STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375347	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLoud Nursing Center	701 South 8th Street McLoud, OK 74851

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 33097 Based on record review and interview, the facility failed to complete a SNF ABN for two (#1 and #42) of three sampled residents reviewed for beneficiary notices. The administrator reported 43 residents resided in the facility. Findings: The DON identified 17 residents who had been discharged from a Medicare Part A covered stay with benefit days remaining in the past six months. 1. Res #1 admitted to Part A skilled services on 03/26/24 and discharged from skilled services on 05/30/24. There was no documentation a SNF ABN was provided to Res #1 or their representative. 2. Res #42 admitted to Part A skilled services on 05/08/24 and discharged from skilled services on 06/06/24. There was no documentation a SNF ABN was provided to Res #42 or their representative. On 06/12/24 at 9:28 a.m. the social service director stated they were not aware the form SNF ABN needed to be completed for residents discharged from Part A services. The director stated the SNF ABN form had not been completed for resident #1 and #42.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36191 Based on observation, record review, and interview, the facility failed to ensure the hot water was at a comfortable temperature for one (#12) of one sampled resident who was observed for hot water temperatures. The administrator identified 43 residents who resided in the facility. Findings: The facility's Water Temperatures, Safety of policy, revised 12/2009, read in part, Maintenance staff shall conduct periodic tap water temperature checks. The temperature logs were reviewed and revealed Resident #12's water temperatures had not been monitored in May and June 2024. On 06/09/24 at 11:49 a.m., Res #12's family member stated the resident did not have hot water at their sink faucet. On 06/09/24 at 11:49 a.m., the hot water was turned on the water felt cool and was not warm. On 06/12/24 at 12:50 p.m., the hot water temperature in Res #12's room was 71.2 degrees F. On 06/12/24 at 1:09 p.m., the maintenance supervisor obtained the hot water temperature in Res #12's room; the temperature was 68 degrees F. They stated they could adjust the water temperature. On 06/12/24 at 1:11 p.m., Res #12 stated their hot water had never been warm and they would like it to be warmer. On 06/13/24 from 10:10 a.m. through 10:13 a.m., the hot water was turned on in Res #12's sink faucet in their room. The hot water temperature was 73.9 F after it had been turned on for three minutes and did not feel warm.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 36191 Based on record review and interview, the facility failed to ensure a new PASARR Level I screening was conducted when a new serious mental illness diagnosis was received for one (#13) and the PASARR level I included the mental health diagnoses for one (#14) of two sampled residents reviewed for PASARR assessments. The administrator identified 43 residents who resided in the facility. Findings: 1. Res #13 had diagnoses, dated 06/02/23, which included unspecified psychosis not due to a substance or known physiological condition. On 06/11/24 at 1:46 p.m., the MDS coordinator stated they were unaware they needed to submit a PASARR level I for a new diagnosis of serious mental illness. 2. Res #14 had diagnoses which included major depressive disorder single episode on 04/23/15 and psychotic disorder with delusions due to known physiological condition on 07/27/15. A PASARR Level I Screening, submitted on 08/17/15, documented Res #14 did not have a diagnosis of a serious mental illness. On 06/13/24 at 11:36 a.m., the DON stated Res #14 had diagnoses of depression and serious mental illness on admission. The DON stated the PASARR Level I screening had not been filled out correctly and they did not have any documentation another PASARR Level I with the correct information had been submitted.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 36191 Based on observation, record review, and interview, the facility failed to ensure a care plan was updated to include oxygen therapy and enhanced barrier precautions for one (#14) of eight residents reviewed for care plans. The DON identified four residents who had catheters, two residents who had wounds, and seven residents who utilized oxygen. Findings: The facility's Care Plans, Comprehensive Person-Centered policy, revised 12/2016, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan also read, The comprehensive, person-centered care plan will .Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Incorporate identified problem areas. Res #14 had diagnoses which included asthma, urinary retention, and stage four pressure ulcer. A physician's order, dated 04/07/23, documented to administer oxygen at 3 liters nasal cannula as needed for shortness of breath. An ADL care plan for Res #14, documented a catheter was placed on 11/23/23 for urinary retention; interventions included to provide catheter care every shift. The care plan also documented Res #14 had a stage four pressure ulcer. The care plan was not updated with the EBP to include when and what PPE to wear. The care plan was reviewed and did not document Res #14 utilized oxygen. Res #14's annual assessment, dated 04/20/24, documented they had severe cognitive impairment, required substantial/maximal assistance for toileting, showering, dressing, and bed mobility, was dependent on staff for transfers, had an indwelling catheter, and had one stage four pressure ulcer which required a dressing. On 06/09/24 at 10:05 a.m., Res #14 stated they had a pressure ulcer on their bottom. They stated the staff performed the wound care. On 06/09/24 at 10:05 a.m., Res #14 was observed in their bed, they had a catheter and had an oxygen concentrator in their room and was utilizing oxygen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/12/24 at 10:16 a.m., the MDS coordinator stated since the resident had an open wound and a catheter they would need to be on EBP. They stated the use of EBP was not on the care plan. The MDS coordinator stated the care plan should document the flow rate of the oxygen and monitoring for shortness of breath. The MDS coordinator stated Res #14's care plan had not been updated to include the oxygen therapy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 33097 Based on record review and interview, the facility failed to ensure professional accepted standards of quality were met related to a mental health diagnoses given to one (#42) of five sampled residents reviewed for unnecessary medication and diagnoses. The administrator identified 43 residents who resided in the facility. Findings: Res #42 had diagnoses which included myocardial infarction, acute respiratory distress, muscle weakness, lack of coordination, acute on chronic systolic heart failure, chronic obstructive pulmonary disease, cognitive communication deficit, age-related physical debility, essential hypertension, and hyperlipidemia. A physician order, dated 05/11/24, documented the resident received Lexapro (a antidepressant medication) 20 mg by mouth one time a day for depression and anxiety. A physician order, dated 05/11/24, documented the resident received Buspirone (a antianxiety medication) 5mg by mouth three times a day for anxiety. An admission assessment, dated 05/15/24, documented the resident was cognitively intact and had no behaviors or potential indications of psychosis. The assessment documented the resident did not have a diagnosis of an anxiety disorder, depression, or a psychotic disorder. The care plan, dated 05/20/24, documented the resident received Lexapro for depression and Buspar for anxiety. The care plan also documented the resident received Seroquel (a antipsychotic medication). A physician order, dated 05/23/24, documented the resident received Seroquel 25 mg by mouth at bedtime for sleep. The order documented the medication had been discontinued on 05/24/24. A physician progress note, dated 05/24/24, documented the resident was pleasant and cooperative. The note documented the resident stated the initiation of Seroquel had helped and they had a good night sleep. A physician order, dated 05/24/24, documented the resident received Seroquel 25 mg by mouth at bedtime for psychosis. On 06/09/24 at 10:47 a.m., the resident was lying in bed. The resident was pleasant and calm during the interview. The resident verbalized no concerns at this time. On 06/13/24 at 9:32 a.m., the DON reviewed the residents clinical records and stated there was no diagnosis for the use of an antidepressant, antianxiety, or the antipsychotic medication.

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	375347	A. Building B. Wing	06/13/2024

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 36191 Based on record review and interview, the facility failed to complete a discharge summary with a recapitulation of stay for one (#47) of one sampled resident reviewed. The administrator identified 49 residents who had been discharged in the last six months. Findings: Res #47 A review of the progress notes, documented Res #47 was discharged home with medication and belongings on home health via family transport on 03/28/24. There was no documentation in the clinical record the facility completed a discharge summary for Res #47 with a recapitulation of their stay. On 06/11/24 at 2:35 p.m., the DON stated there was not a discharge summary for Res #47.

