STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375188	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocola Health and Rehab	200 Home Street Pocola, OK 74902

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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. 38495 Based on record review and interview, the facility failed to ensure DNR forms were complete and legal for two (#11 and #40) of 24 residents who were reviewed for advanced directives. The DON identified 29 residents in the facility had DNRs. Findings: Policy DNR ACT, dated 06/01/03, read in part, IT IS THE POLICY OF POCOLA NURSING CENTER TO FOLLOW THE OKLAHOMA DNR ACT OF 1997 . 1. Res #11 had diagnoses which included CHF, chronic kidney disease, and Alzheimer's Disease. An annual assessment, dated 01/11/24. documented the resident was moderately impaired with cognition and required substantial to maximal assistance with most ADLs. A care plan revised 01/01/23, documented the resident had a DNR and the resident would not be resuscitated her their wishes. The EHR documented the resident had a DNR. The DNR form in the resident EHR was signed by the resident's POA and dated 12/30/22. The DNR form did not have two witnesses as required. On 03/07/24 at 2:35 p.m., the DON stated there was not two witnesses on the DNR. 2. Res #49 had diagnoses which included major depressive disorder, anxiety disorder, and osteoarthritis. A care plan, revised on 10/04/23, documented the resident was a DNR per signed request. A quarterly assessment, dated 01/09/24, documented the resident was moderately impaired with cognition and was dependent for most ADLs. A DNR form was observed in the DNR book signed by the residents POA. The form was not dated. (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	On 03/07/24 at 2:15 p.m., the DON stated it was an over site and they would get the POA to sign and date a DNR.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45913 Based on interview and record review, the facility failed to follow their abuse prevention policy by not obtaining criminal background checks upon hire for 13 of 74 employees hire between 2016 and 2024. The DON identified 53 residents who resided in the facility. Findings: The Abuse Prevention Policy, undated, read in part, .Candidates for employment will be screened for a potential history of abuse, neglect, or mistreating residents before employment. Employee background checks will be done upon hiring and the facility will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals. The following methods for screening will be utilized: .OK Screen background checks . The Consent and Release Form, undated, read in part, .You must be fingerprinted to work with this employer . The Employee Information Report, dated 03/06/24, documented the following: a. CNA #7 was hired on 04/18/16 b. BOM was hired on 03/23/17 c. Laundry #1 was hired on 10/03/21 d. CNA #11 was hired on 08/22/22 e. CNA #2 was hired on 10/16/22 f. CMA #2 was hired on 10/17/22 g. CNA #8 was hired on 01/06/23 h. CMA #1 was hired on 03/22/23 i. CNA #4 was hired on 05/12/23 j. CMA #3 was hired on 06/02/23 k. CNA #5 was hired on 10/05/23 l. CNA #9 was hired on 11/24/23 m. CNA #6 was hired on 01/08/24 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. CNA #10 was hired on 01/08/24 The [Facility name] Employee Roster, dated 03/07/24, provided by OK Screen did not document CNA #2, CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, CNA #10, CNA #11, Laundry #1, CMA #1, CMA #2, and CMA #3, as current eligible employees. On 03/07/24 at 1:30 p.m., the BOM could not provide criminal background checks for these employees (CNA #2, 4, 5, 6, 7, 8, 9, 10, and #11. Laundry #1 and CMA #1, 2, and #3) Payroll records for 03/07/24 documented CNA #2, CNA #6, CNA #7, CNA #10, CNA #11 and CMA #2 were permitted to work without a criminal background check. Payroll records for 03/08/24 documented CMA #1, CMA #3, CNA #4, CNA #5, CNA #8 and CNA #9 were permitted to work day shift without a criminal background check. On 03/08/24 at 12:48 p.m., the BOM could not provide clearance letters from OK Screen for CNA #7 or Laundry #1. The BOM reported criminal background checks could not be done because CNA #7 and Laundry #1 had not been fingerprinted. On 03/07/24 at 10:30 a.m., the BOM reported if an employee leaves and comes back within three years of their separation date the facility is not required to do a new background check. On 03/07/24 at 1:30 p.m., the DON was unaware there were employees without criminal background checks. On 03/11/24 at 