STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375166	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Healthcare Center	1501 Clayton Avenue Poteau, OK 74953

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46703 Based on observation, record review, and interview the facility failed to ensure a resident's dignity was maintained by providing clean clothes after meals for 1 (#72) and failed to ensure dignity with dining for 1 (#48) of 2 sampled residents reviewed for dignity. Corporate Nurse #1 identified 87 residents who resided in the facility. Findings: 1. Resident #72 had diagnoses which included dementia. On 02/20/25 at 4:02 p.m., the resident was observed in the dining room waiting to be served dinner wearing a black T-shirt with food debris on it. On 02/25/25 at 2:24 p.m., the resident was observed in the common area, in a chair, with food debris on their shirt and blanket. The quarterly assessment, dated 12/20/24, showed Resident #72 was severely impaired in cognition for daily decision making. On 02/25/25 at 3:15 p.m., LPN #3 stated resident #72 had been in the common area since just after lunch. They stated they did not know why the staff brought the resident out to the common area with food on them, but stated they should have cleaned them up. 35474 2. Resident #48 had diagnoses which included dementia. On 02/21/25 at 8:44 a.m., Resident #48 was observed being assisted with the noon meal in their room. CNA #1 was observed to stand while assisting the resident with their meal. The annual assessment, dated 01/30/25, showed Resident #48 was severely impaired in cognition for daily decision making. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/25 at 7:58 a.m., CNA #1 stated they preferred to stand when assisting residents with their meals in their rooms. On 02/25/25 at 10:30 a.m., LPN #1 stated they thought staff should sit when assisting residents with their meal but would need to check with their supervisor. On 02/25/25 at 10:38 a.m., the DON stated staff were to sit when assisting residents with their meals to maintain the residents' dignity. On 02/25/25 at 11:21 a.m., LPN #1 stated they had found out from their supervisor that staff should sit when assisting residents with their meal.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46703 Based on observation, record review, and interview the facility failed to assess a resident for self administration of medication for 1 (#35) of 1 sampled residents who was reviewed for self administration of medication. The DON identified 5 residents that self administered medication. Findings: Resident #35 had diagnoses which included chronic obstructive pulmonary disease. On 02/21/25 at 9:15 a.m., Resident #35 was observed at the bedside self administering Albuterol Sulfate HFA Aerosol Solution 108 (90 base) MCG/ACT. The Self Administration of Medications policy, dated December 2016, read in part, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. In addition to general evaluation of decision making capacity the staff and practitioner will perform a more specific skill assessment. The annual assessment, dated 11/28/24, showed the resident was cognitively intact for daily decision making. On 02/26/25 at 8:30 a.m., LPN #5 reviewed the electronic clinical record and stated there was not an assessment for self administering an inhaler for Resident #35. They stated it was the nurses responsibility to perform an assessment to have medications at the bedside. The nurse stated they did not know why an assessment had not been completed. On 02/26/25 at 8:50 a.m., the DON stated the charge nurses were responsible to complete an assessment for residents to self administer medications. They stated the facility's policy for self administration of medications had not been followed for Resident #35.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41809 Based on record review and interview, the facility failed to ensure notification was made to a resident's guardian for 1 (#15) of 1 resident reviewed for notification of change. The administrator identified 87 residents who resided at the facility. Findings: A Change in a Resident's Condition or Status policy, revised May 2017, read in part, Our facility shall promptly notify the resident, [their] Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .changes in level of care, billing/payments, resident rights. Resident #15 had diagnoses which included major depressive disorder, schizophrenia, and anxiety. A behavior note, dated 02/06/25 at 9:23 p.m., showed the nurse had overheard Resident #15 state they wanted to die to their roommate. A behavior note, dated 02/06/25 at 9:26 p.m., showed the nurse entered the room of Resident #15 and asked if they were okay. Resident #15 stated they wanted to be changed and put to bed. The note showed Resident #15 was frustrated about having to wait to be changed for bed. A behavior note, dated 02/06/25 9:41 p.m., showed a CNA approached LPN #3 and stated Resident #15 stated, [They] wishes [they] was dead and [they] didn't have to deal with this [expletive]. That [they] just wanted to die. A health status note, dated 02/06/25 at 9:50 p.m., showed emergency management services was notified per the physician, but Resident #15 declined to go for further evaluation. A health status note, dated 02/06/25 at 9:54 p.m., showed Resident #15 had declined a blood draw and urine sample and stated they were tired and they were speaking out of frustration and being agitated. Resident #15 stated they did not want any of their family notified of the situation. A health status note, dated 02/07/25 at 9:04 a.m., showed Resident #15 was previously on 1:1 due to their comment of wanting to die. The note showed LPN #4 spoke with Resident #15 and they reported they were just upset the day before and wanted to retract their statement. Resident #15 stated they had no plans or intentions of hurting themselves. A communication note, dated 02/07/25 at 10:18 a.m., showed the SSD consulted with Resident #15 and the resident expressed having thoughts of suicide, which appeared to be more a result of frustration. The note showed Resident #15 discussed their feelings and clarified they had no active plan to act on their thoughts. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note, dated 02/07/25 at 2:28 p.m., showed a call was placed to the physician to notify of recent behaviors, but had to leave a message. An outside physician visit note, dated 02/09/25 at 2:39 p.m., showed Resident #15 voiced no concerns or needs and to continue with current plan of care. On 02/25/25 at 8:36 a.m., the SSD stated Resident #15 was asked about suicidal ideations and they stated they had a thought about suicide a while back, but after speaking to Resident #15 they had said it out of frustration. On 02/26/25 at 10:06 a.m., LPN #4 stated the behavior of Resident #15 happened the day before it was reported to them. They stated Resident #15 told them they did not mean what was said about suicide and was frustrated from the situation. LPN #4 stated they had Resident #15 brought to the nurses station for one on one observation. LPN #4 stated they informed Resident #15 of the policy and why they were required to receive one on one. LPN #4 stated Resident #15 did not like being at the station and stated they would never again. LPN #4 stated they did not notify the guardian of the suicide statement because Resident #15 made their own decisions. They stated it had occurred on the previous shift and was passed on to them in report. LPN #4 stated if the previous shift had notified the guardian, it would have been documented in the progress notes. No documentation of notification to the guardian was located in the clinical record. On 02/26/25 at 12:50 p.m., LPN #3 stated they had heard Resident #15 was upset and mentioned something about wanting to die, and spoke with them. They stated they asked how the statement came about and Resident #15 reported they was aggravated because it was taking the aides too long to get to them. LPN #3 stated Resident #15 was very upset and aggravated and after telling them the consequences of their words, Resident #15 tried to take everything back and they did not want anybody notified. They stated they tried to notify family around 11:00 p.m. and there would be a progress note in the clinical record. No progress note regarding notification to the guardian was located in the clinical record. On 02/26/25 at 11:36 a.m., the corporate nurse stated Resident #15 was not their own person and had a guardian. The stated the guardian should have been informed, but they did not see any documentation they were notified.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41809 Based on record review and interview, the facility failed to assess and monitor the dialysis port for 1 (#24) of 1 resident who was reviewed for dialysis services. The corporate nurse identified four residents who received dialysis services. Findings: A Hemodialysis Access Care policy, revised September 2010, read in part, Central catheters for hemodialysis are generally inserted in the neck, chest or groin area. This is not the preferred site for long-term placement. There is more risk of clotting and infection than with either fistulas or grafts. Central dialysis catheters are used for short term dialysis (less than three weeks) while [arteriovenous fistula] or [arteriovenous graft] is healing.Care of Central Dialysis Catheters 1. The central catheter site must be kept clean and dry at all times. Bathing and showering are not permitted with this device. 2. Catheter lumens should be capped and clamped when not in use. 3. Dialysis catheters should be marked for dialysis use only so they are not confused with central venous access devices. 4. Flushing, drawing blood or administering medications via central hemodialysis catheters require specialized training and/or certification of an [registered nurse]. Do not allow non-dialysis personnel to access the catheter. 5. Those caring for the catheter site must wear a mask and gloves when doing so. Dressing changes, if ordered, should be done using sterile technique. 