STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 43844 Based on interview, record review, and policy review, the provider failed to provide bed-hold notice to the resident and/or their representative regarding the transfer to a hospital for one of one sampled resident (5) for two of three occasions. Findings include: 1. Review of resident 5's electronic medical record (EMR) revealed: *He was transferred to the hospital on 12/27/23, 4/23/24, and on 7/6/24. *His representative was notified of resident 5's 12/27/23 transfer and the bed hold policy. *There was no documentation that the bed hold information was given to the resident or his representative for the 4/23/24 and 7/6/24 hospital transfers. 50916 Interview on 11/15/24 at 4:39 p.m. with social service designee F revealed she was unable to find documentation to support bed hold information had been provided to resident 5 or his representative for the hospital transfers on 4/23/24 and 7/6/24. Review of the provider's undated Bed Reserve Policy Notification revealed: *This Bed Reserve Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility. *Under normal circumstances, if you leave the facility for a hospitalization , you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can reserve your existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before. Review of the provider's April 2021 Bed-Hold and Return Agreement revealed the resident, or their representative would be given the opportunity to request a bed-hold and pay a basic per-diem (daily) rate when absent from the facility.

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 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on record review, interview, and policy review the provider failed to ensure: *Fourteen of twenty-nine residents (10, 23, 46, 49, 53, 55, 64, 65, 67, 70, 224, 274, 375 and 424) had received a summary of their baseline care plan. *One of one sampled resident (424) had a baseline care plan completed within forty-eight hours of admission. Findings include: 1. Record review of resident 64's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 2. Record review of resident 65's EMR revealed: *He had been admitted on [DATE]. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 3. Record review of resident 53's EMR revealed: *He had been admitted on [DATE]. *There was no documentation in his EMR a baseline care plan summary had been reviewed with the resident or resident's representative. 4. Record review of resident 67's EMR revealed: *He had been admitted on [DATE]. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 5. Record review of resident 55's EMR revealed: *He had been admitted on [DATE]. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Record review of resident 23's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 7. Record review of resident 10's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 8. Record review of resident 46's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 9. Review of resident 49's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 10. Review of resident 70's EMR revealed: *He had been admitted on [DATE]. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 11. Review of resident 274's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 12. Review of resident 224's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Review of resident 375's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 14. Review of resident 424's EMR revealed: *She had been admitted on [DATE]. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. *Her baseline care plan was not signed as completed until 10/29/24. 15. Interview on 11/13/24 at 4:30 p.m. with social services designee F regarding residents' baseline care plans revealed: *She would have completed the baseline care plan upon admission. *She would not have reviewed the baseline care plan with the resident or the resident's representative. *She had not provided a summary of the baseline care plan to the resident or the resident's representative. *She had been in her position since June 2024 and felt she had not received very much training for her position. 16. Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator registered nurse (RN) C regarding residents' baseline care plans revealed: *She would have reviewed the baseline care plan with the resident or the resident's representative. *She had not been documenting in the resident's EMR that the baseline care plan had been reviewed with the resident or representative or that a summary of that care plan had been offered. 17. Review of the provider's September 2019 Care Plans policy revealed: *A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later the 48 hours after admission. 51472

