STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shanoan Springs Nursing and Rehabilitation	2500 South 12th Street Chickasha, OK 73018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and interview, the facility failed to ensure residents were offered to formulate an advance directive, or implemented the choice to formulate an advanced directive, for three (#8, 20, and #42) and posted the correct information regarding code status for one (#2) for 24 residents reviewed for advance directives. The administrator identified 50 residents who resided in the facility. Findings: 1. Res #8 had diagnoses which included atrial fibrillation, COPD, and chronic pain. A quarterly assessment, dated 03/27/24, documented the resident was moderately impaired with cognition and required partial to moderate assistance with most ADLs. On 04/15/24 at 10:55 a.m., a green name tag, indicating full code status, was observed by the resident room. 04/16/24 at 9:00 a.m., the residents advance directive acknowledgment form was provided. The undated form documented the resident had an advance directive. The AD acknowledgment form was signed by the resident. The resident did not have an AD in the EHR or in the hard chart. On 04/16/24 at 9:20 a.m., the administrator stated Res #8 had documented they had an advanced directive but they were not able to find one in the resident's record. On 04/16/24 at 11:39 a.m., the social service director stated they filled out the admission paper work for the resident. The social service director stated they had not went over an advance directive with Res #8. The social service director stated Res #8 had a POA and they went over the information with the POA on the day of admission. The social service director stated they were not aware if the previous social service director had went over the AD with residents or not. 2. Res #20 had diagnoses which included COPD, PVD, and lymphedema. A form titled Advance Directive Acknowledgement, dated 05/26/22, the form documented the resident did not have an advance directive, but was interested in implementing one. (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly assessment, dated 03/24/24, documented the resident was intact with cognition and required assistance with ADLs. A care plan, last revised 01/18/24, documented the resident had an advance directive. On 04/15/24 at 10:54 a.m., a green name tag for the resident, indicating full code status, was observed by the residents room. On 04/16/24 at 1:07 p.m., the DON stated they removed the care plan regarding the resident having an advance directive. The DON stated the social service director would talk with the resident today and find out if the resident wanted an advance directive. 3. Res #42 had diagnoses which included PVD, cardiac arrhythmia, HTN, and dementia. A form titled Advanced Directive Acknowledgement, dated 10/01/22, documented the resident's POA had indicated the resident did not have an advance directive and was interested in implementing one. A quarterly assessment, dated 04/07/24, documented the resident was moderately impaired with cognition and required assistance with ADLs. On 04/15/24 at 1:40 p.m., a green name tag for the resident, indicating full code status, was observed by the resident's room. On 04/16/24 at 9:18 a.m., the administrator stated social service should have followed up on the advance directives 24 to 48 hours when a resident or representative documented they wished to formulate an advance directive. 46909 4. Res #2 had diagnoses which included multiple sclerosis, dementia in other diseases with agitation, delusional disorder, cognitive communication deficit, and dementia with behavioral disturbances. A quarterly assessment, dated 01/28/24, documented the resident was cognitively intact and require minimal to moderate assistance with ADLS. A physician's order, dated 04/24/2024, documented the resident had a DNR. On 04/15/24 at 09:36 a.m., an observation was made of the resident's name on a green paper directly on the doorframe outside of the resident's room indicating the full code status of the resident. On 04/17/24 at 01:16 p.m., an interview with LPN #2 stated the green paper on the doorframe was documentation of the resident as a full code. On 04/17/24 at 01:17 p.m., the DON stated they had just checked every chart, residents' code status, and checked every paper on the doorframes to ensure the correct code status was posted outside of the residents' room but had missed Res #2's.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38495 Based on record review and interview, the facility failed to ensure an allegation of abuse was reported within two hours of the reported incident for one (#8) of three residents sampled for abuse. The administrator identified 50 residents residing in the facility. Findings: A facility policy titled Reporting Abuse to Facility Management, dated April 2012, read in part, .The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or paged and informed of such incident . Res #8 had diagnoses which included atrial fibrillation, COPD, and chronic pain. A quarterly assessment, dated 03/27/24, documented the resident was moderately impaired with cognition and required partial to moderate assistance with most ADLs. On 04/15/24 at 2:40 p.m., Res #8 stated stated yesterday a nurse said the F word at them and it hurt their feelings. The resident stated they told other staff member but did not know their names. On 04/15/24 at 2:57 p.m., the allegation was reported to the administrator. The administrator stated they had not been informed of the incident until that time. On 04/18/24 at 2:57 p.m., CMA #2 stated Res #8 told them on Sunday night around 10:00 p.m.,that the nurse was mad at them. The resident told the CMA the nurse walked to the door and said the F word. CNA #2 stated they asked the resident if they were sure and stated they then told Res #8 to talk to the nurse. The CMA stated they did not want to make it a bigger situation because the resident fed off of situations such as that. The CNA #2 stated they reported it on Monday morning to the ADON. On 04/18/24 at 3:17 p.m., the ADON stated they reported the incident to the DON and the DON from a sister home in another town. The ADON stated they personally did not do an incident report.

