| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465173 | A. Building<br>B. Wing | 05/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stonehenge of Richfield | 125 East 600 North<br>Richfield, UT 84701 |

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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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 3 of 15 sampled residents, the facility did not ensure that residents who used psychotropic drugs received a gradual dose reduction, and behavioral interventions unless clinically contraindicated in an effort to discontinue the drugs; additionally the facility did not ensure PRN (as needed) orders for psychotropic drugs were limited to 14 days unless clinically contraindicated. Specifically, there was no rationale after 90 days for continued use of a prn anti-anxiety medication, another resident did not have a rationale for continuation of an anti-depressant and anti-anxiety and another resident did not have a gradual dose reduction that was ordered by the physician implemented. Resident identifiers: 2, 7 and 11.<br><br>Findings included:<br><br>1. Resident 2 was admitted to the facility on [DATE] with diagnoses that included depression, anxiety disorder, muscle weakness, bradycardia and history of falling.<br><br>Resident 2's medical record was reviewed between 5/27/25 and 5/29/25.<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident 2 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment.<br><br>Resident 2's care plan dated 3/18/25 included a focus area, I use an anti-anxiety medication(s) r/t [related to]: Anxiety Disorder. The goal was, I will be free from discomfort or adverse reactions related to anti-anxiety therapy during my stay. Interventions included to administer anti-anxiety medications as ordered by the physician and monitor for side effects.<br><br>A physician's order dated 12/17/24 and discontinued on 3/16/25 revealed, Ativan Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth every 4 hours as needed for Anxiety related to GENERALIZED ANXIETY DISORDER (F41.1) for 90 Days.<br><br>A physician clinic note dated 12/17/24 revealed, .Patient is at [facility] today for evaluation and discussion about agitation that the patient's been having recently .Nursing is concerned about her being more aggressive, yelling more frequently and has been getting Ativan as needed. This medication has been helpful but has just been a couple of times a day .Continue Ativan but actually increase to every 4 hours as needed severe agitation. Again try to use that medication sparingly now that we are adding the citalopram, readdress how this is working at next visit.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A current physician order dated 3/16/25 revealed, Ativan Oral Tablet 1 MG [milligram] (Lorazepam) *Controlled Drug*; Give 1 mg by mouth every 4 hours as needed for Anxiety related to GENERALIZED ANXIETY DISORDER for 90 days.<br><br>On 3/16/25 at 1:57 PM, a Nurses Note revealed New order for continued use per [Physician Name redacted] as follows: Ativan Oral Tablet 1 MG Give 1 mg by mouth every 4 hours as needed for Anxiety related to GENERALIZED ANXIETY DISORDER for 90 days. Continued use date for 90 days set for 6/14/2025.<br><br>[Note: There was no rational for the continued use of prn Ativan that was ordered on 3/17/25.]<br><br>Resident 2's March, April, and May 2025 Medication Administration Record revealed Ativan was administered on 3/19/25, 3/21/25, 4/2/25, 4/8/25, 4/15/25, 4/20/25, 4/29/25, 5/6/25, 5/13/25, 5/22/25, 5/23/25, and 5/24/25.<br><br>On 4/22/25, a quarterly psychotropic medication review revealed a review of Ativan 1 mg Q 4 hours PRN. Resident 2 had 7 verbal episodes of anxiety and 6 episodes of agitation. IDT determination was to maintain the medication regimen, and the physician agreed.<br><br>On 5/29/25 at 10:59 AM, an interview was conducted with Registered Nurse (RN) 1 who stated the physician usually wrote a prescription for a 14 day PRN medication. RN 1 stated if the medication was still needed after the 14 days the physician would assess the resident and renew the resident for 90 days.<br><br>On 5/29/25 at 11:08 AM, RN 1 stated she could not find a document or progress note for a continued use of the Ativan from the new physician ordered date of 3/17/25. The Regional Nurse Consultant (RNC) who was also present stated she would ask the Director of Nursing (DON) about it.<br><br>No additional documentation was provided by the facility with the physician's rationale for the continued use of prn Ativan that was ordered on 3/17/25.