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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** 51472 Based on observation, interview, record review and policy review the provider failed to ensure the timely review and revision of one of one (424) sampled resident's care plan. Findings include: 1. Observation on 11/12/24 at 4:22 p.m. of resident 424 revealed: *There was personal protective equipment (equipment worn to minimize exposure to a hazard, such as gowns, gloves, face shield and/or masks) (PPE) sign on her door. *There was PPE hanging in a supply caddy on her door. *She had a sign that indicated to check in with the nurse before entering the color of the sign was pink indicating enhanced barrier precautions *She was sitting in her recliner, feet elevated, with Prevlon pressure reduction boots on both of her feet. *A pressure reduction cushion was in her wheelchair. Interview on 11/13/24 at 10:03 a.m. with resident 424 revealed that she: *She was admitted to the facility about three weeks ago. *Her husband also lived in the facility. *She had sores on her feet that she said resulted from her falling and laying on a garage floor for about two to three days before she was found. Review of resident 424's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her diagnoses include: rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood) and acute kidney failure. *Her nurse progress notes indicated: -She had barricaded herself in her husband's room on 10/26/24 and 10/28/24. -Her family had been called in to help calm her behaviors on 10/26/24 and 10/27/24. Interview on 11/13/24 at 11:46 a.m. with nurse supervisor, registered nurse (RN) S revealed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was unable to identify which transmission-based precaution was to be followed when attending to resident 424 by looking at the sign on the door. *She identified that she would look in resident 424's care plan to identify which precautions were to use. Interview on 11/13/24 at 11:58 a.m. with licensed practical nurse (LPN) Y revealed: *She identified that resident 424 was on EBP by the color of the sign on her door. *She stated that resident 424 was on EBP due to her wounds. Review of resident 424's 11/13/24 care plan revealed: *Upon admit she was placed on EBP related to multiple wounds. *She had a focus area of impaired skin integrity. -Prevalon boots were not listed as an intervention related to her wounds. *She was diagnosed with MRSA on 11/6/24. -Her care plan indicated the antibiotic therapy related to wound infection with MRSA. -Contact precautions were not added to her care plan with the addition of the MRSA diagnosis. -EBP remained on her care plan related to multiple wounds. *Her admitting diagnosis was Rhabdomyolysis. -There were no focus areas, goals, or interventions that addressed possible complications related to this diagnosis. *There was a focus area that identified barricades self in husbands room. -There were no interventions for that focus area. -Her care plan did not address the use of family as an intervention for her behaviors. Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator, RN C and director of nursing (DON) B regarding resident 424 revealed: *She was on EBP due to her wounds. -She was recently diagnosed as being positive for Methicillin-resistant Staphylococcus aureus (MRSA) (a bacteria that is resistant to multiple antibiotics) in one of her wounds. --That was an indication to advance her precautions from EBP to contact precautions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Her care plan was not changed from EBP to contact precautions. *She had a history of behaviors that involved barricading herself in her husband's room. -RN C agreed there was no intervention addressed on the care plan related to this. -Her family had been called multiple times as an intervention to her behaviors. -RN C agreed the use of family as an intervention for her behaviors was not addressed in her care plan. Review of the provider's September 2019 Care Plans policy revealed: * Individualized, resident- centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay. * The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. * Interventions act as the means to meet the individual's needs. * Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51471 Based on interview, record review, and policy review, the provider failed to ensure adequate pain management for one of one sampled resident (375) who expressed she had pain. Findings include: 1. Interview on 11/13/24 at 10:08 a.m. with resident 375 revealed she: *She had asked for medication for pain relief that morning during medication administration time for her pain. *Reported she had pain to the whole left side of her body. *Was told by licensed practical nurse (LPN) L there was no pain medication available. 