STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385046	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Center	1201 McLean Blvd. Eugene, OR 97405

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34703 Based on interview and record review it was determined the facility failed to provide risk and benefit information for a psychotropic medication for 1 of 5 sampled residents (#37) reviewed for unnecessary medications. This placed the residents at risk for lack of ability to make informed decisions about their care. Findings include: Resident 37 admitted to the facility in 7/2022 with diagnoses including depression, anxiety, and insomnia. The 1/24/24 physician order indicated Resident 37 received Trazodone (antidepressant) for insomnia. Review of Resident 37's medical record revealed no indication the risks and benefits of the medication was reviewed with the resident. On 8/27/24 at 12:05 PM Resident 37 stated she/he received Trazodone for sleep, depression, and anxiety. Resident 37 stated she/he did not recall going over the risks and benefits of the medication with facility staff or signing a consent for the medication. On 8/29/24 at 1:21 PM Staff 3 (LPN-Unit Manager)) acknowledged there was no evidence to indicate the risk and benefits for Trazodone were reviewed with Resident 37.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48830 Based on interview and record review it was determined the facility failed to obtain information related to advance directives and health care decisions for 3 of 4 sampled residents (#s 17, 34 and 37) reviewed for advance directives. This placed residents at risk for not having their health care decisions honored. Findings include: 1. Resident 17 was admitted to the facility in 7/2016 with diagnoses including depression. A review of Resident 17's clinical record revealed no evidence the resident was provided with information on the right to formulate an advance directive. On 8/29/24 at 1:40 PM Staff 7 (Director of Social Services) confirmed Resident 17 was not provided information on formulating an advance directive. 34324 2. Resident 34 admitted to the facility in 6/2024 with diagnoses diabetes. Review of Resident 34's medical record indicated no documentation an advance directive was offered or reviewed with the resident or her/his family. On 8/29/24 at 1:42 PM Staff 7 (Director of Social Services) stated he was unable to recall or provide documentation of an advance directive being offered or reviewed with Resident 34 or her/his family. 34703 3. Resident 37 admitted to the facility in 7/2022 with diagnoses including diabetes. Review of Resident 37's medical record indicated no documentation an advance directive was offered or reviewed with the resident or her/his family. On 8/29/24 at 1:42 PM Staff 7 (Social Services Director) stated he was unable to provide documentation of an advance directive being offered or reviewed with Resident 37 or her/his family.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48830 Based on observation, interview, and record review it was determined the facility failed to ensure a resident rooms were in good repair and free of odors for 5 of 5 sampled residents (#s 6, 19, 27, 32 and 33) reviewed for environment. This placed residents at risk for lack of a homelike environment. Findings include: 1. On 8/26/24 at 1:33 PM the following observation was made: Resident 19's air conditioner unit made a loud, high pitch squeak. On 8/30/24 at 10:59 AM Staff 1 (Administrator) and Staff 9 (Maintenance Director) acknowledged the identified environment issue. 2. On 8/27/24 at 9:17 AM the following observation was made: Resident 6's light in the bathroom was burned out. On 8/30/24 at 10:31 AM Staff 20 (Nursing Assistant) stated Resident 6's bathroom light had been burned out for about one week. Staff 20 stated he reported the light and it had not been fixed. On 8/30/24 at 10:59 AM Staff 1 (Administrator) and Staff 9 (Maintenance Director) acknowledged the identified environment issue. 34324 3. On 8/26/24 at 10:57 AM the following observation was made: Resident 27's head of the bed was located by the window against the wall. A large portion of the bottom window trim paint was peeled off with exposed particle board peeling off. On 8/30/24 at 11:04 AM Staff 9 (Maintenance Director) and Staff 1 (Administrator) acknowledged the identified environment issues for Resident 27. 4. On 8/26/24 at 1:22 PM the following observations were made: Resident 33's head of the bed was located by the window against the wall. Two window trim pieces were observed to be separated in the corner with exposed edges. On 8/30/24 at 11:04 AM Staff 9 (Maintenance Director) and Staff 1 (Administrator) acknowledged the identified environment issues for Resident 33. 34703 5. Resident 32 was admitted to the facility in 8/2020 with diagnoses including urge incontinence. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 12:05 PM Resident 32's room was noted with a strong odor of urine. On 8/26/24 at 12:06 PM Resident 32 stated she/he was incontinent and wore briefs Resident 32 stated she was aware of the strong urine odor but was not sure if it was from her/his room or wheelchair or from another room. Resident 32 stated she/he would like to have staff clean her/his wheelchair. On 8/28/24 at 9:46 AM Staff 5 (CNA) the resident's room and wheelchair had a strong odor of urine. Staff 5 stated night shift cleaned the wheelchairs and the resident needed her/his wheelchair cleaned. On 8/28/24 at 9:51 AM Staff 23 (CNA) Staff 22 stated the resident's room and wheelchair had a strong odor of urine all the time. Staff 22 stated night shift was supposed to clean the wheelchairs, and Resident 32's wheelchair was to be cleaned. On 8/28/24 at 2:11 PM Staff 15 (LPN) stated Resident 32 wore more than one brief at a time and had multiple incontinent pads on her/his wheelchair. Staff 15 acknowledged the resident's room and wheelchair always had a strong odor of urine and the wheelchair needed to be cleaned. On 8/28/24 at 2:30 PM Staff 24 (Housekeeping) stated she mopped the resident's room daily. Staff 24 stated there were days the resident would not allow a deep clean of her/his room but she cleaned and mopped the room everyday. Staff 24 stated Resident 32's wheelchair also had a strong odor of urine. On 8/29/24 at 10:40 AM Staff 3 (LPN-Unit Manager) stated Resident 32 was incontinent and doubled or tripled her/his briefs for more protection which caused the strong urine odor. On 8/29/24 at 11:55 AM Staff 2 (DNS) and Staff 4 (Corporate RN) stated the resident's room and wheelchair had a strong urine odor. Staff 4 stated wheelchairs were to be cleaned on night shift, and acknowledged there was no documentation wheelchairs were cleaned and no documentation Resident 32 refused to have her/his wheelchair cleaned.

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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. 48830 Based on observation, interview, and record review it was determined the facility failed to ensure oxygen was administered as ordered and failed to ensure residents' respiratory equipment was maintained for 2 of 2 sampled residents (#s 6 and 10) reviewed for respiratory care, ADLs and dialysis. This placed residents at risk for respiratory concerns. Findings include: 1. Resident 6 was admitted to the facility in 2018 with diagnoses including chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). The 10/13/23 Annual MDS indicated Resident 6 was cognitively intact. Resident 6's physician order dated 7/12/24 revealed the oxygen concentrator filter was to be changed weekly. The 8/2024 TAR indicated the external filters were changed weekly and it was last completed on 8/25/24. On 8/27/24 at 9:17 AM the external filters on the oxygen concentrator were observed to have a layer of dust. Resident 6 stated she/he used the oxygen concentrator nightly. On 8/29/24 at 11:11 AM Staff 16 (Med Tech) stated the evening nurse was to clean Resident 6's oxygen concentrator filters. On 8/29/24 at 11:15 AM Staff 2 (DNS) observed the oxygen concentrator filters and acknowledged the filters were not clean. 34703 2. Resident 10 was admitted to the facility in 11/2014 with diagnoses including respiratory failure. A 7/20/23 physician order indicated the resident was to receive supplemental oxygen at 2 l/m (liters per minute) to keep oxygen levels above 90% every shift. Observations made from 8/26/24 through 8/29/24 revealed Resident 10 utilized oxygen and wore a nasal cannula (a device that fits into the nostrils for delivery of oxygen therapy) at 3 l/m. A review of Resident 10's medical record revealed there was no documentation the oxygen tubing was changed. On 8/28/24 at 2:11 PM Resident 10 stated staff did not change her/his oxygen tubing weekly and the tubing became crusty. Resident 10 stated staff turned up her/his oxygen to 3 l/m and she/he knew the oxygen was to be at 2 l/m per physician orders. Resident stated 3 l/m was high and dried her/his nose. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 2:42 PM Resident 10's oxygen tubing was observed with dried crusty debris on the nasal cannula. Staff 15 (LPN) came into Resident 10's room and stated oxygen tubing should be changed every seven days, the tubing marked with the date and the task documented as completed. Staff 15 acknowledged there was no date on the oxygen tubing, the tubing had dried crusty white debris on the nasal canula, and the resident's oxygen was turned up to 3 l/m which was not what the physician order indicated. On 8/28/24 at 2:43 PM Staff 4 (Regional RN) stated the facility did not have a policy for cleaning or changing oxygen tubing and acknowledged there was no documentation on the TAR which indicated the tubing was changed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34702 Based on observation, interview and record review it was determined the facility failed to ensure Staff 13 (LPN) had the appropriate competencies and skills for infection control during CBG checks and administration of insulin. This placed residents at risk for bloodborne illness and reduced efficacy of medications. Findings include: a. On 8/29/24 at 12:17 PM Staff 13 (LPN) was observed to obtain a CBG for Resident 24. Staff 13 exited the room