10:00 a.m., the BOM reported Laundry #1 was working in the facility and CNA #7 was scheduled to work at 7:00 p.m. CNA #7 and Laundry #1 had not been fingerprinted yet. On 03/11/24 at 3:13 p.m., the administrator reported they were not aware there were employees without criminal background checks. The administrator reported the BOM was not aware there were so many staff members without background checks. The administrator reported Laundry #1 and CNA #7 have been scheduled for fingerprinting, and the BOM did not know they had not been fingerprinted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46909 Based on observation, record review, and interview, the facility failed to ensure the accuracy of MDS assessments for four (#2, #25, #38 and #42) of 21 residents whose assessments were reviewed. The Long-Term Care Facility Application for Medicare and Medicaid form documented 53 residents resided in the facility. Findings: 1. Res #2 had diagnoses which included idiopathic peripheral autonomic neuropathy, dysphagia, pharyngoesophageal, hyperlipidemia, hypertension, and history of deep vein thrombosis. A physician order, dated 05/30/22, doucmented the facility was to administer apixaban (an antiplatelet medication) 5 mg twice a day for a diagnosis of history of deep vein thrombosis. A care plan, date 12/02/23, documented to administer one tablet twice a day related to deep vein thrombosis and to monitor for adverse reactions of anticoagulants. An quarterly assessment, dated 02/25/24, documented the resident was independent in cognitive skills for daily decision making. The assessment documented the resident was frequently incontinent of bladder and always incontinent bowel and required moderate to maximum assistance with most ADLs. The assessment documented Res #2 utilized a walker and wheelchair for transporting. The assessment also documented the resident had taken an anticoagulant, a diuretic, and an antiplatelet in the past seven days. On 03/07/24 at 11:45 a.m., the MDS coordinator stated the resident was not on an anticoagulant but was on a antiplatelet. she also stated the anticoagulant should not have been marked on the MDS. 45913 2. Res #25 had diagnoses which included blindness to left and right eye and dementia. A care plan, last revised on 04/22/23, documented in part, .communication problem related to hearing deficit (when in noisy environment). An annual resident assessment, dated 02/15/24, documented in error Res #25's hearing is adequate. On 03/06/24 at 9:03 a.m., Res #25's guardian reported the resident is blind and hard of hearing, essentially deaf. The guardian reported they felt it was important for anyone caring for their mother to know hearing and sight is a challenge On 03/11/24 at 3:06 p.m., the DON reported Res #25 has trouble hearing in a noisy environment. 3. Res #38 had diagnoses which included dementia, left femur fracture, traumatic subdural hemmorrhage without loss of consciousness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident report, dated 02/24/24, documented Res #25 had a non-injury fall. An incident report, dated 02/29/24, documented Res #25 had a fall resulting in a subdural hematoma. A significant change resident assessment, dated 03/04/24, did not document the falls for Res #38 on 02/24/24 and 02/29/24. On 03/11/24 at 3:06 p.m., the DON reported MDS Coordinator #1 completed the MDS and was not available to ask why the falls were not documented on the significant change resident assessment for Res #25. The DON reported the falls for Res #25 should have been documented. 38495 4. Res #42 had diagnoses which included CHF, Alzheimer's Disease, and hypertension. A physician order, dated 09/26/23, documented to place a Foley catheter due to urinary retention. A quarterly assessment, dated 02/21/24, documented the resident was severly impaired with cognition and was dependent on staff for most ADLs. The assessment documented the resident had a catheter and was always incontinent of urine. On 03/05/24 at 12:24 p.m., the resident was observed to have a catheter it was positioned below the bladder in a privacy cover. On 03/06/24 at 9:26 a.m., a phone interview with the POA. The POA stated the resident had a catheter a while for a UTI. On 03/08/24 at 12:46 p.m., RN #1 stated the resident had urinary retention. RN #1 stated at one time the resident had ESBL and when we removed the catheter the resident was not able to urinate. On 03/08/24 at 1:24 p.m., the DON stated well some times the resident had a catheter and when she did not have one the resident was incontinent.

