STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366194	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Glen Nursing & Reha	825 State Route 61 Marengo, OH 43334

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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** 34298 Based on observation, medical record review, review of resident council minutes, review of facility policy, and resident and staff interview, the facility failed to prevent the resident's clothing from being lost when sent to laundry and failed to properly clean the resident's floor. This affected two (Residents #48 and #224) of three residents reviewed for clothing and a safe, clean, and comfortable environment. The facility census was 74. Findings include: 1. Review of the medical record revealed Resident #48 was admitted on [DATE]. Diagnoses included chronic respiratory failure, acute kidney disease, and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively intact. Interview on 10/21/24 at 9:48 A.M. with Resident #48 revealed a shirt and shorts were missing. Resident #48 stated he could not find the shirt or shorts in his room. Resident #48 stated missing laundry was brought up at resident council meetings a lot and it was still a problem. Interview on 10/22/24 at 2:57 P.M. with Licensed Nursing Home Administrator (LNHA) revealed sometimes resident names were not put on clothing items brought in by family. Resident #48's missing items were discussed on 10/18/24. Head of Housekeeping/Laundry #360 was notified of the missing clothing. LNHA stated there was a quality improvement plan in place to have families give new clothing items to staff so the clothing could be labeled. Interview on 10/22/24 at 3:07 P.M. with Head of Housekeeping/Laundry #360 verified he was not aware Resident #48 was missing any clothing. Additional interviews on 10/23/24 at 11:40 A.M. and on 10/24/24 at 10:18 A.M. Head of Housekeeping/Laundry #360 verified Resident #48's clothing had not been found. Review of monthly resident council meeting minutes from October 2023 through September 2024 revealed missing clothing was mentioned at every meeting except in April 2024. 48568 (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record for Resident #224 revealed an admitted [DATE]. Diagnoses included displaced fracture of the seventh cervical vertebra, displaced fracture of the sixth vertebra, ankylosis spondylitis of unspecified sites in spine, and foot drop of the left foot. Review of the care plan revealed Resident #224 was at risk for falls with interventions including call light in reach, keep walkway free of clutter, and provide a safe environment. Observation and interview of Resident #224's room on 10/21/24 at 3:23 P.M. revealed the floor was very sticky. Licensed Practical Nurse (LPN) #414 confirmed the floor was sticky. Observation and interview of Resident #224's room on 10/22/24 at 2:32 P.M. revealed the floor was still sticky. Resident #224 was observed doing occupational therapy in his room. Occupational Therapy Assistant (OTA) #777 confirmed the floor was sticky. OTA #777 stated she doesn't think the floor should be sticky for Resident #224. Interview on 10/22/24 at 4:50 P.M. with State tested Nursing Assistant (STNA) #387 stated Resident #224 has thickened liquids and if they spill, it gets very sticky. STNA #387 stated housekeeping cleans rooms once a day. Observation and interview of Resident #224's room on 10/23/24 at 11:14 A.M. revealed the floor was sticky in spots. STNA #391 stated there were sticky spots on the floor and then pointed to them. STNA #311 also confirmed sticky spots on the floor and pointed to a different spot. Interview on 10/23/24 at 11:16 A.M. with Resident #224 stated he has noticed the sticky floor. Review of the undated Hallway Assignment policy revealed all floors need to be swept and mopped or vacuumed on a daily basis. Review of the Safe and Clean Environment policy dated August 2024 revealed the facility should provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure admission and annual comprehensive Minimum Data Set (MDS) 3.0 assessments were completed timely and as required. This affected three (Residents #35, #39, and #171) of 36 residents reviewed for resident assessments. The facility census was 74. Findings include: 1. Review of Resident #35's medical record revealed an admitted [DATE]. Diagnoses included dementia, depression, and Parkinson's Disease. Review of Resident #35's annual MDS 3.0 assessment, dated 08/27/24 revealed the assessment was in progress (indicating incomplete and not yet submitted as required). Resident #35's prior annual MDS assessment was dated 08/30/23. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the comprehensive assessments for Resident #35 was not completed timely. 2. Review of Resident #39's medical record revealed an admitted [DATE]. Diagnoses included dementia, anxiety, and depression. Review of Resident #39's annual MDS 3.0 assessment, dated 08/20/24, revealed the assessment was in progress. Resident #39's prior admission MDS assessment was dated 08/21/23. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the comprehensive assessments for Resident #39 was not completed timely. 3. Review of Resident #171's medical record revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic respiratory failure, and congestive heart failure. Review of Resident #171's admission MDS assessment, dated 09/26/24, revealed the assessment was in progress. Resident #171 had no prior comprehensive MDS assessments. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the comprehensive assessments for Resident #171 was not completed timely. (continued on next page)