<br><br>2. Resident 7 was admitted on [DATE] with diagnoses of orthopedic aftercare, diabetes, and anxiety disorder.<br><br>Resident 7's medical record was reviewed on 5/27/25 to 5/29/25.<br><br>Resident 7's physician orders revealed the following;<br><br>a. On 11/15/23, Citalopram Hydrobromide oral tablet 20 MG orally in the morning for dysthymic disorder. The order was discontinued on 10/17/24.<br><br>On 10/17/24, Citalopram Hydrobromide Oral Tablet 20 MG, give 15 mg orally in the morning related to dysthymic disorder.<br><br>b. On 11/14/23, Bupropion HCL (hydrochloride) tablet 150 MG give by mouth twice daily related to anxiety. The order was discontinued on 1/17/25.<br><br>On 1/17/25, Bupropion HCl Oral Tablet 100 MG, Give 100 mg by mouth two times a day related to anxiety disorder.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An MDS assessment on 2/27/25 stated the resident was on antidepressant medications.<br><br>On 11/18/2023 at 3:03 PM, a nurses note revealed, A Physician Rationale for Duplicative Medication: Antidepressant: Patient admitted with orders for Bupropion to manage s/s (signs and symptoms) of anxiety and orders for Citalopram to manage s/s of dysthymic disorder. Patient expresses that both of these medications are working well to minimize the s/s of depression and anxiety. Patient expressed that she would like to continue with this regimen. At this time, patient benefits from duplicative medication: antidepressant (Bupropion, Citalopram). Patient has appropriate dx [diagnosis] (F34.1 Dysthymic Disorder and F41.9 Anxiety Disorder) to merit the appropriate usage of medication. Appropriate paperwork has been completed, awaiting MD response. [Note: There was no information regarding the MD's response located in resident 7's medical record.]<br><br>On 7/17/24, a psychotropic drug review revealed to maintain Bupropion 150 MG twice daily and Citalopram 20 MG daily with no other documented rationale information.<br><br>On 10/15/24, a psychotropic drug review revealed to maintain Bupropion at 150 MG. Citalopram was decreased to 15 MG daily.<br><br>On 1/14/25, a psychotropic drug review revealed Bupropion 150 MG was recommended to decrease to 100 MG twice daily.<br><br>On 4/22/25 a psychotropic drug review revealed Bupropion 100 MG twice daily and Citalopram 15 MG daily were to maintain with no other documented rationale information.<br><br>On 6/3/25 at 10:03 AM, a phone interview was conducted with the DON. The DON stated the order for Citalopram had 20 MG and 15 MG was confusing. The DON stated the pharmacy provided a 15 MG dose. The DON stated she did not have any further documentation of a second gradual dose reduction or rationale to not reduce the Citalopram and Bupropion.<br><br>3. Resident 11 was admitted to the facility on [DATE] with diagnoses which included other neurological conditions, respiratory failure, and seizure disorder.<br><br>Resident 11's medical record was reviewed 5/27/25 to 5/29/25.<br><br>On 9/30/24, resident 11 had an order for Trazadone oral tablet 50 MG (milligrams) orally at bedtime related to insomnia.<br><br>On 4/22/25, in the psychotropic review meeting, the physician recommended a decrease in Trazodone to 25 MG.<br><br>On 4/26/25 at 2:49 PM, a nurses note stated, Pt (patient) was reviewed in psychotropic meeting on 4/22/25. They recommend to maintain current Valproic Acid orders. Recommend to decrease Trazodone to 25mg PO (per oral) QHS (every night at bedtime) r/t insomnia. Psychotropic drug review agreed to & signed by [physician's name removed], all changes implemented. N.O. (new order) DC (discharge) Trazodone 50mg PO QHS and start Trazodone 25mg PO QHS r/t insomnia. MAR updated.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/29/25, an interview was conducted with the DON who stated the GDR order for Trazodone was not written correctly. The DON stated she wrote the progress note in the medical record but forgot to change the order for the physician to sign. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 1 out of 15 sampled residents the facility did not send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. Resident identifier: 13<br><br>Findings included:<br><br>Resident 13 was admitted to the facility on [DATE] with diagnoses which included aftercare following joint replacement surgery and presence of right artificial knee joint.<br><br>On 3/1/25 at 4:16 PM, a nurses note documented, .Patient discharged AMA [Against Medical Advice] . Patient discharged to home .