6. Never pull or tug on the catheter. Do not use scissors near the catheter, . Documentation The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis. Resident #24 had diagnoses which included renal failure. A care plan for Resident #24, revised 11/21/24, showed hemodialysis related to renal failure and the resident was non-adherent to attending treatments as scheduled. Review of the December 2024, January 2025, and February 2025 treatment records showed no documentation of assessments for pre and post dialysis. Review of the progress notes for December 2024, January 2025, and February 2025 showed no documentation of assessments for pre and post dialysis. A quarterly assessment, dated 02/16/25, showed dialysis as a special treatment. On 02/21/25 8:48 a.m., Resident #24 stated their dialysis days were Tuesday, Thursday, and Saturday in the morning. They stated the facility sent papers back and forth in a book. Resident #24 stated the facility did not do anything before they left for dialysis or when they returned from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 at 8:56 a.m., LPN #5 stated Resident #24 left for dialysis prior to their shift, but when they returned they reviewed the dialysis paper and put Resident #24 back in bed. They stated they monitored the central catheter by reviewing the document from the dialysis center for changes in kidney function, but it was not documented. LPN #5 stated they prevent infection and maintain patency of the dialysis catheter during showers by covering it the site with something waterproof. On 02/26/25 at 9:10 a.m., the corporate nurse stated dialysis residents were monitored in collaboration of care with the dialysis team, they communicate back and forth. They stated it was documented in a dialysis note in the clinical record. The corporate nurse stated the assessment/notes were not completed because the prior leadership missed entering that on the treatment administration record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41809 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than five percent for one (#47) of four sampled residents who were observed to receive medications. The medication error rate was 6.9% The corporate nurse identified 87 residents who received medications from the facility. Findings: On 02/25/25 at 7:24 a.m., CMA #1 was observed to administer an albuterol sulfate hydrofluoroalkane inhalation aerosol 90 mcg per actuation. CMA #1 was observed to administer two puffs to Resident #47 without waiting one minute between puffs. CMA #1 was observed to administer aller-flo fluticasone 50 mcg/spray with 2 sprays to Resident #47 in each nostril. They administered one spray, then counted to three and administered another spray. Out of 29 opportunities two medication errors resulted in a medication error rate of 6.9% The undated manufacturer instructions for Albuterol sulfate hfa inhalation aerosol, read in part, Step 6. Hold your breath for about 10 seconds, or for as long as is comfortable. Breathe out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat step 2 through step 6. An Administering Medications policy, revised April 2019, read in part, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame.The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of the physician orders for Resident #47 showed an active order to administer aller-flo fluticasone 50 mcg/spray one spray both nostrils twice a day. On 02/25/25 at 11:51 a.m., the DON stated their expectation of staff during medication administration was to follow the five rights, stay with the resident until completed, use precautions and administer medications in the ordered way. They stated the CMA supervisor was responsible to educate and train the CMA staff. On 02/25/25 at 11:58 a.m., the CMA supervisor stated their expectation was the staff administer medications effectively. They stated CMA #1 was the only CMA they had not trained because CMA #1 was hired before they started at the facility. The CMA supervisor stated they monitored to ensure medications were administered correctly by watching during the medication administration from a distance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on observation, record review, and interview, the facility failed to ensure medications were secured for 2 (300 hall and 400 hall) medication/treatment carts of 6 medication/treatment carts observed. The DON identified 6 medication/treatment carts in the facility. Findings: On 02/20/25 at 3:45 p.m., LPN #3 was observed to enter room [ROOM NUMBER]. The 300 hall medication/treatment cart was observed to be left unattended and unlocked for less than one minute. On 02/20/25 at 3:55 p.m., LPN #3 was observed to leave the 300 hall medication/treatment cart unattended and unlocked. On 02/20/25 at 3:56 p.m., LPN #7 was observed to lock the 300 hall medication/treatment cart. On 02/20/25 at 4:11 p.m., LPN #3 was observed to enter room [ROOM NUMBER]. The 300 hall medication/treatment cart was observed to be left unattended and unlocked. On 02/20/25 at 4:14 p.m., LPN #3 was observed to again enter room [ROOM NUMBER]. The 300 hall medication/treatment cart was observed to be left unattended and unlocked. On 02/20/25 at 4:20 p.m., LPN #3 was observed to enter room [ROOM NUMBER]. The 300 hall medication/treatment cart was observed to be left unattended and unlocked. On 02/20/25 at 4:25 p.m., LPN #3 was observed to again enter room [ROOM NUMBER]. The 300 hall medication/treatment cart was observed to be left unattended and unlocked. On 02/25/25 at 10:13 a.m., the 400 hall medication/treatment cart was observed to be unlocked and unattended on the 400 hall. The Security of Medication Cart policy, dated April 2007, read in part, The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. On 02/20/25 at 4:26 p.m., LPN #3 stated they locked the medication/treatment cart when they were finished on the hall and parked the cart by the nurses station. They stated they did not lock the cart when they would go from room to room. On 02/25/25 at 10:25 a.m., LPN #5 stated the medication/treatment carts were to be locked. On 02/25/25 at 11:34 a.m., the DON stated they randomly checked medication/treatment carts to ensure the staff had locked them when they were unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41809

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for 1 (#58) of 5 sampled residents whose labs were reviewed. Corporate Nurse #1 identified 75 residents who had physician's orders for labs. Findings: Resident #58 had diagnoses which included diabetes, hyperlipidemia (high cholesterol), congestive heart failure, and end stage renal disease. A physician's order, dated 06/03/24, showed the resident was to have labs which included a complete blood count, hemoglobin A1C, comprehensive metabolic panel, lipids, and a liver function test every 3 months. The September 2024 medication administration record showed the ordered labs were completed on 09/03/24 and were documented as completed by LPN #1. Review of the clinical record did not reveal the lab reports for September 2024. On 02/25/25 at 11:14 a.m., the DON stated lab orders were documented on the treatment record by the nurse when they were completed. On 02/25/25 at 11:22 a.m., LPN #1 stated they documented on the treatment record when labs were completed. LPN #1 reviewed the treatment record and stated they would look for the lab reports for September 2024. On 02/25/25 at 11:31 a.m., LPN #1 stated the ordered labs for September 2024 had not been completed for Resident #58 and they did not know why they had documented they were completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on observation, record review, and interview, the facility failed to ensure appropriate hand hygiene was practiced in the kitchen and failed to ensure food delivered to residents on the hall were covered for 1 (C hall) of 1 hall observed during the noon meal. The administrator reported the census was 87 and the facility map showed six halls residents resided on in the facility. Findings: 1. On 02/21/25 at 11:52 a.m., dietary aide #2 was observed to enter the kitchen, touch their pants with both hands, and begin working without washing their hands. On 02/21/25 at 11:53 a.m., the dietary manager was observed to put on gloves without washing their hands. On 02/21/25 at 12:01 p.m., dietary aide #1 was observed to enter the kitchen and to begin preparing meal trays without washing their hands. On 02/21/25 at 12:03 p.m., dietary aide #2 was observed to enter the kitchen, touch their pants with both hands, prepare a meal [NAME], exit the kitchen, serve the meal to a resident in the dining room, return to the kitchen, touch face with right hand, don gloves, prepare two turkey sandwiches, and then to remove the gloves without washing their hands. A facility policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised 10/2017, read in part, Employees must wash their hands .whenever entering or re-entering the kitchen .Antimicrobial hand gel cannot be used in place of handwashing in foodservice areas .use of disposable gloves does not substitute for proper handwashing. On 02/21/25 at 12:05 p.m., dietary aide #2 stated hands should be washed when re-entering the kitchen. On 02/21/25 at 2:39 p.m., the dietary manager stated staff should wash their hands when entering the kitchen and prior to serving food. 2. On 02/25/25 at 12:15 p.m., the cart with meal trays, for residents on the C hall, was delivered to the front of the hall by the dietary manager. On 02/25/25 at 12:22 p.m., staff were observed to deliver meal trays, from the cart, down the length of the hall. The cake was observed to be on a saucer and uncovered. On 02/25/25 at 12:35 p.m., cook #1 stated they placed the meal on plates with covers, but did not cover small bowls or saucers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/25 at 12:39 p.m., the dietary manager stated they did not cover food items that were not on the main plate because the foods were covered by the cart. They stated staff were to push the cart down the hall to each room to deliver the trays rather than walk down the hall with the foods uncovered.

