STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375388	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Nursing Center, LLC	1100 East Street Northeast Miami, OK 74354

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 30267 Based on observation and interview, the facility failed to: a. provide for the residents' dignity for three (#55, #4, and #50) of three residents observed for full visual privacy and for two (#50 and #26) of two residents observed with signage to always keep the residents' door open; and, b. provide enough dishware to allow for meals to be served without use of disposable containers and/or cutlery. The DON identified 73 residents in the facility. Findings: 1. Resident #55 had diagnoses which included dysphagia. On 07/15/24 at 10:28 a.m., there was no privacy curtain observed to provide privacy for the middle bed of a three-bed bedroom. On 07/15/24 at 10:30 a.m., stated they had episodes of incontinence. The resident stated the staff closed the door but there was no curtain to provide full visual privacy from the two roommates. On 07/17/24 at 3:30 p.m., CNA #6 stated the staff pulled the door closed and pulled the curtains around bed A and bed C but did not have a curtain to pull for B bed to provide full visual privacy for the resident. - Resident #4 had diagnoses which included PTSD and depression. On 07/16/24 at 3:18 p.m., there was no privacy curtain observed to provide privacy for the middle bed of a three-bed bedroom. On 07/16/24 at 3:20 p.m., Resident #4 stated they did not have privacy in their own room. They stated they did not have a curtain to pull for visual privacy and their roommates frequently yelled out day and night which made her feel as though they had no privacy at all. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/24 at 3:30 p.m., CNA #6 stated the staff pulled the door closed and pulled the curtains around bed A and bed C but did not have a curtain to pull for B bed to provide full visual privacy for the resident. On 07/22/24 at 6:15 p.m. the DON stated they had not noticed the lack of privacy curtains for the middle bed in the rooms in the rooms with three residents. The DON stated the staff would not be able to provide full visual privacy for those without a curtain. The DON stated they would have expected the nursing staff to have notified the housekeeping supervisor and the DON of the missing privacy curtains. - Resident #50 had a diagnosis which included anoxic brain damage. An Annual Assessment, dated 04/15/24, documented Resident #50 had severe cognitive impairment. On 07/16/24 at 12:32 p.m., there was a sign on the door stating to keep the door open at all times. The resident's bed was closest to the door and the privacy curtain was observed pulled around the bed and pinned low and to the wall beside the door with a tack, leaving a gaping open area above the tack to observe the resident. Facility residents were observed to stand at the door and to look in at the resident from over the privacy curtain. Resident #50 was observed laying in bed, flat on their back, with their hospital gown up around their chest and their abdomen, pelvic/pubic area, and legs exposed for viewing. On 07/22/24 at 2:45 p.m., LPN #5 stated they were to keep the door open at all times to allow staff to check on the resident frequently. The LPN stated they pinned the privacy curtain to the wall because the curtain track did not reach all the way to the wall, which left the resident visible to others. On 07/22/24 at 3:00 p.m., the DON stated they provided privacy by keeping the curtain pinned to the wall but since that did not work they would try other options to limit the resident's exposure. The DON stated they would need to get a longer curtain track. - Resident #26 had diagnoses which included dementia. On 07/15/24 at 10:00 a.m., a sign on the door to Resident #26 read to keep door always open to allow for Resident #26 to be observed in bed. On 07/22/24 at 6:15 p.m. the DON stated Resident #26 had frequent falls and one intervention was to keep the door open at all times to allow for frequent observations. The DON stated the resident did not seem to mind having their door open but the DON could see how the signage on the door might be construed as a dignity issue. 2. On 07/15/24 at 07:40 a.m., cook #1 was observed to plate food in styrofoam containers. [NAME] #1 stated there were some residents who would write or otherwise mark up the dishware and there were other residents who would poke one another with their cutlery. The cook stated to help mitigate the behaviors, some residents received their meals in styrofoam containers and some residents who received plasticware to eat with instead of the standard cutlery. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/24 thru 07/19/24 and on 07/22/24, meals were observed to be served with side dishes/deserts in styrofoam containers. On 07/22/24 at 2:10 p.m., the dietary manager stated the facility did not have enough bowls to serve all side items to the residents and the lids for the bowls were expensive. The dietary manager stated the kitchen staff used small styrofoam container to serve the side items. 46703

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure the security of all personal funds of residents deposited with the facility. 30267 Based on record review and interview, the facility failed to maintain a surety bond in an amount to cover the facility trust. The business office manager identified 38 residents in the facility trust. The surety bond, dated 10/07/22, documented the bond to cover the balance of the trust was in the amount of $90,000.00. The April 2024 bank statement documented the daily balance on 04/03/24 was $91,136.92 and on 04/09/24 the daily balance was $91,773.92. The May 2024 bank statement documented the daily balance on 05/03/24 was $92,755.93 and on 05/10/24 the daily balance was $92,739.71. The June 2024 bank statement documented the daily balance on 06/03/24 was $97,106.92 and on 06/10/24 the daily balance was $95,842.14. On 07/19/24 at 9:38 a.m., the administrator stated they thought the trust was around $70,000.00 and did not realize the trust had such a high balance. The administrator stated they would have the bond raised to cover the higher balance.