<br><br>On 5/28/25 at 10:39 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that she or the Business Office Manager (BOM) would be the facility staff that would notify the Ombudsman. The RA stated that she was never trained to notify the Ombudsman when residents were discharged and would only contact the Ombudsman if a discharge was difficult. The RA stated that she did not notify the Ombudsman about resident 13's discharge.<br><br>On 5/28/25 at 10:56 AM, an interview was conducted with the BOM. The BOM stated that the Ombudsman was not notified of every resident that was discharged from the facility. The BOM stated that she only notified the Ombudsman when she was worried about a resident leaving the facility and had concerns for their safety. The BOM stated she did not notify the Ombudsman regarding resident's 13 discharge.<br><br>On 5/28/25 at 1:34 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Ombudsman would be notified about difficult resident discharges by the RA or BOM for residents that the facility was worried may have unresolved issues. The DON stated that the Ombudsman should be notified if a resident discharged AMA. The DON stated that she did not know that the Ombudsman should be notified regarding all resident discharges from the facility.<br><br>On 5/28/25 at 1:47 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that anytime a resident was discharged from the facility the Ombudsman should be notified. The RNC stated that this should be done usually by a monthly summary with the names of the residents who discharged . |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 2 of 15 sampled residents, the resident assessment did not accurately reflect the resident's status. Specifically, two residents who were using oxygen had assessments stating they were not using oxygen at the facility. Resident identifiers: 2 and 10.<br><br>Findings included:<br><br>Resident 2 was admitted to the facility on [DATE] with diagnoses that included atypical atrial flutter, depression, anxiety disorder, and history of falling.<br><br>Resident 2's medical record was reviewed between 5/27/25 and 5/29/25.<br><br>A review of resident 2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed under Special Treatments, Procedures and Programs-Oxygen-While a resident: No.<br><br>Resident 2's physician orders included:<br><br>a. 2 L (liters) nocturnal oxygen by NC (nasal cannula) at bedtime.<br><br>b. Change O2 (oxygen) humidifier every month on first Sunday.<br><br>c. Change nasal cannula and tubing every Sunday, label with name and date every Sunday, every day shift, every Sunday.<br><br>Resident 2's treatment administration record revealed:<br><br>a. 2 L oxygen administered at night.<br><br>b. April: Humidifier changed on April 1, 2025 and May 1, 2025.<br><br>c. Cannula changed every Sunday.<br><br>Resident 2's care plan had a focus area The resident has oxygen therapy use prn [as needed] noc [at night] r/t [related to] ineffective gas exchange. Date initiated: 3/21/25. The goal was, The resident will have no s/sx [signs or symptoms] of poor oxygen absorption through the review date. Interventions included providing oxygen as ordered and monitoring for respiratory distress.<br><br>Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy, pneumonia, left bundle branch block, and generalized anxiety disorder.<br><br>Resident 10's medical record was reviewed between 5/27/25 and 5/29/25.<br><br>A review of resident 10's quarterly MDS assessment dated [DATE] revealed under Special Treatments, Procedures, and Programs- Oxygen- While a resident: No.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 10's physician orders included:<br><br>a. Notify PCP (primary care physician) for increased oxygen needs and oxygen sats (saturation) < 90%.<br><br>b. Change O2 humidifier every month on first Sunday.<br><br>c. Change nasal cannula and tubing every Sunday, label with name and date every Sunday.<br><br>Resident 10's treatment administration record revealed:<br><br>a. Resident 10's oxygen was checked twice daily in April and May.<br><br>b. Nasal cannula was changed every Sunday in the months of April and May.<br><br>c. A humidifier was not observed on resident 10's oxygen concentrator throughout the survey.<br><br>On 5/28/25 at 10:27 AM, an interview was conducted with CNA (Certified Nursing Assistant) 1 who stated oxygen tubing was changed every Sunday to make sure the residents had clean tubing. CNA 1 stated a plastic bag was attached to the resident's concentrator to put the cannula and tubing in when the resident was not using it to keep it clean and the concentrators were turned off. CNA 1 stated when the tubing was changed, the date was written on the tubing with a black marker, so staff would know when it was changed. CNA 1 showed the surveyor where the tubing was labeled.