STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375470	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chandler Therapy & Living Center LLC	601 West 1st Street Chandler, OK 74834

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46703 Based on observation and interview, the facility failed to honor a resident's choice of dining location for one (#1) of one resident sampled for choices. The administrator identified 40 residents resided in the facility. Findings: Resident #1 had diagnoses which included a history of traumatic brain injury. On 08/13/24 at 12:51 p.m., Resident #1 was observed being fed lunch in their room. On 08/13/24 at 2:15 p.m., CNA #3 stated Resident #1 liked to eat meals in the living room but they were told because State was in the facility Resident #1 must be fed in their room. CNA #3 asked Resident #1 if they liked to eat in the living room or in their room. The resident stated living room. On 08/13/24 at 2:16 p.m., the DON stated Resident #1 ate their meals in the living room, it was their preference. The administrator stated the resident could communicate their preference and there was no reason they must eat meals in their room.

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: 375470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 35474 Based on record review and interview, the facility failed to ensure an annual comprehensive assessment was completed within 14 days of the ARD for one (#11) of 14 sampled residents whose assessments were reviewed. The DON identified 40 residents who resided at the facility. Findings: Resident #11 had diagnoses which included diabetes. The annual assessment, dated 06/12/24, documented it had been completed on 06/28/24. The MDS 3.0 NH Final Validation Report, dated 08/09/24, documented the annual assessment, dated 06/12/24 was completed more than 14 days after the ARD date and was late. On 08/14/24 at 10:47 a.m., the administrator stated the previous MDS coordinator has not been completing MDS assessments timely. They stated they had not monitored MDS assessments to ensure they were completed timely but the previous DON had monitored.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 35474 Based on record review and interview, the facility failed to ensure quarterly assessments were completed within 14 days of the ARD for one (#27) of 14 sampled residents whose assessments were reviewed. The DON identified 40 residents who resided in the facility. Findings: Resident #27 had diagnoses which included end stage renal disease. The quarterly assessment, dated 07/16/24, documented it had been completed on 08/09/24. The MDS 3.0 NH Final Validation Report, dated 08/09/24, documented the quarterly assessment had been completed more than 14 days after the ARD. On 08/14/24 at 10:47 a.m., the administrator stated the previous MDS coordinator has not been completing MDS assessments timely. They stated they had not monitored MDS assessments to ensure they were completed timely but the previous DON had monitored.

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	375470	A. Building B. Wing	08/14/2024