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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 38495 Based on record review and interview the facility failed to ensure the OHCA was notified of a resident with a serious mental illness who stayed in the facility long term for one (#22)of two residents reviewed for PASRR level I screenings. The DON identified 53 residents who resided in the facility. Findings: Res #22 had diagnoses which included generalized anxiety disorder, major depressive disorder, and schizophrenia. A PASRR I, dated 06/26/14, documented the resident had a serious mental illness. The PASRR I documented the hospital called OHCA they stated with a letter from the physician and a short stay for therapy only was a PASRR level II not required. A care plan, revised 08/26/22, documented the resident was always worried someone was talking about her and constantly thinks they are going to die due to diagnosis of schizophrenia. The care plan documented the resident used psychotropic medications related to behavior management. An annual assessment, dated 09/19/23 documented the resident was not considered by the state level two PASRR process to have a serious mental illness or intellectual disability or related condition. On 03/11/24 at 3:06 p.m., the DON stated she called OHCA and they would have to order a PASRR II. She stated another staff member didn't do another PASRR I when the resident stayed in the facility.

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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. 46909 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for weight loss for one (#10) of two sampled residents whose care plans were reviewed. The DON reported 53 residents resided in the facility. Findings: Res #10 had diagnoses which included diabetes mellitus type 2 without complications, abdominal hernia without obstruction, and major depressive disorder. A physician's order dated, 04/15/23, documented snacks three times a day for nutritional supplements. A physician's order dated, 04/16/23, documented health shakes for weight management. A physician's order dated, 06/27/23, documented protein powder three times a day for weight loss of 6.2 pounds in five months. A quarterly assessment, dated 12/29/23, documented the resident was cognitively impaired and required moderate to maximum assistance with all ADLs. A care plan, dated 02/04/24, contained no documentation of weight loss for Res #10. On 03/07/24 at 12:40 p.m., the MDS coordinator stated there was no care plan for weight loss for the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46909 Based on record review, observation, and interview, the facility failed to ensure residents were not catheterized unless required by a clinical condition and assess a resident for continued need for an indwelling urinary catheter for two (#25 and #29) of four resident reviewed for an indwelling urinary catheter. The DON indentified eight residents with an indwelling urinary catheter Findings: 1. Res #29 was admitted to the facility on [DATE] with diagnoses of left artificial hip joint, hypertension, type 2 diabetes mellitus, nephropathy, and was later diagnosed with stage 3 kidney disease, dementia, congestive heart failure, and urinary tract infection. A physician's order, dated 02/06/24, documented Foley catheter 18 F/30 CC, place for isolation: ESBL. A physician's order, dated 02/06/24, documented clean foley catheter every shift with soap and water. A 5-day assessment, dated 02/26/24, documented the resident was cognitively impaired and required total assistance with all ADLs. The assessment also documented the resident was frequently incontinent of urine. A care plan, dated 02/20/24, documented res #29 had a urinary tract infection with ESBL. There was no documentation of a catheter for res #29. On 03/11/24 the DON stated res #29 had ESBL in their urine and should have been isolated but some residents will not stay in their rooms. The doctor will order a catheter for isolation precautions then the staff would educate the resident and family on the risk and benefits of the catheter. The DON also stated the care plan should have been updated for the catheter. The DON stated ESBL was not a proper diagnoses for a catheter they use a catheter to keep from spreading the bacteria. 