STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365605	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milcrest Nursing Center	730 Milcrest Drive Marysville, OH 43040

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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 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 44070 Based on review of Resident Council minutes, resident interview, and staff interview, the facility failed provide ongoing communication to residents about their rights. This had potential to affect all residents. The facility census was 44. Findings include: Review of Resident Council meeting minutes dated 04/29/24, 05/27/24, 06/20/24, 07/24/24, 08/2024, 09/30/24, 10/29/24, 11/27/24, 12/30/24, 01/27/25, 02/26/25, and 03/26/25 revealed no resident right was documented as being discussed. Interview on 04/10/25 at 11:30 A.M. with Resident #36 revealed staff does not review any resident rights at the Resident Council meetings. Interview on 04/10/25 at 11:49 A.M. with Activity Director #42 confirmed she was not discussing resident rights during Resident Council meetings. She revealed she had been running the meetings since 09/2024 and was informed in March 2025 of the need to discuss the rights with the residents.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, resident and staff interview, and record review, the facility failed to ensure a resident's bathroom door opened and closed properly. This affected one (#08) resident out of sixteen residents reviewed for environment. The facility census was 44. Findings include: Review of the medical record revealed Resident #08 admitted to the facility on [DATE]. Diagnoses included anxiety disorder and fibromyalgia. Review of Resident #08's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact,. Resident #08 was independent with personal hygiene. Resident #08 required supervision with toilet transfers and walking ten feet. Observation of Resident #08's room on 04/07/25 at 1:59 P.M. revealed Resident #08's sliding door to her bathroom was difficult to open and close because it was stuck on the track. Interview with Resident #08 on 04/07/25 at 1:59 P.M. revealed she could not open and close her bathroom door because it would get stuck. Observation of Resident #08's room on 04/09/25 at 3:41 P.M. revealed Resident #08's sliding door to her bathroom remained stuck on the track and difficult to open and close. Interview with Corporate Registered Nurse (CRN) #500 on 04/09/25 at 3:41 P.M. verified Resident #08's sliding door to her bathroom was difficult to open and close because it was stuck on the track.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51524 Based on observation, staff interview, and policy review, the facility failed to ensure a resident had a care plan for elopement and the use of a Wanderguard. This affected one (#25) out of one residents reviewed for elopement. The facility census was 44. Findings include: Review of Resident #25's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, high blood pressure, diabetes and depression. Review of an elopement risk assessment dated [DATE] identified the resident to be at risk for elopement. An interventions on the assessment included the use of a Wanderguard. Review of the care plan dated 02/06/25 did not identify the resident to be at risk for elopement or identify the us of the Wanderguard. Observation of Resident #25 on 04/07/25 at 02:17 P.M. revealed she was wearing a Wanderguard on her leg. Review of policy titled Wanderguard Devices, dated 06/19/17, revealed a potential for elopement plan of care will be implemented including Wanderguard as an intervention. Interview on interview 04/10/25 at 2:13 P.M. with Corporate Registered Nurse (RN) #500 verified Resident #25 did not have a care plan identifying her risk for elopement and use of a Wanderguard.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure care conferences were completed quarterly and included participation of the interdisciplinary team and the resident/responsible party. This affected two (#1 and #13) residents reviewed for care conferences. The facility census was 44. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included vascular dementia, anxiety disorder, major depressive disorder, and chronic kidney disease stage three. Review of Significant Change Data Set Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had cognitive impairment. This resident was assessed to be independent with eating, require substantial assistance with toileting and transfers, and partial assistance with bathing and dressing. Review of the care conferences for the last 12 months revealed Resident #1 received a care conference on 03/10/24, 06/14/24, and 09/24/24 with no documentation of the meeting, no evidence of the resident/representative participating and no evidence of members of the interdisciplinary team participating. There was no evidence of any quarterly care conferences after 09/24/24. Review of facility policy titled Plan of Care Meeting, dated 01/26/17, revealed facility shall establish a procedure for care conferences. Facility shall hold care conference meetings within 72 hours of admission and at least quarterly to review and revise the care plan. This shall include members of the interdisciplinary team, resident and family. Interview on 04/09/25 at 10:05 A.M. with Social Services Designee (SSD) #26 verified all department heads should be attending the care conference, including the resident and resident representatives. SSD #26 verified the 03/10/24, 06/14/24 and 09/24/24 contained no evidence of any staff or resident participation and there were no quarterly care conferences held after 09/24/24. 2. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included dysphasia, dementia, Alzheimer's, insomnia, cognitive communication deficit, and Crohn's disease. Review of the MDS assessment dated [DATE] revealed Resident #13 was cognitively intact. Review of care conference dated 09/26/24 revealed it was completed by the admissions director and did not name any staff or resident/family attendance and was left blank without any details about discussion. There was no evidence of any quarterly care conferences after 09/24/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 04/09/25 at 10:05 A.M. with SSD #26 and Corporate Registered Nurse (RN) #500 confirmed facility did not have any evidence of care conferences for Resident #13 since 09/24/24. SSD #26 confirmed the care conference on 09/24/24 contained no evidence of any staff or resident participation. Corporate RN #500 revealed facility identified the problem of missing care conferences and was including this as a Quality Improvement plan, but was unable to provide evidence of having recent quarterly care conferences.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, staff interview, and review of the facility policy, the facility failed to maintain hospice documentation for one (#11) of one resident reviewed for Hospice. The facility identified three residents receiving hospice care (#11, #14 and #37). The facility census was 44. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included adult failure to thrive, malnutrition, muscle weakness Parkinson's disease, atrial fibrillation, and chronic kidney disease. Review of Hospice election and admission paperwork dated 02/10/25 revealed Resident #11 was admitted to hospice care. Review of the hospice communication binder for Resident #11 contained no documentation from hospice visits. Interview on 04/10/25 at 9:36 A.M. with Unit Manager (UM) #511 confirmed the hospice communication binder for Resident #11 had no documentation from visits. UM #511 revealed they had blank communication forms in the binder. The electronic medical record and paper medical record were reviewed and found no documented communication from hospice visits. Interview on 04/10/25 at 9:40 A.M. with Registered Nurse (RN) #68 confirmed she had never seen communication forms completed for Resident #11 and reported it was difficult to get a binder from hospice. Interview on 04/10/25 at 9:45 A.M., Medical Records #52 revealed she did not have any record of hospice notes. Review of facility policy titled Hospice Services, dated 11/20/17, revealed facility shall establish a procedure for hospice services. The policy revealed the facility shall maintain hospice communication.

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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** 39967 Based on observation, interview and record review, the facility failed to provide pressure reducing interventions as recommended to aide in the healing of a pressure ulcer for one (#08) out of four residents reviewed for pressure ulcers. The facility census was 44. Findings include: Review the medical record revealed Resident #08 admitted to the facility on [DATE]. Diagnoses included pressure ulcer of sacral regional stage three, pressure ulcer of left hip stage three, adult failure to thrive, malignant neoplasm of right female breast, polyneuropathy, anxiety disorder, iron deficiency anemia, type two diabetes mellitus, and fibromyalgia. Review of Resident #08's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #08 required supervision with rolling left and right, sitting to lying, lying to sitting, sitting to standing, and transfers. Resident #08 had one stage three pressure ulcer that was present upon admission to the facility. Review of Resident #08's skin care plan dated 12/27/24 revealed Resident #08 was at risk for skin integrity related to fragile skin, impaired mobility, incontinence and resisting care. Resident #08 had a stage three pressure ulcer to the left hip. Interventions included a pressure reducing mattress to bed. Review of Resident #08's initial wound evaluation and management summary signed by Wound Care Physician (WCP) #501, dated 12/13/24, revealed Resident #08 had a stage three pressure wound of the right hip full thickness. The wound was 7 centimeters (cm) by 1.5 cm by 0.1 cm. Recommendations included a low air loss mattress. Review of Resident #08's wound evaluation and management summary signed by WCP #501, dated 04/09/24, revealed Resident #08 had a stage three pressure wound of the right hip full thickness. The wound was 2.5 cm by 0.8 cm by 0.1 cm. The wound was listed as healing. Recommendations included a low air loss mattress. Review of Resident #08's physician orders dated 12/10/24 to 04/09/25 revealed Resident #08 did not have an order for a low air loss mattress. Review of Resident #08's progress notes from 12/10/24 to 04/09/25 revealed no information related to Resident #08 having a low air loss mattress. Observations of Resident #08's room on 04/07/25 at 1:59 P.M. and 04/09/25 at 3:41 P.M. revealed Resident #08 was lying in bed on her right hip. Resident #08 did not have a low air loss mattress in place. Interview with Corporate Registered Nurse (RN) #500 on 04/09/25 at 3:41 P.M. verified Resident #08's was lying in bed on her right hip and Resident #08 did not have a low air loss mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Wound and Skin Care Program, dated 12/20/24, revealed residents will be assessed for risk of skin breakdown and appropriate interventions will be initiated. Wound treatments and dressings will be supported by a physician's order.