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 35474 Based on record review and interview, the facility failed to ensure assessments were transmitted within seven days of completion for two (#11 and #92) of 14 sampled residents whose assessments were reviewed. The DON identified 40 residents who resided in the facility. Findings: 1. Resident #11 had diagnoses which included diabetes. The MDS 3.0 NH Final Validation Report, dated 08/09/24 documented the following assessments had been submitted late: a. The annual assessment, dated 06/12/24; and b. The discharge return not anticipated, dated 07/03/24. 2. Resident #92 had diagnoses which included acute kidney failure and sacral ulcer. The MDS 3.0 NH Final Validation Report, dated 08/09/24 documented the admission assessment, dated 06/21/24, had been submitted late. On 08/14/24 at 10:47 a.m., the administrator stated the previous MDS coordinator has not transmitted MDS assessments timely. They stated they had not monitored MDS assessments to ensure they were transmitted timely but the previous DON had monitored.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 35474 Based on record review and interview, the facility failed to ensure a level two PASARR was requested for one (#27) of one sampled residents who were reviewed for PASARR. The DON identified seven residents who had a diagnoses of a serious mental illness. Findings: Resident #27 had diagnoses which included schizophrenia and unspecified psychosis. The electronic health record documented the diagnoses of schizophrenia and unspecified psychosis were both present upon admission to the facility. The admission assessment, dated 01/19/24, documented the resident had a diagnoses of schizophrenia. The Nursing Facility Level of Care Assessment, dated 02/01/24, documented the primary diagnoses was sepsis and the secondary diagnoses was diabetes. The assessment read in part, .Diagnoses of serious mental illness (for example, schizophrenic, paranoid, panic, mood .or other psychotic disorder?) . The question was documented as no. Review of the electronic health record did not reveal a level two PASARR had been requested. On 08/13/24 at 11:48 a.m., documentation for the request of a level two PASARR was requested from the DON. On 08/13/24 at 12:04 p.m., the DON stated they had not found documentation a level two PASARR had been requested for Resident #27. On 08/14/24 at 5:05 p.m., the administrator stated a former employee who was responsible to request level two PASARR's informed them they were caught up.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 35474 Based on record review and interview, the facility failed to ensure a baseline care plan was completed for three (#22, 27, and #92) of 12 sampled residents whose care plans were reviewed. The DON identified 40 residents who resided in the facility. Findings: The Care Plans - Baseline policy, dated December 2016, read in part, .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission . 1. Resident #22 had diagnoses which included congestive heart failure and end stage renal disease. The Baseline Care Plan, dated 06/10/24, in the electronic health record, was documented as In Progress and was blank. 2. Resident #27 had diagnoses which included schizophrenia and end stage renal disease. The Baseline Care Plan, dated 01/13/24, in the electronic health record, was documented as In Progress and was blank. 3. Resident #92 had diagnoses which included absence of left leg below the knee, absence of right foot, and schizoaffective disorder bipolar type. The Baseline Care Plan, dated 06/14/24, in the electronic health record, was documented as In Progress and was blank. On 08/14/24 at 12:55 p.m., the DON stated the baseline care plans were supposed to be done within 48 hours of admit by the admitting nurse. The DON stated they did not know why the baseline care plans were blank.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35474 Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed for four (#3, 27, and #92) of 14 sampled residents whose care plans were reviewed. The DON identified 40 residents who resided in the facility. Findings: The Care Plans, Comprehensive Person-Centered, dated December 2016, read in part, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 1. Resident #3 had diagnoses which included end stage renal disease. The annual assessment, dated 05/14/24, documented the resident received dialysis. Review of the electronic clinical record did not reveal a care plan had been developed to address end stage renal disease/dialysis with goals or interventions. On 08/13/24 at 8:32 a.m., CNA #1 stated Resident #3 was getting ready for dialysis. On 08/13/24 at 2:27 p.m., the DON reviewed the electronic clinical record and stated the previous care plan coordinator had not developed a care plan related to end stage renal disease/dialysis. The DON stated they had not had time to audit all of the care plans. 2. Resident #27 had a diagnoses of schizophrenia. The admission assessment, dated 01/19/24, documented the resident had a diagnoses of schizophrenia and received an antipsychotic medication routinely. The quarterly assessment, dated 04/19/24, documented the resident had a diagnoses of schizophrenia and received an antipsychotic medication routinely. Review of the electronic clinical record did not reveal a care plan had been developed to address the diagnoses of schizophrenia, treatment/interventions, or goals. On 08/14/24 at 2:54 p.m., the DON stated the care plan for Resident #27 needed updated to include schizophrenia and the use of antipsychotic medications. 3. Resident #92 had diagnoses which included acute kidney failure and sacral ulcer. On 08/12/24 at 11:36 a.m., Resident #92 was observed to have an indwelling urinary catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 07/12/24, documented to change the indwelling urinary catheter every month and as needed. Review of the electronic clinical record did not reveal a care plan had been developed to address the use of an indwelling urinary catheter, goals, or interventions. On 08/12/24 at 12:17 p.m., the DON stated they had been completing and updating care plans for code status, falls, elopement risk, and hospice. The DON stated they had been completing care plans since the previous care plan coordinator had quit at the end of June/beginning of July. The DON stated no one had developed care plans related to the use of catheters.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46703 Based on record review and interview, the facility failed to ensure a care plan was reviewed for one (#141) of one sampled resident reviewed for care plans. The administrator identified 40 residents resided in the facility. Findings: Resident #141 was admitted on [DATE] and had diagnoses which included dementia, hypertension and anxiety. On 08/11/124 at 3:10 p.m., a family member for Resident #141 was interviewed and stated they were not notified of or offered an opportunity to participate in the resident's care plan meeting. On 08/11/24 at 3:30 p.m., the Resident #141's clinical record was reviewed. There was no documentation the resident's representative participated in a care planning process. On 08/13/24 at 10:03 a.m., the social services coordinator stated they have not had a care plan meeting for Resident #141. They stated they usually did a care plan meeting within one week, but they were behind and had not had one yet.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 35474 Based on record review and interview, the facility failed to ensure a discharge summary which included a recapitulation of the residents stay was completed for one (#39) of one sampled resident who was discharged . The DON identified 13 residents who had been discharged in the past three months. Findings: Resident #39 had diagnoses which included dementia. A physician's order, dated 05/14/24, documented the resident was discharged from skilled services to home with home health. The Discharge Summary progress note, dated 05/14/24 at 12:00 p.m., documented the Resident #39 was transported home by family with all personal belongings, medications, discharge instructions, and information regarding upcoming appointments. The progress note did not document a recapitulation of the resident's stay. On 08/12/24 at 12:14 p.m., the DON stated they assumed the MDS coordinator or the DON would complete discharge summaries. They stated they would need to find out. On 08/13/24 at 12:07 p.m., the DON stated they were not sure what information the facility's discharge summary form contained but the discharge summary should include a recapitulation of the residents' stay.

