STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375483	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmond Health Care Center	39 East 33rd Street Edmond, OK 73013

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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 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. 33148 Based on observation, record review, and interview, the facility failed to promote resident dignity by during dining for two (#6 and #21) of four sampled residents reviewed for dignity. The Administrator identified 82 residents resided in the facility. Findings: 1. An admission assessment, dated 05/10/24, documented Res #6's cognition was intact. It was documented the resident had impairment of their upper extremities and required partial to moderate assistance with eating. 2. A quarterly assessment, dated 05/08/24, documented Res #21's cognition was severly impaired. It was documented the resident was understood, was able to understand, and had adequate vision. It was documented the resident required partial to moderate assistance with eating. On 07/08/24 at 8:43 a.m., CNA #1 was observed standing over Res #6 while assisting them with their breakfast meal. On 07/08/24 at 8:47 a.m., Res #21 was observed with their breakfast plate on the table in front of them. They were placed at the same table as Res #6. Res #21 was observed watching CNA #1 assist Res #6 with their breakfast. On 07/08/24 at 8:55 a.m. CNA #1 was observed assisting Res #21 with their breakfast meal. On 07/09/24 at 8:53 a.m., CNA #1 was asked what was the protocol for assisting residents with their meals. They stated they were instructed not to assist two residents at the same time. They stated they were not trained on if they should sit or stand while assisting a resident. They were made aware of the above observations.

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 33148 Based on record review and interview, the facility failed to refer residents with newly evident or possible serious mental illnesses to the OHCA for a level II PASARR evaluation for three (#22, 71 and #8) of four sampled residents reviewed for PASARR's. The Administrator identified 82 residents resided in the facility. Findings: 1. A level I PASARR, dated 12/08/23, documented Res #71 did not have evidence or diagnosis of a serious mental illness. The resident's primary diagnosis was documented as CVA and their secondary diagnosis was documented as dementia. On 04/23/24, the resident had a new diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms. There was no documentation the resident had been referred to the OHCA for a level II PASARR evaluation. On 07/10/24 at 11:31 a.m., MDS Coordinator #1 was made aware the resident had a negative level I pre-screen and was later identified with newly evident of possible serious mental illness. They were asked if the resident was referred to the OHCA for a level II PASARR evaluation. They stated they did not contact the OHCA due to the resident having a diagnosis of dementia. 46387 2. A level 1 PASARR screening, dated 09/20/2019, documented Res #8 had no diagnosis of a serious mental illness. A diagnosis, dated 01/15/2020, documented Res #8 had disorganized schizophrenia. On 07/10/24 at 10:08 a.m., the MDS coordinator stated they were unaware a new level 1 PASARR needed to be completed with a new diagnosis of a serious mental illness. 3. A level 1 PASARR screening, dated 02/04/2016, documented Res #22 had no diagnosis of a serious mental illness. A diagnosis, dated 08/20/2016, documented Res #22 had bipolar disorder. A diagnosis, dated 01/01/2018, documented Res #22 had unspecified psychosis not due to a substance or known physiological condition. On 07/10/24 at 10:08 a.m., the MDS coordinator stated they were unaware a new level 1 PASARR needed to be completed with a new diagnosis of serious mental illness.

