STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, interview, and policy review, the facility failed to ensure Resident #186 had an order in place for advanced directives and Resident #7's was listed correctly throughout the medical record. This affected two (#7 and #186) of two residents reviewed for advanced directives. The facility census was 33. Findings include: 1. Record review revealed Resident #186 admitted to the facility on [DATE] with diagnoses including displaced bimalleolar fracture of right lower leg, muscle weakness, difficulty in walking, hypothyroidism, and severe intellectual disabilities. Review of Resident #186's orders from 10/04/24 revealed there were no orders in place for the residents code status in the physical chart or in the electronic chart. Interview on 11/05/24 at 2:31 P.M. with Director of Nursing (DON) confirmed Resident #186 did not have an order in place for her code status until an audit was completed after being made aware of another concern with advanced directives. The DON stated there should have been an order for a code status upon Resident #186's admission to the facility. Review of a policy titled Advanced Directive, dated December 2016, revealed upon admission, a resident would be provided with written information concerning the right to refuse or accept medical or surgical intervention and to formulate advanced directives if they choose to do so. If the resident was incapacitated, the information could be provided to a legal representative. Information regarding advanced directives should be displayed prominently in the medical record. Advanced directives included, but were not limited to, code status. Advanced directives should be reviewed annually. 50538 2. Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including severe sepsis with septic shock, major depressive disorder, unspecified psychosis not due to a substance or known physiological condition, and systolic congestive heart failure. Review of Resident #7's electronic healthcare record revealed an advanced directive physician order indicating the resident's code status was a Full Code (all life-saving procedures would be preformed to treat cardiac or respiratory arrest). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's hard chart (paper chart) revealed a form indicating the resident's code status was Do Not Resuscitate Comfort Care (DNR-CC) (no life-saving procedures would be preformed to treat cardiac or respiratory arrest). Interview on 11/04/24 at 2:12 P.M. with the Director of Nursing (DON) verified the advance directive order in the electronic health record read that Resident #7's code status was a Full Code and the form in the hard chart stated the resident's code status was a DNR-CC. She further confirmed that the order and paper should match to prevent confusion about the resident's care in the event of cardiac or respiratory arrest. Review of the policy titled Advanced Directives (revised December 2016) revealed information regarding advanced directives should be displayed prominently in the medical record. Advanced directives included, but were not limited to, code status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 26706 Based on observation, interview, and review of facility invoices, the facility failed to ensure the facility floors, walls, air vents and rooms were maintained, clean, and free of insects. This affected five residents (Resident's #5, #24, #29, #30, and #32) out of 24 residents reviewed in the initial pool. The facility census was 33. Findings include: Observations and interviews on 11/06/24 at 1:31 P.M. with the Administrator confirmed the following environmental concerns: a. The tile and grout around the base of Resident #24's toilet was a discolored dark brown/black color. b. The air vent going into the bathroom of Resident #30's room was rusty. There was a hole in the wall above the baseboard on the right side of the door. The tile and grout around the base of Resident #30's toilet was a discolored dark brown/black color. c. The wall above the vinyl baseboard in Resident #5's bathroom was torn around the entire perimeter of the bathroom. d. Resident #32's bed was positioned long-ways against the wall. The wall had scraped drywall and paint removed in eight areas, all measuring over a foot long each. In addition, the floor made a sticky sound when walking. Interview on 11/04/24 at 1:14 P.M. with Resident #32's family member revealed when Resident #32 moved into the room, the toilet was held on by one bolt and wiggled around and it took quite a while to get the issue fixed. The family member also stated there was an odor in the room and the floor was occasionally sticky. Observation on 11/04/24 at 4:52 P.M. of Resident #32's room revealed there were three wheelchair legs lying on the floor, one was toward the center of the bedroom area. There was a urinal on the stand in front of Resident #32's roommates (Resident #29) television. The bedding on Resident #32's bed was soiled, there was a one foot diameter light brown drainage on his pillow case and a two foot diameter area of drainage on his sheets at the foot of the bed. There was a soiled, dried wash cloth on the window sill and a dried flower shedding leaves on the areas around it. The lunch tray was still in the room after the supper tray was served and there were three insects, that looked like flies, flying around the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview at 11/04/24 at 4:52 P. M with State tested Nurse Aide (STNA) #535, at the time of the observation, verified Resident #32's bedding was soiled. STNA #535 stated that the resident didn't usually lay in the bed, but she thought he was resting his legs on the bed when he was sitting in the wheelchair. She verified there were some flies in the room and two meal trays. She also confirmed the window sill was cluttered with a shedding dead flower and the soiled, dried washcloth. STNA #535 indicated the resident was slow at eating so they did not take his tray when they were picking up trays. STNA #535 also verified the floor made a sticky sound when walking. STNA #535 was observed changing the sheets on the bed, but she left the meal tray in the room, left the wheelchair leg in the middle area of the floor, and left the dead flower and washcloth on the window sill. Observation on 11/05/24 at 12:36 P.M. revealed Resident #32 was in his room asleep in his wheelchair holding a glass of juice. There was a lunch tray with a hamburger, tater tots, a cut up fruit and coffee in front of him and a breakfast tray was noted on a chair in his room. There was a fly on his head and a fly on his left sleeve. The residents dead flowers were no longer present. Interview on 11/05/24 at 12:45 P.M. with STNA #506 confirmed Resident #32's breakfast tray was on a chair in his