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	375347	A. Building B. Wing	06/13/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36191 Based on observation, record review, and interview, the facility failed to ensure a portable electric space heater was not utilized in resident rooms for one (#3) of one sampled resident observed with a portable electric space heater in their room. The DON identified 43 residents who resided in the facility and two residents who utilized electric space heater in their rooms. Findings: The facility's undated, Electrical Safety for Residents policy, read in part, The resident will be protected from injury associated with the use of electrical devices, including electrocution, burns and fire. The policy also read, Portable space heaters are not permitted in the facility. Res #3 had diagnoses which included psychotic disorder with hallucinations and dementia. On 06/10/24 at 9:15 a.m., Res #3 was asked why they were using a portable electric space heater. They stated because they were cold. Res #3 stated they covered the heat and air vent because it blew out cold air. On 06/10/24 at 11:03 a.m., a portable electric space heater was observed plugged in and turned on in Res #3's room. On 06/12/24 at 12:54 p.m., the administrator observed the portable electric space heater in Res #3's room. On 06/12/24 at 12:55 the administrator stated the space heater in Res #3's room did not meet safety guidelines. The administrator stated the facility's policy prohibited space heaters.

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	375347	A. Building B. Wing	06/13/2024

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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. 36191 Based on observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter was anchored to prevent dislodgement and injury for one (#14) of three sampled residents who had a urinary catheter. The administrator identified four residents who had urinary catheters. Findings: The facility's policy titled, Catheter Care, Urinary, revised 09/2014, read in part, Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) Res #14 had diagnoses of urinary retention. Res #14's ADL care plan, dated 11/24/23, documented to provide catheter care every shift. Res #14's annual assessment, dated 04/20/24, documented they had an indwelling catheter. On 06/09/24 at 10:15 a.m., Res #14 was observed in bed, the catheter bag was hanging off the bed below the bladder. On 06/13/24 at 10:22 a.m., LPN #3 was observed providing pericare to Res #14. Res #14's catheter tubing was not anchored. The resident had small amount of dark reddish colored dried drainage on their vulva area. On 06/13/24 at 10:34 a.m., LPN #3 stated it looked liked the catheter had pulled and the tubing was in the crease of Res #14's leg and may have caused the drainage that looked like old blood.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36191 Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours a day, seven days a week. The administrator identified 43 residents who resided in the facility. Findings: A document titled, Nursing Department Schedule as Worked, dated 06/08/24, documented there was not an RN who had worked on the day, evening, or night shift. On 06/13/24 at 1:52 p.m., the administrator stated they did not have an RN scheduled to work on 06/08/24 and 06/09/24. They stated an RN had not worked on 06/08/24. The administrator stated they did not utilize staffing agencies.

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	375347	A. Building B. Wing	06/13/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 36191 Based on observation, record review, and interview, the facility failed to post the required staffing information. The DON identified 43 residents who resided in the facility. Findings: On 06/09/24 at 8:00 a.m., a white dry erase board was observed hanging on the wall at the nurses' station. The white dry erase board was not filled out. A schedule was observed in a book at the nurses' station. The schedule did not document the current census. On 06/10/24, 06/12/24, and 06/13/24 the white dry erase board was observed on the wall at the nurses' station. The dry erase board did not document the name of the facility, census or the hours worked for each staff member. On 06/13/24 at 3:04 p.m., the DON stated the required information was not documented on the dry erase board at the nurses' station.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 36191 Based on record review and interview, the facility failed to ensure a medication had a diagnosis for use for one (#3) of five sampled residents reviewed for unnecessary medications. The DON identified 43 residents who resided in the facility. Findings: Res #3 had diagnoses which included MDD, dementia, and psychotic disorder with hallucinations. The DON identified 43 residents who resided in the facility. Findings: A physician's order, dated 05/14/24, documented to administer Lamictal 25 mg two times a day. There was not a diagnosis for the medication. On 06/13/24 at 9:10 a.m., the DON stated there was not a diagnosis for the Lamictal. They stated the nurse practitioner's note documented based on last week's assessment.