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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 46387 Based on record review and interview, the facility failed to ensure an accurate PASARR screening was completed for one (#9) of four sampled residents reviewed for PASARR screenings. The Administrator identified 82 residents resided in the facility. Findings: A level 1 PASARR, dated 11/04/21, documented Res #9 had a diagnosis of a serious mental illness and a recent history of mental illness or was prescribed a psychotropic medication. There was no documentation in the resident's chart or on the form indicating a determination for level 2 PASARR was made. On 07/09/24 at 1:25 p.m., the MDS coordinator stated there should have been documentation on the form with the determination for a level 2. They stated the facility was likely told a level 2 was not necessary but did not document it on the form or in the resident's chart.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 33148 Based on observation, record review, and interview, the facility failed to provide ADL care to dependent residents for two (#26 and #85) of three sampled residents reviewed for ADLs. The Administrator identified 82 residents resided in the facility. Findings: 1. Res #26 had diagnoses which included aphasia, need for assistance with personal care, and flaccid hemiplegia affecting the left dominant side. An annual assessment, dated 05/30/24, documented the resident's speech was not clear, sometimes understood, and usually understands. It was documented the resident required substantial/maximal assistance with personal hygiene. The June 2024 survey report for personal hygiene documented personal hygiene to include combing the resident's hair was not completed six out of 30 opportunities. On 07/08/24 at 7:49 a.m., the resident was observed with a bonnet on their head. On 07/08/24 at 9:31 a.m., the resident was observed without a bonnet on their head. Their hair was not combed. 07/11/23 at 8:56 a.m., the resident was observed without a bonnet on their head. The hair on the back of their head was flattened to their head and their hair was not combed. They were asked if their hair was combed daily. They shook their head no. They stated their hair had been matted. They gestured with their hands their hair was much longer than what it was now. They were asked who cut their hair. They stated staff. They were asked if they wanted their hair combed daily. They shook their head yes. On 07/11/24 at 9:06 a.m., CNA #2 was asked how often the resident's hair was combed. They stated when they got the resident up they combed their hair. They stated they documented completion of personal hygiene in the EHR. They stated the resident wore a bonnet while in bed to prevent their hair from becoming matted. They stated not too long ago the resident's hair had to be cut due to being matted. On 07/11/24 at 9:51 a.m., LPN #2 was asked how often the resident's hair was combed. They stated their hair was combed all of the time. They stated if the resident stayed in bed their hair got tangled. They stated staff did not always know how to manage the resident's hair and it got matted. They stated they were not aware of the resident's hair being cut due to being matted. On 07/11/24 at 10:20 a.m., the DON was asked about the resident's hair having to be cut due to matting. They stated they knew the resident's hair had to be cut due to being matted. They stated staff who had experience dealing with ethnic hair cut it. They were shown on the survey report where it was not documented personal hygiene was being completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #85 had diagnoses which included cerebrovascular disease, dementia, and failure to thrive. A care plan, dated 06/17/24, documented the resident was incontinent of bowel and bladder. It was documented the resident used a brief and to change frequently and as needed. A significant change assessment, dated 06/28/24, documented the resident's cognition was severly impaired. It was documented the resident was dependent on staff for toileting, hygiene, and was always incontinent of bowel and bladder. On 07/12/23 at 10:26 a.m., Resident #60 was observed in bed positioned to their left side. Resident #60's incontinent brief was observed to be saturated with urine. LPN #3 stated Resident #60 had not been changed this shift. On 10:30 a.m., the DON and CNA #7 were observed to provide incontinent care for Resident #60. Resident #60's incontinent brief was observed to be saturated with urine.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation, record review, and interview, the facility failed to ensure CPR was administered in accordance with standards of practice and facility policy. The Administrator identified 82 residents resided in the facility. Findings: A facility policy documented a rate of 30 compressions to two rescue breaths during the administration of CPR. On [DATE] at 12:58 p.m., a staff member retrieved LPN #1 to assist with an unresponsive resident. On [DATE] at 1:04 p.m., CPR was initiated. On [DATE] at 1:09 p.m., the Ambu-bag was observed squeezed five times. On [DATE] at 1:11 p.m., the Ambu-bag was observed squeezed four times, 30 compressions were administered, and a single rescue breath was given and compressions were re-started during the administration of the second rescue breath. On [DATE] at 2:10 p.m., the DON stated they observed compressions and rescue breaths were alternated until EMS responded to the scene. They stated they had corrected the issue with the rescue breaths immediately.