room during lunch. Observation and interview on 11/05/24 at 12:55 P.M. revealed License Practical Nurse (LPN) #519 came in the room. She stated she does see flies in Resident #32's room. During the interview, LPN #519 killed a fly that was on the residents curtain, and the fly had landed on his head and then his arm. Interviews on 11/06/24 at 2:22 P.M. with STNA #506 and STNA #532 revealed they fill out a maintenance form for things like light bulbs or clogged sinks. They stated the facility had not had a maintenance man for over a month, but someone from their corporate office would come into the facility about every other day. STNA #506 and STNA #532 stated they did not notice the holes in the dry wall from the molding being pulled off in the bathrooms or toilet tiles being dark, but they were aware of Resident #32's wall being damaged. The STNA's stated the floors had been sticky for years, they thought there was too much soap being used, leaving a residue, and they had reported it before. They further stated they had seen flies in the building, and they felt the flies were in Resident #32's room because his room tended to be dirty and he didn't always shower. STNA #506 further stated that Resident #32 ate slow and he would fuss sometimes if you tried to take away the tray, so she would sometimes take things off the tray, like cake for example, and leave it in his room. Interview on 11/06/24 at 5:14 P.M. with the Administrator revealed they did have flies in the facility at times and they had a quarterly contract with an exterminator. She included they can call the exterminator to come more often if needed, which they have done. Observation on 11/07/24 at 9:04 A.M. revealed Resident #32 was sitting up in a wheelchair eating breakfast, there was a urinal on the floor and dried spilled brown liquid on the floor. Interview on 11/07/24 at 09:07 A.M. with STNA #506 verified the floor was soiled. Review of the pest control invoices revealed the last invoice dated 10/16/24 was a quarterly visit. The invoice also indicated that the last visit prior to 10/16/24, was 07/29/24. There was no indication of the facility treating for flies on the invoices.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was accurate regarding a psychiatric diagnosis. This affected one resident (Resident #7) of one resident reviewed for PASRR. Findings include: Review of Resident #7's medical record revealed an admitted [DATE] with diagnoses including major depressive disorder and unspecified psychosis not due to a substance or known physiological condition. Resident #7's care plan revealed care plans were in place for depression and psychosis. Review of Resident #7's PASRR documentation revealed only a PASRR document dated 05/24/19. The diagnosis for major depressive disorder and unspecified psychosis were not indicated on the PASRR documentation in section D of the document (indications of serious mental disorder). Review of Resident #7's Minimum Data Set (MDS), dated [DATE], revealed in section A: Pre-admission Screening and Resident Review the resident did not have a serious mental illness, intellectual disability or a related condition. Review of the MDS section I revealed the diagnosis of depression and psychotic disorder were indicated as active. Further review of the MDS revealed in section N (medications) the resident had received antidepressant medication in the past seven days. Interview on 11/04/24 at 3:05 P.M. with the Director of Nursing (DON) verified the diagnosis of major depressive disorder and unspecified psychosis were not indicated on the PASRR dated 05/24/19 and that the facility had not completed a resident review related to these diagnoses. Review of the policy titled Preadmission Screening and Resident Review (PASRR) Policy, updated January 2023, revealed if a resident was admitted with a result of a negative level I and there was subsequent evidence of possible, but previously, unrecognized or unreported serious mental illness the facility would complete a resident review.

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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** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure residents had comprehensive care plans to address their diagnoses, medications received, and activities of daily living (ADL's). This affected three residents (#4, #5, and #33) out of 15 residents reviewed for care plans. Findings include: 1. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified mild dementia without behavioral disturbances, major depressive disorder, hallucinations, insomnia, and adult onset diabetes mellitus. Review of Resident #5's admission Minimum Data Set (MDS) assessment, dated 08/28/24, revealed the resident's cognition was severely impaired. The MDS assessment was coded to reflect the resident was given insulin on five of the seven days of the assessment period. She was also coded as having received an antipsychotic and antidepressant medications. Review of Resident #5's physician's orders revealed the resident had orders to receive Aricept (a medication used in the treatment of Alzheimer's/dementia) 10 milligrams (mg) by mouth (po) once daily for dementia, Seroquel (an antipsychotic medication) 25 mg po every morning and 50 mg po at bedtime for hallucinations, Remeron (an antidepressant) 15 mg po at bedtime for major depressive disorder, Zoloft (an antidepressant) 75 mg po daily for depression, Melatonin (a supplement used for insomnia) 5 mg po at bedtime for insomnia, and Insulin Glargine (slow acting insulin) 100 units/milliliter (ml) with instructions to give 10 units subcutaneously at bedtime for diabetes mellitus. Review of Resident #5's active care plans revealed the facility did not develop a comprehensive care plan to address the resident's diagnoses of dementia, major depressive disorder, hallucinations, or insomnia. The active care plans also did not address the resident's diagnosis of adult onset diabetes mellitus or the use of insulin. On 11/06/24 at 2:08 P.M., an interview with Registered Nurse (RN) #600 confirmed Resident #5's active care plans were not comprehensive and did not include care plans to address multiple diagnoses or the use of psychotropic medications. She stated she noted the care plans seemed a little light when she printed them off. She stated the care plans were being developed by an MDS nurse that worked off-site, as well as the facility's nurse managers. They were hoping with the new Director of Nursing (DON) and Assistant Director of Nursing (ADON) starting, they would have them oversee the care planning process to ensure all the residents had the appropriate care plans in place to direct their care. Review of a policy titled Care Planning dated 08/2023 revealed the facility's interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident which should have been developed within seven days of the completion of the residents MDS assessment and should have been based on the comprehensive assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50538 2. Review of Resident #4's medical records revealed an admitted [DATE] and diagnoses of cerebral infarction, atherosclerotic heart disease, hypertension and hyperlipidemia. Review of Resident #4's physician orders revealed an order for Eliquis (an anticoagulation medication used to reduce the risk of blood clots) oral tablet 2.5 milligrams (mg) with instructions to administer 2.5 mg by mouth two times a day related to cerebral infarction. Review of Resident #4's care plan revealed there were no care plans present for anticoagulation medications or for the increased risk of bruising and bleeding related to the medications use. Interview on 11/06/24 at 2:30 P.M. with the Director of Nursing (DON) verified that there were no anticoagulation or risk for bleeding care plans present in Resident #4's medical record. Review of a policy titled Care Planning dated 08/2023 revealed the facility's interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident which should have been developed within seven days of the completion of the residents MDS assessment and should have been based on the comprehensive assessment. 47985 3. Record review revealed Resident #33 admitted to the facility on [DATE] with diagnoses including dementia, hypothyroidism, anxiety disorder, and insomnia. Review of an admission minimum data set (MDS) assessment, dated 08/01/24, revealed Resident #33's cognition was impaired and she required the following assistance for activities of daily living (ADLs): set-up help for eating and oral hygiene, moderate assistance for toileting hygiene, maximum assistance with bathing, supervision for upper and lower body dressing, moderate assistance for applying and taking off footwear and personal hygiene, supervision for transfers, substantial assistance for shower transfers, moderate assistance for car transfers, and was independent for walking 10 feet and bed mobility. Review of Resident #33's comprehensive care plan revealed there was not a care plan in place for ADLs. Interview on 11/06/24 at 4:28 P.M. with the Director of Nursing (DON) confirmed Resident #33 did not have an ADL care plan in place. Review of a policy titled Care Planning dated 08/2023 revealed the facility's interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident which should have been developed within seven days of the completion of the residents MDS assessment and should have been based on the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review, observation, interview, and review of policies and procedures, the facility failed to ensure a dependent resident received assistance with bathing, showers, shaving, and oral care. This affected one (Resident #32) of three residents reviewed for activities of daily living. The census was 33. Findings include: Review of Resident #32's record revealed the resident was admitted on [DATE] with diagnoses including dementia with behavioral disturbance, myocardial infarction, acute kidney failure, gastroesophageal reflux disease, Alzheimer's disease, muscle weakness, repeated falls, cognitive communication deficit, malignant neoplasm of bronchus or lung, chronic gout, and osteoarthritis. Review of the quarterly Minimum Data Set Assessment (MDS) assessment, dated 10/10/24, revealed Resident #32 was moderately impaired for daily decision making, had difficulty focusing, was easily distractible or had difficulty keeping track of what was said, he had behavior fluctuations, had no rejection of care, had no upper or lower extremity impairment, and he utilized a wheelchair. The resident required substantial/maximum (sub/max) assistance for oral hygiene, toileting, transfers, upper and lower body dressing, and going from a sitting position to lying, as well as lying to sitting. The resident also refused showers, was frequently incontinent of bladder and occasionally incontinent of stool. Review of the activities of daily living (ADL) care plan for Resident #32, dated 03/12/24, revealed the resident had a self care performance deficit related to dementia with other behavior disturbance, acute respiratory failure with hypoxia, nutrition deficiency, hyponatremia, Alzheimer's disease, muscle weakness, repeated falls, cognitive communication deficit, malignant neoplasm of bronchus or lung, vitamin B deficiency, chronic gout, and osteoarthritis. He required set-up to total dependence to complete ADLs. The resident required sub/max assistance to partial/moderate assistance of one staff member to maintain his current level of function in bed mobility, ambulation, transfers, eating, dressing, toilet use, personal hygiene and bathing. The assessment also indicated the resident required total assistance of one staff for bathing. Review of the shower binder revealed Resident #32 was to receive a shower on Wednesdays and Sundays during the night shift. Review of the shower sheets for October 2024 through November 2024 revealed on 10/03/24 (Thursday) the resident refused bathing assistance, on 10/06/24 (Sunday) the resident received a shower, there was no evidence of attempting a shower/bath on 10/09/24 (Wednesday), on 10/13/24 (Sunday) the resident received a shower, on 10/16/24 (Wednesday) the resident received a bed bath, on 10/20/24 (Sunday) the resident received a shower, on 10/23/24 (Wednesday) and 10/27/24 (Sunday) the resident refused bathing assistance, on 10/30/24 (Wednesday) the resident received a shower, there was no evidence of attempting a shower/bath on 11/03/24 (Sunday), and on 11/06/24 (Wednesday) he refused bathing assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 11/04/24 at 1:20 P.M. of Resident #32 revealed he was in his room in a wheelchair. The front of his shirt was wet, his pants were pulled down to his thighs, and his underwear were pulled up. The resident was not shaved. The resident stated he had used the urinal and he could not get his pants up. He stated he had dentures, but didn't brush them, and he had a toothbrush, but no toothpaste. Interview and observation on 11/04/24 at 4:52 P.M. revealed Resident #32 in a wheelchair. His right hand and arm were shaking. The resident stated he was concerned about his right arm shaking, making his whole body shake. Interview and observation on 11/05/24 at 8:37 A.M. revealed Resident #32 was sitting in a wheelchair in his room. The resident was in a patient gown and he remained unshaven. The resident stated he needed shaved and he had, again, not brushed his dentures because he had no toothpaste. Interview on 11/05/24 at 12:45 P.M. with State tested Nursing Assistant (STNA) #506 revealed she could usually talk Resident #32 into a shower and