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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. 38495 Based on record review and interview, the facility failed to ensure resident assessments were accurate for two (#8 and #20) of 13 sampled residents whose resident assessments were reviewed. The administrator identified 50 residents who resided in the facility. Findings: 1. Res #8 had diagnoses which included anxiety disorder, major depressive disorder, bipolar disorder, and schizophrenia. A quarterly assessment, dated 03/27/24, documented the resident was moderately impaired with cognition. The assessment documented the resident received an antipsychotic, antianxiety, and an antidepressant medication. The assessment documented a GDR had been attempted on 10/06/23. On 04/18/24 at 10:57 a.m., the MDS coordinator stated they were brand new to the MDS position as of September of 2023. The MDS coordinator stated they found the date on a psychiatric consultation progress note for September and it had been signed and dated on 10/06/23. On 04/18/24 at 11:36 a.m., the DON stated on 09/18/24 the psychiatrist came to the facility and made changes in the resident's medication. They stated the attending physician did not want those changes to be made so the date on the MDS was not correct for a medication reduction. 2. Res #20 had diagnoses which included pressure ulcer of right heel stage 3, PVD, non-pressure chronic ulcer to right thigh, lymphedema, and non-pressure chronic ulcer of the other part of left lower leg with unspecified severity. A care plan, revised 03/09/24 documented the resident had actual impairment to their right lateral thigh, bilateral buttocks, left heel, left great toe, left shin, right lateral foot, and scabs to left toes/foot/shin. A quarterly assessment, dated 03/24/24 documented the resident had two unhealed stage three pressure ulcers. The assessment did not contain documentation of the resident having other wounds. A wound progress note, dated 04/12/24, documented the resident had a non-pressure wound right posterior lateral thigh full thickness , duration was 157 days. The note documented the resident had a stage three pressure wound of the left heel full thickness, duration of 151 days. The note documented the resident had lymphedema wound to left shin full thickness, duration 88 days. The note documented a venous wound of right medial ankle was resolved on 04/12/24. On 04/16/24 at 3:28 p.m., the DON stated they would have to do a correction for the wound section of the MDS assessment as the resident did have wounds that were not pressure ulcers which were not captured on the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46909 Based on record review and interview, the facility failed to refer a resident with a new mental health diagnosis to OHCA for a PASRR level II evaluation for one (#2) of one sampled residents reviewed for PASRR. Findings: A PASRR level I was provided by another facility that was transferring services to this facility, dated 06/30/10, documented Res #2 had diagnoses including multiple sclerosis, neurogenic bladder, paraplegia, sebaceous cysts, and [NAME]-[NAME] syndrome. Res #2 was admitted on [DATE] after being transferred from another facility, and had diagnoses which included multiple sclerosis, [NAME]-[NAME] syndrome, neurogenic bladder, paraplegia, sebaceous cysts, dementia in other diseases with agitation, delusional disorder, cognitive communication deficit, and dementia with behavioral disturbances. A significant change assessment dated [DATE] documented the resident was severely impaired with cognition and diagnosed with psychotic disorder. A care plan revised on 08/14/23, documented the resident had a diagnoses of psychosis with risk of hallucinations with delusional paranoia. On 04/17/24 at 3:26 p.m., the DON confirmed diagnoses of psychosis with risk of hallucinations with delusional paranoia was listed as an admission diagnoses was not documented on the