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. 30267 Based on record review and interview, the facility failed to ensure residents were not charged separately for services paid for by Medicare/Medicaid for one (Resident #174) of four residents who were charged room and board during covered periods of stay and for four (#8, #44, #55, and #174) of four residents charged for administrative supplies and whose monies were managed in the Resident Trust. The BOM identified 38 residents with funds in the Resident Trust. Findings: Resident #174 had diagnoses which included depression. On 07/19/24 at 10:30 a.m., the Trust Transaction History for Resident #174 was reviewed and compared to the facility's monthly billing statements from admission to 07/19/24 with BOM and Administrator #2. The transaction history and facility statements documented the following: February 2024 facility statement documented a charge of $2015.00 for Medicaid pending stay from 01/19/24 to 01/31/24 which left a balance due of $2015.00; Resident #174 trust transactions with posting dates of January thru February 2024: - 01/22/24 balance of $95.47 in trust account; - 01/29/24 $24.00 purchase for a trust balance of $71.47; - 02/05/24 $44.00 purchase for a trust balance of $27.47; - 02/16/24 $10.00 cash deposit for trust balance of $37.47; - 02/16/24 $10.00 withdrawal for a trust balance of $27.47; The March 2024 facility statement documented a forwarded balance due of $2015.00 and the following transactions: - 01/19/24 $2015.00 payment for facility stay 01/19/24 through 01/31/24. - 02/16/24 $490.00 cash payment by Resident #174; - 03/13/24 $3800.00 charge for room and board charges for 03/13/24 through 03/31/24 which left a monthly balance due of $3310.00. The Resident #174 trust transactions with posting dates of March 2024: (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 03/01/24 deposit of $552.00 for a trust balance of $579.47; - 03/04/24 payment to facility of $447.00 for a trust balance of $102.47; - 03/22/24 February interest accrued of $0.00 for a trust balance of $102.47; - 03/26/24 $37.91 store purchase for a trust balance of $64.56; The April 2024 facility statement documented a forward balance due of $3310.00 and the following transactions: - 03/07/24 $477.00 facility payment; - 03/13/24 $1400.00 payment for room and board charges for 03/13/24 thru 03/19/24 which left a monthly balance due of $1433.00. The Resident #174 trust transactions with posting dates of April 2024: - 04/03/24 $477.00 facility payment for a trust balance of $(-412.44); - 04/03/24 deposit of $552.00 for a trust balance of $139.56; - 04/19/24 $104.42 store purchase for a trust balance of $35.14; - 04/24/24 $3.25 purchase to order new checks to draw on Resident Trust funds for a trust balance of $31.89. The May 2024 facility statement documented a forward balance due of $1433.00 and the following transactions: - 04/10/24 $1431.00 payment (no description of payment documented) - 04/10/24 $954.00 charge (listed as payment); - 01/19/24 $477.00 liability charge due for 01/19/24 through 01/22/24; - 02/01/24 $477.00 liability charge due for 02/01/24 through 02/05/24; - 03/20/24 $2400.00 payment for room and board charges for 03/20/24 through 03/31/24; - 04/04/24 $477.00 liability charge due for 04/01/24 through 04/08/24; and - 05/01/24 $236.00 liability charge due for 05/01/24 through 05/06/24 (liability charge change due to an adjustment in liability to cover other insurance premiums) which left a balance due of $223.00. The Resident #174 trust transactions with posting dates of May 2024: (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 05/03/24 $44.00 purchase for a trust balance of $(-12.11); - 05/03/24 $72.00 insurance premium for a trust balance of $(-84.11); - 05/03/24 $236.00 facility payment for a trust balance of $(-320.11); - 05/03/24 $110.00 insurance premium for a trust balance of $(-430.11); - 05/03/24 deposit of $552.00 for a trust balance of $121.89; - 05/03/24 $59.00 insurance premium for a trust balance of $62.89; The June 2024 facility statement documented a forward balance due of $223.00 and the following transactions: - 05/13/24 $236.00 payment - 06/01/24 $236.00 liability charge for 06/01/24 through 06/03/24 which left a balance due of $223.00. The Resident #174 trust transactions with posting dates of June 2024: -06/03/24 $552.00 deposit for a trust balance of $614.89; - 06/04/24 $44.00 store purchase for a trust balance of $570.89; - 06/04/24 $59.00 insurance premium for a trust balance of $511.89; - 06/04/24 $223.00 facility payment for a trust balance of $288.89; - 06/04/24 $110.00 insurance premium for a trust balance of $178.89; - 06/04/24 $72.00 insurance premium for a trust balance of $106.89; - 06/20/24 $67.51 store purchase for a trust balance of $39.38; and, - 06/27/24 $5.00 cash withdrawal for a trust balance of $34.38. The July 2024 facility statement documented a forward balance due of $223.00 and the following transactions: - 06/13/24 $223.00 payment - 07/01/24 $236.00 liability charge for 07/01/24 through 07/08/24 which left a balance due of $236.00. The Resident #174 trust transactions with posting dates of July 2024: (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 07/03/24 $236.00 facility payment for a trust balance of $(-201.62); - 07/03/24 $552.00 deposit for a trust balance of $350.38; - 07/03/24 $110.00 insurance premium for a trust balance of $240.38; - 07/03/24 $72.00 insurance premium for a trust balance of 168.38; and - 07/03/24 $59.00 insurance premium for a trust balance of $109.39. On 07/19/24 at 11:15 a.m., the BOM stated the resident had discharged from the facility and would receive the remaining funds of $109.38 still in the Resident Trust, plus any accrued interest, within 30 days of their discharge. On 07/19/24 at 11:30 a.m., the BOM stated they enter charges on a resident's account based on their instructions from corporate. The BOM stated the resident would have paid the $490.00 for their estimated portion of the cost of the facility charges and once the actual amount was determined, their account should have been credited the difference. The BOM stated the resident did not have a payment due for January 2024. They stated the resident was charged $477.00 