2. Review of resident 375's current care plan on 11/8/24 revealed: *She was at risk for pain, she had: -Recently had a right-hand surgery and an incision. -Back pain due to a fall. -Diagnoses of peripheral vascular disease, congestive heart failure, and type 2 diabetes. *A focus area indicated that she was at risk for pain. *The goal for this focus, states that level of pain is through next review. *The interventions included: * Evaluate efficacy of pain management. * Notify MD if inadequate pain relief. * Provide analgesic as ordered. *Utilize non-pharmacological intervention (cold/warm wash cloth, massage, distractive activities, reposition, etc.) or ordered analgesic medications. If interventions not effective, then notify MD. 3. Review of resident 375's Electronic Medical Record (EMR) revealed: *She was admitted to the facility on [DATE]. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Her Brief Interview of Mental Status assessment (BIMS) score was a 9, which indicated she was moderately cognitively impaired. *Her diagnoses included: dorsalgia (pain in the back), gout, postural kyphosis (spinal deformity), peripheral vascular disease, type 2 diabetes mellitus without complications, rhabdomyolysis (muscle tissue break down), pain in left shoulder, pain in left hip, pain in left knee. *A progress note (PN) on 11/13/24 at 2:39 a.m. indicated Resident 375 complained of pain and requested pain medication. -There was an active order for Tramadol on the medication administration record (MAR). -She was agreeable to changing positions by moving from her bed to her recliner. -There was no Tramadol in the medication cart. *She had a physician order for Tramadol (pain medication) 50mg give 1 tablet by mouth every 8 hours as needed (PRN) for severe pain. *There was no documentation that the Tramadol had been administered. *A PN on 11/13/24 at 1:29 p.m. by LPN L indicated The resident calling out in pain to the bottom while sitting upright in reclining chair. Resident has an PRN order for Tramadol without medication available to issue. LPN L, had called the clinic and awaiting signature from the doctor to have the prescription sent to pharmacy for the medication. *No current order for additional available pain medications indicated in her EMR. 4. Interview on 11/14/24 at 1:39 p.m. with director of nursing (DON) B and clinical care coordinator (CCC) C revealed: *The pharmacy had not received a written prescription from the physician for the Tramadol. *The pharmacy is not able to fill the order until the written prescription is received. *CCC, C confirmed the provider should have followed up with the physician regarding the Tramadol. *Standing orders for additional pain control were not always put in a resident's EMR when they were admitted . 5. Interview on 11/14/24 at 1:00 p.m. LPN L, regarding resident 375's pain revealed: *She had assessed resident 375's pain level and location of her pain on 11/13/24. -She confirmed resident 375 had complained of pain in her bottom. *She checked resident 375's MAR to see what pain medication the physician had ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She confirmed resident 375 had an order for Tramadol and there was no Tramadol available on the medication cart for administration to resident 375. *She called the clinic and requested the written Tramadol prescription be sent to the pharmacy. *It had been 7 days since the physician had ordered the Tramadol. 6. Observation on 11/14/24 at 3:05 p.m. with LPN L, verified the Tramadol was now available on the medication cart for resident 375. Review of the provider's 3/23/23 Pain Management Policy revealed: *The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. *'Pain Management' is defined as the process that includes the following: a. Assessing the potential for pain. b. Effectively recognizing the presence of pain. c. Identifying the characteristics of pain. d. Addressing the underlying causes of pain. e. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain. g. Monitoring for effectiveness of interventions; and h. Modifying approaches as necessary. *Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including: -Peripheral vascular disease *Pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. *Pain management interventions shall reflect the sources, type and severity of pain. *Strategies that may be employed when establishing the medication regimen include: -Combining long-acting medications with PRNs [as needed] for breakthrough pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Implement the medication regimen as ordered, carefully documenting the results of the interventions. *Report the following information to the physician or practitioner: -Significant changes in the level of the resident's pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43844 Based on interview, record review and policy review the provider failed to ensure one of one sampled resident (67) who required dialysis treatment was monitored for abnormalities upon returning from his dialysis treatment. Findings include: 