a shave, but the resident was suppose to receive his showers from the night shift. Interview and observation on 11/05/24 at 1:03 P.M. with STNA #500 revealed night shift was suppose to take out the resident's dentures and day shift was to assist the resident to put the dentures back in, but Resident #32 already had them in this morning. She stated the resident had supplies if he wanted to brush his dentures, but that she didn't help the resident brush his dentures. The aide pointed out where the supplies were, the tooth brushing supplies were in a bath basin in the bathroom, on a shelf that the resident would not be able to reach from his wheelchair. She said they had to take the basin down for the resident and he could brush his own dentures. Toothpaste was observed in the basin. STNA #500 stated she showered and shaved Resident #32 last week (on 10/30/24) because he had an odor. She indicated the resident allowed day shift to shower him and she didn't know if night shift asked him to shower and shave. She indicated she was going to shave Resident #32 today. Interview on 11/06/24 at 2:22 P.M. with STNA #506 revealed the staff were to give Resident #32 his bath basin of personal hygiene products to brush his teeth. The STNA then verified she had seen Resident #32's right arm shaking and she agreed that Resident #32 should not be cleaning his dentures by himself when he was shaking for fear of dropping them. Interview on 11/06/24 at 4:26 P.M. with the Director of Nursing (DON) revealed the facility bathing policy didn't address how often a resident was to be showered or what to do for a refusal. She confirmed the shower schedule indicated Resident #32 was to receive assistance with showers on Wednesdays and Sundays. The DON verified there was no evidence of the staff offering showers on the next shift after a refusal. The DON further confirmed Resident #32 went a week without a shower from 10/06/24 to 10/13/24 and 10 days without a shower from 10/20/24 to 10/30/24. Review of the facility's Bathing Policy, revised August 2023, included residents had the option to take a bath/shower/bed bath as often as they would like and the resident could choose what time of day they wanted to bathe.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, family interview, staff interview, review of the facility assessment, and review of facility policy and procedure, the facility failed to ensure activities were available for resident participation. This affected one resident (Resident #30) out of three residents reviewed for activities. The census was 33. Findings include: Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including mild protein calorie malnutrition, abnormalities of gait, anxiety, vitamin D deficiency and alcohol dependence. Review of the Admission Minimum Data Set Assessment (MDS) assessment, dated 12/18/23, revealed it was somewhat important for the resident to listen to music, to do things with groups of people, to do favorite activities, to go outside to get fresh air, and attend religious services; music and bingo were a current interest, and watching movies were a past interest. The Quarterly MDS assessment, dated 09/06/24, revealed the resident was moderately impaired for daily decision making, had no behaviors, and utilized a walker. Review of the activity care plan, dated 12/31/23, revealed the resident was dependent on staff for activities, cognitive stimulation, social interaction related to a disorder of bone density, anxiety, left hip pain, dermatitis, history of falls, abnormalities in gait and mobility, mild protein calorie malnutrition, hyperosmolality/hyponatremia, hypokalemia, alcohol dependence, nicotine dependence and urinary tract infection. Interventions included the resident would attend and participate in activities of choice three to five times weekly, to encourage ongoing family involvement, invite family to attend special events, activities, and meals, the resident needed 1 to 1 bedside/in-room visits and activities if unable to attend out of room events, and the resident needed assistance/escort activity functions. Review of the October 2024 activity participation calendar revealed Resident #30 did not have three to five activities per week for the month, per the care plan. The resident was identified as participating in one arts and crafts activity, two religious services, one sing along, and two special events. Additional activities noted for the month of October 2024 revealed activities such as social hour (going to the dining room for meals), personal grooming (defined as the aides assisting the resident to get ready for the day), a movie (they have a machine in the Administrators office that would play a movie of choice over a certain channel so all residents could watch the movie in their room on that channel), group discussion (talking to others at dining), and family visits. Review of the November 2024 activity participation calendar revealed Resident #30 had not been to any activities except to go to the dining room at lunch and supper. Interview on 11/04/24 at 11:01 A.M. with Resident #30's family member revealed he never saw Resident #30 in activities and never saw activities staff in the resident's room. The family member further stated that Resident #30 had very poor vision. (continued on next page)

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Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/04/24 at 11:01 A.M. of Resident #30 revealed she was in her room sitting on the bed, dressed in street clothes, with a clean appearance. The television was off and there was no music on, there was nothing noted in the room that would be considered an activity. Observation on 11/04/24 at 2:07 P.M. revealed Resident #30 was lying on her left side in the bed and the television was off. Observation on 11/05/24 at 8:36 A.M. revealed Resident #30 was sitting on the side of the bed in her room and the television was off. Interview on 11/05/24 at 9:04 A.M. with Activity Director #531 revealed she was the only activity person for the building since Coronavirus (COVID) started and the Administrator had recently been allowed to hire activity aides. She stated the building had a locked memory care unit on the second floor and it was difficult to do activities in the Memory Care and the regular unit. Activities Director #531 further revealed that Resident #30 participated in a few activities and sometimes she will sit and talk to Resident #30 for a 1:1 activity. Interview on 11/05/24 at 11:49 A.M. with Activities Director #532 revealed there had been days where she was pulled to work other areas, such as dietary or to help on the floor as an aide. She stated any activities scheduled those days, would not be completed. Activities Director #532 stated she would help bring residents to the dining