PASRR level I. The DON stated they would call OHCA to check on if a PASRR level II evaluation was needed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46909 Based on record review and interview, the facility failed to ensure nutritional supplements were given to one (#49) of two residents reviewed for weight loss. The DON identified 50 residents residing in the facility. Findings: Resident #49 was admitted with diagnoses including diffuse traumatic brain injury and hemorrhage with loss of consciousness of unspecified duration and need for assistance with personal care. The resident was also admitted with a gastric tube. A physician's order on 03/28/24 documented enteral feed TwoCal HN four times a day via gastric tube. On 04/02/24 a dietitian recommended the resident be given TwoCal HN five times a day via gastric tube. There was no documentation of the physician being notified of this dietitian recommendation. On 04/17/24 at 11:01 a.m., the ADON stated the dietitian would examine each resident remotely and send the recommendations to their email. They also stated there are times when we miss those recommendation related to not looking at our emails. On 04/17/24 at 11:07 a.m., the DON stated they did not see the note from the dietitian. They also stated the physician was not notified of any new recommendations.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46909 Based on observation, record review, and interview, the facility failed to follow physician's orders for oxygen tubing care maintenance for one (#33) of one resident sampled for oxygen therapy. The administrator reported 50 residents resided in the facility. Findings: Resident #33 was admitted with diagnoses of chronic obstructive pulmonary disease, respiratory failure, and dependency of supplemental oxygen. A physician's order, dated 01/22/24, documented to change the oxygen tubing on the 5th and 20th of each month on the night shift. A quarterly assessment, dated 03/25/24, documented the resident utilized oxygen. On 04/15/24 at 10:59 a.m., an observation was made with the resident wearing oxygen via nasal canula and the tubing documented a date of 03/06/24. On 04/16/24 at 8:10 a.m., an observation was made with the resident wearing oxygen via nasal canula and the tubing documented a date of 03/06/24. On 04/17/24 at 11:50 a.m., an observation was made with the resident wearing oxygen via nasal canula and the tubing documented a date of 03/06/24. The treatment administration record for the month of April of 2024 did not document any dates suggesting the oxygen tubing had been changed since 03/06/24. On 04/18/24 at 8:09 a.m., the DON stated the oxygen tubing should have been changed on the 5th of April of 2024.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the use of side rails was appropriate for one (#49) of one sampled residents who were reviewed for side rails. The administrator identified 21 residents residing in the facility utilized bed rails of any type. Resident #49 was admitted with diagnoses including diffuse traumatic brain injury and hemorrhage with loss of consciousness of unspecified duration and need for assistance with personal care. An admission assessment, dated 03/25/24, documented the resident was severely impaired with cognition and was totally dependent with ADLs. A physician order, dated 03/25/24 at 7:00 a.m., documented to monitor placement and function of low air loss mattress every shift for placement and function. On 04/15/24 at 10:55 a.m., an observation was made of Res #49 lying on an air mattress with bed rails on both sides of the bed. The resident's EHR did not document a physician order for bed rails. The resident's care plan did not document a care plan for the use of side rails. The resident's records contained a consent signed by the resident's representative for bed rails. On 04/16/24 at 4:00 p.m., the DON stated the resident's representative wanted the bed rails on the bed, but had not signed a consent at that time.