1. Interview on 11/13/24 at 8:40 a.m. with resident 67 revealed: *He received dialysis on Mondays, Wednesdays, and Fridays. *There was a dialysis port located in his chest. -He stated that port went directly to his heart. Review of resident 67's electronic medical record (EMR) revealed: *His admitted was 3/22/24. *His diagnoses included: end stage renal disease, dependence on renal dialysis, heart disease, Parkinson's disease, and cognitive communication deficit. *His physician orders included: -Dialysis Monday Wednesday Friday. -REMINDER NURSES: Open and complete 1st section of dialysis UDA [user defined assessment] prior to leaving dialysis and then complete 2nd 2 sections of UDA after dialysis upon return two times a day every Mon, Wed, Fri. *His care plan included Report significant changes in pulse, respirations and BP [blood pressure] immediately. Review of resident 67's vitals recorded in his dialysis UDA section three Post-Dialysis Evaluation vitals recorded revealed: *His 11/1/24 blood pressure (BP), temperature, pulse, and respirations vitals were documented as his post-dialysis vitals on 11/4/24; and his 10/30/24 oxygen saturations (O2) were documented as his post-dialysis vitals on 11/4/24. *His 10/30/24 O2 was documented as his post-dialysis vitals on 11/6/24. *His 11/6/24 BP, temperature, pulse, and respirations were documented as his post-dialysis vitals on 11/8/24; and his 10/30/24 O2 was documented as his post-dialysis vitals on 11/8/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*His 11/6/24 his BP, temperature, pulse, and respirations were documented as his post-dialysis vitals 11/11/24; and his 10/30/24 oxygen saturations were documented as his post-dialysis vitals on 11/11/24. *On 11/13/24 there were no vital signs documented. Interview on 11/14/24 at 2:14 p.m. with registered nurse BB regarding dialysis assessments revealed: *She was aware resident 67 required dialysis. *She had completed the post-dialysis UDA section three that included resident 67's vital signs taken upon his return from dialysis. -Section three vitals should be the vitals when the resident returns from dialysis. *Ideally would be done each time. -They try to get the CNAs to get the vitals and then the nurse would document. *Confirmed this does not always happen. Interview and record review on 11/14/24 at 4:29 p.m. with director of nursing (DON) B regarding their process for when a resident returned from dialysis was to: *Complete the dialysis UDA, which included: -The amount of fluid removed from the resident during dialysis. -Medications administered during the dialysis treatment. -Obtain the resident's vital signs. --A certified nursing assistant or a nurse could obtain the resident's vital signs. *The nurse was responsible for documenting the vital signs on the post-dialysis UDA. *DON B confirmed resident 67's vital signs documented in his post dialysis UDAs were not always taken the day the assessment was completed. -Her expectation was for the vitals to be obtained and documented each time a resident would return from their dialysis treatment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on observation, interview, record review, and policy review, the provider failed to maintain clean and sanitary conditions in one of one observed kitchen where residents' food was stored and prepared. Findings include: 51472 1. Observation on 11/12/24 at 3:30 p.m. of the kitchen revealed: *The walk-in freezer revealed: -There was a form (form 403) on the door of the walk-in refrigerator/freezer titled [NAME] Frig Freezer where daily temperatures for November were documented. --It indicated Code for adequate temperature: Freezer: Not greater than 0 degrees F [Fahrenheit] or food maintained solid. --Daily documented freezer temperatures of the walk-in freezer were recorded chronologically in November were as follows: 12, 15,12, 28, 12, 23, 29, 30, 2, 0, 5, 0 degrees F. --There was no documented actions taken for temperatures that were outside the adequate temperature range. -There was ice build up around the door to the walk-in freezer. -The metal lining of the walk-in freezer door was separated and had exposed cracked foam. -There was frost on the cooling unit in the walk-in freezer and ice build-up on the pipes on the back of the unit. *The 3 Door Fridge Unit had: -Two temperature gauges were being documented daily on the provider's form 403. -The temperature gauges were identified as GUAGE A and GUAGE2. -Between November 1st through the 12th GUAGE A was documented as reading 36-41 degrees Fahrenheit. -During the same time frame GUAGE2 was documented as 38-45 degrees F. -There were four days with greater than the 2-degree variance from 40 degrees. --There was no documentation of actions taken for temperatures that were outside the adequate temperature range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A container of diced ham in the three-door refrigerator dated 10/24. -There was uncooked corn beef hash stored above the potatoes and wine. *Another stand-up freeezer had: -Two baked pies with pieces removed that were dated 9/22 and 8/18. --The pies were covered loosely with plastic wrap. *The plastic liners in the flour and sugar containers were ripped. 