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, observation, staff and resident interviews, and policy review, the facility failed to ensure nail care was provided for one (#30) of three residents reviewed for activities of daily living. The facility census was 44. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included vascular dementia,, stage three kidney disease, anxiety, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact and required assistance from staff for activities of daily living (ADLs). Review of the care plan dated 02/02/25 revealed Resident #30 needs assistance from staff for ADL needs with interventions to assist with bathing as needed. The care plan did not specify assistance with nail care. Review progress notes dated 02/01/25 to 04/10/25 revealed no notes related to toe nail care or podiatry services. Review of skin and shower sheets from 02/01/25 to 04/08/25 revealed no mention of nail care being offered or refused. Observation and interview on 04/07/25 at 10:56 A.M. with Resident #30 revealed her toenails were long, thick and the left foot big toenail was torn. Resident #30 revealed she was interested in seeing the podiatrist and would like to have her toenails cut. Interview on 04/09/25 at 10:05 A.M. with Social Service Designee (SSD) #26 revealed residents were on the list for podiatry. The facility identified several residents that had been missed for consents and were working to get consents signed and services provided as needed and desired. Observation and interview on 04/09/25 at 3:40 P.M. with Licensed Practical Nurse (LPN) #510 confirmed Resident #30's nails were long and thick with the small toe nails wrapping around the tips of the toes. The left big toenail was split about half way down and jagged. LPN #510 confirmed the nails were long and the left toenail was broken. LPN #510 stated She definitely needs to see the podiatrist. Resident #30 informed LPN #510 she was agreeable to the podiatrist. Interview 04/10/25 at 4:00 P.M. with SSD #26 revealed she may have had consents for podiatry from Resident #30, but was unable to provide evidence of offering or scheduling a podiatrist to the resident. Review of the undated facility policy titled ADLs revealed the facility shall establish a procedure to ensure the level of care and services of each resident. Residents unable to carry out ADL abilities shall shall be assisted.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on review of the medical record and staff interviews, the facility failed to implement interventions in a timely manner after a significant weight loss. This affected one (#29) of four residents reviewed for nutrition. The facility census was 44. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included with fracture of superior rim of right pubis, major depressive disorder, anxiety disorder, and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had severe cognitive impairment. The resident was assessed to be independent with eating. Review of the care plan dated 04/04/25 revealed Resident #29 was at risk for altered nutrition related to medical diagnoses including Alzheimer's disease. Interventions included administer medications as ordered, encouraged intake as needed, obtain and monitor laboratory work as needed, obtain weight as ordered, provide and serve diet as ordered, and provide nutritional supplements as ordered. Review of the weights recorded for Resident #29 revealed on 08/02/24 a weight of 107.5 pounds (lbs). On 09/03/24 the resident weighed 98.9 lb for an 8.6-pound loss, which equaled an eight percent weight loss in 30 days. Review of the progress note dated 09/05/24 at 3:20 P.M. revealed due to a significant weight variance, re-weight requested. Review of the weights record for Resident #29 revealed no re-weight was completed until 10/02/24 when the resident was identified to weigh 101 lbs. With no interventions implemented. Review of the resident's weight on 12/10/24 revealed a weight of 99.5 lbs. This was an eight pound loss, or 7. 4 percent weight loss in four months. On 12/28/24 and 01/06/25 the resident's weight was documented as 99.5 lbs. No interventions were implemented from August 2024 until January 2025. Review of the physician order dated 01/23/25 revealed Resident #29 was ordered a magic cup in the afternoon for supplement. The resident's weight on 02/05/25 was 96 lbs, a loss of 11.5 lbs or 10.6 percent loss in six months. Review of the physician order dated 02/10/25 revealed Resident #29 was ordered house supplement two ounces three times a day for to monitor stability related to significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician order dated 02/10/25 revealed Resident #29 was ordered to obtain weekly weight times four weeks for weight loss. Review of the weights on 02/18/25 and 0/25/25 revealed the resident weighed 94 lbs. On 03/05/25 the resident weighed 91.5 lb, down eight lbs, or eight percent in three months. The resident's weight on 04/03/25 was 96.5 pounds. Interview on 04/08/25 at 2:48 P.M. with Registered Dietician (RD) #503 verified a re-weight was not completed on Resident #29 after requested in September 2024. RD #503 verified no interventions were put into place until January 2025 after a significant weight loss of eight percent in September 2024.