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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. 38495 Based on record review and interview, the facility failed to: a. ensure a consultant pharmacist reviewed the medication of each resident in the facility monthly for two (#8 and #42) of five sampled residents reviewed for unnecessary medications. b. ensure the physician responded in the time frame documented by the facility policy to the MRR for one (#42) of five sampled residents reviewed for unnecessary medications, and c. ensure the physician responded to the MRR request for two (#8 and #42 of five sampled residents reviewed for unnecessary medications. The administrator identified 50 residents who resided in the facility. Findings: A facility policy, dated 2024, titled Drug Regimen Review, read in part .The Consultant Pharmacist reviews the medication regimen of each resident at least monthly .If the facility has not received any communication from the physician regarding the Drug Regimen Review (DRR) within 30 business days, the facility staff will call the physician .The physician provides a written response of the report to the facility within one month after the report is sent. A copy of the report is kept by the facility until the physicians' signed response is returned .The facility maintains copies of signed reports on file for at least one year . 1. Res #8 had diagnoses which included anxiety disorder, major depressive disorder, bipolar disorder, and schizophrenia. A MRR, dated 09/21/23, documented the following medications are not being used and to indicate below if any or all of the listed medications could have been safely discontinued due to non-use at that time. The listed medications were artificial tears PRN, ketotifen ophthalmic solution PRN, loperamide PRN, lubricant eye drops PRN, milk of magnesia PRN, Mylanta PRN, and ondansetron PRN. A physician response to the request was not found for the MRR. A MRR request, dated 01/26/24, documented aripiprazole 15 mg daily, diazepam 2 mg BID, divalproex 250 mg TID, duloxetine 30 mg daily, olanzapine 2.5 mg at HS, quetiapine 50 mg at HS, topiramate 50 mg BID, were being used by the resident. The request was made to attempt a reduction for the medications. There was no documentation the request was addressed by the resident's physician. A MRR for the month of February 2024 was not found for the resident. A quarterly assessment, dated 03/27/24, documented the resident received an antipsychotic, antianxiety, and an antidepressant medication. The assessment documented a GDR had been attempted on 10/06/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/18/24 at 10:33 a.m., the physician response for 09/21/23 and 01/26/24 and the MRR for February 2024 were asked for again. On 04/18/24 11:35 AM DON stated they were not able to find documentation for the September review or the January review from the physician. 2. Res #42 had diagnoses which included generalized anxiety disorder, major depressive disorder, bipolar disorder, and dementia. A MRR request, dated 11/21/23, asked a GDR for Rilutek (an ALS agent) 50 mg po bid to be assessed for possible reduction. The physician documented they disagreed with the request as the resident was stable no changes at this time. The form was dated 01/23/24. The facility did not provide a MRR for January 2024 to review. A quarterly assessment, dated 04/07/24, documented the resident had verbal behaviors one to three days during the look back period. The assessment documented the resident had received antipsychotic, antidepressant, and opioid medications. On 04/18/24 at 1:20 p.m., the DON stated the November MRR did not have a timely response from the physician. On 04/18/24 at 2:18 p.m., the ADON stated they were not able to find the MRR request for January 2024 for Res #42.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation, record review, and interview, the facility failed to ensure menus were followed. The facility identified one resident who received a puree meal, one resident who received finger foods, for a total of 48 residents who received their meals from the kitchen. Findings: On 04/17/24 at 11:00 a.m., the menu was observed and documented the noon meal was to have been french onion pork chops, pork gravy, white cheddar mac and cheese, green peas, wheat dinner roll, margarine, apple [NAME], milk, and coffee. On 04/17/24 at 11:54 a.m., cook #1 was observed to have pureed the meal for the resident who required pureed meals and had not included a roll. On 04/17/24 at 12:01 p.m., during the meal service, four meals were observed to be served without rolls. On 04/17/24 at 12:15 p.m., Res # 25 was observed to have been served butter noodles, the white cheddar mac and cheese and green beans. The resident was not served a pork chop with their noon meal. DA #3 stated the resident received finger foods. On 04/17/24 at 12:16 p.m., the DM stated the resident should have received a pork chop for lunch and it would have been cut up for finger food size. On 04/17/24 at 12:36 p.m., cook #1 confirmed they had not pureed a roll for the resident's meal. On 04/18/24 at 10:00 a.m., the menu was observed for the puree and finger foods. The menu documented the puree should get a soaked wheat dinner roll and the finger food had a square on the meat area. On 04/18/24 at 10:16 a.m., the DM stated the square under finger foods was to represent the resident could have what was on the regular menu cut up to finger food size.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38495 Based on observation and interview, the facility failed to ensure food was served at an appetizing temperature. The facility identified 48 residents who received their meals from the kitchen. Findings: 1. On 04/17/24 at 11:00 a.m., the menu was observed and documented the noon meal was to have been french onion pork chops, pork gravy, white cheddar mac and cheese, green peas, wheat dinner roll, margarine, apple [NAME], milk, and coffee. On 04/17/24 at 11:10 a.m., [NAME] #1 was observed to obtain the temperature of the pork chops when they were removed form the oven. The temperature at that time was 184 degrees F. The pork chops were place in a deep pan and then placed on the steam table. The other food items were not observed to be temped before placing on the steam table. On 04/17/24 at 12:01 p.m., the meal service started. The steam table was not temped before service started. On 04/17/24 at 12:20 p.m., the DM stated they should have temped the food on the steam table before serving the meal. The DM stated the holding temperature on the steam table was 145 degrees. The DM temped a pork chop which was on top of the other pork chops and the temperature reading was 106 degrees F. 2. On 04/15/24 at 9:37 a.m., Res #2 stated the facility served cold food. On 04/17/24 at 12:46 p.m., the kitchen cart with the hall trays left the dining area and went to the north hall. A test tray was taken to north hall at this time also. On 04/17/24 at 12:56 p.m., the test tray was obtained immediately after the last meal had been served on the hall cart and the temperatures were as follows. The pork chop was 115 degrees F and luke warm to taste. The peas were 105 degrees F and cold to taste. The mac and cheese noodles were 107 degrees F and cold to taste. The apple dessert was 81.5 F degrees cold. The test meal was not served with a roll. On 04/18/24 at 9:28 a.m., the DM stated they had not had any complaints of cold food, but agreed the food should have been served at a palatable temperature.