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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. 46703 Based on observation, record review, and interview, the facility failed to ensure the urinary drainage bag was positioned in a manner to maintain infection control for two (#92 and # 6) of two sampled residents who were reviewed for urinary catheters. The Resident Matrix documented two residents who had urinary catheters. Findings: An undated policy titled Catheter Care, Urinary, read in parts .Be sure the catheter tubing and drainage bag are kept off the floor . 1. Resident #6 had diagnoses which included pressure induced deep tissue damage of the right buttocks and the sacral region. On 08/13/24 at 2:00 p.m., Resident #6 was observed in bed with the urinary catheter bag on the floor. On 08/14/24 at 10:45 a.m., Resident #6 was observed in bed, lying on their left side. The urinary catheter bag was observed to be attached to the bed frame and resting on the floor. On 08/14/24 at 10:49 a.m., LPN #1 was observed to provide urinary catheter care for Resident #6. On 08/14/24 at 10:53 a.m., LPN #1 stated the catheter bag should not be on the floor and repositioned the bag. On 08/14/24 at 1:00 p.m., the adminsitrator stated they do not have a policy regarding positioning of a urinary catheter. 35474 2. Resident #92 had diagnoses which included acute kidney failure and sacral wound. The Physician Order, dated 07/15/24, documented to clean the indwelling urinary catheter twice daily. Review of the electronic clinical record did not reveal documentation of care twice daily for the indwelling urinary catheter. On 08/11/24 at 11:53 a.m., Resident #92 was observed in their wheel chair in their room. The bottom of the indwelling urinary catheter bag was observed to touch the floor. On 08/12/24 at 10:49 a.m., Resident #92 was observed, in their wheel chair, propelling down the hallway. The bottom of the catheter bag was observed to drag on the floor, under the wheel chair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/24 at 11:36 a.m., Resident #92 stated the staff provided catheter care if the catheter was dirty but it did not happen very often. On 08/12/24 at 11:39 a.m., CNA #1 stated the CNAs and nurses performed indwelling urinary catheter care. CNA #1 reviewed the electronic clinical record and stated the CNAs did not document catheter care. They stated the nurses documented catheter care. On 08/12/24 at 11:48 a.m., RN #1 stated the CNAs were responsible to perform indwelling urinary catheter care for Resident #92. On 08/12/24 at 12:15 p.m., the DON stated the nurses and CNAs performed indwelling urinary catheter care. The DON stated the nurse documented on the treatment record and the aides documented under the task tab in the electronic clinical record. Documentation of catheter care for Resident #92 was requested from the DON. On 08/12/24 at 12:35 p.m., RN #1 stated they wanted to clarify that both the nurses and the CNAs performed indwelling urinary catheter care but they had not documented. On 08/14/24 at 10:10 a.m., CNA #2 stated indwelling urinary catheter bags were not to touch the floor. On 08/14/24 at 3:03 p.m., Resident #92 was observed to propel down the hallway in their wheel chair. The bottom of the catheter bag/dignity bag was observed to drag on the floor under the wheel chair.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46703 Based on observation and interview, the facility failed to ensure an enteral tube feeding bag was properly labeled for one (#33) of two sampled residents reviewed for tube feeding management. The Facility Matrix, identified two residents who received enteral tube feeding via continuous pump. Findings: On 08/12/24 at 10:44 a.m., Resident #33 was observed with tube feeding running at 45ml/hr. No label was observed on the tube feeding bag. On 08/13/24 at 8:42 a.m., Resident #33 was observed with tube feeding running at 45ml/hr. The hand written label, on the tube feeding bag, documented, Jevity 08/13/23 @ 0300. The resident's name or prescribed rate was not documented on the label. On 08/13/24 at 10:11 a.m., RN #1 stated by looking at the tube feeding bag they could not tell what resident it was for or the rate it should be running. RN #1 stated there should be a label on the bag with the resident's name, date, time, formula, and rate. On 08/13/24 at 11:00 a.m., the DON stated the tube feeding bag should contain a label with the resident's name, time the formula was hung, the type of formula, and the rate.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35474 Based on record review and interview, the facility failed to ensure orders for dialysis and pre/post dialysis assessments were completed for three (#3, 22, and #27) of three sampled residents who were reviewed for dialysis. The DON identified three residents who received dialysis. Findings: The End-Stage Renal Disease, Care of a Resident with policy, dated September 2010, read in parts, . Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care . 1. Resident #3 had diagnoses which included end stage renal disease. The annual assessment, dated 05/14/24, documented the resident received dialysis and was cognitively intact for daily decision making. Review of the Dialysis Information forms, dated 07/01/24 through 07/31/24, revealed the following: a. The pre dialysis assessment did not document a weight two times out of 12 opportunities; b. The post dialysis assessment had been completed by dialysis staff, rather than facility staff, seven of 12 opportunities; and c. The clinical record did not contain any documentation, nor was documentation provided for pre/post dialysis assessments by the end of the survey, for five of 12 opportunities. Review of the Dialysis Information forms, dated 08/01/24 through 08/10/24, revealed the following: a. The post dialysis assessment had been completed by dialysis staff, rather than facility staff, for four of five opportunities; and b. The clinical record did not contain any documentation, nor was documentation provided for pre/post dialysis assessments by the end of the survey, for one of five opportunities. Review of the physician's orders in the electronic clinical record did not reveal an order for dialysis. On 08/11/24 at 12:04 p.m., Resident #3 stated the nurses at the facility obtained vital signs and their weight but did not assess the access site. 2. Resident #22 had diagnoses which included end stage renal disease. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission assessment, dated 06/15/24 documented the resident received dialysis and was cognitively intact for daily decision making. Review of the Dialysis Information forms, dated 07/01/24 through 07/31/24, revealed the following: a. The pre dialysis assessment did not document a weight three times out of 13 opportunities; and b. The post dialysis assessment had been completed by dialysis staff, rather than facility staff, 10 times out of 13 opportunities. Review of the Dialysis Information forms, dated 08/01/24 through 08/10/24, revealed the following: a. The pre dialysis assessment did not contain a weight for four of five opportunities; and b. The post dialysis assessment had been completed by dialysis staff, rather than facility staff, for five of five opportunities. Review of the physician's orders in the electronic clinical record did not reveal an order for dialysis. On 08/11/24 at 12:20 p.m., Resident #22 stated they received dialysis three times a week on Tuesday, Thursday, and Saturday. The resident stated the scales had not been working so the staff had not obtained weights recently. They stated their access site was in their right upper chest and the facility staff did not assess the site, the dialysis nurses maintained it. 3. Resident #27 had diagnoses which included end stage renal disease. The quarterly assessment, dated 04/19/24, documented the resident received dialysis and was severely impaired in cognition for daily decision making. Review of the Dialysis Communication forms, dated 07/01/24 through 07/31/24, revealed the following: a. The pre dialysis assessment did not document a weight one time out of 13 opportunities; b. The post dialysis assessment had been completed by dialysis staff, rather than facility staff, eight times out of 13 opportunities; and c. The clinical record did not contain any documentation, nor was documentation provided for pre/post dialysis assessments by the end of the survey, for four of 13 opportunities. Review of the physician's orders in the electronic clinical record did not reveal an order for dialysis. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 at 10:51 a.m., RN #1 stated Resident #3 and Resident #22 had access to their right upper chest. They stated they obtained weights and vital signs before dialysis and assessed the dialysis access site after dialysis to ensure it was not bleeding. RN #1 stated they utilized the Dialysis Information form to document the pre dialysis assessment and the post dialysis assessment was completed by the nurse at the dialysis center. On 08/14/24 at 9:42 a.m., the DON stated they did not have a policy regarding dialysis assessments. They stated they coordinated with the dialysis center and followed physician's orders. The DON was asked how they followed physician's orders when there were no orders for dialysis documented in the electronic clinical record. They stated they had done what they could but needed to look into why there were no orders. On 08/13/24 at 2:06 p.m., LPN #1 stated they obtained vital signs and weights before and after dialysis for Resident #27. They stated if the access site appeared abnormal after dialysis they would document in the progress notes. On 08/13/24 at 2:27 p.m., the DON stated the charge nurses were to complete the communication/information forms. They stated the dialysis center conducted the post dialysis assessments and the charge nurses were to monitor for bleeding. They stated the nurses followed the standards of practice with dialysis assessments and only documented if something was abnormal. The DON stated there should have been orders for dialysis from the physician in the electronic clinical record.