2. Observation on 11/14/24 at 9:22 a.m. of the kitchen revealed: *The office freezer had: -Chicken nuggets that were not dated. -One thermometer that had a solid red line that extended to 34 degrees Fahrenheit with a broken red line extending from 34 degrees to 52 degrees Fahrenheit. *The walk-in refrigerator had dust on the front of the cooling unit and on the walls and ceiling. *The walk-in freezer had: -There were no documented actions taken for the temperatures that were outside the adequate temperature range. -Dates on the bags of cut up chicken ranged from 1/8 to 11/3. -There were multiple bags of undated cut-up chicken. -One bag of undated chicken pieces appeared freezer burned, and the bottom of the bag contained a frozen bloody liquid. -There was 3/4 inch of frost build-up on the side of the walk-in cooler cooling unit that extended to 1/3 of the front portion of the unit. -The back of the walk-in cooler cooling unit had one to three inches of ice build-up on the back of the unit that extended onto the tubing behind the unit. *In the three-door refrigerator there was a container of frozen meat that extended above the sides of the container and was stored above wine and a box of pastries. 3. Interview on 11/14/24 at 9:22 a.m. with dietary manager T revealed: *She indicated that all freezer and refrigerator temperatures were documented daily and there needed to be two thermometers in the refrigerator and one in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*She indicated that if the two thermometers in the refrigerators did not match, she would check the temperature with another thermometer and discard the thermometer that did not read accurately. -She stated that this action was not documented anywhere. *When asked how she determined when food was discarded according to the dates on the packages, she stated she did not know the answer. *She stated she had discarded all the food that was thawed out in the walk-in freezer when the temperatures were out of range. *She stated she was told the walk-in freezer door was being replaced. *She indicated that on Friday (11/8/24) the cooling unit in the walk-in freezer was not working. -Maintenance director I removed the ice from the cooling unit and the cooling unit then began working. -Maintenance director I installed longer screws on the wall side exterior latch of the walk-in freezer so the door would latch. *She stated that the ice currently present on the cooling unit of the walk-in freezer was better than it was previously. *She agreed that the metal liner on the door of the walk-in freezer was separated with exposed cracked foam and light was visible around the door. *When shown the undated bag of chicken pieces that appeared freezer burned with frozen bloody liquid on the bottom of the bag, she indicated that this bag appeared to have thawed and refrozen. -She did not throw out any of the turkey or chicken on that Friday because she felt they had not thawed. -She said she would dispose of that bag of chicken. -The bags of chicken should be dated. *She stated that maintenance oversaw the cleaning of the cooling unit in the walk-in refrigerator. *She indicated that when she defrosted meat in the cooler, and raw meat needed to be stored on the bottom shelf in a container. *If meat was precooked, she did not put it on the bottom of the refrigerator. *If meat needed to be defrosted more rapidly than able to in the refrigerator she would run it under cool water. 4. Review of the provider's temperature logs revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*On 10/9/24 dietary manager T documented on the [NAME] Frig and Freezer titled temperature log margin Got rid of the stuff out of [the] freezer. -Below the above documentation was written Freezer door wouldn't shut but got fixed on the 8th. *Daily documented freezer temperatures for [NAME] Frig and Freezer reported in degrees Fahrenheit between October 1st and 11th, 2024 were 22, 20, 18, 20, 20, 20, 18, 20, 20, 22, 23. -There was a note in the margin that stated, walk in door not shutting properly Got rid of all the food *Logs of freezer defrosting was requested but not provided 5. Interview on 11/14/24 at 9:40 a.m. with dietary aide P revealed that she was unfamiliar with the process of checking temperatures in the coolers because the cooks performed this task. 6. Interview on 11/14/24 at 9:45 a.m. with dietary aide V revealed: *If the two thermometers in the refrigerator did not match, she would double-check the gauge that was reading out of range. *If she determined that gauge was reading inaccurately, she would notify her supervisor to replace the inaccurate gauge. 