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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** 44412 Based on review of the medical record, pharmacy recommendations, interviews, and policy review, the facility failed to timely implement pharmacy recommendations for one (#29) of five residents reviewed for medications. The facility census was 44. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included with fracture of superior rim of right pubis, major depressive disorder, anxiety disorder, and alzheimer's disease. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had cognitive impairment. Review of the monthly medication review (MMR) dated May 2024 revealed Resident #29 was recommended laboratory (lab) tests of magnesium, complete metabolic panel (CMP), thyroid stimulation hormone (TSH), and complete blood count (CBC). Review of the physician orders revealed no order was placed for the magnesium, CMP, TSH, or CBC for Resident #29 per the recommendation of the MMR. Review of the physician order dated 08/13/24 revealed Resident #29 was ordered a CBC, CMP, and urinalysis (UA) with culture and sensitivity (C&S) related to back and left flank pain. Review of the MMR dated November 2024 revealed Resident #29 was to have TSH levels checked. Review of the physician order dated 01/15/25 revealed Resident #29 was ordered TSH levels next lab draw. Interview on 04/09/25 at 1:44 P.M. with the Corporate Registered Nurse (RN) #503 verified labs were not completed per recommendations.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure a resident received dental care after breaking a tooth. This affected one (#05) resident out of two residents reviewed for dental care. The facility census was 44. Findings include: Review of the medical record revealed Resident #05 admitted to the facility on [DATE]. Diagnoses included muscle weakness, protein calorie malnutrition, iron deficiency anemia, constipation, anxiety disorder, and dysphagia. Review of Resident #05's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired. Resident #05 was independent with eating and required set up assistance with oral hygiene. Resident #05 had obvious or likely cavities or broken natural teeth. Review of Resident #05's census information dated 04/10/25 revealed Resident #05 was on Medicaid. Review of Resident #05's oral cavity assessment dated [DATE] revealed Resident #05 had her own teeth. Resident did not have any broken, loose or carious teeth noted on the assessment. Review of Resident #05's dental care plan dated 08/11/24 revealed Resident #05 had the potential for oral and dental health problems related to natural teeth with likely cavities. Interventions included administer medications as ordered, assist with oral care as needed, and monitor, document and report to the physician as needed of signs and symptoms of oral and dental problems needing attention including broken teeth. Review of Resident #05's undated dental visit history revealed Resident #05 had no history of dental visits while at the facility. Observation of Resident #05 on 04/07/25 at 2:15 P.M. revealed Resident #05 had a front left tooth that appeared to be broken in half with the bottom half of the tooth missing. Interview on 04/07/25 at 2:15 P.M. Resident #05 stated she broke her front left tooth while she resided at the facility and she had not seen the dentist. Interview with Corporate Registered Nurse (CRN) #500 on 04/09/25 at 5:15 P.M. revealed staff at the facility had reported Resident #05 had broken her tooth at the facility but CRN #500 did not know the date when the tooth was broken. CRN #500 verified Resident #05 had not been seen by the dentist since she had broken her front tooth. Interview with Registered Nurse (RN) #502 on 04/10/25 at 10:41 A.M. revealed she completed an oral assessment for Resident #05's 03/28/25 MDS on 03/25/25 and Resident #05 was noted to have cavities. RN #502 stated she did not observe any broken teeth. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nursing Assistant (CNA) #36 on 04/10/25 at 11:44 A.M. revealed she was not aware Resident #05 had a broken front tooth until 04/09/25 when staff asked her if her broken front tooth was a change. CNA #36 stated Resident #05 was admitted with no broken front teeth, but CNA #35 noticed Resident #05 had a broken front tooth on the left side when asked about it by management on 04/09/25. CNA #36 stated she frequently cares for Resident #05 and she never noticed the broken tooth. Resident #05 never had any complaints about the tooth. Review of the facility's policy titled Ancillary Services, revised 03/28/24, revealed the nurse will contact the resident's physician immediately when any resident has a perceived change in condition. An assessment will be made by the nurse prior to the phone call so that the nurse is prepared to discuss condition changes. The facility will refer to ancillary services as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365605	A. Building B. Wing	04/10/2025