for their stay for February 2024. The BOM stated the resident started a skilled nursing stay toward the end of February and would not have incurred a room and board charge for their stay in March 2024. The BOM stated the facility resumed charging Resident #174 at a rate of $477.00 per month in April 2024, when the resident discharged from skilled services. The BOM stated there were adjustments which lowered the facility charges in May, June, and July to allow for insurance premiums for vision, hearing, and dental insurance coverage. The BOM stated Medicaid covered all of the charges for January and the resident should not have been charged for January 2024 room and board. The BOM stated Medicare covered the skilled days starting 02/02/24 and ending 04/03/24 and the resident should not have been charged for room and board in March 2024. The BOM stated the the billing errors were entered at the corporate level and the facility accounting of the resident's Trust was correct based on the information they received. On 07/19/24 at 11:35 a.m., Administrator #2 stated the facility charges billed to the resident's account during the resident's skilled stay from 02/19/24 to 04/03/24 were incorrect and the corporate person responsible for entering the transactions no longer worked for the corporation. The business office manager identified 38 residents in the facility trust. (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #8, #44, #55, #174 had monies deposited in the facility's Resident Trust account. On 04/24/24, a charge of $3.25 was applied to each of their accounts for the purchase of checks. On 07/19/24 at 11:25 a.m., the BOM stated $3.25 was charged to each persons' account in the Trust to purchase new checks drawn on the Residents' Trust account. The BOM stated when the Trust needed more checks, they divided up the cost of ordering the checks by the number of residents with monies in the Trust so the cost was shared among all. The BOM stated the checks were used to pay the facility's fees for room and board, insurance costs (such as vision, hearing, and dental), and resident purchases (such as Walmart).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46703 Based on observation and interview, the facility failed to provide a privacy curtain to allow for full visual privacy for two (#4 and #55) of two residents whose rooms were observed for a privacy curtains. The DON identified 73 residents resided in the facility. On 07/19/24 at 2:26 p.m., there was privacy curtain present for resident #4. On 07/19/24 at 2:30 p.m., the resident stated there had never been a curtain, and they would like to have one for visual privacy from their two roommates. On 07/19/24 at 2:44 p.m., CNA # 2 stated if resident #4 received incontinent care they pulled both curtains around the two roommates and shut the door. The CNA stated there was not a curtain to pull to provide full visual privacy for Resident #4. 30267 2. Resident #55 had diagnoses which included dysphagia. On 07/15/24 at 10:30 a.m., Resident #55 stated they had episodes of incontinence. The resident stated the staff closed the door but there was no curtain to pull for the resident to have full visual privacy from the two roommates. On 07/17/24 at 3:30 p.m., CNA #6 stated to provide the resident with privacy, the staff pulled the door closed and pulled the curtains around bed A and bed C but did not have a curtain to pull for B bed to provide visual privacy from others in the resident's room. On 07/22/24 at 2:30 p.m., Maintenance #2 stated the privacy curtain's ceiling track was not long enough to provide the resident with full visual privacy and they were adding more track to fix the problem. On 07/22/24 at 6:15 p.m. the DON stated they had not noticed the lack of privacy curtains for the middle beds in the rooms in the rooms with three residents. The DON stated the staff would not be able to provide full visual privacy for those without a curtain. The DON stated they would have expected the nursing staff to have notified the housekeeping supervisor and the DON of the missing privacy curtains.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 35474 Based on observation, record review, and interview, the facility failed to ensure the care plan was revised for one (#8) of 16 sampled residents whose care plans were reviewed. The DON identified 73 residents who resided in the facility. Findings: Resident #8 had diagnoses which included atrial fibrillation. The Admit/Readmit Screener, dated 07/09/24, documented the resident had returned from a hospital stay and had a midline placed in the left arm. The Care Plan updated 07/11/24, documented the resident had returned from the hospital with an order for an intravenous antibiotic. The care plan did not document the resident had intravenous access. On 07/16/24 at 1:20 p.m., Resident #8 was observed to have a PICC line to their left upper arm. On 07/22/24 at 2:15 p.m., the MDS coordinator stated care plans were updated quarterly, with a significant change, when new orders were received, and upon readmission from the hospital. They stated the care plan for Resident #8 had not been updated to reflect the PICC line. On 07/22/24 at 3:13 p.m., the DON stated they did not have a system in place to monitor care plans to ensure they had been updated upon readmission to the facility or with a change in a resident's status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35474 Based on observation, record review, and interview, the facility failed to ensure skin assessments were conducted for two (#42 and #3) and failed to ensure orders for intravenous care were obtained upon return from the hospital for one (#8) of three sampled residents who were reviewed for quality of care. The DON identified 73 residents who resided in the facility and one resident with intravenous access. Findings: The undated Procedure for Care of the Central Venous Catheter policy, read in parts, .Specific flush orders are obtained from the physician .DRESSING CHANGE Frequency .24 post insertion or on admission, at least weekly . 