STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515197	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Crystal Springs	200 Whitman Avenue Elkins, WV 26241

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50801 Based on observation and staff interview, the facility failed to allow residents to have a dignified existence related to having an uncovered catheter bag. This failed practice was a random opportunity of discovery. Resident identifier: #23. Facility census: 77 Findings included: a) Resident #23 On 03/03/2025 at 2:46 PM, during a resident interview, it was observed that Resident # 23's catheter bag did not have a bag cover. On 03/03/25 at 2:44 PM the LPN acknowledged the catheter bag was not covered. During an interview, on 03/05/2025, at approximately 3:45 PM, the facility administrator stated the facility had purchased enough catheter bag covers for all needed residents but did not know why Resident # 23 did not have one

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50795 Based on observation and interviews, the facility failed to display notices regarding the availability of survey results, and the related plans of correction, in areas that are prominent and easily accessible to residents and their representatives. Facility census: 77. Findings include: a) Observation on 03/04/25 at approximately 10:55 AM, revealed there was no signage posted indicating the availability of the survey results for residents to review. After being notified of this lapse, on 03/04/25 at approximately 11:30 AM, the Administrator indicated that the survey results were available for review in a binder located on the table near the entrance of the facility. During a resident council meeting on 03/05/25, at approximately 2:05 PM, when resident council members were asked, Do you know where the facility survey results are? Resident #5 stated, That's not our business; that's for the staff! The Assistant Director of Nursing (ADON) confirmed on 03/05/25 at approximately 2:30 PM that there was no posted notice identifying where residents or their representatives could review the survey results. During a meeting with the Administrator, on 03/05/5 at 3:18 PM, the Administrator addressed Resident #5's response to a question about the survey results. The Administrator noted that they had a meeting last year and explained to the residents what survey tags were and what they were doing to correct each of them following the last annual survey. The Administrator said the current resident council president was not a resident at that time. The Administrator also said they had discussions in resident council with residents about being involved in the healthcare information of others.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50801 Based on record review and staff interview, the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC) letter to one (1) of three (3) residents reviewed during the annual survey process. This failure placed residents at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident identifiers: #333, #334, and #335. Facility census: 77. Findings Included: a) Resident #333 On 02/19/25 at 2:15 PM, a review was completed regarding the beneficiary protection notification liability notices given for the following resident: Resident #333 began Medicare Part A skilled services on 01/07/25. The last covered day of Part A service was 02/08/25. There was no evidence that a NOMNC form was provided. Review of the social worker's social service notes to Resident # 333's daughter, dated 02/06/25, verified a planned discharge. The note stated, This worker updated (Resident #333) on upcoming discharge that PT/OTwill be put in the home and Lincare is dropping resident off an oxygen tank to have on Saturday after discharge. In an interview on 02/20/25 at approximately 1:10 PM, the Administrator stated the facility was unable to provide verification the NOMNC form was given to Resident # 333.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50801 Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment. Resident #34's bathroom wall was not in good repair. This was a random opportunity for discovery. Resident identifier: #34. Facility census: 77. Findings included: a) Resident #34 Upon entering Resident #34's bathroom on 03/06/25 at approximately 9:20 AM, an immediate observation found one (1) rectangle shaped tear approximately 11 inches wide by 8 inches long in the dry wall on the left wall area, to the left side above the sink. On 03/06/25 at 9:25 AM, during an interview with Registered Nurse (RN) #5 she acknowledged there was a tear in the drywall on the bathroom wall left of the sink. She said she would notify maintenance for repair schedule.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50795 Based on observation and interviews, the facility failed to established a grievance policy that meets essential requirements. Specifically, it failed to: Notify residents individually or provide clear postings throughout the facility about their right to file a grievance. The facility did not provide easy access to grievance forms. They facility did not notify residents of the right to file a grievance anonymously. Additionally, the facility did not provide easily accessible and clearly presented contact information for independent entities where grievances can be filed, such as the appropriate state agency, Quality Improvement Organization, State Survey Agency, and State Long-Term Care Ombudsman programs. Facility Census: 77 Findings include: a) On 03/03/25, at around 2:00 PM, it was observed that there were no posted notices informing residents about their right to file a grievance, including the option to do so anonymously. Further investigation indicated that residents had been directed to submit any complaints or grievances directly to the administrator. During an interview with Resident #14 on 03/03/25 at approximately 2:08 PM, when asked how she would file a complaint, she responded, I'll talk to the nurse, I guess! During another interview with Resident #26 on 03/03/25 at 2:45 PM, the resident stated that he would have to request a grievance form. On 0303/25, at approximately 3:00 PM, the administrator stated during an interview that the contact information for submitting a grievance was prominently displayed on the facility's TV screens in