45913 2. Res #25 had diagnoses which included chronic kidney disease stage 4 and dementia. A progress note, dated 02/27/24 at 10:40 a.m., documented Res #25 had ESBL and Ecoli in their urine and a 16 Fr indwelling urinary catheter was placed and isolation initiated. A physician's order, dated 02/27/24, read in part, 16 Fr foley cath while being treated for ESBL. There were no physician's orders for catheter care or the changing of the indwelling foley catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, last revised on 02/28/24, read in part, risk for UTI related to history of ESBL .foley catheter per infection control . On 03/06/24 at 10:00 a.m., Res #25 was observed to have an indwelling urinary catheter in place. On 03/06/24 at 2:00 p.m., the infection preventionist reported there was no policy or infection control protocol for catheterizing people with urinary tract infections. The infection preventionist reported they were not knowledgeable regarding the requirements for indwelling urinary catheters and reported catheterizing a resident for a urinary tract infection probably doesn't meet criteria. On 03/11/24 at 3:30 p.m., the DON reported they catheterize residents who are difficult to keep in their rooms for contact precaution isolation. The DON did not feel a brief would be a viable, less invasive alternative because of the risk of urine not being contained. The DON reported ESBL was not a proper diagnoses for a use of an indwelling urinary catheter.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46909 Based on observation, record review, and interview, the facility failed to ensure residents were fully assessed for the use of side rails for four (#11, 22, 42, and #45) of 35 sampled residents who were reviewed for side rails. The DON identified 35 resident utilized bed rails out of 53 residents residing in the facility. Findings: 38495 1. Res #11 had diagnoses which included CHF, chronic kidney disease, and Alzheimer's Disease. A care plan revised 01/01/23, documented the resident required the assistance of half bed rails. The care plan documented to assess and evaluate the use of half bed rails. An annual assessment, dated 01/11/24. documented the resident was moderately impaired with cognition and required substantial to maximal assistance with most ADLs. The assessment documented the resident required substantial/maximal assistance to roll left to right, sit to lying, lying to sitting, sit to stand, chair to bed, and toilet transfer. The resident EHR did not contain bed rail assessments. On 03/05/24 at 11:26 a.m., the resident was observed sitting in the bed with half rails up on both sides of the bed. On 03/06/24 at 8:30 a.m., the resident was sitting up in bed eating breakfast, the rails were up on both sides of the resident's bed. On 03/07/24 at 2:54 p.m., during an observation of care the resident was in bed bed rails in the up position on both sides of the bed. The rail were not observed to be used by the resident during the observation. On 03/11/24 at 1:15 p.m., the POA was visiting they stated they had been informed of the risk of the bed rails. The POA stated they wanted the bed rails so the resident would not try and get out of the bed. On 03/11/24 at 4:43 p.m., LPN #1 stated they just started doing bed rail assessments last week. The LPN stated they do not have a template to go by for the assessment. The LPN stated the resident used the bed rail to help roll for care to assist the CNAs. The LPN stated they did feel the bed rail was beneficial to the resident and was not a restraint. The LPN stated the resident did not have the strength to get out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #22 had diagnoses which included generalized anxiety disorder, major depressive disorder, diabetes mellitus with diabetic neuropathy, CHF, and schizophrenia. A care plan, revised 10/31/21, documented the resident requires the assistance of half bed rails for bed mobility. The care plan documented the resident would be safe while half rails were in use to maximize independence with turning and positioning. The care plan documented to assess and evaluate the use of half bed rails. A quarterly assessment, dated 12/20/23, documented the resident was moderately impaired with cognition and was dependent with most ADLs. The assessment documented the resident was dependent to roll left to right, sit to stand, and lying to sitting. The assessment documented the bed rails were not used a a restraint. There were no bed rail assessment observed in the EHR. On 03/05/24 at 12:09 p.m., the resident stated she used the bed rails for positioning. The resident stated she had never fallen out of the bed and wanted the rails. On 03/11/24 at 4:45 p.m., LPN #1 stated the resident did use the bed rail to assist staff with care and the resident did not get out of bed on their own. Bed rail assessments for the resident had not been completed. 3. Res #42 had diagnoses which included CHF, Alzheimer's Disease, anxiety disorder, and insomnia. A quarterly assessment, dated 02/21/24, documented the resident was severly impaired with cognition and was dependent with most ADLs. The assessment documented the resident required substantial/maximal assistance to roll left to right, sit to lying, lying to sitting, sit to stand, bed to chair, toilet transfer, and tub/shower transfer. The resident's care plan, documented the resident required the use of half bed rails. The care plan documented the resident used half bed rails to maximize independence with turning and repositioning in bed. The care plan documented to assess and evaluate the use of half bed rails. The EHR did not contain assessments for bed rails for the resident. A bed rail waver, dated 12/15/22, was signed by the resident's POA. On 03/05/24 at 12:23 