7. Interview on 11/14/24 at 4:39 p.m. with administrator A regarding the kitchen revealed: *She was aware the walk-in refrigerator door had ice build-up around the door. *They had thrown out food numerous times after identifying the food had partially thawed out. -She was not aware the chicken and turkey had not been thrown away after having been partially thawed out. 8. Review of the provider's 8/31/18 Freezer policy revealed: *Freezer defrosting was to be completed monthly. *Freezers should remain frost free. 9. Review of the provider's 10/15/18 Freezer Storage Chart revealed: *Unopened frozen chicken nuggets were to be disposed of after 1-3 month *Unopened whole or cut up chicken was to be disposed of after 10 months. *Baked pies were to be stored unopened and be disposed of after 8 months. *Opened baked pies recommended storage was not applicable. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Review of the provider's 3/9/20 Food Storage policy revealed: *Products were to be examined for signs of defrosting. *The refreezing of defrosted food is not recommended because of increase in growth of-food bacteria and the deterioration in food quality. *Thaw meat preferably by placing in deep pan and setting on the lowest shelf in refrigerator. *Thawing food under cold running water is no longer recommended due to strict guidelines set forth by the 2013 Food Code. *Alcoholic beverages must be stored in a separate locked area. 11. Review of the provider's 8/8/19 Record of Refrigeration Temperatures policy revealed: *A daily temperature record is to be kept of refrigerated items. *The freezer must be clean and food must be frozen solid with no indications of thawing and must be frost free. *The refrigerator must be 41 degrees Fahrenheit or less (1-2-degree variance) *Note on temp forms the plan of action when temps are not acceptable. 12. Review of the provider's 12/28/20 Refrigerated Storage Chart policy revealed that opened ham should be discarded after one week.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 A. Based on observation, interview, record review, policy review, and manufacturer's recommendations, the provider failed to ensure one of two observed ice machines were maintained in a clean and sanitary manner. Findings include: 1. Observation on 11/14/24 at 9:22 a.m. of an ice machine located in the therapy room revealed: *The water/ice spout had pink slime (a bacteria colony that can grow in ice machines) in it. *The water tray had metal bars over the top of it that were rusted. *There was a white, flaky, residue, that covered the underside of the machine where the spout extended from. Interview on 11/14/24 at 9:22 a.m. with certified medication aide (CMA) U regarding the ice machine located in the therapy room revealed that the ice machine was used three times daily for resident water passes. Interview on 11/14/24 at 1:42 p.m. with housekeeper K regarding the ice machine located in the therapy room revealed:*Each housekeeper is assigned a different area to keep clean. *He has cleaned the ice machine, by having wiped down the outside areas of it. *He said the housekeepers do not clean the internal parts of the ice machine. *He said supervisor would know more about the ice machine. Interview on 11/14/24 at 1:46 p.m. with housekeeper supervisor R regarding the ice machine located in the therapy room revealed: *Housekeepers wiped down the outsides of the ice machine. *She said housekeepers had tried to keep the ice machine clean. *She confirmed the bars on the tray were rusted, and did not know if they could be replaced. *She confirmed there was pink slime on spout of the machine. *She said the maintenance staff takes apart and does the internal cleaning of the ice machine. Interview on 11/14/24 at 1:49 p.m. with maintenance director I regarding the ice machine located in the therapy room revealed: *Confirmed there was pink slime on the spout of the ice machine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Used a brush to clean it every six months. *A chlorine spay product was used. *The product observed was CDS liquid chlorinator pool water disinfection. -He said he would pour that into a spray bottle and would add a little water to it. -He said he does not measure the amounts of the product or the water he would add to the spray bottle. Review of the provider's Ice Machine Log Semi-Annual Inspection revealed: *The 4/13/24 documentation included cleaned/checked. *The 7/27/24 documentation included checked cleaned as needed cleaned air filters. *The 10/22/24 documentation included Cleaned all Ice machine/cleaned Ran through cleaning cycles/filters. Review of the provider's June 2019 Sanitization policy revealed: *Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. *Damaged or broken equipment