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NAME OF PROVIDER OR SUPPLIER Chandler Therapy & Living Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 601 West 1st Street Chandler, OK 74834	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 35474 Based on record review and interview, the facility failed to monitor for side effects of an anticoagulant medication and obtain hemoglobin A1C monitoring as ordered by the physician for one (#27) of five sampled residents who were reviewed for unnecessary medications. The DON identified eight residents who received anticoagulant medications and 13 residents who were diabetic. Findings: Resident #27 had diagnoses which included diabetes mellitus and hypertension. A physician order, dated 01/12/24, documented the resident was ordered Eliquis (an anticoagulant medication) 2.5 mg twice daily. A physician order, dated 03/11/24, documented a hemoglobin A1C was ordered every March, June, September, and December. The Nursing Clarification/Comments form from the consultant pharmacist, dated 05/09/24, documented to monitor for side effects of Eliquis. The quarterly assessment, dated 07/16/24, documented the resident received anticoagulant and hypoglycemic medications. Review of the electronic clinical record did not reveal side effect monitoring for the use of anticoagulants had been documented or that the hemoglobin A1C had been completed in June 2024. On 08/14/24 at 2:23 p.m., LPN #1 stated they monitored for side effects of anticoagulant medications daily and documented on the treatment record. On 08/14/24 at 2:51 p.m., the DON stated they had side effects of anticoagulants listed on the treatment record and the nurses were to document on the treatment record every shift when they monitored for the side effects. The DON asked LPN #1 to review the treatment record for Resident #27. LPN #1 reviewed the treatment record and stated anticoagulant side effect monitoring was not documented. The DON stated the nurses should document on the treatment record. On 08/14/24 at 3:03 p.m., the DON stated the hemoglobin A1C was ordered for Resident #27 but had not been completed in June. They stated they did not know why it had not been completed. The DON stated the nurses were responsible to ensure labs were completed as ordered.