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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. 35474 Based on observation, record review, and interview, the facility failed to: a. ensure proper PPE was utilized during care for EBP for 2 (#42 and #48) of 6 sampled residents who were reviewed for EBP; b. ensure clean laundry was transported in a manner to maintain infection control; c. implement a water management program to prevent the spread of waterborne pathogens; and d. maintain indwelling urinary catheters in a manner to prevent infection for 2 (#48 and #15) of 4 sampled residents reviewed for indwelling urinary catheters. Corporate Nurse #1 identified 16 residents with indwelling urinary catheters, 10 residents with wounds, and 87 residents who resided in the facility. Findings: 1. Resident #42 had diagnoses which included diabetes. On 02/24/25 at 1:42 p.m., LPN #2 was observed to provide wound care for Resident #42. LPN #2 was not observed to utilize a gown during wound care. EBP signage was not observed outside the resident's room. On 02/25/25 at 9:02 a.m., LPN #2 stated Resident #42 was on EBP, but they had forgotten to utilize a gown during wound care. 2. Resident #48 had diagnoses which included dementia. On 02/20/25 at 3:39 p.m., Resident #48 was observed by the nurses station in a wheel chair. The catheter bag and tubing was observed to be in contact with the floor. On 02/25/25 at 1:45 p.m., CNA #1 and CNA #2 were not observed to wear gowns during catheter care for Resident #48. EBP signage was not observed outside the resident's room. On 02/25/25 at 2:55 p.m., the catheter bag and tubing for Resident #48 was observed to be in contact with the floor. The Catheter Care, Urinary, policy, dated September 2014, read in part, Be sure the catheter tubing and drainage bag are kept off the floor. The care plan, revised 02/11/25, showed the resident had an indwelling urinary catheter and staff were to maintain EBP during high contact care activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375166	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks Healthcare Center	1501 Clayton Avenue Poteau, OK 74953

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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	On 02/25/25 at 2:10 p.m., CNA #2 stated they were unaware of EBP for Resident #48 and did not utilize a gown during catheter care. On 02/25/25 at 2:15 p.m., the DON stated the charge nurses were responsible to place EBP signage on the residents' doors so staff knew to utilize PPE. 3. On 02/25/25 at 1:58 p.m., the clothing racks for clean clothes was observed in the laundry room. Covers for the clean laundry racks were not observed. The Laundry and Bedding, Soiled policy, dated October 2018, read in part, Clean linens protected from dust and soiling during transport and storage to ensure cleanliness. On 02/25/25 at 2:00 p.m., the laundry supervisor stated they did not cover the clothing on the laundry racks when they were transported to residents. They stated they did not have covers for the clothing racks. On 02/25/25 at 3:26 p.m., the administrator stated they did not cover clothing when it was transported to the residents. On 02/25/25 at 3:46 p.m., corporate nurse #1 stated the reference to linen in the facility's policy was interchangeable with clothing. They stated they did not cover residents' clothing when it was transported down the hallways but should to protect against soilage. 4. The Legionella Water Management Program policy, dated July 2017, read in parts, The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of legionnaire's disease.The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility .c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. On 02/25/25 at 3:20 p.m., the maintenance supervisor stated they had not assessed the facility for areas in the water system that could encourage the growth or spread of waterborne bacteria. On 02/25/25 at 3:25 p.m., the administrator stated they had not implemented the Legionella Water Management Program policy, but had started some classes about waterborne bacteria. 