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the RAI Manual, dated October 2023, revealed the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires nursing homes that are Medicare certified, Medicaid certified, or both, to conduct initial and periodic assessments for all their residents. The RAI process is the basis for the accurate assessment of each resident and contains but comprehensive and non-comprehensive assessments. Comprehensive assessments include both the completion of both the MDS and the Care Area Assessment (CAA) process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change has occurred. The Admission assessment is a comprehensive assessment for a new resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a Significant Change in Status Assessment (SCSA) or Significant Change to Prior Assessment (SCPA) has been completed since the most recent comprehensive assessment. The Assessment Reference Date (ARD) must be set within 366 days after the ARD of the previous comprehensive assessment. The MDS completion date must be no later than 14 days after the ARD.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure quarterly Minimum Data Set (MDS) 3.0 assessments were completed timely and as required. This affected nine residents (#14, #15, #23, #27, #30, #47, #52, #56, and #60) of 36 residents reviewed for resident assessments. The facility census was 74. Findings include 1. Review of Resident #14's medical record revealed an admitted [DATE]. Diagnoses included dementia. Review of Resident #14's MDS assessments revealed a quarterly assessment dated [DATE] was in progress. Resident #14's prior quarterly assessment was dated 06/01/24. The resident's MDS tab in her electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #14 was incomplete and not completed timely. 2. Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with early onset. Review of Resident #15's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #15's prior annual assessment was dated 05/30/24. The resident's MDS tab in her electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #15 was incomplete and not completed timely. 3. Review of Resident #23's medical record revealed an admitted [DATE]. Diagnoses included dementia. Review of Resident #23's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #23's prior admission assessment was dated 05/20/24. The resident's MDS tab in his electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #23 was incomplete and not completed timely. 4. Review of Resident #27's medical record revealed an admitted [DATE]. Diagnoses included chronic respiratory failure. Review of Resident #27's MDS assessments revealed two quarterly assessments, one dated 07/04/24 and another dated 10/03/24, both listed as in progress. Resident #27's last completed assessment was a comprehensive significant change in status assessment (SCSA) dated 04/03/24. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessments for Resident #27 were incomplete and not completed timely. 5. Review of Resident #30's medical record revealed an admitted [DATE]. Diagnoses included Parkinson's disease. Review of Resident #30's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #30's prior quarterly assessment was dated 05/06/24. The resident's MDS tab in his electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #30 was incomplete and not completed timely. 6. Review of Resident #47's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease. Review of Resident #47's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #47's last completed assessment was a comprehensive SCSA dated 05/22/24. The resident's MDS tab in her electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #47 was incomplete and not completed timely. 7. Review of Resident #52's medical record revealed an admitted [DATE]. Diagnoses included dementia. Review of Resident #52's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #52's prior quarterly assessment was dated 04/27/24. The resident's MDS tab in her electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #52 was incomplete and not completed timely. 8. Review of Resident #56's medical record revealed an admitted [DATE]. Diagnoses included cerebral infarction due to embolism (clot). Review of Resident #56's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #56's prior annual assessment was dated 05/09/24. The resident's MDS tab in her electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #56 was incomplete and not completed timely. 9. Review of Resident #60's medical record revealed an admitted [DATE]. Diagnoses included acquired absence of right leg above the knee. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #60's MDS assessments revealed a quarterly assessment dated [DATE] was listed as in progress. Resident #60's prior admission assessment was dated 05/01/24. The resident's MDS tab in his electronic medical record indicated the assessment was overdue. An interview on 10/22/24 at 2:54 P.M. with MDS Coordinator #393 confirmed the quarterly assessment for Resident #60 was incomplete and not completed timely. Review of the RAI Manual, dated October 2023, revealed the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires nursing homes that are Medicare certified, Medicaid certified, or both, to conduct initial and periodic assessments for all their residents. The RAI process is the basis for the accurate assessment of each resident and contains but comprehensive and non-comprehensive assessments. The quarterly assessment is a non-comprehensive OBRA assessment that must be completed at least every 92 days following the prior OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. The Assessment Reference Data (ARD) of the assessment must not be more than 92 days after the ARD of the most recent OBRA assessment of any type. The MDS completion date must be no later than 14 days after the ARD.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48568 Based on observations, staff interview, and facility policy review, the facility failed to ensure pureed food was an appropriate smooth texture prior to serving residents on a pureed diet. This had the potential to affect five residents (Residents #4, #19, #29, #34, #172) who were on a prescribed pureed diet. The facility census was 74. Findings include: Interview on 10/22/24 at 10:03 A.M. with Dietary [NAME] (DC) #344 stated she wanted the puree textures at a mashed potato consistency. DC #344 stated when the puree texture was complete, it was like baby food, which was smooth with no chunks. DC #344 said she tastes her puree food, and a resident should not have to chew a puree food item. DC #344 said there were six residents on a puree diet. DC #344 stated she was going to puree chicken enchiladas, peppers and onions, and mashed potatoes for lunch that day (10/22/24). Observation and interview on 10/22/24 at 10:08 A.M. revealed DC #344 started the chicken enchilada puree. DC #344 said the puree was done at 10:09 A.M. Observation of the puree revealed it looked chunky. DC #344 then tasted the puree. DC #344 stated it was okay to serve to the residents. At 10:10 A.M., the chicken enchilada puree tasted chunky and it had to be chewed before it could be swallowed. DC #344 put it on the stove to keep warm before serving. Interview on 10/22/24 at 10:11 A.M. with Dietary Supervisor #359 stated she tasted it and confirmed it was chunky. Review of the undated Pureed Food policy revealed food will be provided in a form designed to meet individual needs. Pureed diets will be served as ordered by they physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observations, policy review, review of Centers for Disease Control and Prevention (CDC) guidance, medical record review, and resident and staff interviews, the facility failed to properly do contact tracing or implement broad-based testing when staff and residents tested positive for COVID-19. The facility also failed to offer Resident #3 another room (if available) when roommate tested positive for COVID-19, and Resident #3 was not tested in a timely manner while exhibiting symptoms of COVID-19. This affected 14 Residents (#3, #6, #22, #23, #33, #35, #60, #63, #121, #171, #173, #279, #280, and #500). The facility census was 74 residents. Findings include: Review of the facility COVID-19 tracking information revealed the following positive COVID-20 cases in 27 days. On 09/26/24, Certified Nursing Assistant (CNA) #305 tested positive for COVID-19. No tracking was provided for CNA #305. On 10/01/24. Contracted Therapy/CNA #600 tested positive for COVID-19. Residents #37, #41, #44, #52, #53 #171, #174, and #273 were identified as being in close contact with the contracted staff member. On 10/02/24, Resident #33 tested positive for COVID-19. No tracking information was provided for Resident #33. On 10/03/24, CNA #320 tested positive for COVID-19. No tracking was provided for CNA #320. On 10/04/24, Resident #171 was sent to the hospital and tested positive for COVID-19. No tracking information was provided for Resident #171. On 10/07/24, Resident #279 tested positive for COVID-19. The only tracking for Resident #279 identified Resident #121. No staff were listed that had close contact with Resident #279. On 10/12/24, Housekeeper #363 tested positive for COVID-19. No tracking was provided for Housekeeper #363. Resident #121 also tested positive for COVID-19. The only tracking for Resident #121 was roommate Resident #36. No staff were listed that had close contact with Resident #121. On 10/15/24, Resident #500 and Resident #501 tested positive for COVID-19. The tracking information revealed Resident #500 had close contact with Resident #501. Resident #501 had no close contact with anyone due to Resident #501 stayed in his room. No staff were listed and they had close contact with Resident #500 and #501. On 10/20/24, Residents #23, #60, and #280 tested positive for COVID-19. The only tracking for Resident #23 and #60 included Resident #17 and #39. No staff were listed that had close contact with Resident #23 and #60. No tracking information was provided for Resident #280. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 CNA #382 and Admission/Licensed Practical Nurse (LPN) #392 tested positive for COVID-19. No tracking information was provided for CNA #382 and Admission/LPN #392. Upon entrance to the facility on [DATE] at 7:30 A.M., no signs were observed to reveal masks should be worn or there were COVID-19 positive cases in the facility. Upon entering Resident #36 and Resident #121's room on 10/21/24 at 9:15 A.M., the door to the resident's room was open and a large wooden [NAME] with a stuffed animal was on the door. CNA #321 was walking down the hallway and stated the personal protective equipment (PPE) was required in Resident #36 and #121's room. CNA #321 verified a green sign on the door that stated PPE needed to be worn was not visible from the hallway. An observation on 10/21/24 at 9:55 A.M. revealed a green sign was now located on the wall in the hallway under Resident #36 and #121's nameplate. Interview on 10/21/24 at 9:57 A.M. CNA #321 verified the nurse had been notified the green isolation sign was hung on Resident #36 and #121's door and was not visible until leaving the room. CNA #321 stated the nurse hung the green isolation sign outside the door above the stand with PPE. On 10/22/24, LPN #418 tested positive for COVID-19. An interview on 10/22/24 at 9:21 A.M. with Infection Preventionist (IP) #394 informed the survey team, the facility was now requiring surgical masks to be worn about the facility, as the facility was in COVID-19 outbreak mode. IP #394 indicated this outbreak was in response to three residents testing positive for COVID-19 on 10/20/24. The facility started outbreak testing on 10/23/24. On 10/23/24, Residents #3, #6, #22, #35, #63, and #173 tested positive for COVID-19. An observation on 10/23/24 at 7:55 A.M. revealed a sign was located on the door at the main entrance that indicated there were positive COVID-19 cases in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/23/24 at 9:41 A.M. with IP #394 revealed she had been in the role as IP since 03/04/24. IP #394 stated outbreak status or testing was not done until there were two or three positive COVID-19 cases in a three-day time period which would indicate a cluster of positive cases. If there were more than three days between positive COVID-19 cases, IP #394 would not consider the positive cases an outbreak. IP #394 stated the facility considered yesterday 10/22/24 the start of the outbreak, because of the three positive cases of COVID-19 identified on the 200-hallway on 10/20/24. IP #394 verified Residents #23, #60, and #280 tested positive for COVID-19 on 10/20/24. IP #394 explained the two-day delay in identifying an outbreak was because she was working as a floor nurse on 10/20/24 and verified she was aware of the three positive cases on 10/20/24. IP #394 indicated she had made a recommendation to the Director of Nursing (DON) and Administrator but had not gotten their approval to implement outbreak procedures. IP #394 explained outbreak procedures would include for facility staff to wear surgical masks throughout the building and would implement in-house COVID-19 testing once weekly for all residents and staff. IP #394 verified she received orders to test residents for COVID-19 on 10/22/24 and testing started by nightshift the morning of 10/23/24. IP #394 verified 10/23/24 was day one of the outbreak. IP #394 stated residents will be retested in five days and staff will test themselves when they arrive at work. Prior to the outbreak, residents were monitored for signs and symptoms that included a temperature over 100 degrees Fahrenheit (F) which was a direct sign of COVID-19. If a resident did not have a temperature, the resident could just be experiencing cold symptoms. IP #394 stated the nurses used their nursing judgement to decide when to test residents for COVID-19. IP #394 stated residents that tested positive for COVID-19 were placed in droplet precaution isolation. If the positive resident had a roommate, the roommate would be moved if there was an available room. IP #394 verified tracking had not been completed for all the staff and residents who tested positive for COVID-19. IP #394 verified outbreak mode had been delayed and not put in place immediately when three residents tested positive on 10/20/24. IP #394 indicated she followed CDC guidelines and would periodically go online to find the most up-to-date CDC guidelines. IP #394 stated it was the facility practice to monitor residents for signs and symptoms in order to validate testing a resident but was unsure if an assessment or evidence of this monitoring was a piece the nursing staff were recording on a daily basis. IP #394 verified there was a delay in implementing resident testing to identify any other residents who could be positive for approximately two days. An interview on 10/23/24 at 10:38 A.M. with the Administrator revealed the facility's delay in implementing their outbreak procedures was related to the facility being caught up with the unannounced annual survey which began on 10/21/24 but stated the residents should have been the priority. The Administrator stated residents with the same respiratory pathogen should be cohorted, and resident movement should be only for medically essential purposes. The Administrator also stated the staff were only considered to be in close contact if they were close to a resident for 15 minutes or longer. Interview on 10/23/24 at 10:59 A.M. with the DON verified IP #394 did not have to obtain permission to call for a COVID-19 outbreak in the facility. IP #394 was the IP and was the lead person on all infections including COVID-19. An observation on 10/24/24 at 7:45 A.M. revealed a sign was located on the door at the main entrance that indicated masks should be worn. 47990 2. Review of Resident #03's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, chronic kidney disease stage IV, obesity, and obstructive sleep apnea. (continued on next page)