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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, prepare and serve food in accordance with professional standards for food service safety. The facility identified 48 residents who received their meals from the kitchen. Findings: 1. On 04/15/24 at at 8:21 a.m., an initial tour of the kitchen was conducted. The following observations were made. [NAME] # 1 was observed to take the trash out of the trash can and the trash was taken outside. [NAME] #1 was observed to return to the kitchen and did not wash their hands. [NAME] #1 placed a lid on the chicken, which was on the prep counter in marinade, and then placed the container in the refrigerator. [NAME] #1 was then observed to cover a bowl of cream cheese with plastic wrap, and then placed individual containers of butter into a bowl. Hand washing was not observed during this observation. On 04/15/24 at 8:30 a.m., the following was observed in the refrigerator: Opened containers of Thick and Easy drinks were not dated with an open date An opened bottle of water, with some water missing, in the refrigerator and did not document a name or date of opening. 17 glasses of juice which did not document a label or date. 34 small cups of both pudding and fruit which were not labeled or dated. Two containers which held half sandwiches in plastic bags were not labeled or dated. On 04/15/24 at 8:36 a.m., scoops were observed in the brown sugar, flour, and granulated sugar bins. On 04/15/24 at 8:38 a.m., the outside storage was observed to have a lock on the door. In the storage room there were items stacked on the floor including a box of tomato ketchup, a bag of pure sugar, which was on top of the ketchup, and two boxes of Thick and Easy liquid drinks. The freezers in the storage room were observed to contain food which had not been labeled and/or dated. A second freezer contained an open box of chile chicken tacos and a box of frozen beef patties both of which were open to air. In the pantry, some of the items were not dated with the date they arrived in the facility. On 04/15/24 at 8:52 a.m., which was a Monday, [NAME] #1 stated the facility received food shipments on Tuesdays and Fridays. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/15/24 at 8:53 a.m., in the kitchen hot pads and mitts were observed on top of a plastic container, and top of the container was observed to have been covered with debris and was next to the storage shelving holding the clean pans. Two small storage containers bins were observed to hold the serving utensils and debris was observed on the top of the bins and in the floor around the bins. The inside of the microwave was observed to have had a yellow substance spillage on the glass plate. The area under the prep counter, where the large pots were stored, had dirt and debris on the shelving. The floor in the kitchen was observed to have been dirty with dirt, debris, and dead crickets along the walls, by the refrigerator, and under the steam table. On 04/15/24 at 8:59 a.m., the floor mat by the ice machine in the dining room, was observed to have circle hole shapes through it and a black substance was observed around the mat and was also observed through the holes under the mat. The DM stated housekeeping were the ones who should have cleaned under the mat. On 04/15/24 at 9:36 a.m., housekeeper #1 stated they had not seen anyone ever take the mat up in the dining room and clean it. They stated they had only cleaned around the outside of the mat. 04/15/24 at 9:03 a.m., the DM stated the items in the refrigerator, freezers, and on the shelving in the pantry/storage room should all have been dated when it arrived, or was made and placed in the refrigerator. The DM stated the items in the freezer should not have been open to air. The DM stated the scoops should not have been left in the bins. The DM stated they had never labeled or dated the snack items in the refrigerator, or the thickened drinks when they had been opened. The DM stated floors and shelving should have been cleaned daily and did not look like they have been cleaned. 