1. Resident #42 had diagnoses which included hypertension. The Order Recap Report, dated 07/03/24 through 07/31/24, read in part, .Skin assessment to be completed within 24 hours of admission and then at least every 7 days thereafter .Order Date 07/03/24 . The Admit/Readmit Screener, dated 07/03/24, documented the resident had right antecubital bruising. The Care Plan, dated 07/03/24, documented Resident #42 required weekly skin inspections. The admission assessment, dated 07/10/24, documented the resident was cognitively intact for daily decision making. On 07/15/24 at 9:53 a.m., Resident #42 stated the facility was supposed to obtain a cream for under their breast but they had not been applying any treatment. On 07/18/24 at 10:58 a.m., skin assessments for Resident #42 were requested from the DON. The Skin Observation Tool, dated 07/18/24 at 1:22 p.m., documented the resident had redness with a foul odor noted under their left breast and new orders were received. A Physician's Order, dated 07/18/24, documented Resident #42 was ordered Nystatin powder under the left breast twice daily for ten days. On 07/19/24 at 12:44 p.m., the DON stated the charge nurses were to complete skin assessments weekly and document them in the electronic health record. They stated they did not know why Resident #42 had not had skin assessments conducted between 07/03/24 and 07/18/24. 2. Resident #3 had diagnoses which included a history of erysipelas (an infection of the outer layers of skin) and cellulitis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan, revised 04/29/24, documented the resident required weekly skin inspections and to report to the charge nurse if the resident has any open areas, redness, bruises, scratches, or cuts. The Skin Observation Tool, dated 07/03/24, documented Resident #3 had scabbed areas to the bilateral lower legs, to encourage the resident to not pick at the scabbed areas, and the resident's nails were trimmed. On 07/15/24 at 11:02 a.m., Resident #3 was observed to have superficial open areas to the bilateral lower legs. No dressings or bandages were observed. Resident #3 stated the staff used to place dressing on their legs but have not done so recently. On 07/16/24 at 11:45 a.m., Resident #3 was observed in their room with superficial open areas to both lower legs. No bandages or dressings were observed. The Skin Observation Tool, dated 07/20/24, documented Resident #3 had nervously scratched sores to the bilateral lower legs, they were cleaned, and a treatment had been ordered. A physician order, dated 07/21/24, documented to apply genetian violet 1% to the bilateral lower leg scabbed areas daily. On 07/22/24 at 12:33 p.m., the DON stated they did not know why Resident #3 had not had a skin assessment between 07/03/24 and 07/20/24. They stated skin assessments were to be completed weekly by the charge nurses. They stated the areas the resident had scratched/picked at on the bilateral lower legs should have been addressed before 07/20/24. 3. Resident #8 had diagnoses which included atrial fibrillation. The Admit/Readmit Screener, dated 07/09/24, documented the resident had returned from a hospital stay and had a midline placed in the left arm. The Care Plan updated 07/11/24, documented the resident had returned from the hospital with an order for an intravenous antibiotic. On 07/16/24 at 1:20 p.m., Resident #8 was observed to have a PICC line to their left upper arm. Review of the July medication and treatment administration records did not reveal orders for PICC line care. On 07/19/24 at 11:35 a.m., LPN #2 stated the facility had one resident with intravenous access. They stated the protocol was for the nurse assigned to treatments to flush the access every shift, change the dressing every three days, and to document on the treatment administration record. They stated LPN #1 was assigned to treatments. On 07/19/24 at 11:37 a.m., LPN #1 stated Resident #8 was not ordered any treatments related to the PICC line. They stated the charge nurse was going to speak to the physician about discontinuing the PICC line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375388	A. Building B. Wing	07/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/19/24 at 11:39 a.m., LPN #1 observed the PICC line in Resident #8's left upper arm. They stated the dressing was dated 07/08 and had not been changed since the resident was readmitted from the hospital on 07/09/24. On 07/19/24 at 11:41 a.m., the DON stated the treatment nurse was to complete the dressing changes and flushes for the PICC line for Resident #8. The DON reviewed the electronic health record and stated they did not know why but they had not obtained orders from the physician for flushes or dressing changes for the PICC line for Resident #8 when they were readmitted from the hospital.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 30267 Based on record review and interview, the facility failed to provide routine catheter care for one (Resident #2) of one resident whose records were reviewed for catheter care. The DON identified three residents with catheters in the facility. Findings: Resident #2 had diagnoses which included quadriplegia and neurogenic bladder. On 07/16/24 at 3:07 p.m., Resident #2 stated only one nurse consistently provided catheter care and when that nurse was off, they did not receive catheter care. On 07/19/24 at 3:08 p.m., CNA #7 stated they did not provide catheter care for Resident #2. They stated it was the nurse who provided catheter care. On 07/19/24 at 3:22 p.m., CNA #6 stated they did not provide catheter care for Resident #2. They stated it was the nurse who provided catheter care. On 07/19/24 at 3:30 p.m., LPN #1 stated catheter care was assigned to the certified nurse aides. On 07/22/24 at 11:28 a.m., LPN #5 stated catheter care was assigned to the nurse aides. On 07/22/24 at 3:35 p.m., LPN #3 stated they provided catheter care each shift they worked but had no place to document it. On 07/22/24 at 6:17 p.m., the DON stated catheter care was the responsibility of the licensed nurses and certified nurse aides and documented every shift. The clinical records for Resident #2 was reviewed with the DON. On 07/22/24 at 3:40 p.m., the DON stated there was no record the facility provided catheter care. The DON stated even if the nursing staff had perform catheter care, there was no documentation to support it was done. They stated if it was not charted, it was not done.