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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 - Some	Review of the admission Minimum Data Set (MDS) assessment, dated 08/14/24, revealed Resident #03 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #03 required hands on assistance for activities of daily living and mobility tasks. Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #03 requested and received a dose of as-needed Tylenol extended relief eight-hour (a mild pain reliever and fever reducer) 650 milligrams (mg) tablet for a complaint of general discomfort on 10/20/24 at 8:00 A.M. A follow-up MAR note on 10/20/24 at 10:00 A.M. indicated the medication was effective. Review of Resident #03's interdisciplinary progress notes dated 10/20/24 revealed the resident complained of head congestion, occasional cough, and nasal congestion. The resident was not recorded as having a fever, his lungs were clear, and he had no respiratory distress. The provider was notified and provided a new order for cough syrup every four hours, and one dose had been given earlier in the morning and Resident #03 had no further complaints throughout the day. An observation and interview on 10/21/24 at 11:34 A.M. revealed Resident #03 up in his recliner chair in his room. He was wearing a hospital gown, was observed blowing his nose and had a small pile of used tissues on his overbed table in a pile. Resident #03 stated he had sinus pain and pressure as he gestured to his face, a runny nose, and had a cough. Resident #03 stated he had been taking cough medicine and he thought it had helped. Resident #03 stated no one had offered to or tested him for COVID-19 recently. Resident #03 was not listed as in isolation and had a roommate, Resident #41. A follow up observation and interview on 10/21/24 at 2:36 P.M. revealed Resident #03 remained in a hospital gown. Resident #03 stated he was just not feeling well. Resident #03 was observed to still have used tissues on his overbed table. Resident #03 endorsed he was still having sinus discomfort, pressure, nasal drainage, and an occasional cough. An interview on 10/21/24 at 2:59 P.M. with Certified Nursing Assistant (CNA) #325 stated she regularly worked on the 200 unit, and today she was assigned to 200-B. CNA #325 stated she was aware Resident #03 was feeling unwell, but stated she was told his symptoms were not signs of COVID-19. Review of Resident #03's interdisciplinary progress notes revealed no notes on Resident #03's condition or symptoms were recorded on 10/21/24. A note dated 10/22/24 which stated the resident continued to have nasal congestion, an occasional moist cough, but the resident was not in respiratory distress nor did he have a fever. The note indicated Resident #03 continued to have mild discomfort. An interview on 10/23/24 at 8:11 A.M. with CNA #384 revealed she donned personal protective equipment (PPE) and preparing to answer Resident #03's call light. CNA #384 stated she had been told early this morning Resident #03 tested positive for COVID-19. CNA #384 stated she was not surprised, as Resident #03 had been sick with a runny nose, cough, and fatigue. CNA #384 stated Resident #03 was continuing to reside with his roommate, Resident #41, who had tested negative for COVID-19 earlier that morning (10/23/24). CNA #384 was unsure why the residents were still rooming together if one was positive, and one was negative. (continued on next page)

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	366194	A. Building B. Wing	10/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/23/24 at 9:41 A.M. with IP #394 stated Resident #03 was not tested upon the onset of his symptoms, as he did not have a recorded fever, but confirmed she was aware of his other symptoms. IP #394 indicated she followed Centers for Disease Control (CDC) guidelines and would periodically go online to find the most up-to-date CDC guidelines. IP #394 confirmed residents were tested earlier that morning (10/23/24) and six additional residents were identified to be positive for Covid-19 and subsequently were placed in isolation. An observation on 10/24/24 at 1:38 P.M. of Resident #03 revealed the resident was seated up in his recliner and appeared to be asleep. Resident #03 was seated directly next to his roommate Resident #41, whose chairs were positioned side by side in the room. An interview on 10/24/24 at 1:46 P.M. with the DON confirmed Resident #03 was COVID-19 positive as of 10/23/24 and remained in the same room as his roommate, Resident #41. The DON confirmed there was no evidence in either resident's medical record of attempts to offer one a temporary private room, provide any education on risk versus benefit of cohorting, nor was there evidence Resident #41's family was notified he was cohorted with a COVID-19 positive resident. The