<br><br>On 5/28/25 at 10:55 AM, an interview was conducted with the Director of Nursing (DON) who stated resident 2 and resident 10 both used oxygen at night and occasionally during the day.<br><br>On 5/29/25 at 9:37 AM, an interview was conducted with the MDS Coordinator who stated he completed the MDS assessments on each resident. The MDS Coordinator stated he used observations of the residents, physician orders, and clinical information when completing the resident assessments. The CMS Coordinator reviewed the MDS assessments with the surveyor and confirmed the assessments for resident 2 and resident 10 were incorrect. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 out of 15 sampled residents, the facility did not develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet the resident's nursing needs. Specifically, a care plan was not developed to address the resident's oral hygiene care. Resident identifier: 11.<br><br>Findings included:<br><br>Resident 11 was admitted to the facility on [DATE] with diagnoses which included other neurological conditions, respiratory failure, and seizure disorder.<br><br>On 05/27/25 at 12:00 PM, resident 11 was observed in the dining room. Resident 11 was observed to have white buildup on his teeth. Resident 11 stated he brushed his own teeth, had not seen a dentist while in the facility, and had not been to a dentist out of the facility.<br><br>Resident 11's medical record was reviewed from 5/27/25 through 5/29/25. The minimum data set (MDS) assessmen dated 4/8/25, revealed resident 11 required setup or cleanup assistance with oral hygiene.<br><br>A care plan dated 10/14/24, revealed staff were to assist with (activities of daily living) and mobility as needed. Some interventions included, Improve ADL (activities of daily living) self-performance, encourage as much independence as possible, provide any adaptive equipment needed to assist patient with obtaining, staff to assist with ADLs and mobility as needed.<br><br>Certified Nursing Assistant (CNA) documentation from 5/15/25 to 5/27/25, revealed resident 11 had received oral care assistance 8 times in the last 14 days.<br><br>A review of Resident 11's nursing progress notes from 4/28/25 to 5/28/25 revealed no documented concerns with teeth or gums.<br><br>On 5/28/25 at 9:09 AM, an interview was conducted with CNA 2. CNA 2 stated staff had tried encouraging resident 11 with brushing teeth. CNA 2 stated staff talked with resident 11's sister to encourage him to brush his teeth. CNA 2 stated before he was admitted to the facility, resident 11's sister encouraged him to take care of his teeth. CNA 2 stated staff reminded resident 11 to brush his teeth daily. CNA 2 stated resident 11 usually responded to morning staff saying he would brush his teeth after dinner. CNA 2 stated staff assisted residents to brush their teeth after showering. CNA 2 stated resident 11 was scheduled as an afternoon shower. CNA 2 stated resident 11 always stated he would brush his teeth later when prompted to brush. CNA 2 stated it was not being passed from shift to shift whether resident 11 completed brushing his teeth.<br><br>On 5/28/25 at 9:34 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the care plan should have been developed to address resident 11's need for more assistance with oral hygiene. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 of 15 sampled residents, the facility did not provide appropriate treatment and services to maintain or improve his ability to carry out the activities of daily living (ADL). Specifically, a resident was observed to have buildup on his teeth and there was no documentation that he was provided oral care routinely. Resident identifier: 11.<br><br>Findings included:<br><br>Resident 11 was admitted to the facility on [DATE] with diagnoses which included other neurological conditions, respiratory failure, and seizure disorder.<br><br>On 05/27/25 at 12:00 PM, Resident 11 was observed in the dining room. Resident 11 was observed to have white buildup on his teeth. Resident 11 stated he brushed his own teeth, had not seen a dentist in the facility, and had not been to a dentist out of the facility.