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44070 Based on observations, staff interviews, and policy review, the facility failed to ensure safe storage of food in the kitchen. This had potential to affect all facility residents as they all ate food from the kitchen. The facility census was 44. Findings include: Observation and interview on 04/07/25 at 10:21 A.M. of the freezer with Kitchen Manager (KM) #66 revealed a bag of tater tots and a bag of crinkle fries were open and left undated. A bag of hot dogs had a hold in it and was left open to air. A box of garlic bread was left open to air and uncovered. In the fridge two undated carry out boxes with leftovers were present. One contained cake and another had breakfast food. In the dry storage are there were two cans with dents near the seals, including apple pie filling and apple sauce. KM #66 confirmed findings and acknowledged food should be dated and sealed/covered after opening. KM #66 stated the facility uses dented cans of food. Observation and interview on 04/09/25 at 11:51 A.M. with Kitchen Consultant (KC) #504 confirmed a container of shredded cheese was in the service line refrigeration and dated 03/23/25 to 03/29/25. KC #504 confirmed the cheese was outdated and should have been removed 03/29/25. Review of facility policy titled Food Storage Dry Goods, dated 06/20/17, revealed dietary shall ensure all packaged and canned food items would be kept cleaned, dry and properly sealed. All can goods will be inspect for dents, rust or bulges. All damaged cans would be placed in a designated area for vendor return. Review of facility policy titled Food Storage Cold, dated 08/01/17, revealed dietary would ensure all refrigerated food items would be stored properly, labeled and dated and stored in a manner that would prevent cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record reviews, observations, staff interviews, and policy review, the facility failed to ensure infection control measures were followed during medication administration. This affected one (#197) of four residents reviewed for medication administration. The facility census was 44. Findings include: Review of the medical record for Resident #197 revealed an admitted [DATE]. Diagnoses included bacteremia, end stage renal disease (ESRD), and atrial fibrillation. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #197 had intact cognition. Review of the care plan dated 04/08/25 revealed Resident #197 was at risk for infection related to indwelling medical device, open wound and central vein catheter (CVC). Interventions included to wear gown and gloves when providing high-contact resident care activities. Review of the physician order date 04/05/25 revealed Resident #197 was ordered enhanced barrier precautions (EBP) related to indwelling devices every shift for monitoring. Review of the physician order dated 04/07/25 revealed Resident #197 was ordered the antibiotic meropenem-sodium chloride intravenous solution reconstituted one gram per 50 milliliters (ml), use 1000 milligrams (mg) intravenously (IV) one time a day for bacteremia. Observation on 04/08/25 at 4:23 P.M. of medication administration revealed Registered Nurse (RN) #68 popped medications into her hands without gloves on and placed them into medication cup. RN #68 administered those medications to Resident #197. At 4:20 P.M. RN #68 administered IV antibiotics through Resident #197's central venous catheter (CVC) on the left side of chest. RN #68 did not wear a gown for enhanced barrier precautions (EBP) during the administration of the IV. Interview on 04/08/25 at 4:25 P.M. with RN #68 verified she placed medications into her hands and then into the medication cup. RN #68 verified she administered those medications to Resident #197. RN #68 verified she did not wear a gown for EBP when administering the resident's IV. Review of the facility policy titled Enhanced Barrier Precautions, revealed the policy of the facility was to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care.