and placed the glucometer in the east hall treatment cart without cleaning it. On 8/29/24 from 12:17 PM to 12:40 PM continuous observations were made. Staff 13 passed medication and administered insulin to multiple residents. Staff 13 did not clean the glucometer during the observations. On 8/29/24 at 12:40 PM Staff 13 stated Resident 24 was the last CBG check she had to complete prior to lunch. Staff 13 stated she cleaned the glucometers at the beginning and end of shift with purple wipes. Staff 13 further stated she worked at the facility for one month and this was her first nursing job. Staff 13 stated she was trained for about three weeks and did not think the facility checked her for nursing competencies. On 8/29/24 at 12:57 PM Staff 2 (DNS) Staff 2 stated nursing competencies were not completed for Staff 13. b. The Novolog manufacturer instructions indicated to prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/29/24 at 12:37 PM Staff 13 (LPN) was observed to administer Novolog insulin via insulin pen to Resident 24. Staff 13 did not prime the insulin pen with two units prior to drawing up the insulin for administration. On 8/29/24 at 12:40 PM Staff 13 acknowledged she did not prime the insulin pen prior to administration and stated she was not aware the Novolog insulin pen needed to be primed. Staff 13 stated she was trained for about three weeks and did not think the facility checked her for nursing competencies. On 8/29/24 at 12:57 PM Staff 2 (DNS) Staff 2 stated nursing competencies were not completed for Staff 13.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34702 Based on interview and record review it was determined the facility failed to ensure an RN was available for at least eight consecutive hours per day for 3 of 31 days reviewed for RN coverage. This placed residents at risk for delayed nursing assessments. Findings include: A review of the Direct Care Staff Daily Reports from 7/26/24 through 8/25/24 revealed the following dates with no RN coverage: -8/20/24 -8/21/24 -8/22/24 On 8/29/24 at 10:38 AM Staff 1 (Administrator) acknowledged the lack of RN coverage on the identified dates.

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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. 34702 Based on observation, interview, and record review it was determined the facility failed to ensure proper storage temperatures were maintained for 1 of 2 medication storage refrigerators, and proper labeling of biologicals and securing of treatment carts for 1 of 3 treatment carts reviewed for medication storage. This placed residents at risk for reduced efficacy of medication and unauthorized access to medications. Findings include: 1. The 8/2024 east hall medication refrigerator temperature logs indicated the temperatures exceeded 46 degrees F on multiple occasions and the temperatures were as high as 73 degrees on 8/21/24. On 8/30/24 at 12:00 PM the medication refrigerator on the East Hall was observed with Staff 2 (DNS) and contained flu vaccines and insulin. On 8/30/24 at 12:00 PM Staff 2 (DNS) stated the medication refrigerator on the east hall contained flu vaccines and insulin and the temperatures were to be kept between 36 degrees F and 46 degrees F. Staff 2 acknowledged the 8/2024 temperature logs indicated the east hall medication refrigerator exceeded 46 degrees F on several occasions and the temperatures were as high as 73 degrees F on 8/21/24. 2. On 8/29/24 at 12:13 PM two open Tresiba insulin pens were observed in the East Hall treatment cart with no open dates. On 8/29/24 at 12:13 PM Staff 13 (LPN) acknowledged the two Tresiba pens were open and were not labeled with open dates. 34703 3. On 8/26/24 at 12:38 PM an East Hall treatment cart was observed to be unlocked. The cart was in the middle of the hall with residents and staff walking by. Nursing staff walked by the cart multiple times but did not lock the cart. On 8/26/24 at 12:43 PM Staff 14 (LPN) acknowledged she left the treatment cart unlocked and the cart was to be secured at all times. 4. On 8/27/24 at 9:22 AM an East Hall treatment cart was observed to be unlocked. The cart was in the middle of the hall with residents sitting around it and staff walking by. Nursing staff walked by the cart multiple times but did not lock the cart. On 8/27/24 at 9:30 AM Staff 14 (LPN) acknowledged she left the treatment cart unlocked both times and the cart was to be secured at all times.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48830 Based on observation, interview and record review it was determined the facility failed to ensure a system was in place to honor resident food preferences for 4 of 4 sampled residents (#s 17, 19, 21, and 37) reviewed for dietary needs. This placed residents at risk for unmet nutritional needs and lessened quality of life. 1. Resident 17 was admitted to the facility in 2016 with diagnoses including diabetes. On 8/27/24 at 10:36 AM Resident 17 stated she/he was not given a menu to select her/his preferred meals. On 8/29/24 at 10:38 AM Staff 22 (CNA) stated about one month ago the facility stopped providing residents with a menu to choose between the main or alternate meal. Staff 22 stated several residents, including Resident 17, were upset about this as their opportunity to make a choice was taken away. On 8/29/24 at 2:00 PM Staff 18 (Dietitian) stated the facility recently changed the menu system from providing menus to residents each day to providing menus once per week on Fridays. On 8/30/24 at 9:54 AM Resident 17 stated she/he did not receive a weekly menu on Fridays. On 8/30/24 at 12:02 PM Staff 1 (Administrator) stated the facility recently changed the menu distribution to once per week on Fridays. Staff 1 stated the change was discussed in Resident Council and at a food committee which some residents attended. 