<br><br>Resident 11's medical record was reviewed from 5/27/25 through 5/29/25. The minimum data set (MDS) assessment dated [DATE], revealed resident 11 required setup or cleanup assistance with oral hygiene.<br><br>A care plan dated 10/14/24, revealed staff were to assist with ADLs and mobility as needed. Some interventions included, Improve ADL self-performance, encourage as much independence as possible, provide any adaptive equipment needed to assist patient with obtaining, staff to assist with ADLs and mobility as needed.<br><br>Certified Nursing Assistant (CNA) documentation from 5/15/25 to 5/27/25, revealed resident 11 had received oral care assistance 8 times in the last 14 days.<br><br>A review of resident 11's nursing progress notes from 4/28/25 to 5/28/25 revealed no documented concerns with teeth or gums.<br><br>On 5/28/25 at 9:09 AM, an interview was conducted with CNA 2. CNA 2 stated staff had tried encouraging him with brushing teeth. CNA 2 stated staff talked with resident 11's sister to encourage him to brush his teeth. CNA 2 stated before resident 11 was admitted to the facility, the sister encouraged him to take care of his teeth. CNA 2 stated staff reminded resident 11 to brush his teeth daily. CNA 2 stated resident 11 usually responded to morning staff saying he would brush his teeth after dinner. CNA 2 stated staff assisted residents to brush their teeth after showering. CNA 2 stated resident 11 was scheduled as an afternoon shower. CNA 2 stated resident 11 always stated he would brush his teeth later when prompted to brush. CNA 2 stated it was not being passed from shift to shift whether resident 11 was completing his teeth brushing.<br><br>On 5/28/25 at 9:34 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the CNA's instructed resident 11 in the morning to brush his teeth. The DON stated she was not aware of where CNA's document oral hygiene. The DON stated she didn't know if reminders to brush teeth were passed along in shift change to ensure it was getting done in the afternoon. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on interview, the facility did not employ a full time Director of Food and Nutrition Services with the required qualifications of Certified Dietary Manager, Certified Food Service Manager or with a degree in food service management or 2 or more years of experience as a director of food and nutrition services. Specifically, the facility's Certified Dietary Manager was employed part time and the full-time Dietary Manager was not yet certified to work as a Dietary Manager.<br><br>Findings included:<br><br>On 5/27/25 at 12:42 PM an interview was conducted with the Dietary Manager in Training (DMT) who stated she was the full-time manager but was not certified. The DMT stated she was preparing to take the courses necessary to be certified. The DMT stated the previous Dietary Manager (DM) was working part time and training her.<br><br>On 5/28/25 at 8:15 AM, an interview was conducted with the DM who stated she was a certified dietary manager and was working 20 hours per week, and sometimes less, but was available by phone all the time. The DM confirmed she was training the DMT and preparing her to take the necessary courses for certification. The DM stated the Corporate Dietitian (CD) completed remote assessments for the facility and visited the facility quarterly for 1 day. The DM stated the CD reviewed the resident charts and documentation, resident assessments, completed kitchen and sanitation audits, meal audits, and addressed resident issues that required the care of a dietitian. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465173 | A. Building<br>B. Wing | 05/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stonehenge of Richfield | 125 East 600 North<br>Richfield, UT 84701 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer, walk-in refrigerator and dry food storage room were open to the air. Additionally, food items in the food storage room were past their use by dates.<br><br>Findings included:<br><br>On 5/27/25, at 12:42 PM, an initial walk-through of the kitchen was conducted.<br><br>In the walk-in freezer, a box of bulk frozen peas was open to air.<br><br>In the dry food storage room, a box of dried mashed potatoes was open to air, a box of baking soda was open to air. A bottle of apple cider vinegar with an open date of 11/13/23 had a use by date of 12/20/24. A container of baking powder had a best used by date of 4/24/25. Two packages of yeast had expiration dates of 12/21/24.<br><br>On 5/29/25 a second walk-through was conducted in the kitchen.