p.m., the resident was observed laying in the bed, on an air mattress, with half rails up on both sides of the bed and a bed alarm in place. On 03/08/24 at 12:25 p.m., CNA #1 stated the resident was one that was more active and fidgets. CNA #1 stated the resident would use the bed rails to turn over in the bed. 4. Res #45 had diagnoses which included unspecified osteoarthritis, chronic obstructive pulmonary disease, primary osteoarthritis of right and left shoulder, and pain in right and left shoulder. On 10/31/21 a waiver was signed by the resident for side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 10/31/21, documented to assess and evaluate the use of half side rails. A physician order, dated 05/30/22, documented the half side rails x 2 to assist resident with turning and re-positioning. A care plan, dated 08/28/23, documented the resident would be safe while half rails are in use. A quarterly assessment, dated 12/29/23, documented the resident was intact with cognition and required maximum assistance with ADLs. The assessment also documented the resident was utilized bed rails for repositioning. A physician's order, date 05/15/23, documented air mattress to bed, no directions specified. On 03/05/24 at 12:12 p.m., an observation was made of half side rails and an air mattress on the resident's bed. On 03/07/24 at 3:25 p.m., a registered nurse stated the assessment and evaluation for side rails should be in the chart under assessments or progress notes. There was no documentation found in the chart on bed rails. On 03/07/24 at 3:48 p.m., the resident stated the bed rails were utilized daily. On 03/09/24, the DON stated the nurses asses the side rails every day but do not document the assessment anywhere in the chart. They also stated there was a bed rail assessment form in the chart and they would start utilizing the form routinely.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 45913 Based on observation and interview, the facility failed to post the required staffing information in a manner easily accessible to residents and vistors. This affected 53 of 53 residents. The DON identified 53 residents who resided in the facility. Findings: On 03/06/24 at 10:00 a.m., surveyor was unable to locate posted staffing. RN #1 reported posted staffing was on the bulletin board on 200 Hall outside the dining room entrance. Observed posted staffing information on an 8.5 x 11 piece of copy paper pinned to a bulletin board approximately six feet from the floor. Surveyor was unable to read the posted staffing information unless directly in front of the bulletin board looking up ten inches. Posted staffing information did not document the census or staffing hours for each employee. Posted staffing remained in the same location and without the facility census or staffing hours for each employee for the remainder of the survey. On 03/08/24 at 10:00 a.m., the DON questioned why the residents can't tilt their heads up and read the staffing information. The DON reported that's a new one when informed of the regulations regarding posted staffing requirements and accessibility for residents and visitors.

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	375188	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocola Health and Rehab	200 Home Street Pocola, OK 74902

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on record review, and interview, the facility failed to ensure the physician documented a rationale on a consultant pharmacist recommendation, for one (#42) of five residents whose's medications were reviewed. Also the MRR policy did not contain timeframes for the steps in the MRR process. The DON identified 13 residents who resided in the facility who receive psychotropic medication. Findings: An undated PHARMACY SERVICES POLICYread in part, .DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON .The attending physicain will document in the resident's medical record irregularity has been reviewed and what, if any, action has been taken to adress it. If there is to be no change in the medication, the attending physician will document his or her rationale in the resident's medical record . Res #42 had diagnoses which included CHF, Alzheimer's Disease, anxiety disorder, and insomnia. On 01/18/24 a MRR requested a reduction in the following medications. Ativan 2mg every four as needed, Buspirone 15mg TID, Seroquel 25mg BID, or Sertraline 50mg daily. The physician documented to continue current use of medications. The physician signed and dated the MRR on 02/02/24. The physician did not documented a rational. A quarterly assessment, dated 02/21/24, documented the resident was severly impaired with cognition and received an antipsychotic medication. The assessment documented a GDR had not been attempted. The MRR policy was reviewed and did not contain time frames on which the MRR process was to be completed. On 03/08/24 at 10:00 a.m., the DON stated the policy did not contain time frame. The DON stated most of the time the physician will document [NAME] on the MRRs.