room at lunch, pass out drinks and clothing protectors, make sure they had their silverware, and at the breakfast meal she would help pass out room trays. Observation on 11/05/24 at 2:15 P.M. revealed Resident #30 was in bed resting and the television was off. Observation on 11/06/24 at 10:00 A.M. revealed Resident #30 was in bed on her left side and the television was off. Review of the Facility Wide Assessment, undated, revealed the facility would utilize the information collected in the resident profile to identify the care and services needed to care for their residents. It stated the facility would evaluate the type of staff members, other health care professionals, and medical practitioners that were needed to provide support and care for the residents. Activities Professionals and other activities staff were listed as staff that were needed to care for the facility's resident population. Review of the facility policy titled, Activities, revised January 2020, revealed activities were to be scheduled daily including weekends.

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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** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure skin prevention interventions were implemented for a resident with a known pressure ulcer per the plan of care. This affected one resident (Resident #28) of one resident reviewed for pressure ulcers. Findings include: Review of Resident #28's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included an unstageable pressure ulcer to an unspecified site, history of a right femur fracture, reduced mobility, muscle weakness, difficulty in walking, protein- calorie malnutrition, unspecified dementia, and adult failure to thrive. Review of Resident #28's quarterly Minimum Data Set (MDS) assessment, dated 09/17/24, revealed the resident had clear speech and minimal difficulty hearing, she was able to understand others and was usually able to make herself understood, her cognition was severely impaired and she had a functional limitation in her range of motion on one side of her lower extremity. The resident was at risk for pressure ulcers and she was identified as having an unhealed pressure ulcer. It stated she had two Stage II pressure ulcers (partial-thickness loss of skin with exposed dermis, that presents as a shallow open ulcer) that was present upon admission. She was also identified as having two deep tissue injuries (type of pressure ulcer that occurs when the soft tissue beneath the skin was damaged by pressure or shear forces) that were not present on admission. Review of Resident #28's physician's orders, dated 08/01/24, revealed the resident had an order in place to apply Prevalon boots to her bilateral feet while in bed or in a chair, and anytime there could be pressure to the heels. She also had an order, dated 08/09/24, to encourage the resident to elevate her heels while in bed as tolerated. Review of Resident #28's treatment administration record (TAR) for November 2024 revealed the nurses were initialing the implementation of the use of Prevalon boots to the resident's bilateral feet every shift. The TAR was signed off to reflect the Prevalon boots were in place daily through 11/05/24. On 11/04/24 at 10:52 A.M. an observation of Resident #28 noted her to be lying in bed. She had a dressing intact to her right foot/heel. Her heels were not offloaded as they were in direct contact with her air mattress and there were no Prevalon boots in place as ordered. On 11/05/24 at 12:20 P.M., further observation of Resident #28 revealed the resident was lying in bed without Prevalon boots on and her heels were not offloaded to help promote wound healing of her pressure ulcer on her right heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 12:22 P.M., an interview with Licensed Practical Nurse (LPN) #530 verified Resident #28 did not have the Prevalon boots on and her heels were not offloaded while in bed. She stated Resident #28 did have a pressure ulcer on her right heel and that the resident was supposed to have the use of Prevalon boots to help alleviate pressure off her heels. She claimed the resident did not like to wear them and she would kick them off, and that they also tried to float her heels, but the resident would kick the object used, out from under her feet, as well. She acknowledged the resident was observed to not have her Prevalon boots on her bilateral feet the past couple of days and the boots were not able to be located in her room. She stated they likely had a pair in the storage closet in the hall that could be retrieved for use. LPN #530 further acknowledged they were initialing the TAR to reflect the Prevalon boots were being implemented as ordered the past couple of days, when the resident was actually observed to not have them on and they could not be found in the resident's room. She obtained a pair of Prevalon boots from the storage closet and asked the resident if she would allow her to put them on. The resident agreed and the nurse applied the Prevalon boots as ordered. Review of the facility's policy on Pressure Injury Treatment, reviewed August 2023, revealed residents with pressure injuries would be treated with consistent treatment protocols to aid in the healing process. In addition, residents with pressure injuries would have an individualized treatment program that provided the appropriate treatment to facilitate healing and that assessed and addressed comorbid conditions in a systematic manner.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure fall prevention interventions were implemented for residents at risk for falls. This affected three (Resident #5, #11, and #28) of five residents reviewed for accidents/supervision. Findings include: 1. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included mild dementia without behavioral disturbances, adult onset diabetes mellitus, hypertension, and osteoarthritis. Review of Resident #5's admission Minimum Data Set (MDS) assessment, dated 08/28/24, revealed the resident had clear speech, she was able to make herself understood, and was usually able to understand others. Her cognition was severely impaired and she displayed verbal behaviors directed at others 1 to 3 days over the seven day assessment period. The resident required a substantial to maximum assistance for going from a sitting to a lying position, lying to sitting on the side of the bed, chair to bed transfers, and toilet transfers. She was not noted to have had any falls since her admission into the facility. Review of Resident #5's active care plan revealed she had a care plan in place for being at risk for falls due to her cognitive deficit, with a goal for her to be free of falls. The interventions included staff were to assist the resident with ambulation and transfers. She was