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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 and interview, the facility failed to ensure medications were secured one (Southwest treatment cart) and failed to ensure medications were dated when opened for two (Southwest treatment cart and North medication cart) of two medication/treatment carts and one of one medication rooms observed for medication storage. The DON identified four medication/treatment carts and one medication room in the facility. Findings: 1. On 08/11/24 at 11:00 a.m., the Southwest treatment cart was observed to be unlocked by the nursing station. RN #2 was observed to leave the unlocked cart unattended. They were asked who was responsible for the cart and they stated they had forgotten to lock it. RN #2 locked the cart and walked down the hall. On 08/13/24 at 4:08 p.m., RN #3 was observed to obtain the glucometer, blood pressure cuff, and pulse oximeter and entered room [ROOM NUMBER]. The Southwest treatment cart was unlocked and unattended by the nurse. RN #3 was asked who was responsible for the medication/treatment cart. They stated they were responsible and locked the cart. On 08/13/24 at 4:45 p.m., RN #3 was observed to enter room [ROOM NUMBER]. The Southwest treatment cart was observed to be unlocked and unattended by the nurse. On 08/13/24 at 4:46 p.m., RN #3 exited room [ROOM NUMBER] and locked the treatment/medication cart. On 08/14/24 at 9:35 a.m., the DON stated medications were to be kept secured on the treatment/medication carts by keeping them locked. They stated they monitored medication/treatment carts by checking them when they walked by. 2. On 08/14/24 at 9:08 a.m., the Southwest treatment cart was observed with LPN #1. LPN #1 stated medications were to dated when they were opened. The following medications were observed to be opened but not dated: a. docusate sodium 50mg/5ml for Resident #2; b. hydrogen peroxide 3% for Resident #6; and c. nystop powder for Resident #21 and Resident #16. On 08/14/24 at 9:15 a.m., the North hall medication cart was observed with CMA #4. The following medications were observed to be opened and not dated: a. refresh eye drops for Resident #10; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. miralax powder 17 gm for house stock; and c. diabetic tussin liquid for Resident #2. On 08/14/24 at 9:21 a.m., CMA #4 stated they were supposed to date medications when they were opened. On 08/14/24 at 9:22 a.m., the medication room was observed with CMA #4. The following medication was observed to be opened but not dated: a. lansaprazole 3ml/ml for Resident #33. On 08/14/24 at 9:35 a.m., the DON stated staff were to date medications when they were opened. They stated they monitored the insulins but not other medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46703 Based on observation and interview, the facility failed to ensure there was qualified dietary staff to meet the needs of the residents. The DON identified 38 residents who received meals from the kitchen. Findings: On 08/12/24 at 11:30 a.m., there were two employees observed in the kitchen, a cook and a dishwasher. On 08/12/24 at 11:45 a.m., cook #1 stated there had not been a DM for more than two weeks. The previous DM had quit without notice. [NAME] #1 stated they are also short staffed on cooks and dietary aides. On 08/12/24 at 12:00 p.m., the administrator provided a list of facility managers. Review of the list identified the dietary manager position was open, no staff name was listed. On 08/13/24 at 1:00 p.m., the administrator stated they had interviews scheduled for the DM position and hoped to have a new DM by next week. They stated it has been difficult keeping dietary staff.