2. On 04/17/24 at 11:01 a.m., a second tour of the kitchen was made and the following things were observed. On 04/17/24 at 11:16 a.m., DA #3 was observed to run a disposable wash cloth under the faucet to wet it and clean a prep counter and microwave with the cloth without using sanitizer solution. On 04/17/24 at 11:18 a.m., [NAME] #1 was observed to touch their glasses on their face, retrieve a lid for the noodles on the stove, place hot pad mitts on their hands, and move a hot pan to the dish washing area. [NAME] #1 was then observed to have put on gloves and place some of the noodles in the food processor. Hand hygiene was not observed. On 04/17/24 at 11:26 a.m., the DM was observed to come into the kitchen, did not wash their hands, obtained a glass of tea for a resident which they took to the resident in the dining room, and then returned to the kitchen to washed their hands. On 04/17/24 at 11:26 a.m., CNA #4 was observed to enter the kitchen and did not put on a hair net or wash their hands. The CNA retrieved coffee and then stood in the kitchen by the steam table waiting on other drinks to take to a resident in the dining room. On 04/17/24 at 11:40 a.m., DA #3 was observed to use another cloth and run it under tap water to clean the prep counters without using sanitizer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/17/24 at 11:53 a.m., the DM stated they did not have a sanitizer bucket made up for cleaning the prep areas. On 04/17/24 at 12:00 p.m., DA #2 was observed to enter the kitchen without washing their hands, retrieved coffee for a resident and return to the dining room. Hand hygiene was not observed. On 04/17/24 at 12:03 p.m., DA #3 was observed to wear disposable gloves and was serving the noon meal. DA #3 touched the bread sack and got bread out for a resident with same gloved hand. DA #3 did not change gloves or perform hand hygiene when they went back to serving the meals. On 04/17/24/at 12:09 p.m., DA #2 was observed to enter the kitchen without washing their hands, retrieved coffee, and returned to the dining room. On 04/17/24 at 12:13 p.m., a plate, which was served to the dining room for a resident meal, came back into the kitchen through the window pass to DA #3 as they were still serving meals. DA #3 took the plate from the other staff member and placed it in the dish washing area. DA #3 then returned to serving meals without doffing the contaminated gloves, washing their hands, and donning clean gloves. 3. On 04/17/24 at 12:48 p.m., LPN # 3 was observed to not perform hand hygiene before they started passing meals on the hall. LPN #3 was observed to scratch their head, touch their glasses and move them on to the top of their head, move a resident's overbed table, and set up a meal, uncovered food and drinks. LPN #3 pushed the cart to the other hall and delivered more resident meals in the same manner. Hand hygiene was never observed during the observation of LPN #3. On 4/18/24 at 9:27 a.m., the DM stated hair nets should be worn in the kitchen all the times and hand washing should be performed when entering the kitchen and serving meals. The DM stated they should not be taking items back through the window pass from the dining room. The DM stated, when serving the meals, the kitchen staff should not be touching anything dirty, or holding the drinking glasses by the rims. The DM stated any time they stepped away from the steam table they should have taken off their gloves, got the item, washed their hands, and re-gloved to start serving meals again. 4. On 04/15/24 at 11:56 a.m., during the dining observation, DA #1 was serving the meals in the dining room with the resident's meal plate balanced against their clothing. This was observed to occur multiple times with multiple resident meal plates. DA #1 was not observed to have performed hand hygiene during this dining observation. On 04/15/24 at 12:00 p.m., the administrator was observed serving meals without performing hand hygiene between residents, after they touched their pants, and before they went back to the window pass for another resident meal. On 04/15/24 at 12:02 p.m., DA #1 took a resident's cup into the kitchen took the lid off the cup filled the cup with liquid and took the cup back to the resident. The DA was observed to not wash their hands on entry to the kitchen. On 04/15/24 at 12:08 p.m., DA #1 was observed to carry drink glasses by the rim, touched their pants while pulling them up, and entered the kitchen to get the hall cart. Hand washing was not observed when entering the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	34945 4. On 04/15/24 at 11:52 a.m., to 11:57 a.m., an unidentified dietary aide was observed going from the kitchen pass to deliver food trays to residents in the supervised dining room and back to pass multiple times without using hand hygiene. On 04/15/24 at 11:58 to 12:01 p.m., the unidentified dietary aide was observed delivering plates of food to residents in regular dining room and was observed to hold the plates of food against their shirt for balance. On 04/17/24 at 12:07 p.m., an unidentified dietary worker was observed to enter the kitchen, obtain drinks, and exit the kitchen without washing their hands. On 04/17/24 at 12:08 p.m., a separate unidentified dietary worker was observed to enter and obtain drinks for residents, and exit the kitchen area without washing their hands. On 04/17/24 at 12:09 p.m., an unidentified dietary aide entered the kitchen area again without washing their hands, obtained a drink for a resident, exited the kitchen, and after giving the drink to the resident, went back into the kitchen and washed their hands. They were then observed to return to the dining room. On 04/18/24 at 9:39 a.m., the administer stated the nursing staff who passed the meals to the residents should be using hand sanitizer between residents and after every three passed they should have washed their hands.