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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. 49701 Based on record review and interview, the facility failed to monitor and document blood pressures as ordered by physician for two (#60 and #189) of 22 sampled residents reviewed for following physician's orders. The Administrator identified 82 residents resided in the facility. Findings: 1. Resident #189 had diagnoses which included anoxic brain damage. A physician order, initiated on 03/21/24, documented the resident was to receive amlodipine 10 mg daily via peg tube. Hold if blood pressure is less than 110/65. March, April, May, June, and July 2024 MARs/TARs were reviewed for blood pressure monitoring. There was no documentation blood pressures had been monitored. On 07/12/24 at 9:45 a.m., the DON stated the medication order initiated 3/21/24 was to be held if BP was less than 110/65. There was no documentation blood pressure had been monitored from 03/21/24 through 04/25/24. There were 34 missing blood pressure entries to ensure blood pressure had been monitored. The DON stated the nurses would be unable to hold the medications appropriately if the blood pressures were not monitored. The DON stated staff were not following the physician's orders. 35749 2. Resident #60 had diagnoses which included hypertension. A Physician's Order, dated 05/08/24, documented to administer Clonidine Oral Tablet 0.1 mg every eight hours as needed for SBP 160 or greater. May, June, and July 2024 MARs/TARs were reviewed for blood pressure monitoring. There was no documentation blood pressures had been monitored every eight hours. On 07/12/24 at 2:13 p.m., the corporate nurse was asked how frequently staff should monitor a resident's blood pressure if they had an order for Clonidine as needed every eight hours for SBP of 160 or greater. They stated it should be monitored every eight hours.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on observation, record review, and interview, the facility failed to provide treatment and services to treat a contracture for one (#22) of one sampled residents reviewed for range of motion. The DON identified three residents with contractures. Findings: 1. Res #22 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction. A physician order, dated 05/17/24, documented Res #22 was to have a hand roll to the left hand at all times except when showering. A quarterly MDS, dated [DATE], documented Res #22 was severely cognitively impaired and had impairment to range of motion on one side. A care plan, revised 07/09/24, documented Res #22 had a contracture to their left hand due to a cerebral vascular accident. The care plan documented the resident was to have a hand roll in their left hand at all times except when showering. On 07/09/24 at 9:32 a.m., Res #22 was observed in their geri-chair being pushed by a staff member. No hand roll was observed in their left hand. The hand was observed to be contracted inward with the pointer finger extended. On 07/11/24 at 8:28 a.m., Res #22 was observed in the dining room seated at a table in their geri-chair. Their left hand was observed contracted with the pointer finger slightly extended. A hand roll was not present in their hand. On 07/11/24 at 8:40 a.m., the restorative aide stated they were not providing any services for Res #22. On 07/11/24 at 8:50 a.m., CNA #3 stated the contracture had been present for a while. They stated they do not do anything for the resident. They stated they would rely on core staff to provide information on resident's care needs. On 07/11/24 at 8:57 a.m., CNA #4 stated the resident's contracture was not new. They stated a rag can be placed in the residents hand. They stated they were unsure if an order to place a hand roll was in place, and no one had communicated that to them. They stated they would have to check with the nurse. On 07/11/24 at 9:03 a.m., LPN #3 stated they were supposed to place a wash cloth and check the hand and nails every shift for changes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33148 Based on observation, record review, and interview, the facility failed to ensure O2 was administered as ordered by the physician for one (#85) of three sampled residents reviewed for respiratory therapy. The ADON identified 12 residents who received O2. Findings: Res #85 had diagnoses which included SOB and failure to thrive. A physician order, dated 06/27/24, documented O2 via NC 3 liters continuously. On 07/12/24 at 9:50 a.m., the resident was observed with their O2 tubing not in place. The tubing was on the floor. The O2 concentrator was set at 1.5 LPM. On 07/12/24 at 10:06 a.m., the resident was observed with O2 in place. The O2 concentrator was set at 1.5 LPM. On 07/12/24 at 10:16 a.m., LPN #3 was asked what was the resident's O2 supposed to be set at. They stated they thought they saw it set at 2 LPM, but did not know what the physician ordered. They reviewed the order in the EHR and stated it was supposed to be set at 3 LPM. LPN #3 was asked to verify what the resident's O2 concentrator was set at. They stated 1.5 and it should be 3. They stated that is the reason for the resident's O2 saturation had been 93.

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	375483	A. Building B. Wing	07/12/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46387 Based on observation and interview, the facility failed to ensure expired supplies were disposed, narcotic medications were kept behind two locks, refrigerator temperatures were checked daily, and multi-use vials were dated when opened. The Administrator identified 82 residents resided in the facility. Findings: On 07/10/24 at 10:29 a.m., the medication room was observed with LPN #2. On 07/10/24 at 10:35 a.m., the white refrigerator was observed containing an undated opened vial of TB skin test, an unopened vial of lorazepam concentrate, not in the clear locked narcotic box, and a bottle of vancomycin solution prepared for enteral administration that was frozen. The temperature log on the front of the refrigerator did not document the month, and had no temperatures documented for the sixth and seventh day. On 07/10/24 at 10:37 a.m., LPN #2 stated they were unable to determine when the TB skin test vial was opened. They stated the narcotic should have been behind two locks. They stated they were unsure how often the med aides were supposed to check the medication room for expired medications. On 07/10/24 at 10:39 a.m., an opened hypodermoclysis kit, five CADD high volume administration sets expired 06/15/23, and 10 CADD high volume administration sets expired 07/18/23 were observed. On 07/10/24 at 10:45 a.m., the DON stated the med aides should check the medication room at least once per week for expired medications and supplies. They stated the TB skin test solution should have been dated when opened. They stated the lorazepam should have been locked behind two locks. On 07/10/24 at 12:09 p.m., the DON stated the night nurse was responsible for obtaining and documented the temperatures of the refrigerator in the medication storage room every shift.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35749 Based on record review and interview, the facility failed to ensure laboratory tests were obtained per physician's orders for one (#67) of five sampled residents reviewed for laboratory testing. The Administrator identified 82 residents resided in the facility. Findings: A Lab Policy & Procedure, undated, documented all laboratory tests will be done as ordered by the physician in a timely manner and the results reported to the physician. Resident #67 had diagnoses which included bipolar, major depression, Diabetes Mellitus, and CHF. A physician's order, dated 06/11/24, documented to obtain a CBC and CMP weekly times two. A laboratory test, dated 06/12/24, documented a CBC and CMP had been collected. There was no documentation the second test had been collected. On 07/12/24 at 4:02 p.m., LPN #4 was asked where Resident #67's second CBC and CMP would be located. LPN #4 looked in Resident #67's EMR and stated they only saw the 06/12/24 lab. LPN #4 then looked in the facilities lab online and stated, I'm not pulling up anything. On 07/12/24 4:21 p.m., the ADON stated, We are missing the second weeks.