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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. 46703 Based on observation, record review, and interview, the facility failed to ensure interventions were in place to prevent unnecessary weight loss for one (#33) of one resident reviewed for weight loss. The DON identified 73 residents resided in the facility. Findings: Resident #33 had diagnoses which included dementia. An undated policy titled, Nutrition Policy read in part, .The resident will be assessed for weight gain or loss. Significant gain or loss will be reported to the resident's physician for possible diet adjustment. If the resident eats 50% or less of two consecutive meals, a nutritional supplement will be provided . A care plan dated 05/02/24 documented Resident #33 had a nutritional problem or the potential to have a nutritional problem, would maintain adequate nutritional status as evidenced by maintaining weight within 5% of current weight with no signs or symptoms of malnutrition, and would consume at least 50% of the three daily meals through the review date. On 05/02/24, the resident's electronic medical record documented the resident's weight was 132.2 lbs. On 07/03/24, the electronic medical record documented the resident's weight was 116.8 lbs, a significant weight loss of 11.65% weight loss in two months. On 07/16/24 at 5:06 p.m., Resident #33 was ambulating in the hall. The resident appeared emanciated. CNA #6 was observed to redirect the resident to the dining area but the resident was seen to quickly return to the center hall and wander the hall with their roommate. On 07/18/24 at 2:32 p.m., LPN #4 stated if a resident ate less than 50% of a meal, the CNA was to give the resident a house shake and document it in the ADLs. On 07/19/24 at 10:39 a.m., CNA's #3, #4, and #5 stated if a resident ate less than 50% of a meal the staff went to the kitchen to obtain a house shake for the resident. The CNAs stated they reported the supplement to the charge nurse and documented it under nutrition in the task section of the electronic medical record. The Resident's electronic medical record documented on 07/11/24, 07/12/24, 07/14/24, 07/16/24, 07/17/24, and 07/18/24 the resident consumed less than 50% of their meals. There was no documentation of a house shake was offered to the resident in the last 30 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/19/24 at 12:49 p.m., the DON stated if a resident ate 50% or less of a meal, the staff were to provide a health shake to the resident. The DON stated the restorative aide obtained the residents' weight, documented their weights, and notified the DON of any significant weight loss. On 07/19/24 at 1:03 p.m., the DON stated they do not know how they missed the significant weight loss for Resident #33 and had not notified the physician or dietician of the weight loss. On 07/22/24 at 3:04 p.m., the DON stated they notified the physician of the significant weight loss for Resident #33. They stated the physician ordered a medication generally used to stimulate a resident's appetite. On 07/22/24 at 3:38 p.m., the physician stated they visit the facility at least monthly. They stated while there, they reviewed the resident's entire chart and examined the resident. The physician stated the facility staff notified them of any significant weight loss. The physician stated they were notified of significant weight loss for resident #33 on 07/19/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46703 Based on record review and interview, the facility failed to ensure a resident was assessed after dialysis treatments for one (#64) of one resident reviewed for pre/post dialysis assessments. The DON reported four residents in the facility received dialysis treatments. Findings: Resident #64 had diagnoses which included end stage renal failure. A comprehensive assessment, dated 06/17/24, documented Resident 64 was cognitively intact. On 07/16/24 at 11:19 a.m., Resident #64 stated the nurse usually checked their blood pressure and temperature before they went to dialysis but when they returned from dialysis, they did not see the nurse unless the resident asked for something from them. The resident stated recently their port was infected and they had to take antibiotics. Resident #64 stated the laboratory test finding documented they had a blood infection. The resident's electronic medical record was reviewed for Resident #64. The electronic medical record did not document a post dialysis assessment to include vital signs, weight, or fistula/port assessment for the following dates: 07/12/24, 07/15/24, 07/17/24, 07/19/24, or 07/22/24. On 07/22/24 at 11:45 a.m., RN #1 stated they do not have a specific dialysis protocol, but they were to take pre and post vital signs and assess the fistula or access site. On 07/22/24 at 12:03 p.m., LPN #5 stated they were to take the resident's vital signs, weight and assess the shunt/port before dialysis and when the resident returned from dialysis.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 46703 Based on record review and interview, it was determined the facility failed to ensure the physician was notified of significant weight loss for one (#33) of one sampled resident who was reviewed for nutrition. Findings: On 05/02/24, the resident's electronic medical record documented the resident's weight was 132.2 lbs. On 07/03/24, the electronic medical record documented the resident's weight was 116.8 lbs, a significant weight loss of 11.65% weight loss in two months. 07/18/24 at 1:00 p.m., the Resident's electronic medical resident documented the resident ate less than 50% of one of more of their daily meals on 07/11/24, 07/12/24, 07/14/24, 07/16/24, 07/17/24, 07/18/24 On 07/18/24 at 2:32 p.m., LPN #5 stated if a resident eats less than 50% of a meal the CNA was to go to the kitchen and get a house shake to offer the resident. The LPN stated they were to document the supplement in with the activities of daily living. On 07/18/24 at 2:52 p.m. the Resident's electronic medical record did not document a house shake being offered in the last 30 days. On 07/19/24 at 10:39 a.m., CMA #3 stated if a resident ate less than 50% of a meal they offered the resident a health shake and reported it to the charge nurse. On 07/19/24 at 12:49 p.m., the DON stated if a resident ate less than 50% or less of a meal they should be offered a health shake. The DON stated the restorative nurse aide kept a list of all the residents' weights and gave it to the DON for review. On 07/19/24 at 1:03 p.m., the DON stated they do not know how they missed the significant weight loss for Resident #33 and had not notified the physician or dietician of the weight loss. On 07/22/24 at 3:38 p.m., the physician stated they visit the facility at least monthly. The physician stated they were notified of significant weight loss for resident #33 on 07/19/24 and ordered a appetite stimulant for the resident. On 07/19/24 at 1:03 p.m., the DON stated they do not know how they missed the significant weight loss for Resident #33 and had not notified the physician or dietician of the weight loss. On 07/22/24 at 3:04 p.m., the DON stated they notified the physician of the significant weight loss for Resident #33. They stated the physician ordered a medication generally used to stimulate a resident's appetite. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/24 at 3:38 p.m., the physician stated they visit the facility at least monthly. They stated while there, They reviewed the resident's entire chart and examined the resident. The physician stated the facility staff notified them of any significant weight loss. The physician stated they were notified of significant weight loss for resident #33 on 07/19/24.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46703 Based on observation, record review, and interview, the facility failed to post the required staffing information. The DON identified 73 residents resided in the facility. Findings: On 07/17/24, 07/18/24, 07/19/24, and 07/22/24 a staffing schedule was observed on the nurses station. The schedule did not document the census or the nursing hours. On 07/22/24 at 5:50 p.m., the administrator stated they posted a copy of the schedule but it did not have the nursing hours or the resident census on it.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35474 Based on record review and interview, the facility failed to ensure medications were administered per physician orders for one (#42) of seven sampled residents who were reviewed for unnecessary medications. The DON identified 73 residents who resided in the facility. Findings: Resident #42 had diagnoses which included transient ischemic attack (mini stroke). The Discharge Summary from the hospital, dated 07/01/24, read in parts, .CONTINUE taking these medications .clopridogrel 75 MG tablet TAKE 1 TABLET BY MOUTH EVERY DAY . The Order Recap Report, dated 07/03/24 through 07/31/24, did not document Resident #42 had been started on clopridogrel upon admission to the facility. The admission assessment, dated 07/10/24, documented the resident was cognitively intact for daily decision making. On 07/15/24 at 9:51 a.m., Resident #42 stated they were supposed to take clopridogrel for a history of strokes but they had not received it while a resident at the facility. On 07/17/24 at 6:26 p.m., the DON stated admission orders for the facility were obtained from the hospital discharge orders. The DON stated they were not aware clopridogrel had not been ordered upon admission to the facility. On 07/18/24 at 8:16 a.m., the DON stated they had reviewed the clinical record, including the hospital discharge orders for Resident #42. The DON stated they had put the orders in for Resident #42 but had failed to continue to clopridogrel.

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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. 35474 Based on record review and interview, the facility failed to ensure residents who received psychotropic medications were monitored for behaviors and side effects for three (#3, 44, and #28) of five residents who were reviewed for unnecessary medications. The DON identified 22 residents who received antipsychotic medications and 53 residents who received psychotropic medications. Findings: The undated, Monitoring of Extra Pyramidal Side Effects policy, read in parts, .Monitoring of EPS symptoms will be conducted through a universal procedure known as Abnormal Involuntary Movement Scale (AIMS) testing .a minimum of quarterly . 1. Resident #3 had diagnoses which included schizophrenia. The Care Plan, dated 04/29/24, documented to monitor for anxiety, tearfulness, and agitation every shift. The Behavior Monthly Flow Sheet dated May 2024, documented behaviors were monitored 50 out of 93 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated June 2024, documented behaviors were monitored 32 out of 90 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated 07/01/24 through 07/18/24, documented behaviors were monitored 15 out of 51 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. 2. Resident #44 had diagnoses which included Bipolar disorder. The Care Plan, dated 05/04/24, documented AIMS were to be completed upon admission and quarterly. The Behavior Monthly Flow Sheet dated May 2024, documented behaviors were monitored 50 out of 93 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated June 2024, documented behaviors were monitored 23 out of 90 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated 07/01/24 through 07/18/24, documented behaviors were monitored 29 out of 51 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Order Summary Report, dated 07/22/24, documented Resident #44 was ordered Risperdal (an antipsychotic medication) 1 mg at bedtime on 05/31/23. Review of the clinical record did not reveal an AIMS assessment had been completed for Resident #44. On 07/22/24 at 10:16 a.m., the DON stated behavior monitoring was documented on the behavior flow sheets each day. They stated there was not a way for the staff to know what specific behaviors to monitor because the flow sheets did not indicate the behavior. The DON stated the psychiatric nurse visited the facility twice a month, reviewed medications, and monitored for side effects. The DON stated they did not know why AIMS assessments had not been completed as indicated in the care plan for Resident #44. They stated they had not been monitoring very well to ensure staff were monitoring for behaviors and side effects, including AIMS assessments. On 07/22/24 at 12:26 p.m., the DON stated the CMAs were responsible to complete the behavior flow sheets and they were to communicate any behaviors to the nurse so they could document a progress note. The DON stated the charge nurses should be doing rounds to monitor for behaviors and side effects but they did not know how often the rounds were being conducted. 