also to wear non-skid footwear at all times, as tolerated, initiated on 10/28/24. Review of Resident #5's nurses' progress notes revealed a nurse's note dated 10/25/24 at 5:00 A.M. that indicated the nurse was notified by an aide that the resident was sitting on the floor in the hallway in front of her closed door, next to her wheelchair. The nurse noted that she had witnessed Resident #5 in her bed, with the wheelchair by her bed, less than 15 minutes prior to the fall. The resident stated she was trying to come back out so she was ready when they came to get her. She stated she slipped while trying to get into her chair. The nurse assessed the resident for injuries and no injuries were noted. The resident was reminded to use her call light for assistance when needing to transfer. Further review of Resident #5's progress notes revealed an interdisciplinary team (IDT) note dated 10/26/24 at 11:33 A.M. and the IDT met to review the resident's recent fall. Root probable cause of the fall was the resident self-transferred without proper footwear to prevent sliding. The resident was to have non-skid footwear on at all times. Staff were made aware of the new intervention. On 11/04/24 at 2:16 P.M., an observation of Resident #5 noted her to be lying in bed with bare feet. She was not noted to have any non-skid socks on per her plan of care for fall prevention. On 11/06/24 at 8:08 A.M., a follow up observation of Resident #5 noted her to be in bed eating her breakfast. She was not noted to be wearing non-skid socks per her plan of care for fall prevention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 8:10 A.M., an interview with Licensed Practical Nurse (LPN) #504 revealed she was somewhat familiar with Resident #5. She stated she was not sure if the resident was at risk for falls as she stated she only worked at the facility part time and the last time she worked she was assigned a different hall. She confirmed the resident's plan of care for her fall risk included the use of non-skid socks to be worn at all times and she confirmed Resident #5 did not have on non-skid socks. LPN #504 was informed that on 11/04/24, Resident #5 was also observed in bed with bare feet. She stated sometimes residents would kick their socks off. The nurse was asked to go to Resident #5's room to see if she had non-skid socks in her bed to show they may have been in place and just removed by the resident, but she was not able to find any non-skid socks in the resident's bed or in her room. She obtained a pair of non-skid socks from the storage closet in the hall and assisted the resident with putting them on, the resident was compliant in doing so. Review of the facility's policy on Managing Falls and Fall Risk, reviewed August 2023, revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. 2. Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included a history of a right femur fracture, adult onset diabetes mellitus, unspecified dementia, reduced mobility, muscle weakness, difficulty in walking, and hypertension. Review of Resident #28's quarterly Minimum Data Set (MDS) assessment, dated 09/17/24, revealed the resident had clear speech and minimal difficulty hearing, she was able to understand others and was usually able to make herself understood, and her cognition was severely impaired. It stated the resident had verbal behaviors directed at others and was known to reject care 1 to 3 days out of the seven day assessment period. The resident had a functional limitation in her range of motion on one side of her lower extremity and the resident was identified as having had a fall since the prior assessment and the resident had one fall with injury that was not major. Review of Resident #28's active care plans revealed the resident had a care plan in place for being at moderate risk for falls related to ulcers to her bilateral feet, impaired mobility, decreased safety awareness, generalized weakness, diabetes mellitus, and prescribed use of pain medication and insulin. The goal was for the resident to have decreased falls through the next review date. Resident #28's interventions included fall mats at bedside on floor which was initiated on 09/17/24. Further review of Resident #28's care plans, initiated 04/29/24, revealed she also had a care plan in place for having had an actual fall, with a goal to have decreased falls through the next review date. The interventions included to encourage non-skid socks at all times as the resident allowed/tolerated (initiated 05/10/24), and a sign to remind the resident to call for assistance with transferring and ambulating (initiated 05/10/24). Review of Resident #28's physician's orders revealed the orders included the need for a sign in the resident's room to remind resident to call for assistance with transferring/ambulating (initiated 05/13/24), and to encourage non-skid socks at all times as the resident allowed and/or tolerated (initiated 05/10/24). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/04/24 at 1:18 P.M. an observation of Resident #28 noted her to be in bed, she did not have any fall mats on the floor at her bedside and was not noted to be wearing any non-skid socks. There were also no signs posted in her room to remind the resident to ask for assistance for transfers and ambulation. On 11/05/24 at 8:40 A.M., further observation of Resident #28 noted her to be lying in bed in a supine position with the head of her bed up. The resident had just been given her medications by Licensed Practical Nurse (LPN) #530. As the nurse left the resident's room, she was asked to verify if the resident had her fall prevention interventions in place. On 11/05/24 at 8:41 A.M., an interview with LPN #530 confirmed Resident #28 did not have a sign posted in her room to remind her to ask for assistance when needing up. LPN #530 further confirmed Resident #28 was not wearing non-skid socks and there were no fall mats on the floor next to the residents bed. LPN #530 stated she was not aware the resident was supposed to have fall mats on the floor next to the residents bed. Review of the facility's policy on Managing Falls and Fall Risk, reviewed August 2023, revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. 