2. Resident 19 was admitted to the facility in 12/2023 with diagnoses including diabetes. On 8/26/24 at 10:33 AM Resident 19 stated she/he was not given a menu to select her/his preferred meals. Resident 19 stated the facility did not inform her/him of any changes related to menus. On 8/29/24 at 10:38 A Staff 22 (CNA) stated about one month ago the facility stopped providing residents with a menu to choose between the main or alternate meal. Staff 22 stated several residents, including Resident 19, were upset about this as their opportunity to make a choice was taken away. On 8/29/24 at 2:00 PM Staff 18 (Dietitian) stated the facility recently changed the menu system from providing menus to residents each day to providing menus once per week on Fridays. On 8/29/24 at 2:10 PM Resident 19 stated she/he did not receive a weekly menu on Fridays. On 8/30/24 at 12:02 PM Staff 1 (Administrator) stated the facility recently changed the menu distribution to once per week on Fridays. Staff 1 stated the change was discussed in Resident Council and at a food committee which some residents attended. 34703 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Resident 21 was admitted to the facility in 1/2020 with diagnoses including heart disease. On 8/26/24 at 11:32 AM Resident 21 stated the kitchen removed the menus and she/he was not able to make choices for a meal. Resident 21 stated she/he used to look forward to meals but now there was nothing to look forward too because the kitchen delivered whatever they cooked. Resident 21 stated she/he wanted the menus back to be able to choose her/his meal. Resident 21 stated she/he does not receive a weekly menu on Fridays. On 8/28/24 at 12:41 PM Staff 10 (CNA) stated about one month ago the facility stopped providing residents with a menu to choose between the main or alternate meal. Staff 10 stated several residents were upset about this as their choices were taken away. On 8/29/24 at 12:35 PM Staff 23 (CNA) stated the facility stopped providing residents with a menu for at least a month and were upset they were not given the right to make choices about their meals. On 8/29/24 at 2:00 PM Staff 18 (Dietitian) stated the facility recently changed the menu system from selection based to preference based and residents received a weekly menu every Friday. 4. Resident 28 was admitted to the facility in 11/2023 with diagnoses including diabetes. On 8/30/24 at 8:53 AM Resident 28 stated about a month ago the facility stopped providing menus to residents to choose their meals. Resident 28 stated she/he received a meal of whatever the kitchen cooked. Resident 28 stated she/he was not given a menu on Fridays and wanted the menus back. On 8/28/24 at 12:41 PM Staff 10 (CNA) stated about one month ago the facility stopped providing residents with a menu to choose between the main or alternate meal. Staff 10 stated several residents were upset about this as their choice was taken away. On 8/29/24 at 12:35 PM Staff 23 (CNA) stated the facility stopped providing residents with a menu for at least a month and were upset they were not given the right to make choices about their meals. On 8/29/24 at 2:00 PM Staff 18 (Dietitian) stated the facility recently changed the menu system from selection based to preference based and residents received a weekly menu every Friday. 5. Resident 37 was admitted to the facility in 7/2022 with diagnoses including stroke. On 8/27/24 at 12:45 PM Resident 37 stated the facility stopped providing residents with menus for at least a month. Resident 37 stated she/he wanted her/his choices of meals back. Resident 37 stated she/he was not given a menu on Fridays. On 8/28/24 at 12:41 PM Staff 10 (CNA) stated about one month ago the facility stopped providing residents with a menu to choose between the main or alternate meal. Staff 10 stated several residents were upset about this as their choice was taken away. On 8/29/24 at 12:35 PM Staff 23 (CNA) stated the facility stopped providing residents with a menu for at least a month and were upset they were not given the right to make choices about their meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/24 at 2:00 PM Staff 18 (Dietitian) stated the facility recently changed the menu system from selection based to preference based and residents received a weekly menu every Friday.