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 38495 Based on observation and interview, the facility failed to ensure the garbage from the kitchen was disposed of properly. The facility identified 48 residents who received services from the kitchen. Findings: On 04/15/24 at 8:25 a.m., [NAME] #1 was observed to take the trash out of the garbage can in the kitchen and placed the trash sack in a shopping cart which was located outside of the kitchen by the outside storage building. On 04/15/24 at 9:03 a.m., the DM stated the staff had been taking the trash out to the shopping cart and then they would take the trash down to the trash receptacle. The DM stated they should have immediately taken the trash to the trash receptacle bin at the street and not left the trash in the shopping cart. On 04/17/24 at 11 :25 a.m., a small bag of trash was observed unattended in the shopping cart outside by the storage room.

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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. 38495 Based on observation, record review, and interview, the facility failed to ensure: a. wound care was provided in a sanitary manner for one (#20) of four residents observed for wound care, b. residents' catheters were not dragging on the floor for two (#8 and #26) of four sampled resident who had catheters, and c. a water management program was implemented to prevent the growth of Legionella and other opportunistic waterborne pathogens in the buildings water system. The facility identified a census of 50 residents who resided in the facility. Findings: 1. Res #8 had diagnoses which included diabetes mellitus, personal history of urinary tract infections, and neuromuscular dysfunction of the bladder. A care plan, last revised 10/18/23 documented the resident has a suprapubic catheter for neurogenic bladder. The care plan documented to keep the catheter bag below the bladder level and monitor for sign and symptoms of UTI. The care plan documented the resident was on enhanced precautions required due to Res #8 was at an increased risk for infection and MDRO related to indwelling medical device. A quarterly assessment, dated 03/27/24, documented the resident had a indwelling catheter. On 04/15/24 at 11:07 a.m., observed Res #8's catheter under the wheelchair in a bag but the catheter tubing was on the floor. On 04/15/24 at 2:39 p.m., Res #8 was observed in a chair in their room. The catheter tubing was on floor and the bag was hung on on plastic three drawer storage unit. On 04/15/24 at 2:50 p.m., Res #8 stated they had the catheter since 2012 because they could not empty their bladder. Res #8 stated they did not realize the tubing was on the floor. On 04/16/24 at 3:00 p.m., the resident was observed in the dining room with the catheter tubing dragging the floor. On 04/16/24 at 3:45 p.m., Res #8 was observed with staff member assisting them to their room and the catheter tubing was dragging on 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 04/17/24 at 2:03 p.m., CNA #3 stated the catheter bag should be covered and placed under the residents wheelchair. CNA #3 stated they would make sure the catheter was not leaking and not crimped. They stated they tried to make sure the tubing was not dragging on the floor. CNA #3 stated the catheter tubing on the floor was an infection control issue. On 04/17/24 at 2:20 p.m., the IP stated the catheter tubing absolutely should not have been dragging on the floor. 2. Res #26 had diagnoses which included neuromuscular dysfunction of bladder and cystostomy status. A quarterly assessment, dated 04/01/24, documented the resident had a catheter. On 04/15/24 at 11:21 a.m., an observation was made of the resident in the dining area with the catheter tubing dragging on the floor. On 04/17/24 at 12:06 p.m., an observation was made of the resident in the dining area with catheter tubing touching the sole of the resident's tennis shoe and then dragging the floor. On 04/17/24 at 2:21 p.m., the IP stated the catheter should not have been dragging on the floor at any time. 3. A facility policy, dated April 2013, titled Dressings, dry/clean read in part, .Personal protective equipment (e.g., gowns, gloves, mask, ect,, as needed) .clean bedside stand. Establish a clean field .wash and dry hands thoroughly . Res #20 had diagnoses which included pressure ulcer