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	375470	A. Building B. Wing	08/14/2024

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 46703 Based on observation and interview, the facility failed to ensure there were sufficient dietary staff to meet the needs of the residents. The DON identified 38 residents received meals from the kitchen. Findings: On 08/14/24 at 3:34 p.m., the maintenance supervisor stated they helped in the kitchen by putting away deliveries, making plates, and cooking sometimes. They stated they have been told about portions, but have not received dietary training. They stated they do not have a food handlers card. On 08/14/24 at 3:34 p.m., the housekeeping supervisor stated they helped cook meals if the dietary staff does not know how to cook an item on the menu and they helped get meals out on time. They stated they had not received dietary training in the facility and do not currently have a food handlers card. On 08/14/24 at 4:22 p.m., the administrator stated they did not cook but helped put things away when they get food deliveries. They stated they have not gotten dietary training for the maintenance supervisor or for the housekeeping supervisor. They do not have training documentation for the current dietary staff.

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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. 35474 Based on observation, record review, and interview, the facility failed to ensure menus were followed for one (evening meal) of two meal services observed. The DON identified 38 residents who received meals from the kitchen. Findings: An undated policy titled Menus, read in parts, .Deviations from posted menus are recorded, including the reason for the substitution and/or deviation and archived . A menu, dated April 29, June 3, July 8, August 13, and September 23, documented dinner was to be cheese pizza, tossed salad with dressing, vegetable soup, seasonal fruit cup, and milk or beverage of choice. On 08/13/24 at 5:00 p.m., vegetable soup was not observed to be served during the evening meal with pizza and salad. On 08/13/24 at 5:17 p.m., cook #2 stated they could not find vegetable soup so it was not served with the meal. On 08/13/24 at 5:26 p.m., the administrator stated the dietary staff were to notify them if they did not have an item on the menu. 46703

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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. 35474 46703 Based on observation, record review, and interview, the facility failed to ensure food was palatable and served at appetizing temperatures for one (evening meal) of one meal observed for palatability. The DON identified 38 residents received meals from the kitchen. Findings: The Resident Council Meeting Minutes, dated 07/31/24, documented a complaint that the food was cold. On 08/11/24 at 12:03 p.m., Resident #3 stated food on the hall trays was cold and the food was not good. On 08/11/24 at 12:19 p.m., Resident #22 stated hot foods were not served hot and cold foods were not served cold. On 08/13/24 at 5:16 p.m., a test tray was received. The pizza and the fruit cocktail were observed to be room temperature. The dressed salad was on the plate with the pizza and was observed to be wilted, soggy, and room temperature. The food was not observed to be a palatable temperature. On 08/13/24 at 5:24 p.m., the administrator stated they had gotten a test tray and tasted the food. The administrator stated they were aware there was a problem with food palatability.