30267 Resident #28 had diagnoses which included schizophrenia. The Behavior Monthly Flow Sheet dated May 2024, documented behaviors were monitored 52 out of 93 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated June 2024, documented behaviors were monitored 21 out of 67 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. The Behavior Monthly Flow Sheet dated July 2024, documented behaviors were monitored 15 out of 25 opportunities. The specific behaviors to monitor for were not indicated on the flow sheet. On 07/22/24 at 10:24 a.m., the DON stated the behavior sheets utilized a code system to identify what the behavior was to monitor. The DON stated the codes were located on a sheet and the zeroes documented for each shift meant the resident exhibited no behaviors. The DON was unable to identify what behavior the facility monitored for resident #28. The DON reviewed the three months of Behavior Monitoring Flow Sheets which documented the resident exhibited no behaviors. The DON stated the resident regularly exhibited behaviors and based on their knowledge of the resident, the Behavior Monitoring Sheets were not accurate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on observation, record review, and interview, the facility failed to ensure: a. medications were secured for one (North hall) of three medication/treatment carts observed; b. medications were dated when opened for three (North hall, North hall main, and the treatment cart); and c. medications were not expired for one of one medication rooms observed. The DON identified five medication/treatment carts in the facility. Findings: The Quality Control of the Glucometer policy, dated 03/22/12, read in part, .containers of test strips will be dated with the month, day and year when opened . The undated, Cleaning and Maintenance of Nebulizers, Oxygen Supplies and Metered Dose Inhalers policy, read in parts, .Staff will date the box of metered dose inhalers or the inhaler itself .when they are opened . The undated, Insulin Administration policy, read in part, .All insulin should be dated when opened . 1. On 07/16/24 at 4:09 p.m., a bottle of Miralax powder was observed on top of the North hall medication cart by the door to the patio. The cart was left unattended. On 07/16/24 at 4:14 p.m., CMA #1 stated medications were to be kept locked inside the medication carts or in the medication room. They stated they had not seen the Miralax on top of the medication cart when they obtained it for the evening shift. On 07/16/24 at 4:26 p.m., CMA #1 was observed to enter room [ROOM NUMBER] to administer medications. The medication cart was left unlocked and unattended. On 07/17/24 at 5:41 p.m., the DON stated medications were to be kept secured on the locked medication carts or in the medication room. The DON stated they did not monitor to ensure medications were properly stored and secured. On 07/17/24 at 6:01 p.m., CMA #1 was observed to enter room [ROOM NUMBER] to administer medications. The medication cart was left unlocked and unattended. On 07/17/24 at 6:04 p.m., CMA #1 stated they should have locked the medication cart but they had forgotten. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 07/17/24 at 3:57 p.m., the North hall medication cart was observed with CMA #1. CMA #1 stated they were supposed to document an open date on one specific type of eye drop but was not sure about dating anything else when it was opened. The following medications were observed to be opened but not dated: a. fluticasone 50 mg nasal sprays for Resident #21, 41, 37, 42, and Resident #17; b. Astepro allergy nasal spray for Resident #3; c. Refresh eye drops for Residents #44 and Resident #17; d. prednisone 1% eye drops, Moxifloxacin 0.5% eye drops, and artificial tears for Resident #43; e. artificial tears eye drops for Resident #3; f. Naphcon A 0.025% eye drop for Resident #37; g. Systane eye ointment for Resident #17; and h. ondansetron 4 mg for Resident #51, 3, and Resident #38. On 07/17/24 at 4:18 p.m., the North Main medication cart was observed with CMA #1. The following medications were observed to be opened but not dated: a. fluticasone 50 mcg for Resident #71, 36, and Resident #15; b. night time eye ointment for Resident #6; c. Systane eye drop for Resident #15; and d. Combigan 0.2% eye drop, latanoprost 0.005% eye drop, and refresh eye drop for Resident #13. On 07/17/24 at 4:27 p.m., the treatment cart was observed with LPN #3. A note was observed on top of the treatment cart that insulin and inhalers were to be dated when opened. LPN #3 stated everything was to be dated when it was opened. The following medications were observed to be opened but not dated: a. insulin aspart pen for Resident #14; b. two bottles of glucometer test strips; c. diclofenac 1% gel for Resident #22; d. Premarin 0.625% cream for Resident #65; e. preparation H ointment for Resident #31; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miami Nursing Center, LLC	1100 East Street Northeast Miami, OK 74354

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. triamcinolone cream 0.1% for Resident #17; g. diclofenac 1% cream for Resident #13; h. gentian violet 1% solution for Resident #31, 16, 9, and Resident #19; i. Breyna 160/4.5 mg inhaler for Resident #1; j. Trelegy inhaler for Resident #44; k. albuterol inhaler 90 mcg for Resident #31, 41, 11, 15, 38, 1, 71, and Resident #43; l. Advair inhaler for Resident #8; m. Symbicort inhaler for Resident #43; and n. Dulera inhaler for Resident #30. On 07/17/24 at 4:49 p.m., the DON stated medications should be dated when they are opened. They stated the pharmacist reviewed the medication/treatment carts monthly. The DON stated they generally did not do much with the medication/treatment carts. 3. On 07/17/24 at 4:52 p.m., the medication room was observed with LPN #4. The following medications were found to be expired: a. influenza vaccine expired 06/30/24; and b. hydrocort for Resident #60. On 07/17/24 at 5:02 p.m., the DON stated they did not monitor for expired medications but the pharmacist did during monthly visits.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30267 Based on observation, record review, and interview, the facility failed to maintain a sanitary kitchen environment, maintain a sanitary dish machine, and store foods according to professional standards of practice. The DON identified 71 residents who ate meals prepared in the kitchen. An invoice, dated 06/12/24, documented the ice machine was cleaned and the water filter replaced by a contracted company. On 07/15/24 at 7:50 a.m., the following observations were made in the kitchen: - four flies buzzing about and landing on food preparation tables, cookware, and dishware. - two ceiling vents positioned over food preparation tables were covered with a layer grease, dust, and debris. - an open one gallon bottle of apple juice in the refrigerator with no open date; - an open 20 ounce bottle of Pepsi and a 20 ounce bottle of Coke in the refrigerator with no open dates or names; - an open storage bag with sliced luncheon meat in the refrigerator with no open date; - an open storage bag with four left over meat and cheese omelettes in the refrigerator with no prepared date; - an open storage bag with 13 left over waffles in the refrigerator with no prepared date; - a one gallon storage bag of shredded lettuce in the refrigerator with