5. Resident #15 had diagnoses which included retention of urine and chronic kidney disease. On 02/20/25 at 4:04 p.m., Resident #15 was observed in their room, sitting in their wheel chair. The catheter bag and tubing were observed to hang under the wheel chair with the bag and tubing in contact with the floor. On 02/24/25 at 11:10 a.m., Resident #15 was observed in their room, sitting in their wheel chair. The catheter bag and tubing were observed to hang under the wheel chair with the bag and tubing in contact with the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/25 at 8:47 a.m., Resident #15 was observed in their room, sitting in their wheel chair. The catheter bag and tubing were observed to hang under the wheel chair with the bag and tubing in contact with the floor. On 02/25/25 at 9:08 a.m., Resident #15 was observed to be pushed in their wheel chair by staff from their room, through the front lobby by the nurses station, down the 600 hall to the therapy room. The resident's catheter bag and tubing were observed to hang under the wheel chair and drag on floor. The quarterly assessment, dated 12/13/24, showed the resident had an indwelling urinary catheter. On 02/25/25 at 10:24 a.m. CNA #1 stated catheter bags and tubing were to be kept off the floor. On 02/25/25 at 10:26 a.m., LPN #1 stated catheter bags and tubing were to be kept off the floor. LPN #1 stated they did not know why the catheter bags and tubing were in contact with the floor. On 02/25/25 at 11:11 a.m., the DON stated the nurses were to monitor to ensure catheter bags and tubing were not in contact with the floor. 41809 46703

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure residents were provided education and offered the influenza and pneumococcal immunizations for 2 (#88 and #17) of 5 sampled residents who were reviewed for immunizations. The DON identified 87 residents who resided in the facility. Findings: 1. Resident #88 was admitted [DATE] and had diagnoses which included coronary artery disease. Review of the clinical record did not show the resident had been provided education or offered the influenza or pneumococcal immunization. 2. Resident #17 was admitted on [DATE] and had diagnoses which included diabetes mellitus. Review of the clinical record did not show the resident had been provided education or offered the influenza or pneumococcal immunization. On 02/25/25 at 5:24 p.m., corporate nurse #1/infection preventionist stated a previous infection preventionist had been responsible for educating and offering residents influenza and pneumococcal immunizations, but they could not locate documentation for Resident #88 or Resident #17.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure residents were provided education and offered the COVID immunization for 4 (#17, 49, 78, #88) of 5 sampled residents who were reviewed for immunizations. The DON identified 87 residents who resided in the facility. Findings: 1. Resident #78 was admitted [DATE] and had diagnoses which included dementia. Review of the clinical record did not show the resident had been provided education or offered the COVID immunization. 2. Resident #88 was admitted [DATE] and had diagnoses which included coronary artery disease. Review of the clinical record did not show the resident had been provided education or offered the COVID immunization. 3. Resident #17 was admitted on [DATE] and had diagnoses which included diabetes mellitus. Review of the clinical record did not show the resident had been provided education or offered the COVID immunization. 4. Resident #49 was admitted [DATE] and had diagnoses which included diabetes mellitus. Review of the clinical record did not show the resident had been provided education or offered the COVID immunization. On 02/25/25 at 5:24 p.m., corporate nurse #1/infection preventionist stated a previous infection preventionist had been responsible for educating and offering residents COVID immunizations, but they could not locate documentation for Resident #78, 88, 17 or Resident #49.