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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. 38495 Based on record review, and interview, the facility failed to ensure residents did not receive psychotropic medication, unless for a specific diagnosed condition, for one (#48) of five residents reviewed for unnecessary medication. The DON identified 13 residents who resided in the facility who receive psychotropic medication. Findings: An undated PHARMACY SERVICES POLICYread in part, .DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS .An unnecessary drug is any drug when used: .without adequate monitoring . FREE FROM UNNECESSARY PSYCHOTROPIC MEDS/PRN USE .Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat specific condition as diagnoses and documented in the clinical record; . Res #42 had diagnoses which included CHF, Alzheimer's Disease, anxiety disorder, and insomnia. A physician order, dated 06/05/22, documented Seroquel 25mg administer two times a day related to Alzheimer's Disease. On 01/18/24 a MRR requested an appropriate diagnoses for the use of Seroquel 25mg BID. The physician marked the diagnosis of mood disorder. The MRR was signed and dated by the physician on 02/02/24. A quarterly assessment, dated 02/21/24, documented the resident was severly impaired with cognition and received an antipsychotic medication. The resident's care plan, documented the resident received Seroquel related to Alzheimer's Disease. On 03/08/24 at 10:00 a.m., the DON stated they get the diagnoses changed as quick as they could. The DON stated the medication should be changed when we get the MRR request back from the physician.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45913 Based on record review and interview, the facility failed to provide consistent services from a registered dietitian for one (#10) of two residents reviewed for nutrition. The DON reported 53 residents resided in the facility. Findings: Res #10 had diagnoses of diabetes mellitus type 2 without complications, abdominal hernia without obstruction, and major depressive disorder. On 04/15/23, a registered dietitian recommended snack be given to res #10 three times a day. A physician's order dated, 04/15/23, documented snacks three times a day for nutritional supplements On 04/16/23, a registered dietitian recommended health shakes with meals for weight management. A physician's order dated, 04/16/23, documented health shakes for weight management. On 06/18/23, a registered dietitian recommended house supplements be administered every day. On 06/27/23, a registered dietitian recommended protein powder be administered with meals to res #10 for weight loss of 6.9 pounds. A quarterly assessment, dated 12/29/23, documented the resident was cognitively impaired and required moderate to maximum assistance with all ADLs. A care plan, dated 02/04/24, contained no documentation of weight loss for Res #10. On 03/07/24 at 12:40 p.m., the business manager stated the facility contracted with a company for a registered dietitian to come in monthly but the last time a registered dietitian was in the facility was in August of 2023.