26706 3. Review of Resident #11's medical record revealed an admitted [DATE] and diagnoses including fracture of upper end of left humerus, obesity, type 2 diabetes, falls, nontraumatic subdural hemorrhage, non traumatic subarachnoid hemorrhage, fractured right wrist and hand, difficulty walking, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/16/24, revealed Resident #11 was severely impaired for daily decision making and had no behaviors. It stated the resident had no upper or lower extremity impairment, she utilized a walker and wheelchair, she was frequently incontinent of bowel and bladder, and she had no falls since the last assessment. Review of Resident #11's care plan, dated 12/17/24, revealed the resident was at risk of falls with interventions that included to place Dycem to the wheelchair on top of the cushion and Dycem under the cushion of the wheelchair. Review of physician orders revealed an order for Dycem under the residents chair cushion as the resident would tolerate/allow (initiated 01/04/24) and Dycem to the wheelchair (on top of cushion) as the resident would allow/tolerate related to a fall investigation (initiated 05/13/24). Review of the fall investigation for Resident #11 revealed the residents last fall was 04/28/24 when the resident was seated at the nurse station, and she fell out of her wheelchair. Resident #11 had a large goose-egg sized, hematoma above her right eye. Observation on 11/04/24 at 11:53 A.M. revealed Resident #11 was in her room in a wheelchair. There was no Dycem noted to her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/04/24 at 2:01 P.M. revealed Resident #11 was in her room in a wheelchair, a lift pad was under her and there was no Dycem that could be visibly observed. Observation on 11/05/24 at 1:17 P.M. revealed Resident #11 was was self propelling her wheelchair in the hall, and attempted to wheel into another residents room. Licensed Practical Nurse (LPN) #519 stopped Resident #11 and told her that was not her room. Resident #11 was visibly incontinent of urine. State tested Nurse Aide (STNA) #500 and LPN #519 gathered incontinence supplies and returned Resident #11 to her room. When they assisted the resident to stand, there was a Dycem between the lift pad and the top of the seat cushion, but there was no Dycem under the wheelchair cushion as ordered. Interview on 11/05/24 at 1:24 P.M. with LPN #519 verified there was no Dycem under the wheelchair cushion as ordered. Review of the facility's policy on Managing Falls and Fall Risk, reviewed August 2023, revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to adequately assess, monitor, and manage Resident #33's pain after a fall. This affected one (#33) of one resident reviewed for pain. The facility census was 33. Findings include: Record review revealed Resident #33 admitted to the facility on [DATE] with diagnoses including dementia, hypothyroidism, anxiety disorder, and insomnia. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33's cognition was impaired and she did not have pain. Review of a medication administration record for October 2024 revealed Resident #33 had an order in place starting on 09/19/24 for Acetaminophen tablet 325 milligrams take two tablets by mouth every eight hours as needed for pain. Review of a progress note dated 10/21/24 at 9:29 P.M. by Registered Nurse (RN) #512 revealed Resident #33 was found in her room at 5:45 P.M. laying on the floor on her back, was assessed for injuries and vitals were obtained. Resident #33 was assisted into bed by two staff then sent to the hospital due to hitting the back of her head. Family and provider were notified, neurological checks were continued and within normal limits. Review of a progress note dated 10/22/24 at 7:03 P.M. by Licensed Practical Nurse (LPN) #514 revealed a mobile x-ray of left and right hips was completed due to Resident #33 complaining of pain with movement. Review of a progress note dated 10/22/24 at 10:33 P.M. by LPN #514 revealed x-ray results were received of bilateral hips and pelvis with no acute skeletal injuries noted, provider was aware and representative was to be made aware in the morning. No new orders were received. Review of the medical record revealed Resident #33 did not have a comprehensive care plan related to pain and there were no additional notes from 10/22/24 through 10/23/24 to assess, monitor or address Resident #33's pain with movement. Review of the MAR for 10/2024 revealed Resident #33 received 650 mg of Acetaminophen on 10/23/24 at 11:36 A.M. but did not state her pain level or if the medication was effective. Review of a note dated 10/24/24 at 1 P.M. by LPN #501 revealed Resident #33 was sent to the emergency room to get an x-ray of the right hip due to complaints of excruciating pain to right hip. Resident #33 had a fall on 10/21/24 and in-house x-rays were completed but negative for a fracture. Resident #33 was screaming in pain with transfers, standing, and rolling in bed. Provider was notified as well as family. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a hospital note dated 10/24/24 at 9:56 P.M. revealed Resident #33 had a CT scan which showed a intertrochaneric proximal right femur fracture with posterior angulation as well as a transverse sacral fracture. Interview on 11/06/24 at 1:56 P.M. with LPN #501 revealed on 10/24/24, Resident #33 had been quiet unless moved, then she would yell. LPN #501 stated that was not common for Resident #33 because she was ambulatory, and staff would walk with her. LPN #501 stated she asked Resident #33 if her hip hurt, then touched her hip and Resident #33 screamed. LPN #501 stated initially Resident #33 was able to stand and pivot to her chair fine but they went to lay her down to change her and that was when Resident #33 began to screamed and when transferred back to her bed, Resident #33 would not put weight on her right leg. LPN #501 stated when she arrived to work on 10/24/24 the as needed acetaminophen was not effective. Interview on 11/06/24 at 2:16 P.M. with State tested Nursing Assistant (STNA) # 506 revealed when Resident #33 fell on [DATE], she hit her head and was bleeding but did not have complaints of pain anywhere else. STNA #506 stated the following day (10/22/24) Resident #33 began to complain of pain in her right hip. Resident #33 kept touching her hip and saying it hurts. STNA #506 stated Resident #33 would say ouch, it hurts during care and although she is often agitated, her agitation seemed to have increased. STNA #506 stated staff kept checking Resident #33's hip since she was complaining of pain but it looked fine so the staff believed Resident #33 was just sore from the fall. Interview on 11/07/24 at 4:28 P.M. with LPN #514 revealed she could recall Resident #33 had fallen and required staples in her head, in-house x-rays were completed and were negative, but about two days later, Resident #33 was sent out to the hospital where fractures were found. LPN #514 stated Resident #33 was not yelling out or crying, but when she would be rolled there were some uncomfortable sounds but nothing was alarming. LPN #514 could not recall if she had administered the as needed acetaminophen or not. Interview on 11/07/24 at 9:30 A.M. with Director of Nursing (DON) confirmed Resident #33, who began to complain of pain on 10/22/24, did not received pain medication after complaints of pain. DON confirmed Resident #33 did have Acetaminophen