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	375347	A. Building B. Wing	06/13/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33097 Based on observation, record review, and interview, the facility failed to ensure medication was necessary to treat a specific condition indicated in the clinical record for one (#42) and failed to ensure a rationale was documented for declining a gradual dose reduction for one (#3) of five sampled residents reviewed for unnecessary medications. The DON identified 30 residents who received psychotropic medication. Findings: The facility's Consultant Pharmacist Reports policy, dated 04/2018, read in part, Recommendations are acted upon and documented by the facility staff and/or the prescriber .Prescriber accepts and acts upon suggestions or rejects and provides an explanation for disagreeing. 1. Res #42 had diagnoses which included myocardial infarction, acute respiratory distress, muscle weakness, lack of coordination, acute on chronic systolic heart failure, chronic obstructive pulmonary disease, cognitive communication deficit, age-related physical debility, essential hypertension, and hyperlipidemia. A physician order, dated 05/11/24, documented the resident received Lexapro (a antidepressant medication) 20 mg by mouth one time a day for depression and anxiety. A physician order, dated 05/11/24, documented the resident received Buspirone (a antianxiety medication) 5mg by mouth three times a day for anxiety. An admission assessment, dated 05/15/24, documented the resident was cognitively intact and had no behaviors or potential indications of psychosis. The assessment documented the resident did not have a diagnosis of an anxiety disorder, depression, or a psychotic disorder. The care plan, dated 05/20/24, documented the Res #42 received Lexapro for depression and Buspar for anxiety. The care plan also documented the resident received Seroquel (a antipsychotic medication). A physician order, dated 05/23/24, documented the resident received Seroquel 25 mg by mouth at bedtime for sleep. The order documented the medication had been discontinued on 05/24/24. A physician progress note, dated 05/24/24, documented the resident was pleasant and cooperative. The note documented the Res #42 stated the initiation of Seroquel had helped and they had a good night sleep. A physician order, dated 05/24/24, documented the Res #42 received Seroquel 25 mg by mouth at bedtime for psychosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/24 at 10:47 a.m., the resident was lying in bed. The Res #42 was pleasant and calm during the interview. The Res #42 verbalized no concerns at this time. On 06/13/24 at 9:32 a.m., the DON reviewed the Res #42's clinical records and stated there was no diagnosis for the use of an antidepressant, antianxiety, or a antipsychotic medication. 36191 2. Res #3 had diagnoses which included psychotic disorder with hallucinations. A physician's order, dated 05/26/23, documented to administer Seroquel 50 mg every evening for psychosis. A gradual dose reduction request for Seroquel from the pharmacist, dated 04/15/24, documented a request to consider reducing Seroquel. The physician's response to the request documented they disagreed. The physician did not document a rationale for not decreasing the Seroquel. On 06/13/24 at 9:13 a.m., the DON stated the physician did not document a rationale for disagreeing with the pharmacist request for the gradual dose reduction of the Seroquel for Res #3.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36191 Based on record review and interview, the facility failed to guarantee the person designated to serve as the DM met the State requirement for DM. The administrator identified all 43 residents received their meals from the kitchen. Findings: The dietary manager was transferred to the kitchen on 11/16/20. There was no documentation provided the dietary manager had obtained their certification for dietary manager. On 06/12/24 at 12:41 p.m., the DON stated the dietary manager had finished their training and was waiting to take the test. On 06/12/24 at 4:57 p.m., the dietary manager stated they were not certified. The dietary manager stated they needed to take the test.