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48830 Based on observation and interview it was determined the facility failed to ensure the kitchen was cleaned, failed to ensure food was stored appropriately and discarded in a timely manner, and failed to monitor refrigerator temperatures for 1 of 1 kitchen and 1 of 2 refrigerators reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include: 1. On 8/26/24 at 9:29 AM during the initial tour of the kitchen the following was observed: a. Walk-in refrigerator: -A plastic container with pickle spears, opened and undated. -A cardboard box containing bananas that were dark brown in color. -A stick of margarine, open to air and undated. -Food crumbs, brown splatters, and various small debris on the floor throughout the walk-in refrigerator. b. Walk-in freezer: -A bag of frozen tapioca hot dog buns with a manufacture expiration of 12/22/22. -A bag of frozen chicken strips, opened to air and undated. -A bag of frozen hamburger patties, opened to air and undated. -A bag of frozen veggie vegan patties, opened to air and undated. -A zip lock gallon bag labeled pizza sausage, freezer burnt and date illegible. -Food crumbs and brown splatters of debris on the floor throughout walk-in freezer. c. Main Kitchen area: -A wire rack with shelves located next to a garbage can contained metal containers with splatters of debris. -Drips of white and brown debris located on the bottom self of the steam table where clean pots and pans were stored. -A wire shelf containing clean bowls had a sticky brown film on the surface. (continued on next page)

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	385046	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Center	1201 McLean Blvd. Eugene, OR 97405

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Food crumbs, brown splatters, and various small debris on the floor throughout the main kitchen area. On 8/26/24 at 10:04 AM Staff 17 (Dietary Manager) acknowledged the identified findings. 2. On 8/26/24 at 9:54 AM a small refrigerator containing juice, milk, and yogurt located in the kitchen was observed with a thermometer inside. On 8/26/24 at 9:56 AM the temperature log binder located in the kitchen was reviewed and there was no temperature log for the small refrigerator. On 8/26/24 at 9:57 AM Staff 19 (Dietary) and Staff 21 (Dietary) did not know of a temperature log for the small refrigerator and acknowledged the temperature for the small refrigerator was not monitored. On 8/26/24 at 10:04 AM Staff 17 (Dietary Manager) acknowledged there was no temperature log for the small refrigerator that contained juice, milk, and yogurt for residents and acknowledged the temperature for the small refrigerator was not monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34702 Based on observation, interview and record review it was determined the facility failed to ensure the community use CBG glucometer was properly cleaned and sanitized between resident uses for 1 of 1 sampled resident (#24) reviewed during CBG checks. This placed all residents who required CBG checks at risk for bloodborne illness. Findings include: The facility's undated Glucometer Cleaning Competency Check indicated glucometers were to be cleaned with bleach wipes after each use. On 8/29/24 at 12:17 PM Staff 13 (LPN) was observed to obtain a CBG for Resident 24 on the East Hall. Staff 13 exited the room and placed the glucometer in the East Hall treatment cart without cleaning it. On 8/29/24 from 12:17 PM to 12:40 PM continuous observations were made. Staff 13 passed medication and administered insulin to multiple residents. Staff 13 did not clean the glucometer during the observations. On 8/29/24 at 12:40 PM Staff 13 stated Resident 24 was the last CBG check she had to complete prior to lunch. Staff 13 stated she cleaned the glucometers at the beginning and end of shift with purple wipes. Staff 13 stated she did not know where the wipes were located and they were not on the treatment cart. On 8/29/24 at 12:57 PM Staff 2 (DNS) stated the expectation was for staff to clean glucometers with bleach wipes between every glucometer use. On 8/30/24 at 12:50 PM Staff 4 (Corporate RN) stated there were two residents on the East Hall who required regular CBG checks and one resident who had PRN CBG checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385046	A. Building B. Wing	08/30/2024

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48830 Based on observation and interview it was determined the facility failed to maintain essential kitchen equipment in safe operating condition for 1 of 1 kitchen reviewed for kitchen services. Findings include: On 8/26/24 at 9:34 AM an observation of the walk-in refrigerator in the kitchen revealed a missing door handle to exit the refrigerator. On 8/26/24 at 9:53 AM Staff 19 (Dietary) stated the door handle fell off and Staff 19 was not sure where it went. On 8/26/24 at 10:04 AM Staff 17 (Dietary Manager) acknowledged the door handle fell off and needed to be repaired. On 8/28/24 at 11:30 AM during a follow up visit to the kitchen the walk-in refrigerator door handle was still missing. On 8/30/24 at 10:45 AM Staff 8 (Dietitian) stated the staff needed to find the door handle and screw it in.