on 10/23/24, but there was no documentation explaining why the as needed medication was administered, no pain assessment, and no re-assessment to determine if the medication was effective. DON confirmed Resident #33 was sent to the hospital on 10/24/24 with excruciating pain and stated staff should have administered as needed pain medication when Resident #33 began to complain of pain on 10/22/24. Review of a policy titled Pain Assessment and Management dated 08/2022 revealed pain management if based on a facility-wide commitment to appropriate assessment and treatment of pain based on professional standards of practice, the comprehensive care plan ,and the resident's choices related to pain management. Pain management is a multidisciplinary process that includes recognizing the presence of pain, identifying the characteristics of pain, attempting to address the underlying cause of pain, monitoring for the effectiveness of interventions, and modifying approaches as necessary. Pain assessments are completed upon admission, quarterly, for significant changes, and as needed. While recognizing pain, staff should observe for behavioral signs of pain such as crying or groaning; behaviors such as resisting care, irritability, depression, decreased participation in usual activities; and guarding, rubbing, or favoring a particular part of the body. The reported level of pain should be documented, along with the intervention and reassessment of pain after the intervention is implemented.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure abnormal involuntary movement scale (AIMS) assessments were completed on a resident receiving antipsychotic medication to monitor for side effects associated with antipsychotic medication use. This affected one (Resident #5) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included mild dementia without behavioral disturbances, major depressive disorder, and hallucinations. Review of Resident #5's physician's orders revealed the resident was ordered to receive Seroquel 25 milligrams (mg) by mouth (po) every morning and 50 mg po every night at bedtime for hallucinations. The medication had been ordered since 09/03/24. Resident #5's medical record was absent for any evidence of the resident having an AIMS assessment (a 12 item rating scale used to assess the severity of abnormal movements in residents taking neuroleptic/ antipsychotic medications) completed since the antipsychotic medication was ordered. There was no evidence of an AIMS assessment being completed, upon initiation of the antipsychotic medication, to determine a baseline for the presence of any abnormal involuntary movements or ongoing assessments to determine if those abnormal involuntary movements developed or worsened that had previously been noted. Findings were verified by the Director of Nursing (DON). On 11/07/24 at 11:05 A.M., an interview with the DON revealed residents on antipsychotic medications should have an AIMS assessment completed to monitor them for side effects such as extrapyramidal symptoms (Parkinsonian-like symptoms such as stiffness, tremors, or shuffling gait) or tardive dyskinesia (uncontrollable movements involving the face). She stated they should have completed an AIMS assessment upon initiation of the antipsychotic medication, repeating it at 30 days, 60 days, 90 days, then quarterly or after a dosage change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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 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. 47985 Based on observations, interviews, and policy review, the facility failed to ensure foods were stored and served in a sanitary manner. This had the potential to affect 33 of 33 residents who receive food from the facility. Findings included: 1. Continuous observations during an initial tour of the kitchen on 11/04/24 from 8:29 A.M. to 8:44 A.M. revealed two cartons of cream with an expiration date of 11/01/24 in the walk-in refrigerator; an undated gallon Ziploc bag of beets, an undated Styrofoam container of leftovers, a bag of cookies dated 10/16/24, six undated cups of coleslaw, four undated cups of fruit, two undated bowls of salad, and two undated cups of dessert in the standing refrigerator; two 48 ounce jars of Dijon mustard with an expiration date of 10/20/24 and half of a five pound container of chili powder with an expiration date of 09/08/24 were in the dry storage area; and after running the dish washer four times, the machine would not heat past 175 degrees to the required rinse temperature of 180 degrees. Interview on 11/04/24 at 8:31 with [NAME] #537 confirmed the findings in the standing refrigerator. Interview on 11/04/24 with Dietary Supervisor (DS) #538 confirmed findings in the walk-in refrigerator, dry storage area, and the dish washing area. DS #538 stated the rinse temperature of the dishwasher had been reaching 180 degrees, and this was the first time it did not. DS #538 reviewed the dishwasher wash and rise temperature logs and there were no concerns noted. DS #538 immediately began to serve food on disposable dishes until the dishwasher could be repaired. Review of a policy titled Food Safety and Sanitation dated 2021 revealed stored food should be handled to prevent contamination and growth of pathogenic organisms; all time and temperature control for safety foods should be labeled, covered, and dated when stored; when a food package is opened, the food item should be marked to indicate the open date which is used to determine when to discard the food; leftovers should be used with 72 hours or discarded; perishable foods with expiration dates should be used prior to the use by date on the package; and canned and dry foods without expiration dates should be used within six months of delivery or according to the manufacturer's guidelines. 2. Observation of tray line on 11/05/24 at 11:50 A.M. revealed [NAME] #537 removed her gloves, did not wash her hands, and applied new gloves then continued preparing trays. Observation of tray line on 11/05/24 at 11:53 A.M. revealed [NAME] #537 removed her gloves, did not wash her hands, and applied new gloves then continued preparing trays. Observation of tray line on 11/05/24 at 11:56 A.M. revealed [NAME] #537 removed her gloves, did not wash her hands, and applied new gloves then continued preparing trays. Interview on 11/05/24 at 12:21 P.M. with [NAME] #537 confirmed she had changed her gloves multiple times while preparing food for the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	11/07/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a policy titled Hand Washing dated 2021 revealed hands should be washed during food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks, before donning disposable gloves for working with food and after gloves are removed.