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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. 36191 Based on observation and interview, the facility failed to ensure proper food service sanitation and storage requirements were followed. The DON identified 43 residents who received their meals from the kitchen. Findings: The facility's undated, Food Storage policy, read in part, It is the policy .to follow all state and federal guidelines on food storage. The policy also read, Plastic containers with tight fitting covers must be used for storing .flour .Scoops must be provided for .flour .Scoops are not to be stored in food. The policy also read, Perishable food such as meat .fruits, vegetables and frozen products must be refrigerated immediately to ensure nutritive value and quality. Refrigeration temperatures should be thermostatically controlled to maintain food temperatures at or below 40 degrees F. The policy also read, Leftover food is used within 24 hours or discarded. The policy also read, Temperatures for refrigerators should be between 35-39 degrees Fahrenheit. Thermometers should be checked at least three times a day .Frozen meat .should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing. The facility's undated, General Food Preparation and Handling policy, read in part, The kitchen and equipment are clean .The food is kept refrigerated except when being handled .All meats are to be heated to a safe minimum internal temperature. The policy also read, If a fridge .running at unacceptable temperature the staff is to clear the food items from the fridge .and place in alternate appropriate storage. Any foods without proper temperature from fridge .will be disposed of immediately. Non operational equipment with be locked if applicable and out of order sign placed until equipment is either fixed or replaced. The refrigerator temperature log, dated 06/01/24 through 06/09/24, documented the following temperatures: 06/01/24 morning temperature: 50 degrees F/evening temperature was documented; 06/02/24 morning temperature: not documented/evening temperature 51 degrees F; 06/03/24 morning temperature: 51 degrees F/evening temperature 49 degrees F; 06/04/24 morning temperature: 54 degrees F/evening temperature 53 degrees F; 06/05/24 morning temperature: 53 degrees F/evening temperature not documented; 06/06/24 morning temperature: 46 degrees F/evening temperature not documented; 06/07/24 morning temperature: 49 degrees F/evening temperature 46 degrees F; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375347	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McLoud Nursing Center	701 South 8th Street McLoud, OK 74851

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	06/08/24 morning temperature: 49 degrees F/evening temperature 51 degrees F; and 06/09/24 morning temperature: not documented. The refrigerator temperatures were above 41 degrees F for nine out of nine days. On 06/09/24 at 8:09 a.m., dietary aide #1 was asked about the wet blankets by the ice machine. The dietary aide stated the drain leaked and pointed to the pipe behind the ice machine. On 06/09/24 at 8:10 a.m., an initial tour of the kitchen was done with cook #1. The cook stated the refrigerator was not working and several companies had been out to look at it. On 06/09/24 at 8:10 a.m., the following was observed: a. the refrigerator temperature reading was 44.4 degrees F., the following was observed in the refrigerator: cut up cantaloupe, water melon, pineapple, and whole grape fruit platters x2, three pitchers of tea, whole blueberries and strawberries, mixed vegetables in a storage container was dated 06/08/24, barbeque meat thawing in the bottom of the refrigerator. whole intact seedless cucumbers and a box of uncrustables. The refrigerator had a foul odor; b. the ice machine had multiple areas of calcification, debris under and behind the ice machine; c. the oven and stove had black build up of food, food splatters and debris; d. debris under and behind the ice machine and wet blankets on the floor in front of and on the side of the ice machine. On 06/09/24 at 8:31 a.m., the housekeeper #2 stated the debris under and behind the ice machine was coming from what leaked out of the pipe behind the ice machine. On 06/09/24 at 9:11 a.m., cook #1 stated the meat in the refrigerator was shredded beef for lunch and had been in the refrigerator overnight (temperature of refrigerator was 44.4 degrees F.). [NAME] #1 stated they had put the meat in the oven to cook for lunch. [NAME] #1 obtained the temperature of the items in the refrigerator: vegetable mixture: 45.6 degrees F, cut up cantaloupe: 47.3 F, cut up pineapple: 46.5 F, grapes: 47.1, whole red grape not sealed: 47.1 F, and, whole green grape not sealed: 55.0 F. On 06/09/24 at 9:20 a.m., cook #1 was asked what temperature cold food should be stored. They stated 36-45 degrees F. [NAME] #1 was asked about the odor in the refrigerator. They stated they had just thrown out some cabbage and did not know what was causing the odor. On 06/09/24 at 9:33 a.m., the administrator was made aware of the food stored in the refrigerator and the meat that was placed in the oven after being thawed in the non working refrigerator. They stated they were going to throw the meat out and cook the residents something else. The administrator