that cannot be repaired shall be discarded. Review of the manufacturer's instructions for installation, operation, and maintenance of the Manitowoc ice machine that was located in the therapy room revealed: *Manitowoc Ice Machine Cleaner and Sanitizer are available in convenient 16 oz (473 ml) and 1 gal (3.78l) bottles. These are the only cleaner and sanitizer approved for use with Manitowoc products. *Preventative Maintenance Cleaning Procedure Perform this procedure as required for your water conditions. Recommended monthly. -Allows cleaning the ice machine without removing all of the ice from the bin -Removes mineral deposits from areas or surfaces that are in direct contact with water during the freeze cycle (reservoir, evaporator, auger, drain lines). *Cleaning/Sanitizing Procedure This procedure must be performed a minimum of once every six months. -All ice must be removed from the bin -The ice machine and bin must be disassembled cleaned and sanitized -The ice machine produces ice with the cleaner and sanitizer solutions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Agreed that resident 274 had not been on contact precautions for her MRSA infection in her wound. 2. Observation on 11/12/24 at 4:22 p.m. of resident 424 revealed: *There was PPE hanging in a supply caddy on her door. *She had a sign that indicated to check in with the nurse before entering the color of the sign was pink indicating enhanced barrier precautions Observation on 11/13/24 at 8:37 a.m. of resident 424 revealed: *She was being propelled in her wheelchair by an unknown staff member out of the dining room. *The same unknown staff member stopped in the hallway and assisted her to stand and ambulated with assistance of one staff and a front wheeled walker in the hallway. Interview on 11/13/24 at 10:03 a.m. with resident 424 revealed that she: *She was admitted to the facility about three weeks ago. *She had sores on her feet that she said resulted from her falling and laying on a garage floor for about two to three days before she was found. Review of resident 424's electronic medical record (EMR) revealed: *She was admitted on [DATE]. * On 10/6/24 she was diagnosed with a positive Methicillin-resistant Staphylococcus aureus (MRSA) (a bacteria that is resistant to multiple antibiotics) in her right ankle wound. *She was taking Linezolid for the MRSA infection. Interview on 11/13/24 at 11:58 a.m. with licensed practical nurse (LPN) Y revealed: *She identified that resident 424 was on EBP by the color of the sign on her door. *She stated that resident 424 was on EBP due to her wounds. Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator, RN C and director of nursing (DON) B regarding resident 424 revealed: *She was on EBP due to her wounds. -She was recently diagnosed as being positive for MRSA in one of her wounds. --That was an indication to advance her precautions from EBP to contact precautions. *RN C agreed that resident 424 was not advanced from EBP to contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Placed the nasal spray on the PPE cart, discarded her mask into the trash can, and used hand sanitizer to disinfect her hands. -Picked up the nasal spray, opened the medication cart, and put the nasal spray back into the nasal spray manufacturer's original box. 2. Interview on 11/13/24 at 4:26 p.m. with LPN Q revealed: *She knew she did not wipe off the nasal applicator after administering the nasal spray to resident 44. *She did not think she was allowed to wipe down something that went into a nasal cavity. 3. Interview on 11/14/24 at 10:30 a.m. with registered nurse (RN) infection preventionist E revealed: *Nurses were to wipe off the nasal spray applicator in precaution rooms with an alcohol wipe. *Nurses were to clean the bottle outside of the room and then put it back in the medication cart. 4. Interview on 11/14/24 at 11:25 a.m. with staff development coordinator D revealed: *She educated staff on PPE, handwashing, different isolation precautions, infection control, and types of transmission every year. *She stated for nasal sprays, staff were supposed to wipe the tip off after every application with an alcohol wipe. *She did not believe there was any education regarding wiping off nasal spray bottles once out of precaution rooms. 5. Interview on 11/14/24 at 11:35 a.m. with director of nursing DON B revealed: *Staff had not received education recently regarding infection control practices. *They had not provided staff education for administering nasal spray in precaution rooms. *Her expectation was for staff to place a barrier down for nasal sprays and wipe the nasal applicator after each use. The provider's Nasal Spray Administration policy dated 11/21/18 and Infection Prevention Program policy revised 2/20/24 did not address infection control practices following nasal spray administration in precaution rooms. 51472