<br><br>In the walk-in freezer, a box of omelet replacements was open to air, and a box of omelets was open to air.<br><br>In the dry storage room, a box of baking powder had a best used by date of 4/24/25. A box of dried mashed potatoes was open to air, a large container of Worcestershire sauce had a best used by date of 3/17/25. A container of Maltomeal for [name written on container] had an open date of 6/15/23, and a use by date of January 2025.<br><br>On 5/29/25 at 12:00 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the Corporate Dietitian (CD) came to the facility quarterly and completed a kitchen audit that included looking in the refrigerator, and dry storage areas. The DM stated the CD provided the DM or the DMT (Dietary Manager in Training) a report with the findings that also was provided to the Administrator and the Director of Nursing. The DM stated the CD's findings were included in the information that kitchen staff were educated about. The DM stated kitchen staff were continuously educated about sanitation and proper food storage. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 5/27/25 at 12:05 PM, an observation was made of the lunch meal service in the resident's hallway. The meal cart was centered in the hallway between rooms 109-111. Meals were delivered from that central point. A drink cart was parked next to the meal cart.<br><br>At 12:06 PM, a tray was delivered to room [ROOM NUMBER]. The resident's meal was delivered with lemonade uncovered.<br><br>At 12:09 PM, the meal cart was moved to between rooms 117-119.<br><br>At 12:15 PM, a tray was delivered to room [ROOM NUMBER]. The resident's meal was delivered with milk and juice uncovered.<br><br>On 5/28/25 at 8:13 AM, a brief observation was made during the breakfast meal service in the resident's hallway. Two trays were observed to be delivered to room [ROOM NUMBER]. The juice on the trays were uncovered. Additionally, the dietary aide left the room and returned with a cup of milk and a cup of coffee that were both uncovered.<br><br>At 8:17 AM, a tray was delivered to room [ROOM NUMBER] with a pre-packaged container of cold cereal that had been opened and was uncovered.<br><br>On 5/28/25 at 12:10 PM, an observation was made of the lunch meal service in the resident's hallway between rooms [ROOM NUMBERS].<br><br>At 12:15 PM, a tray was delivered to 121 with the soup uncovered. The dietary aide shook a bottle of milk that resulted in water condensate splashing into the soup.<br><br>At 12:18 PM, a tray was delivered to room [ROOM NUMBER] with the soup uncovered. Milk and peach tea were observed to be uncovered.<br><br>Based on observation, interview, and record review, it was determined the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Specifically, during medication pass a staff member was observed to place her bare fingers inside the medication cups prior to administering medications to residents. Additionally, during hallway meal pass, drinks, cold cereal and soup were observed to be transported uncovered to residents. Resident identifiers: 10, 11 and 12.<br><br>Findings included:<br><br>1. On 5/28/25 at 7:15 AM during morning medication pass the following was observed:<br><br>a. At 7:17 AM, Registered Nurse (RN) 1 was observed to touch the computer keyboard, the computer mouse, and the medication cart keys. RN 1 was observed to then pick up a medication cup and place her bare thumb inside the medication cup. RN 1 was then observed to place resident 12's medications inside the cup. RN 1 was then observed to administer the medications to resident 12.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. At 7:23 AM, RN 1 was observed to pick up a medication cup and place her bare thumb inside the medication cup. RN 1 was then observed to place resident 11's medications inside the cup. RN 1 was then observed to administer the medications to resident 11.<br><br>c. At 7:41 AM, RN 1 was observed to pick up a medication cup and place her bare thumb inside the medication cup. RN 1 was then observed to place resident 10's medications inside the cup. RN 1 was then observed to administer the medications to resident 10.<br><br>On 5/28/25 at 8:26 AM, an interview was conducted with RN 1. RN 1 stated that you should never touch the inside of the medication cup before administering medications to residents because it wasn't sanitary.<br><br>On 5/28/25 at 1:40 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that at no time should a nurse touch the inside of a medication cup with bare hands and if this happened the nurse should use a new medication cup. |