of right heel stage 3, PVD, non-pressure chronic ulcer to right thigh, lymphedema, and non-pressure chronic ulcer of the other part of left lower leg with unspecified severity. A care plan, revised 03/09/24 documented the resident had actual impairment to their right lateral thigh, bilateral buttocks, left heel, left great toe, left shin, right lateral foot, and scabs to left toes/foot/shin. A quarterly assessment, dated 03/24/24, documented the resident had two unhealed stage three pressure ulcers. On 04/15/24 at 10:45 a.m., Res #20 stated they had wounds to their left shin, lipedema that developed into a sore, and a right thigh pressure ulcer. Res #20 stated it was on an old scar from road rash and the wound would come and go. Res #20 stated the facility provided daily wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/24 at 01:16 p.m., wound care was observed with LPN #1. LPN #1 used hand sanitizer, gathered supplies on a sheet of wax paper, sanitized hands and put on gloves. The LPN placed the wax paper on the resident's overbed table but had not cleaned the table first. The LPN removed the resident's nonskid sock from their right foot, cleaned the right foot, wrapped it with ace wrap, and placed the sock back on the resident's foot. The LPN moved to the left foot, removed the sock, cleaned the foot and shin, applied the dressings, wrapped the area with Kerlix and ace wrap, and replaced the sock back on the resident foot. The nurse then applied Triad cream to the resident's right thigh area. LPN #1 then removed their gloves and disposed of the supplies and gloves. The LPN did not change gloves, or perform hand hygiene, during the entire wound care observation. On 04/16/24 at 1:33 p.m., LPN #1 stated they forgot something. LPN #1 stated she did not gown up before wound care was performed as the resident was on EBP. LPN #1 was asked when should they do hand hygiene during wound care. LPN #1 stated before it was started and when they finished the wound care. On 04/16/24 at 3:38 p.m., the IP stated hand hygiene should have been performed before staff entered the room, after the field was set up, and before wound care was started. The IP stated glove changes and hand hygiene should have been performed between each wound. The IP stated the overbed table should have been cleaned before setting the wax paper on it. 34945 4. A facility policy titled Legionella Water Management Program, revised in September of 2022, read in part, . 2. The water management team consists of at least the following personnel a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. the director of environmental services .5. The water management program included the following elements: a. An interdisciplinary water management team (see above); b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) waste . The facility provided a book which was to document the water management program to review. The book documented the Legionella Water Management Program and documented a water sample was obtained from the facility in March of 2023 and the results. The rest of the book did not document any other aspects of the program had been instituted. On 04/18/24 at 1:33 p.m., the IP was asked about the Water Management Program. The IP stated they thought the facility was doing something about the water program but was not sure as they were not involved. The IP stated they thought it was the administrator and the maintenance man who took care of this program. On 04/18/24 at 1:59 p.m., the administrator stated all the staff members on the Legionella Water Management Program were on the team. They stated they had not had a meeting for more than a year. The administrator did not provide meeting minutes for the team meeting. The administrator stated they did not think they had obtained a diagram of the plumbing in the facility. They stated they would get with the maintenance man to have them answer questions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 2:11 p.m., the maintenance man stated the facility had not obtained any plumbing schematics but could contact a plumber to obtain them. The maintenance man stated they remembered the meeting and it consisted of themselves, the administrator, and several corporate people. There were no other staff in the meeting to their recollection. The maintenance man stated they had only one meeting to their recollection. They stated there were aerators in all the sinks and shower heads and they cleaned them monthly but they did not have documentation of these activities. The maintenance man stated they cleaned the ice machine monthly and did check the water temperatures on a regular basis. On 04/18/24 at 2:25 p.m., the administrator stated, based on these conversations, the water management program had not been fully put in action.