unspecified carotid artery, hypotension, and diastolic heart failure. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/04/25, revealed Resident #82 was cognitively intact and received dialysis. Review of the care plan dated 11/13/23 revealed Resident #82 had altered cardiovascular status related to atrial fibrillation, cerebrovascular accident (stroke), chronic kidney disease (CKD), hypotension, chronic heart failure, and peripheral vascular disease. Review of physician orders dated 11/27/24 revealed Resident #82 had an order for midodrine five milligram (mg) oral tablet every 12 hours as needed for low blood pressure if the mean arterial pressure (MAP - average blood pressure throughout a cardiac cycle) is under 65. Review of a hospital after visit summary dated 03/24/25 revealed Resident #82 was admitted to the hospital for hypotension, end-stage renal disease, acute hypoxic on chronic respiratory failure, chronic congestive heart failure, and tachypnea (rapid breathing). The hospital discharge summary included a medication change: midodrine 5 mg tablet to be taken by mouth twice daily as needed for a MAP less than 65, and on Mondays, Wednesdays, and Fridays prior to each scheduled hemodialysis. Further review of the physician orders revealed no updated midodrine orders after 03/24/25, following Resident #82's hospitalization . Review of the Medication Administration Record (MAR) for March 2025 and April 2025 revealed no documentation that midodrine was administered to Resident #82 prior to dialysis on Mondays, Wednesdays, and Fridays. Review of dialysis communication form revealed that midodrine was not identified as administered to Resident #82 on the following dates: 03/24/25, 03/28/25, 03/31/25, 04/02/25, 04/04/25, 04/07/25, 04/09/25, 04/11/25, 04/14/25, and 04/16/25. On 04/18/25, midodrine was listed as administered. Further review of Resident #82's record revealed the dialysis communication form for 04/21/25 and 04/23/25 were not available in the record. Review of dialysis report revealed that on 04/25/25 and 04/30/25, Resident #82 received midodrine prior to dialysis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/25 at 10:49 A.M. with the Director of Nursing (DON) and Regional Clinical Manager (RCM) #400 revealed they could not confirm or deny whether midodrine had been administered to Resident #82 prior to hemodialysis at the off-site dialysis center. They stated they would follow up with the dialysis provider, as the facility did not have access to the full administration record at the dialysis clinic. The DON and RCM #400 confirmed midodrine was only listed on the facility's orders as an as-needed medication but not specifically ordered for administration before each dialysis session. The DON verified the hospital after-visit summary documented a change in the midodrine order, specifying that midodrine should be administered prior to each scheduled hemodialysis treatment on Monday, Wednesday, and Friday. She further acknowledged that the instruction to administer midodrine before each dialysis session, as indicated in the hospital summary, had been overlooked and was not entered into the facility ' s physician orders. Review of the facility's medication, treatment, and physician order transcription policy dated 11/03/23 revealed orders are transcribed then noted by the licensed nurse, the licensed nurse noting an order is responsible for accurate transcription and initiation of orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49039 Based on observation, staff interview, and review of facility policy, the facility failed to ensure that medications were stored securely. This had the potential to affect 74 residents, #1, #2, #3, #4, #7, #8, #10, #12, #13, #14, #15, #17, #20, #25, #28, #29, #32, #33, #34, #36, #37, #40, #41, #42, #43, #44, #45, #50, #51, #52, #58, #61, #62, #76, #77, #78, #79, #84, #85, #86, #88, #89, #90, #92, #93, #94, #95, #102, #103, #104, #107, #110, #112, #116, #117, #120, #121, #122, #138, #175, #178, #179, #180, #226, #227, #229, #231, and #232 The facility also failed to ensure that medications, including three cups containing various types of pills, were stored appropriately. The facility census was 120. Findings include: 1. Continuous observation on 04/30/25 from 8:44 A.M. until 8:47 A.M. revealed an unattended and unlocked medication cart on Unit #4. Registered Nurse (RN) #201 exited a room across the hall and to the left of the unlocked medication cart at 8:47 A.M. and returned to the medication cart. Interview with RN #201 on 04/30/25 at 8:47 A.M. confirmed that she had left the medication cart unlocked and further verified the medication cart was out of her line of sight. 2. Observation on 04/30/25 at 9:28 A.M. during medication administration with RN #201, revealed three illegible labeled medication cups with an assortment of pills in the top drawer of the medication cart for unit #4. Interview at the time of the observation with RN #201 confirmed she had prepared the medications for the residents and when she went to administer them, the Residents were not their rooms so RN #201 placed the cups in the top drawer to be able to administer them later when she found the residents. RN #201 explained that she did not have time to re-prepare the medications as she was already behind. RN #201 was unable to identify what the medications were in the each of the medication cups and was unable to denitrify the resident for which the medications were prepared for and not administered. Interview on 05/01/25 at 10:49 A.M. with the