stated they ordered a new refrigerator and the staff were not supposed to be using that refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/12/24 at 6:25 a.m. a follow up observation was made in the kitchen. The vent above the door to the kitchen was observed to be dirty, white build up on the dish machine and dish machine baskets, dirty wash cloth was on top of a yellow barrel. On 06/12/24 at 6:25 a.m., cook #2 stated the ice machine was cleaned monthly by maintenance. On 06/12/24 at 6:50 a.m., the temperature of the food on the steam table was obtained by cook #2. The following foods were not held at a temperature at or above 135.0 degrees F: a. pureed eggs: 132.0 degrees F; b. pureed sausage: 118.9 degrees F; and c. sausage links: 131.5 degrees F. On 06/12/24 at 7:06 a.m., cook #2 was observed serving the pureed eggs and sausage. They did not heat the food to the correct holding temperature prior to serving. On 06/12/24 at 7:14 a.m., cook #2 was asked what temperature the food should be held at on the steam table. They stated no lower than 130 degrees F. The cook was asked if the sausage links, pureed eggs and pureed sausage had been held at or above 135 degrees F. They stated, No. [NAME] #2 was asked if there was anything they could have done to ensure the food was heated to the correct temperature. They stated they could have reheated it in the microwave. On 06/12/24 at 7:26 a.m., cook #2 continued to serve the pureed eggs, sausage and sausage links. On 06/12/24 at 7:28 a.m., a bin of flour was observed in the dry storage area with a styrofoam cup inside the flour container. A clear plastic container with a blue lid contained thickner for thickening food. The container and lid were cracked and a styrofoam cup was observed inside the container. On 06/12/24 at 7:34 a.m., the dietary manager stated the meat was not thawed correctly, they stated it should have been thawed in a working refrigerator, under cold running water, or microwave. The dietary manager stated the staff were aware they should not use the refrigerator. They stated it had not been working since the past week. The dietary manager stated the pipes were backing up and debris was flowing out the pipe behind the ice machine in the dining room. The dietary manager stated the food was not held at the appropriate temperature on the steam table. The dietary manager was shown the pictures of the oven from 06/09/24. They stated the cleaning schedule was weekly and the oven did not look like it had been cleaned weekly and they could not tell by the schedule when it had been cleaned. The dietary manager stated the bins should have been tightly closed and the styrofoam cups should not have been stored in the bins, and the dirty washcloth should not have been stored on top of the yellow barrel. On 06/12/24 at 1:00 p.m., the ice machine was observed with maintenance supervisor. The ice machine had white build up on the inside and outside of the ice machine.

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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. 36191 Based on observation, record review, and interview, the facility failed to ensure: a. nebulizer masks were stored in a manner to prevent cross contamination for two (#12 and #32) of two sampled residents observed for infection control with breathing treatments; b. staff wore appropriate PPE and performed hand hygiene during wound care for one (#14) of two sampled residents who were observed during wound care. c. staff wore appropriate PPE during provision of care for two , (#17, and #38) of three sampled residents reviewed for enhanced barrier precautions; and d. IV tubing was changed per facility policy for intermittent use for one(#17) of one sampled resident who was reviewed for IV therapy. The DON identified seven residents who were placed on enhanced barrier precautions, five residents who received nebulizer treatments, and one resident who received IV medication. Findings: The facility's, Departmental (Respiratory Therapy)-Prevention of Infection, revised 11/2011, documented to remove nebulizer container after completion of therapy, rinse the container with fresh tap water, dry on a clean paper towel or gauze sponge, reconnect to the administration set-up when air dried, reconnect tubing, and store the circuit in plastic bag, marked with date and resident's name, between uses and discard every seven days. A policy titled Guidelines for Preventing Intravenous Catheter-Related Infections read in part .change intermittent sets every 24 hours, immediately upon suspected contamination, or when integrity of product or system has been compromised. Once a secondary administration set (piggyback) is detached from the primary set, it is considered an intermittent set . There was no policy for enhanced barrier precautions. An in-service record, dated 04/03/24, read in part .EPB expands the use of personal protective equipment (PPE) to donning gown an gloves during high-contact care .residents for whom EBP is employed when performing the following high-contact resident care activities: .device care or use: central line urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing . 1. Res #12 On 06/09/24 at 11:53 a.m., a nebulizer mask was observed sitting on the nightstand. The nebulizer mask was dated 05/26/24 and was not stored in a bag. 2. Res #32 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/24 at 9:55 a.m., the nebulizer mask was sitting on the counter next to the sink. The tubing was not stored in a bag and was labeled 05/26/24. On 06/12/24 at 8:41 a.m., the DON observed the pictures of the nebulizer masks and stated they were not stored correctly. The DON stated the nebulizer masks should be changed weekly and were supposed to be stored in a bag after being cleaned and air dried. 3. Res #14 had diagnoses which included urinary retention and stage four pressure ulcer. An ADL care plan for Res #14, documented a catheter was placed on 11/23/23 for urinary retention; interventions included to provide catheter care every shift. The care plan also documented Res #14 had a stage four pressure ulcer. Res #14's annual assessment, dated 04/20/24, documented they had severe cognitive impairment, required substantial/maximal assistance for toileting, showering, dressing, and bed mobility, was dependent on staff for transfers, had an indwelling catheter, and had one stage four pressure ulcer which required a dressing. On 06/09/24 at 10:05 a.m., Res #14 stated they had a pressure ulcer on their bottom. They stated the staff performed the wound care. On 06/09/24 at 10:31 a.m., Res #14 stated the staff did not wear an isolation gown when they were providing care unless they had an infection. On 06/11/24 at 11:12 a.m., LPN #3 was observed performing wound care. The LPN donned gloves and removed Res #14's dressing. LPN #3 removed their gloves disposed of the soiled dressing and left the room. LPN #3 was not observed to clean their hands prior to leaving the room after removing their gloves. LPN #3 returned to the room washed their hands donned gloves and cleaned the wound removed their gloves and donned a new pair of gloves without cleaning their hands. LPN #3 applied medicated ointment to the wound as ordered, and covered with dressing. LPN #3 did not wear a gown while they performed wound care. There were no signs indicating the resident was on enhanced barrier precautions. On 06/11/24 at 11:25 a.m., LPN #3 stated they were nervous and should have performed hand hygiene each time they removed their gloves. LPN #3 stated they had not performed hand hygiene. The LPN stated they had not been provided education on enhanced barrier precautions and did not know which residents required enhanced barrier precautions. 33097 4. Res #17 had diagnoses which included encephalopathy, muscle weakness, and sepsis. A physician order, dated 06/06/24, documented the resident was to receive wound care two times a day for a wound to the left buttock. A physician order, dated 06/11/24, documented the resident was to receive Meropenem Solution (a antibiotic medication) 1 gram intravenously every eight hours for UTI for 14 days. The order documented the staff was to change the IV tubing every 24 hours and label. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/09/24 at 10:04 a.m., the resident was lying in bed. The resident had an IV access to the right upper arm and a catheter bag was hanging from the side of the bed. There was no signage regarding enhanced barrier precautions or PPE by the residents door. On 06/11/24 at 10:32 a.m., RN #1 performed wound care to the residents buttock. There was no signage posted or PPE available for advance barrier precautions when entering the resident's room. The RN did not wear a gown when providing care. The RN stated they were not aware of any residents requiring special contact precautions or enhance barrier precautions in the facility at this time. On 06/11/24 at 10:38 a.m., RN #1 disconnected the IV tubing from a used bag of IV fluid and connected it to a new IV bag of fluid. The RN stated the tubing should be changed every 24 hours. The RN noted the tubing used was not dated and stated they needed to get new tubing because the tubing was not dated. On 06/11/24 at 12:14 p.m., the DON stated the facility currently does not have a policy for enhanced barrier precautions at this time. The DON stated information was provided by the corporate office and an in-service was held for the staff, but no policy had been developed. The DON stated there should be signage and PPE for enhanced barrier precautions by the door for residents with IV access or residents with infections to wounds or urine. The DON stated resident #17 should have enhanced barrier precautions in place due to having IV access and infection in the urine. On 06/11/24 at 2:39 p.m., the DON stated they misunderstood the guidance regarding enhanced barrier precautions the resident had to have an IV or an infection. Upon review of the information provided by the corporate office the DON stated anyone with an IV, wound, or catheter the staff needed to do enhanced barrier precautions with their care. The DON stated they would need to re-educate staff. 5. Res #38 had diagnoses which included malignant neoplasm, unilateral inguinal hernia, and retention of urine. A physician order, dated 05/31/24, documented the resident had wound care one time a day for an abscess to the right buttock. On 06/11/24 at 2:14 p.m., LPN #3 performed wound care for the resident. There was no signage posted or PPE available for advance barrier precautions when entering the resident's room. The LPN did not wear a gown when providing care.