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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. 38495 Based on observation and interview the facility failed to store food in accordance with professional standards for food service safety for 53 of 53 residents who received meals from the kitchen. The DON identified 53 residents who received meals from the kitchen. Findings: On 03/05/24 at 10:07 a.m., the ice machine in the dining room was observed with the pad lock unlocked. On 03/05/24 at 10:10 a.m., an initial tour of the kitchen was conducted. A large trash can by the hand washing sink did not have a lid, the lid was in the floor behind the trash can. On 03/05/24 at 10:13 a.m., the freezer observed to have bags of French fries and onion rings open to air the bags were not dated when they had been opened. On 03/05/24 at 10:16 a.m., the DM stated the items in the freezer should not be open to air and should be dated when opened. On 03/05/24 at 10:21 a.m., the ice machine was wiped with a clean cloth from the the ice drop a brown/black substance on the cloth. The DM stated they did not know what the substance was on the cloth. The DM stated they wiped the ice machine down but had never cleaned it from the ice drop. They stated maintenance cleaned it when the light came on or a company came in to service the ice machine. The DM stated the ice machine should be locked when a staff member was not getting ice. They stated the staff will unlock it and not lock it back at times. On 03/05/24 at 10:26 a.m., the DM entered the kitchen and did no wash their hands. On 03/05/24 at 10:27 a.m., The DM was asked if the trash can should have a lid covering the trash. The DM stated they were worried about touching the lid and contaminating their hands. The DM stated a surveyor last year told them they only needed it covered the trash when transporting the trash. The DM stated staff entering the kitchen should wash their hands.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 46909 Based on record review and interview, the facility failed to develop and implement a QAPI plan to identify problems in the facility. The DON reported 53 residents resided in the facility. Findings: The facilty did not have a policy and procedure for QAPI. On 03/11/24, record review was conduct of the QAPI meetings, these meeting were sporadic and the last meeting was held in September 2023. On 03/11/24 at 04:28 p.m., the DON stated QAPI meeting were not implemented regularly. They also stated there was not a policy and procedure to follow for QAPI. The DON stated when there was a problem that needed to be address then the administrator, DON, ADON, MDS coordinator, and the Infection Preventionalist would have a meeting to correct the problems in question. The DON also stated they will probably have a QAIP meeting after this month related to the COVID outbreak in the facility for the month of February .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46909 Based on record review and interview, the facility failed to ensure the QAA committee met at least quarterly. The DON reported 53 residents resided in the facility. Findings: The QAA committee meetings were reviewed. The last QAA meeting was in September of 2023. There was no documentation the QAA committee met in October, November, and December of 2023. There was no documentation the QAA committee met in January or February 2024. On 03/11/24 at 04:28 p.m., the DON stated QAIP/QAA meeting were not implemented regularly. They stated when there was a problem that needed to be address then the administrator, DON, ADON, MDS coordinator, and the Infection Preventionalist would have a meeting to correct the problems in question. The DON also stated they will probably have a QAIP/QAA meeting after this month related to the COVID outbreak in the facility for the month of February .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38495 Based on observation and interview the facility failed to ensure staff followed infection control guidelines to prevent the potential spread of communicable disease while performing wound care, COVID testing and assisting resident to eat. The DON identified 53 resident who resided in the facility. Findings: 1. On 03/06/24 at 8:03 a.m., CNA #2 was observed assisting residents to eat in the dining room. CNA #2 was observed to scratch their face after assisting a resident with his cup, the CNA then they assisted another resident with bites of food. Hand hygiene was not observed during the observation. On 03/06/24 at 8:07 a.m., CNA#2 was observed to touch their clothing and continued to assist the residents with their breakfast. Hand hygiene was not observed during the observation. On 03/06/24 at 8:15 a.m., CNA #3 was observed assisting a resident to eat breakfast the CNA then assisted another resident with their coffee, CNA #3 then went back to assisting the first resident to eat. Hand hygiene was not observed between residents. On 03/06/24 at 8:17 a.m., CNA #2 was observed to stack the dirty dishes at the table and then assisted a resident to put honey in their oatmeal and assisted the resident to eat the oatmeal. Hand hygiene was not observed. On 03/07/24 at 12:34 p.m., the IP stated the staff should be using hand hygiene between resident and if they touch something dirty when assisting residents to eat. 2. On 03/07/24 at 3:04 p.m., Res #3's wound care was observed performed by RN #2. RN #2 washed their hands before care and the applied gloves. The resident had a BM and the nurse cleaned the resident, changed gloves but hand hygiene was not done. The RN then removed the old dressing from the resident, cleaned the wound changed gloves, hand hygiene was not performed. The RN then treated and dressed the area. The RN then applied skin prep to the residents heels in the same gloves. On 03/07/24 at 3:17 p.m., RN #2 stated they should have washed their hands after cleaning the resident up from a bowel movement before starting wound care. Also between dirty and clean. 3. On 03/07/24 at 9:35 a.m., the IP was observed to test a resident for COVID in the activity room with other resident in the room and without proper PPE on. The IP stated if the resident tested positive they could have spread the infection to others in the facility.