large text, making it visible to everyone. Further investigation revealed that the TV screens displayed various messages in a continuous loop. Observation showed that the following message appeared approximately every two and a half minutes: Questions, comments, or concerns Call our compliance hotline 1-888-983-7080 Compliance is everyone's responsibility Help us improve our care See something, Say something (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The administrator insisted the message was visible to all residents and they could call in their complaints or grievances. During an interview, with the Assistant Director of Nursing (ADON) on 03/04/25, at approximately 10:45 AM, the ADON confirmed that the sign stating Resident Rights was posted too high for a person using a wheelchair to read. During a Resident Council Meeting on 03/05/25 at approximately 2:05 PM, when asked how residents would file a grievance, the Resident Council President (RCP) stated that you write a letter. During an observation on 03/03/25 at approximately 2:00 PM, it was noted that there were no postings indicating where grievance forms were located. Additionally, there were no grievance forms readily accessible for residents to file concerns anonymously. Further investigation revealed that residents had been instructed to submit complaints or grievances to the Administrator. During an interview with the administrator on 03/03/25, at approximately 3:00 PM, the administrator stated that the contact information for submitting a grievance was displayed in large text on the TV screens throughout the facility, making it visible to everyone. When asked how a resident could file a grievance in writing, the administrator explained that grievance forms were available at the nurses' station and that residents could request one whenever needed. A follow-up interview with the administrator revealed that completed grievance forms could be submitted at the nurses' station or dropped off at the administrator's office. When asked how a resident could submit a grievance anonymously, the administrator explained that residents could call the compliance number displayed on the TV screens throughout the facility. During a Resident Council Meeting on 03/05/25 at approximately 2:05 PM, when asked how residents could file a grievance, the Resident Council President (RCP) stated, You write a letter. During a resident council meeting on 03/05/25, at approximately 2:05 PM, the Resident Council President (RCP) was asked how residents could file a grievance. The RCP responded, You write a letter. When inquired about how someone could file a grievance anonymously, she replied, I don't care; I tell them what I want! Upon being asked again how someone who wished to remain unidentified could file a complaint, the RCP stated, You just write a letter and slide it under the Administrator's door! You don't sign it! On 03/05/25, at around 3:00 PM, the Administrator confirmed during an interview that grievance letters could be submitted anonymously by sliding them under her door. However, she noted that the facility is small and that everyone can be easily observed, which limits true anonymity. d) No easily accessible location to submit a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/25, it was observed that there was no lockbox or designated location for residents to drop off grievance forms. During an interview on the same day at approximately 11:25 AM, the ADON mentioned that there was a box located in the lobby. However, upon inspecting the box, it was found to be a small container labeled Suggestions that was fixed to the wall. The ADON confirmed that it was not possible to insert any documents into this box.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to ensure the resident's Pre-Admission Screening (PAS) was updated after a new diagnosis. This was true for two (2) out of three (3) residents reviewed for the category of PASARR (Pre-Admission Screening and Record Review, during the Long-Term Care Survey Process. Resident identifiers: #23, #28 and #27. Facility census: 77. Findings included: a) Resident #28 - A PAS, completed on 01/04/18, marked Mental Retardation under Section III Question 30 entitled, Current Diagnosis . Additionally, Section IV Question 37 entitled, Diagnosis included the following: Spontaneous rupture of flexor tendons, right lower leg. Fracture of unspecified part of scapula, left shoulder, initial encounter for closed fracture. essential (primary) hypertension. Mild intellectual disabilities Anxiety disorder, unspecified. A medical record review, completed on 03/04/25 at 9:18 AM, revealed Resident #28 had a diagnosis of: Unspecified Psychosis Not due to due to a substance or physiological condition with onset date of 06/08/21 and Major Depressive Disorder, Single Episode with an onset of 06/02/21. During an interview, on 03/05/25 at 11:23 AM, the Director of Social Services reported that no new PASARR had been completed after the new diagnosis. b) Resident #27 A medical record review, completed on 03/04/25 at 9:45 PM, revealed Resident #27 had a diagnosis of: Unspecified Psychosis not due to due to a substance or known physiological condition with onset date of 06/22/21. A PAS, completed on 03/21/24, marked NONE under Section III Question 30 entitled, Current Diagnosis . Additionally, Section V Question 40 entitled, Major Mental Illness or Suspected MI was marked NONE, During an interview on 03/05/25 at 11:23 AM, the Director of Social Services reported that new PASARR had been completed after the new diagnosis but failed to capture the diagnosis. c) Resident #23 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review, completed on 03/04/25 at 9:07 AM, revealed Resident #23 had been admitted to the facility on [DATE] with the following diagnoses: -Major Depression Disorder -Schizoaffective Disorder A PAS, completed on 11/27/24, marked NONE under Section III Question 30 entitled, Current Diagnosis (Check all that apply). Additionally, Section V Question 40 entitled, Major Mental Illness (MI) or Suspected MI - Major Depression Disorder was not marked. During an interview on 03/05/25 at 11:23 AM, the Director of Social Services reported that resident's Major Depression Disorder diagnoses had not been captured on the 11/27/24 PAS and a new one had not been completed.