DON confirmed the facility should not be cohorting COVID-19 positive and negative residents in the same room. Review of the COVID-19 Positive Testing Schedule policy revised October 2024 revealed upon identification of a single new positive case of COVID-19 in any staff or residents, it should be evaluated to determine if other in the facility could have been exposed. The approach to an outbreak investigation could involve either: 1. Contact tracing or 2. Broad-based approach. Contact tracing is performed to identify any staff or residents who may have had close contact with the individual that tested positive for COVID-19. If the facility is unable to identify close contacts, all staff and residents, regardless of vaccination status, that are assigned to a specific location where the new positive case occurred will test as soon as possible (but not earlier than 24 hours after the exposure) OR the facility may opt for facility wide outbreak testing. Review of the facilities Infection Control, Isolation Policy dated 01/11/22 revealed transmission-based precautions will be employed for known or suspected infections for which the route of transmission/prevention is known: Airborne, droplet, and contact for COVID-19. Color coded signs instructing visitors to report to the nurses' station before entering the room will be placed at the doorway of the resident's room. Review of CDC Symptoms of COVID-19 online resource, dated 06/25/24, revealed people with COVID-19 have a wide range of symptoms ranging from mild symptoms to severe illness. Possible symptoms include fever or chills, cough, shortness of breath or difficulty breathing, sore throat, congestion or runny nose, new loss of taste or smell, fatigue, muscle or body aches, headache, nausea or vomiting and diarrhea. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC guidance titled Infection Control Guidance: SARS-CoV-2 dated 06/24/24 and found at https://www.cdc.gov/covid/hcp/infection-control/index.html revealed the guidance applies to all U.S. settings where healthcare (HCC) is delivered, including nursing homes and home health. HCC facilities should ensure everyone is aware of recommended infection prevention and control practices in the facility. The guidance listed to post visual alerts (signs, posters) at the entrance and in strategic places. The facility should establish a process to make everyone aware of entering the facility of recommended actions to prevent transmission to others if they have any of the following criteria: A positive test for SARS-CoV02, symptoms of COVID-19, or close contact with someone with SARS-Co-V-2 infection. Under CDC's Perform SARS-CoV-2 Viral Testing, asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative again, again 48 hours after the second negative test. This will typically be on day one (where day of exposure is day zero), day three, and day five. Under CDC's Create a Process to Respond to SARS-CoV-2 Exposures Among HCP (Healthcare Professionals) and Others, HCC facilities should have a plan for how SARS-CoV-2 exposure in HCC facility will be investigated and managed and how contract tracing will be performed. If HCC-associated transmission is suspected or identified, facilities might consider expanding testing of HCP and patients as determined by the distribution and number of cases throughout the facility to identify close contacts. Under CDC's Duration of Emperic Transmission-Based Precautions for Asymptomatic Patients following Close Contact with Someone with SARS-CoV-2 Infection, patients do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control. Under CDC's Patient Placement, if cohorting, only patients with the same respiratory pathogen should be housed in the same room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on record review, staff interview, review of infection control logs, and policy review, the facility failed to implement their antibiotic stewardship program policy and thoroughly track infections to ensure infections and antibiotics were ordered appropriately. This affected 13 (#22, #27, #37, #39, #42, #54, #57, #173, #174, #175, #176, #177, and #273) of 17 residents identified as ordered antibiotics during September 2024 and October 2024. The facility census was 74. Findings include: 1. Review of the Infection Control Log dated for September 2024 revealed the facility tracked residents that had received antibiotics for the month of September 2024. The form included the resident name, admitted , onset date (of infection), site of infection, infection related diagnosis, sections to indicate whether a culture, or x-ray was performed, organism, antibiotic that was ordered, if isolation was ordered, if the infection was a healthcare associated, a recultured date, and a date resolved. For each listed infection, a corresponding sheet was included which provided to detail whether or not the resident met criteria for appropriate antibiotic use. The log revealed for the month of September 2024, there were 11 total occurrences of residents requiring antibiotic use, and eight residents did not meet the criteria for antibiotic use. The following residents were identified on the log as not meeting criteria. A. Resident #177 was admitted to the facility on [DATE]. Resident #177 was ordered Amoxicillin (an antibiotic) on 09/18/24. The