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	375483	A. Building B. Wing	07/12/2024

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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. 33148 Based on observation, record review, and interview, the facility failed to ensure food was palatable and served at appetizing temperatures during meals. The Administrator identified 79 residents received services from the kitchen. Three residents received nutrition and hydration solely through a feeding tube. Findings: 1. A quarterly assessment, dated 04/11/24, documented Res #1's cognition was intact. On 07/08/24 at 6:09 a.m., the resident was asked how was the food. They stated the food was not warm. 2. A quarterly assessment, dated 06/20/24, documented Res #52's cognition was intact. On 07/08/24 at 7:45 a.m., the resident was asked how was the food. They stated the food was cold. 3. A quarterly assessment, dated 05/15/24, documented the Res #28's cognition was moderately impaired. On 07/08/24 at 8:22 a.m., the resident was asked how was the food. They stated the food was not great. They stated they received a mechanical soft diet and the meat was like mush. 4. A annual assessment, dated 04/20/24, documented Res #55's cognition was intact. On 07/08/24 at 8:37 a.m., the resident was asked how was the food. They stated the eggs were always cold. 5. A quarterly assessment, dated 06/21/24, documented Res #56's cognition was moderately impaired. On 07/08/24 at 8:41 a.m., the resident was asked how was the food. They stated the food was always cold. 6. A quarterly assessment, dated 03/29/24, documented Res #38's cognition was intact. On 07/08/24 at 8:43 a.m., the resident was asked how was the food. They stated the French toast was soggy, the bacon was hard to chew, and the food was cold. A weekly menu, dated week three, documented at lunch on 07/10/24 residents were to receive crab cakes, macaroni and cheese, vegetable blend, dinner roll, coconut cake, beverage of choice, and butter. On 07/10/24 at 12:12 p.m., the lunch cart for hall 100 was delivered to the hall from the kitchen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/10/24 at 12:24 p.m., one tray was remaining on hall 100 cart. The tray was removed for testing. The food was luke warm. The crab cake was 112 degrees F, macaroni and cheese was 113 degrees F, and the vegetable blend was 115 degrees F. The crab cake was not palatable. On 07/10/24 at 12:29 p.m., the lunch cart for hall 400 was delivered to the hall from the kitchen. On 07/10/24 at 12:53 p.m., two trays were remaining on the hall 400 lunch cart. A tray for testing was removed from the cart. The food was luke warm. The temperature of the grilled cheese sandwich was 104 degrees F, macaroni and cheese was 118 degrees F, and the vegetable blend was 121 degrees F. On 07/10/24 at 2:44 p.m., the DM was asked how staff ensured the food was palatable and served at appetizing temperatures. They stated they took food temperatures and tasted the food they made. They stated once the hall cart left the kitchen they had no control. They were asked if they tasted the crab cake. They stated they did not. They were made aware of the above observations.