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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** 50551 Based on resident interview, staff interview and record review the facility failed to provide evidence that residents were invited to care plan meetings in order to participate in planning for her their own care. This was true for Resident #15. Facility census: 77. Findings included: a) On 03/03/25 at 3:41 PM during an interview with Resident #15, she reported that she had never been asked to attend her care planning meetings. She reported that she did not feel she was a part of the decision making process for her care. On 03/05/25 at 3:14 PM an interview was conducted with Facility Administrator who reported that they do not have documentation to support that Resident #15 had been invited to care plan meetings. She stated that the facility, was cited for this last time and they were doing what they were supposed to but do not have current documentation that they have been doing this. A review of Minimum Data Set MDS assessment dated [DATE] Section Q, Participation in Assessment and Goal Setting, question A. Resident #15 responded Yes indicating that she would like to be included in this process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 42120 Based on medical record review, observation, and staff interview, the facility failed to ensure Resident's received treatment and care in accordance with professional standards of practice. Resident #68's nebulizer treatment was left running for 20 minutes longer than it should have been. A resident was receiving oxygen at a rate that was not prescribed. Resident #22 did not receive blood sugar monitoring as required by physician order. Resident #28 was identified as a fall risk and had an order for their bed to be in the lowest posiotion did not have their bed in that position. Resident #85 had a seizure disorder and an intervention for padded side rails did not have padded side rails in place. Resident #8, #68, #22, #28, and #28. Facility census: 77. Findings included: a) Resident #68 An observation of Resident #68, on 03/04/25 at 8:55 AM, revealed the Resident was lying in bed receiving a nebulizer treatment (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs.) The nebulizer medication cup was empty at this time. During an Interview on 03/04/25 at 9:29 AM, The Director of Nursing (DON) verified the nebulizer treatment was still running after 40 minutes. She stated that the Treatment should have only been on for about 20 minutes. b) Resident #8 An observation, on 03/04/25 at 10:23 AM, found Resident #8 was receiving oxygen at three (3) Liters via nasal cannula (LPM) from an oxygen concentrator (an oxygen delivery device). A review of Resident #8's medical record revealed a Physicians order for: -Oxygen at 1-2 LPM via Nasal Cannula as needed Post Treatment Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds with an order date 7/11/2024. An observation on 03/06/25 at 9:53 AM found the Resident #8 was receiving oxygen at two (2) Liters via nasal cannula (LPM). During an Interview, on 03/06/25 at 10:00 AM, the Director of Nursing verified an Oxygen order was incorrect with the flow liter. She stated that she would notify the physician for a accurate order. 50551 50795 c) Resident #22 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review and interview on 03/04/25 at 11:18 AM revealed that Resident #22 had been admitted to the hospital on 03/03/25 at approximately 6:15 PM, and returned back to the facility at approximately 9:15 PM on 03/03/25. Record review revealed a physician's order dated 02/12/25, which stated the following: Accu-Chek before meals and at bedtime for diabetes. Insulin Lispro 100 UNIT/ML Solution Inject subcutaneously before meals and at bedtime insulin Lispro 100 UNIT/ML Solution Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451 - 600 = 14 units, subcutaneously before meals and at bedtime Further record review revealed the following historical Accu-Chek results at bedtime: 03/03/25 at 8:04 PM 268.0 mg/dL - Struck out - Clerical correction 03/03/25 at 8:04 PM 268.0 mg/dL - Struck out - Clerical correction 03/02/25 at 9:15 PM 233.0 mg/dL 