log noted the resident had an infection-related diagnosis of pneumonia. An x-ray was not listed as being performed. The log noted the infection resolved on 09/25/24. An attached Infection Report Form dated 09/18/24, on which symptoms or clinical signs or symptoms of infections were to be recorded. The form listed specific (McGeer's) criteria, symptoms, and laboratory criteria for different body systems to determine if the resident met the criteria for treatment with antibiotics. Resident #177 was not listed as having any respiratory symptoms. The infection was listed as in-house and as not meeting surveillance criteria. The form indicated Resident #177 received his course of antibiotic therapy from 09/18/24 to 09/23/24. The form was signed by Infection Preventionist (IP) #394. B. Resident #54 was admitted to the facility on [DATE]. Resident #54 was ordered Ciprofloxacin (an antibiotic) on 09/03/24. The log noted the resident had an infection-related diagnosis of Urinary Tract Infection (UTI). A culture was not listed as performed. The log noted the infection resolved on 09/10/24. An attached Infection Report Form dated 09/03/24 listed Resident #54 as having experienced no urinary symptoms. The infection was listed as in-house and the form indicating whether the infection met surveillance criteria was blank. The form listed no culture as being performed, yet Resident #54 received antibiotic therapy from 09/03/24 to 09/10/24. The form was signed by IP #394. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #57 was admitted to the facility on [DATE]. Resident #57 was ordered Azithromycin (an antibiotic) on 09/11/24. The log noted the resident had an infection-related diagnosis of prophylactic (used for prevention) for Chronic Obstructive Pulmonary Disease (COPD). There were no cultures or x-ray examination performed. An attached Infection Report Form dated 09/11/24 listed Resident #57 as having no respiratory symptoms. The infection was listed as in-house and as not meeting infection surveillance criteria. Resident #57 was listed as receiving Azithromycin on Mondays, Wednesdays, and Fridays from 09/11/24 to indefinitely. The form was signed by IP #394. Resident #57 was discharged from the facility on 09/30/24. D. Resident #42 was admitted to the facility on [DATE]. Resident #42 was ordered Amoxicillin on 09/17/24 for an infection-related diagnosis of acute bronchitis. Resident #42 was not listed as having an x-ray examination performed. An attached Infection Report Form dated 09/17/24 listed Resident #42 as having no respiratory signs or symptoms. An x-ray was not listed as being performed. The infection was listed as in-house and as not meeting infection surveillance criteria. Resident #42 was listed as receiving antibiotic therapy from 09/17/24 to 09/24/24. The form was signed by IP #394. E. Resident #39 was admitted to the facility on [DATE]. Resident #39 was ordered Keflex (an antibiotic) on 09/15/24 for an infection-related diagnosis of a UTI. Resident #39 was not listed as having a urine culture performed. An attached Infection Report Form dated 09/15/24 listed Resident #39 as having experienced no urinary symptoms. The infection was listed as in-house and the form indicating whether the infection met surveillance criteria was blank. The form listed no culture as being performed, yet Resident #39 received antibiotic therapy from 09/15/24 to 09/20/24. The form was signed by IP #394. F. Resident #273 was admitted to the facility on [DATE]. Resident #273 was ordered Ciprofloxacin on 09/12/24 for wound prophylactic. Resident #273 was not listed as having any culture performed. An attached Infection Report Form dated 09/12/24 listed Resident #273 as having no wound signs or symptoms indicative of infection, nor as having any culture performed. The infection was listed as in-house and as not meeting infection surveillance criteria. Resident #273 received antibiotic therapy from 09/12/24 to 10/24/24. The form was signed by IP #394. G. Resident #174 was admitted to the facility on [DATE]. Resident #174 was listed as receiving Trimethoprim (an antibiotic) and Nitrofurantoin (an antibiotic) for bladder prophylactic. Resident #174 was not listed to have had any culture performed. An attached Infection Report Form dated 09/26/24 listed Resident #174 as having no signs or symptoms of a UTI. The infection was listed as prophylactic and as not meeting surveillance criteria. As of 10/24/24, Resident #174 had an active order for both Trimethoprim and Nitrofurantoin and had received both on a daily basis since 09/27/24. The form was signed by IP #394. 2. Review of the Infection Control Log for October 2024 revealed the log was incomplete. The log listed the name of six residents (Resident #22, #176, #27, #175, #173, and #37). Listed on the log was onset dates, the name of the antibiotic, and the date resolved. One infection was listed as resolved on 10/24/24, all others were dates in the future already logged. The log included no indication of the site of the infection, any infection-related diagnosis, or if any culture or x-ray had been performed. There were no attached Infection Report Form for any of the residents on the October 2024 log. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/23/24 at 9:41 A.M. with IP #394 stated her practice was to log all prescribed antibiotics. She filled out the Infection Report Forms, and would include the order for the antibiotic and any laboratory tests or x-ray examination reports if available. An interview on 10/24/24 at 10:55 A.M. with the Director of Nursing (DON) stated IP #394 was previously tracking infections. The infection control logs were reviewed with the DON. The DON confirmed multiple residents did not meet criteria and had no recorded signs or symptoms of infection and many did not have any cultures or testing recorded prior to initiating antibiotic therapy. The DON confirmed there was no documentation reflecting any communication to or follow up with the ordering prescriber. The DON confirmed the October 2024 log contained resolved dates in the future, and that resolved dates should not be listed in advance. The DON confirmed the log should be maintained and kept up-to-date as it is hard to go back and do a complete job, and timely notify the provider if a resident does not meet infection criteria, after the fact. The DON stated the facility's primary physician is reasonable, and frequent residents not meeting infection criteria should have been communicated to and discussed with the provider, and documented accordingly. The DON was unable to locate any staff or provider training on antibiotic stewardship, feedback reports, or antibiotic use protocol/algorithms. Review of the policy Infection Control Program dated 11/08/21 revealed the IP is responsible for the Infection Control Program. Data collection methods for infection surveillance includes clinical rounds, laboratory and radiology reports, medical records, antibiotic lists, and infection events. The IP will complete the infection control log which identifies and tracks all healthcare acquired infections. Resident infection cases are monitored by the IP who completes the infection control log and reports findings to the DON or designee and the Quality Assurance Performance Improvement (QAPI) committee. Review of the policy Antibiotic Stewardship Program Policy dated 11/03/21 revealed nursing staff shall assess residents who are suspected to have an infection and complete an SBAR (a structured communication tool that helps healthcare teams share information about a patient's condition) form prior to notifying the physician. Laboratory testing shall be in accordance with current standards of practice. The McGeer Criteria are used to determine whether to treat an infection with antibiotics. All antibiotics shall specify the dose, duration, and indication for use. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders from consulting, specialty, or emergency providers shall be reviewed for appropriateness. At least annually, each attending physician shall be provided feedback on his/her antibiotic use data in the form of a written report. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families. Documentation related to the program is maintained by the IP, and includes the action plan, assessment forms, antibiotic use protocol/algorithms, data collection forms for antibiotic use, process, and outcome measures, antibiotic stewardship meeting minutes, feedback reports, and records related to education of physician's, staff, residents, and families.

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F 0925 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48568 Based on observation, staff interview, and record review, the facility failed to ensure the food preparation and service areas were free from pests. This had to potential to affect all 74 residents residing in the facility. Findings include: Observation and interview on 10/21/24 at 9:57 A.M. with Dietary Supervisor (DS) #359 revealed five flies flying in the kitchen and landing on the ceiling and beverage line. DS #359 stated they have fly issue but the exterminator was here this morning and confirmed the five flies in the kitchen. Observation and interview on 10/22/24 at 10:04 A.M. with DS #359 revealed flies flying around the kitchen food preparation station and three flies on the ceiling. DS #359 confirmed the flies in the kitchen. Observation on 10/22/24 at 11:03 A.M. revealed three flies on the rack near the food steam table and three additional flies on the ceiling. Interview on 10/22/24 at 11:03 A.M. with Dietary [NAME] #344 confirmed the three flies near the steam table and three flies on the ceiling. Dietary [NAME] #344 revealed they have had a fly issue since the summer. Interview on 10/22/24 at 11:41 A.M. with DS #359 stated they were currently utilizing a pest control specialist every two weeks. DS #359 said if they specify something important, the specialist can come out the same day. Review of the pest control invoices revealed on 09/10/24, an uptick in fly activity. On 09/23/24, the fly pressure has gone way down but the activity was still there. On 10/04/24, there was still some fly activity present at the facility. On 10/21/24, they were still dealing with a few flies in the kitchen area. Review of the Insect/Rodent Control policy dated January 2016 revealed it is the responsibility of the facility to ensure the resident has a right to a safe, clean, and homelike environment. This includes that the facility should incorporate practices that are effective in minimizing the presence of rodents and insects.