no open date; - a one gallon storage bag of white cheese slices in the refrigerator with no open date; - a four quart storage container of chicken noodle soup in the refrigerator, dated 07/07/24; - an open 48 ounce bottle of cranberry juice in the refrigerator with no open date; - approximately 69 individual two ounce disposable cups of canned pineapple with lids with no preparation dates on the lids or the metal basin which housed the disposable cups in the refrigerator; and, - six unlabelled and undated cups of liquid the DM identified as juice were each covered with plastic wrap and stored in a plastic bin in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/15/24 at 8:10 a.m., the DM stated the kitchen knew to label and date foods stored in the refrigerator. They stated left overs were to be discarded within 48 hours. The DM stated the staff knew to not have personal drinks in the refrigerator. The DM stated the ceiling vents were dirty but were too high for the kitchen staff to clean. On 07/15/24 at 9:25 a.m., the ice machine was observed with the maintenance supervisor. The maintenance supervisor stated the ice machine was cleaned by an independent company but they did not know how often the company cleaned the ice machine. The maintenance supervisor opened the ice machine housing the mechanics of the machine. There was a slimy black substance observed in and around the water reservoir. The maintenance supervisor stated they were not qualified to know if an ice machine was dirty. The maintenance supervisor was asked to wipe a portion of the water reservoir with a clean cloth. Then maintenance supervisor was then asked if there was anything on the clean cloth that was not on the cloth prior to wiping the water reservoir of the ice machine. They stated there was a bit of stuff on the cloth but the ice was clean because they did not see anything in the ice they served. On 07/15/24 at 12:35 p.m. a technician from the company contracted to clean the dish machine stated the slimy black substance in and around the ice machine's water reservoir was algae. The technician stated they had a tough time trying to keep this ice machine clean. They stated it was just over a month since they had last cleaned the ice machine and the algae was already back. On 07/15/24 at 3:36 p.m., the kitchen was observed with the back hall door open. Kitchen staff stated they kept the back door open to provide some airflow because the kitchen was hot. Flies were observed to enter the kitchen through the open door. On 07/15/24 at 3:37 p.m., [NAME] #1 stated the flies had been a nuisance for the last few months. The kitchen staff stated they kept the food covered as best they could when they prepared and served meals. On 07/15/24 at 3:38 p.m., the DM stated they agreed the flies had been a nuisance for the last few months. They stated they had complained of the flies and maintenance had caulked around the kitchen window but it had not alleviated the flies. On 07/15/24 at 4:00 p.m., maintenance #2 was observed to remove the ceiling vents in the kitchen. They wiped the interior of the air vent and stated it was dirty. Maintenance #2 stated they were to clean the vents and paint the covers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46703 Based on observation, record review, and interview, the facility failed to: a. Maintain an infection control program for enhanced barrier precautions by donning gowns prior to catheter care or wound care for two (#8 and #2) of two resident who received catheter care and/or wound care; and b. ensure catheter tubing and dignity bags were maintained in a manner to prevent cross contamination for one (#8) of two sampled residents reviewed for urinary catheters. The DON identified three residents with indwelling urinary catheters. The undated Policy and Procedure for Transmission-Based Precautions, read in parts, .The expanded use of PPE and refer to the use of gown and gloves during the high-contact care activities that provide opportunities for transfer of Multi-Drug Resistant Organisms (MDRO) to or from staff hands or clothing or indirectly transferred from resident/client during high contact activities. Use Enhanced Barrier Precautions when providing care to any resident/client with an indwelling medical device such as an indwelling urinary catheter, central line, feeding tube, tracheostomy, or active or colonized infection with an MDRO . 1. Resident #8 had diagnoses which included neuromuscular dysfunction of the bladder. On 07/18/24 at 9:12 a.m., CNA #3 and CNA #5 were observed providing catheter care for Resident #8. CNA #3 and CNA #5 were not observed to don a gown during catheter care. On 07/18/24 at 9:59 a.m., CNA #3 stated Resident #8 was not on any precautions related to their catheter care. On 07/18/24 at 10:48 a.m., the DON stated the facility had not initiated the use of enhanced barrier precautions. They stated after they read the new guidelines they realized staff were to use enhanced barrier precautions during dressing changes and catheter care. 30267 2. Resident #2 had diagnoses which included quadriplegia and had open wounds, a urinary catheter, and a colostomy. On 07/16/24 at 3:00 p.m., there was neither signage for the use of enhanced barrier precautions nor supplies for enhanced barrier precaution around the resident's door nor in the resident's room. On 07/16/24 at 3:10 p.m., Resident #2 stated only LPN #3 provided wound care or catheter care and they wore gloves but no mask or gown. The resident stated they had a urinary tract infection but it did not require them to be in isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/24 at 5:45 p.m., LPN #3 was observed to measure and perform wound care to the resident's right lower leg, left arm, and right hand. The LPN did not utilize enhanced barrier precautions during the measuring and treatment of wounds. 35474 3. Resident #8 had diagnoses which included neuromuscular dysfunction of the bladder. The quarterly assessment, dated 05/27/24, documented Resident #8 had an indwelling urinary catheter. On 07/16/24 at 12:32 p.m., Resident #8 was assisted back to their room in their wheel chair by staff. The bottom of the urinary catheter dignity bag and tubing of the urinary catheter were observed to drag on the floor under the wheel chair. On 07/19/24 at 11:34 a.m., Resident #8 was observed in their wheel chair in the dining room. The bottom of the urinary catheter dignity bag and tubing were observed to touch the floor. On 07/22/24 at 2:12 p.m., CNA #6 stated the urinary catheter bags, tubing, and dignity bags were not to be in contact with the floor. On 07/22/24 at 3:13 p.m., the DON stated staff were to position the catheter bags and tubing in a manner which prevented them from touching the floor.