Director of Nursing and Regional Clinical Manager #400 confirmed that medication cups should not be left in the nurse ' s cart. Residents should receive medications as they are prepared. Review of the facility policy titled Medication Administration, dated 08/07/23 stated medications are to be administered according to physician order and professional standards of practice. Medications are to prepared, and administered one resident at a time and the medication administrated is to be documented directly after administration. Additionally, the policy stated when when a nurse is administering medications the nurse is to lock the medication cart when not it is not in direct view. Review of the facility policy titled Medication and Treatment Storage, dated 08/07/23 stated medications, treatments, biologicals, and supplies should be maintained per manufacturer guidelines. Additionally, the facility is required to ensure accurate labeling and dating of medications and treatments for safe administration, as well as secure storage. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50008

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, resident interview, staff interview, and review of facility policy, the facility failed to provide food and drink at a palatable, attractive, and at a safe and appetizing temperature. This affected one resident (Resident #75) and had the potential to affect all 65 of the residents on units #2 and #4 except for Resident #68 and Resident #114, who did not eat or drink food from the kitchen. The facility census was 120 residents. Findings include: 1. Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type 2 diabetes mellitus, and generalized anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #75, dated 04/11/25, revealed that her short term and long term memories were assessed as being okay. Review of physician orders for Resident #75 dated 08/23/24 revealed the resident was on a regular diet with regular textures. Review of the plan of care dated 04/11/24 for Resident #75 revealed that she was at risk for malnutrition with a goal to maintain adequate nutritional status by consuming at least 75% of at least two meals daily. Interventions included honoring her food preferences and providing her diet as ordered. Observation on 04/30/25 at 8:40 A.M. were delivered to Unit 4. Meal trays were delivered to residents from 8:40 A.M. to 9:17 A.M. Observation on 04/03/25 at 9:14 A.M. of Resident #75's meal plate revealed that it did not appear to be warm. The egg on the breakfast sandwich was visualized to be dry. Holding the surveyor's hand near the plate revealed that no warmth was felt from the proximity of the meal plate. Interviews on 04/28/25 at 10:53 A.M. and on 04/30/25 at 9:14 A.M. with Resident #75 confirmed that food and beverages were not served in a timely manner and at satisfactory temperatures on Unit 4. Resident #75 stated meals are not palatable or attractive. 36648 2. Observation on 04/29/25 from 12:55 P.M. to 1:40 P.M. of food trays being delivered in an enclosed metal cart with doors to the 200 Unit residents revealed on top of the cart there were beverages of milk, juices and water in two plastic bins with ice. A coffee craft and beverage cups. The distribution of the trays when arrived to the unit took and took 55 minutes to pass. A test tray was included on the cart. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The test tray temperature was checked by Dietary Manager (DM) #406 using a facility thermometer and revealed the barbecued chicken was 21 degrees Fahrenheit (F), the carrots were 100 degrees F, and the O'Brien potatoes were 100 degrees F. DM #406 verified the temperatures were not acceptable per guidelines and for residents to enjoy a warm and palatable meal . Review of facility policy titled Food Palatability, dated 04/04/2025, revealed cart delivery times should be followed and updated as needed. Designated staff should deliver all the trays in the cart within 20 minutes of arrival to the unit. Review of facility policy titled Tray line Food Temperatures, dated 08/01/2024 revealed the facility will hold and serve food at acceptable temperatures that deter bacterial growth. The internal temperature of potentially hazardous foods (Time/Temperature for Safety Food) must be 41 degrees Fahrenheit or below for cold foods and 135 degrees Fahrenheit or above for hot at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365272	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview	3710 Olentangy River Road Columbus, OH 43214

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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 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. 36648 Based on observation, staff interview, and policy review the facility failed to distribute and serve food under sanitary conditions. This had the potential to affect all residents residing in the facility who receive food from the kitchen except for residents #68 and #114 who did not eat or drink food from the kitchen. The census was 120. Findings include: Observation and tour on 04/28/25 from 9:30 A.M. to 10:00 A.M of the kitchen with Regional Dietary Manager #400 and Dietary Manager (DM) #216 revealed the following: -One large empty plate warmer unit sitting in the service line area revealed the spring loaded plate dispenser was covered with orange and black particles and dust like substance. When wiped with a white paper towel the brown orange colored substance could be wiped off and what appeared to be rusted areas remained, and unable