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	375483	A. Building B. Wing	07/12/2024

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 33148 Based on observation, record review, and interview, the facility failed to ensure meals were served as scheduled. The Administrator identified 79 residents received services from the kitchen. Three residents received nutrition and hydration solely through a feeding tube. Findings: An undated schedule of meal times, documented breakfast was to be served at 7:30 a.m. On 07/08/24 at 8:31 a.m., food trays were observed being delivered to residents in the dining room. 1. A quarterly assessment, dated 06/20/24, documented Res #52's cognition was intact. On 07/08/24 at 7:45 a.m., the resident was asked about the food. They stated the meals were not always on time. 2. A annual assessment, dated 04/20/24, documented Res #55's cognition was intact. On 07/08/24 at 8:37 a.m., the resident was asked how was the food. They stated the meals were usually late. 3. A quarterly assessment, dated 06/21/24, documented Res #56's cognition was moderately impaired. On 07/08/24 at 8:41 a.m., the resident was asked how was the food. They stated the meals were served late. 4. A quarterly assessment, dated 03/29/24, documented Res #38's cognition was intact. On 07/08/24 at 8:43 a.m., the resident was asked how was the food. They stated meals were not served on time. On 07/10/24 at 2:44 p.m., the DM was asked about meal times. They stated residents who eat in their rooms were served first and then the dining room was served. They stated they tried to get to the dining room within 45 minutes for the scheduled meal time. They were made aware of the above findings.

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	375483	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmond Health Care Center	39 East 33rd Street Edmond, OK 73013