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	375470	A. Building B. Wing	08/14/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46703 Based on observation and interview, the facility failed to ensure meat was thawed in a sanitary manner and that residents plates were delivered in a sanitary manner. The DON identified 38 residents received meals from the kitchen. Findings: On 08/11/24 at 11:20 a.m., a ten pound roll of hamburger meat was observed thawing in a sink filled with water. On 08/11/24 at 11:47 a.m., [NAME] # 3 stated meat should be thawed under cold running water or in a refrigerator. [NAME] #3 stated meat should not sit in a sink filled with water. On 08/11/24 at 1:00 p.m., the administrator stated meat should be thawed under cold running water or in the refrigerator. On 08/13/24 at 12:30 p.m., LPN #1 was observed assisting a resident into the dining room and locking the wheelchair breaks. The nurse continued delivering plates to other residents without sanitizing their hands. On 08/13/24 at 1:00 p.m., LPN #1 stated they should have sanitized their hands after delivering each plate. On 08/13/24 at 1:30 p.m., the administrator stated the staff should be sanitizing their hands after delivering each resident's plate.

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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, interview, and record review the facility failed to ensure enhanced barrier precautions were utilized for one (#6) of one sampled residents observed for infection control and failed to ensure the glucometer was disinfected between uses for three (#3, 93, and #25) of three sampled residents who were observed during glucose monitoring. The administrator identified one resident with a tracheostomy, two residents with urinary catheters, and 13 residents who required glucose monitoring. Findings: An Enhanced Barrier Precautions policy, dated 02/28/22, read in part, The facility may expand the use of PPE and refer to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to hands/clothing. 1. Resident #6 had diagnoses which included atrial fibrillation. On 08/14/24 at 7:31 a.m., signage was posted for EBP on Resident #6's door. LPN #1 was observed during tracheostomy care and catheter care for Resident #6. The nurse changed their gloves four times during tracheostomy care without sanitizing their hands between changes. The nurse then washed their hands and donned gloves to perform catheter care. The nurse was not observed to wear a gown for either procedure. The nurse stated the resident was not on EBP and they should have sanitized their hands between glove changes. On 08/14/24 at 9:00 a.m., the DON stated EBP should be observed for tracheostomy, catheter care, wound care, or enteral tube care. 35474 2. On 08/13/24 at 4:08 p.m., RN #3 was observed to obtain the glucometer from the top drawer of the treatment cart, obtain a FSBS on Resident #3, and place the glucometer on top of the treatment cart. On 08/13/24 at 4:20 p.m., RN #3 obtained the glucometer from the top of the treatment cart, a lancet, a glucose check strip, and obtained a FSBS on Resident #93. RN #3 did not disinfect the glucometer. On 08/13/24 at 4:25 p.m., RN #3 sat the glucometer on top of the treatment cart. RN #3 informed Resident #25 they were coming in to perform a FSBS. RN #3 obtained the glucometer, a lancet, and a glucose check strip and entered the room of Resident #25. RN #3 did not disinfect the glucometer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 4:27 p.m., RN #3 stated the glucometer that had been used was for multiple residents. They stated they had forgotten to disinfect the glucometer between residents. RN #3 stated they were to utilize the bleach santi cloths to disinfect the glucometer. RN #3 obtained a bleach wipe, rubbed it over the glucometer, sat the glucometer on top of the treatment cart for approximately ten seconds, and wiped the wet glucometer with gauze. RN #3 was asked how often they disinfected the glucometer. They stated they should have between each resident but they had not disinfected it between Resident #3 and Resident #93. On 08/13/24 at 5:01 p.m., the DON stated they were to disinfect the glucometer with alcohol or santi wipes between each resident. The DON stated they would need to check the contact time for the disinfecting solutions. On 08/14/24 at 8:54 a.m., the DON stated the container of bleach wipes documented the object had to remain wet with the solution for four minutes to effectively kill bloodborne pathogens but the glucometer manufacturers instructions documented to not store the glucometer near bleach or near cleaners with bleach.