to be removed. The observation was confirmed by DM #216. -One full dome cover dispenser, sitting in the service line area next to the plate warmer revealed multiple food crumbs, dried food and dried liquid marks on both the inside and outside of the unit and on the domes contained in the unit. The observation was confirmed by DM #216. -A plastic crate used in the dishwasher housed several eight ounce hard plastic cups. Six of the cups were covered in a hard white dried powder substance that could be removed with a fork. Regional Dietary Manager #400 verified the white dried powder substance on the plastic cups was lime stains. -The clean area of the kitchen where the utensils and silverware were stored revealed four tray line metal bin dividers sitting on a crate full of clean utensils, The metal dividers had black, white, brown specs of crumbs and dust on them. Hanging off the shelf above the utensils was one pair of large serving tongs with a dried white food substance. This observation was also confirmed by DM #216. Interview with DM #216 at 10:00 A.M. after the kitchen tour, DM #216 verfiied he was not wearing the proper hair restraints. DM #216 was wearing a baseball cap and had no beard cover. An additional observations on 04/29/25 at 10:45 A.M. revealed outside food Sales Representative #500 was observed entering the kitchen, walked through the kitchen and into the clean area of stored dishes and preparation station to meet with DM #216. Sales Representative #500 did not wear a hair cover in place. Regional Dietary Manager # 400 verified the observation. Review of the facility's policy titled Food Service Employee Hygiene/Uniform Policy, dated 12/31/24 revealed food and nutrition service employees will practice good personal hygiene and safe handling procedures. Food Service employees should wear hair restraints that cover the entirety of their hair, including beards grated than a quarter of an inch. Bald employees do not have to wear restraints.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure hand hygiene was performed prior to medication administration and failed to ensure proper sanitary practices were followed when preparing medications for administration. This failure affected one resident (Resident #82) out of the six residents observed during medication administration. The facility census was 120. Findings include: Review of the medical record for Resident #82 revealed an admitted [DATE], with diagnoses including dysphagia, squamous cell carcinoma, and malignant neoplasm of the head, face, and neck. Review of the current physician orders identified the following medications were prescribed on 02/18/25: folic acid, 1 milligram (mg) tablet by mouth once a day, one multivitamin tablet by mouth, once daily, thiamine mononitrate 100 mg by mouth once daily, and Fluticasone propionate nasal suspension, 50 micrograms per activation twice daily. Observation of medication administration on 04/30/25 at 9:22 A.M. with Registered Nurse (RN) #201 revealed while preparing Resident #82's medications, RN #201 opened the medication drawer, touched multiple potentially contaminated surfaces, including the drawer handles, numerous medication cards in the second drawer, and the computer mouse. RN #201 then grabbed a medication cup, removed a bottle of multivitamins, opened it, and dispensed a pill directly into her hand, then placed the pill into the medication cup, closed the bottle and placed it back into the drawer. RN #201 then identified the folic acid bottle, opened it, and transferred a pill into her hand before placing it into the medication cup, closed the folic acid bottle and returned the bottle to the medication cart. Next, RN #201 removed thiamine B-1 from package, directly into her hand, and then transferred it into the medication cup. RN #201 then identified and removed the Fluticasone propionate from its box, prepared a cup of water, locked the medication cart, and turned off the computer screen, and headed to Resident #82's room. Upon entering the room and finding the resident absent, RN #201 exited the room and went to search for Resident #82. After locating the resident in the hallway, RN #201 re-entered the resident's room with the resident. RN #201 then handed Resident #82 the cup of water and the medication cup of pills. Resident #82 was observed taking the medication without issue. RN #201 then removed the cap from the Fluticasone propionate and handed it directly to the resident, who took it without concern. Upon completion of medication administration, RN #201 exited the room, returned to the medication cart, signed off the medication administration using the computer, and proceeded to prepare the next resident's medication. Interview on 05/30/25 at 9:28 A.M. with RN #201 acknowledged that the medications were dispensed directly into her unwashed hands. RN #201 also confirmed hand hygiene was not conducted before or after administering the medication to Resident #82. Interview on 05/01/25 at 10:49 A.M. with the Director of Nursing and Regional Clinical Manager #400 confirmed is it unacceptable for the nurses to dispense medications directly into their hands when preparing medications, and further verfiied hand hygiene should be conducted before and after medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Administration, dated 08/07/23 revealed hand hygiene is to be preformed prior to medication administration. Nurses are not to touch the medication or the the inside of the medication cup when preparing or administering medications for a resident.