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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. 33148 Based on observation and interview, the facility failed to ensure the kitchen was kept clean and maintained in good repair. The Administrator identified 79 residents received services from the kitchen. Three residents received nutrition and hydration solely through a feeding tube. Findings: On 07/09/24 at 11:20 a.m., a tour of the kitchen was conducted. The following observations were made. a. There was a hole in the wall below the two compartment sink, b. There was black and white residue on the floor and the wall below the dish washer area c. There was a gap between the floor and the wall below the dish washer area, d. Two of two door gaskets were torn on the True two door reach in cooler, e. One of two door gaskets were torn on the True three door reach in freezer, f. Base boards were missing near the microwave rack, g. Grout was missing between the counter tiles on the serve out window, h. Black and white residue was on the floor under the ice machine, i. One of two oven hood lights were burned out and/or not working, j. Plastic lids on bulk dry ingredient containers of oatmeal, sugar, and flour were cracked, k. Base boards were missing behind the dry ingredient table, l. Material was peeling off of the wall behind the dry ingredient table, m. There was black residue on the floor and the wall under and behind the stove, n. Water was leaking from the neck of the faucet on the one compartment sink, o. There was a crack in the ceiling near the ice machine, p. Material was peeling off of the ceiling around the fire sprinkler above the steam table, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	q. There was brown residue on the shelf below the food preparation table across from the cook line, r. There was a gap between the wall and the floor behind the one compartment sink. Floor tiles were missing and there was black residue. s. The sides of the hand sink cabinet was warped, t. Material was peeling off of the ceiling and the heat/air unit in the dry storage room; and u. Base boards and Formica were cracked and/or missing on the bottom shelving in the dry storage room. On 07/10/24 at 11:48 a.m., the DM was asked how staff ensured the kitchen was kept clean and maintained in good repair. They stated they cleaned daily and reported maintenance concerns to the maintenance department. They were shown the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49701 Based on observation, interview, and record review, the facility failed to: a) Place dirty linens in a plastic bag before removing from the res room for 1 (#22) of who were dependent on staff for ADL care, b) Provide environmental cleaning, disinfection, and reprocessing of reusable resident medical equipment for wrist blood pressure cuff (CNA #1) between residents, and proper hand hygiene breaks in infection control (CNA #2) wiping sanitized hands on front of their top and pant legs without re-cleaning hands, c) Replace O2 tubing after the NC touched the floor and was placed back into the res nose for 1 (#85) of 12 residents who were O2 dependent; and d) Maintain an infection control program for enhanced barrier precautions by donning gowns prior to wound care for 2 (#60 and #40) of who received wound care at the facility. The Administrator identified 82 residents residing at the facility. Findings: An Enhanced Barrier Precautions policy, dated 04/01/24, read in part, .an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities .High-contact resident care activities include .Wound care . such as pressure ulcers . 1. On 07/08/24 at 5:21 a.m., CNA #5 applied gloves in hallway and entered Resident #22's room to assist them out of bed to go to the bathroom. CNA #5 removed wet sheets from the bed and carried them out to the linen bin at the other end of the hallway. The soiled linens were not placed in a bag. On 07/08/24 at 5:25 a.m., CNA #5 applied clean gloves and then assisted Resident #22 to find clean clothes to wear after redressing the bed. They did not sanitize or wash their hands between applying new gloves either time. On 07/08/24 at 05:54 a.m. CNA #5 stated they should have washed their hands between every room. They stated they should have taken the dirty linen bin to the room with them. On 07/12/24 at 10:03 a.m., the ADON stated direct care staff are to sanitize or wash hands before entering a resident's room. They are to wear gloves when providing care and sanitize and change gloves when going from dirty task to a clean task. Staff are to remove soiled linens from rooms in plastic bags. 46387 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 07/10/24 at 8:29 a.m., CMA #1 was observed obtaining a blood pressure from a resident using a wrist cuff. On 07/10/24 at 8:35 a.m., CMA #1 was observed placing a spoon onto the mouse pad on the medication cart and then using it to stir a medication in water for a resident. On 07/10/24 at 8:42 a.m., CMA #1 was observed using the same blood pressure wrist cuff to obtain a blood pressure reading from a different resident. The CMA was not observed cleaning the blood pressure cuff prior to placing it on the resident. On 07/10/24 at 8:50 a.m., CMA #1 stated they should not have placed the spoon onto the mouse pad. On 07/10/24 at 9:13 a.m., CMA #2 was observed using hand sanitizer and wiping their hands onto the front of their top and legs of their pants. The CMA was not observed re-cleaning their hands. 33148 3. Res #85 had diagnoses which included SOB and failure to thrive. A physician order, dated 06/27/24, documented O2 via NC 3 liters continuously. On 07/12/24 at 9:50 a.m., the resident was observed with their O2 tubing not in place. The tubing was on the floor. On 07/12/24 at 10:06 a.m., the resident was observed with O2 in place. On 07/12/24 at 10:08 a.m., RN #1 was asked if the resident's O2 had been on the floor. They stated it had. They stated they were in training, but wiped off the tubing with an alcohol wipe before they placed it back on the resident. On 07/12/24 at 10:16 a.m., LPN #3 was asked what was the protocol if a residents O2 tubing was observed on the floor. They stated it should be replaced. They stated the floor was dirty. On 07/12/24 at 10:31 a.m., the DON was asked what was the protocol if a residents O2 tubing was observed on the floor. They stated the tubing should be replaced. They were made aware of the above observations. 35749 4. Resident #60 had diagnoses which included stage 3 pressure ulcer to the left outer ankle. A physician's order, dated 05/23/24, Enhanced Barrier Precautions every shift. A physician's order, dated 07/11/24, documented to clean the left lateral ankle with normal saline, pat dry, apply Santyl ointment to wound bed, apply calcium alginate, and cover with a dry dressing on Mondays, Wednesdays, and Saturdays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/24, at 9:20 a.m., Enhanced barrier precaution signage was observed on Resident #60's door. It documented to wear gloves and gowns for wound care. LPN #3 was observed to enter Resident #60's room and perform wound care to the left outer ankle pressure ulcer. LPN #3 did not wear a gown during the wound care. 5. Resident #40 had diagnoses which included sacral pressure ulcer. A physician's order, dated 07/09/24, documented to cleanse sacrum with NS, pat dry- soak gauze with Dakins (wring out gauze) then pack in wound and cover with dry dressing daily and PRN soiled/dislodged. On 07/12/24 at 10:13 a.m., Resident #40 was observed sitting in a wheelchair in their room. Enhanced barrier precaution signage was observed on Resident #40's door. It documented to wear gloves and gowns for wound care. On 07/12/24 at 12:21 p.m., LPN #3 was observed to enter Resident #40's room and perform wound care to Resident #40's the sacral area. CNA #7 came in to assist with positioning the resident. LPN #3 was observed to clean the coccyx area with normal saline, apply Dakins soaked gauze to sacral area, and had placed a dry dressing to the pressure ulcer. LPN #3 and CNA #7 did not wear gowns during the wound care. On 07/12/24 at 12:27 p.m., the IP nurse entered Resident #40's room and told LPN #3 they had to stop wound care, wash their hands, and put a gown on in order to follow enhanced barrier precautions. LPN #3 stated, What's the point? The IP nurse told her she had to stop with wound care. LPN #3 and CNA #7 stopped, removed their gloves, washed their hand, and donned gowns and gloves. LPN #3 resumed securing the dry dressing to the sacral area. On 07/12/25 at 12:33 p.m., the IP was asked what the protocol was for enhanced barrier precautions. They stated staff should put a gown on at the resident's door, wash their hands, and put gloves on. The IP was informed LPN #3 had not followed enhanced barrier precautions with Residents #40 and #60.