03/01/25 at 8:42 PM 234.0 mg/dL 02/28/25 at 8:00 PM 195.0 mg/dL 02/27/25 at 8:55 PM 256.0 mg/dL 02/26/25 at 9:49 PM 320.0 mg/dL (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 03/04/25, at approximately 11:25 AM, the DON stated the records would indicate the resident was not in the facility at 8:00 PM for the regular bedtime Accu-Chek. She further mentioned that the resident's blood glucose was not checked after arriving at the facility because it had already been checked at the hospital prior to discharge. A review of the hospital's discharge summary revealed that the resident's blood glucose level was checked in the hospital on 03/03/25 at 6:34 PM, and it was recorded as 138 mg/dL. The resident returned to the facility at 9:15 PM on 03/03/25. Upon return, records show that the resident was allowed to go to bed without her blood glucose being checked. 50801 d) 28 The facility failed to ensure padding was installed on bed rails due to Seizure precautions, as ordered by his physician. On 03/03/25 at 2:49 PM, during an interview with Nurse Aide (NA) #85, he acknowledged the padding had not ben installed on the resident's bed rails. A physician's order dated 11/27/24 indicated the resident was to have seizure precautions at all times. Padded rails for safety every shift. d) Resident #28 Review of care plan on 03/05/25 at 10:11 AM revealed the following: Focus- Risk for falls related to history of falls, receives antidepressant medications daily. Fracture to right hand on 10/02/24. Date initiated 01/07/25. Interventions included Keep bed at lowest level at all times. initiated on 01/07/25. On 03/05/25 at 01:20 PM observation of Resident #28 lying in bed with non-skid socks, 1/4 assist rails up and his bed in a high position. On 03/05/25 at 01:28 PM during an interview with Nursing Assistant (NA) #83 to inquire about resident's bed position the resident was lying in bed with non-skid slippers. NA #83 stated that she did not know if his bed was in the lowest position. She used the bed control and moved the bed down to lowest position. She acknowledged that the bed had not been in lowest position. During an interview with Licensed Practical Nurse #89 on 03/06/25 at 10:48 AM LPN #89 said that Resident #28 should have his bed in lowest position at all times.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50801 Based on observations, staff interviews, and record review, The facility failed to ensure two (2) of two (2) resident environments were free from accident hazards for which it had control. Resident identifiers: #23 and #34. Facility census: 77. Findings included: a) Resident #23 On 03/03/25 at 02:46 PM It was observed there were no fall mats at Resident #23 bedside per physician orders. 03/03/25 at 2:48 Nurse Aide (NA) #85 acknowledged there were no fall mats on the floor at resident #23's bedside. Physician Order dated 11/27/25 indicated: Fall Mats were to be located at bedside while Resident #23 was in bed. A Care Plan review revealed: Risk for fall R/T (related to) S/P (status post) CVA. Contractures right knee and left hip. Unable to ambulate on own or transfer self in/out of bed. b) Resident #34 During an observation in Resident # 34's room, on 03/06/2025 at 9:20 AM, a 6 fluid ounce bottle of Derma-[NAME] containing Hydro-Cortisone Cream was found in Resident 34's bathroom. A subsequent record review revealed there was no physician order stating that Resident #34 could administer her own medication. In addition, there was no physician order for the bottle of Derma-[NAME], which had been found in the resident's possession. c) Material Safety Data Sheet (MSDS): Review of the MSDS revealed the following information: -This product is not meant for oral consumption or for ophthalmic use. -Inhalation: May cause irritation of nose and throat -Ingestion: May be harmful if swallowed -Skin Contact: May cause slight irritation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Crystal Springs	200 Whitman Avenue Elkins, WV 26241

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Eye Contact: Will cause irritation to the eyes During an interview on 03/06/25 at 9:25 AM, Registered Nurse (RN) #5 verified the Derma-[NAME] with Hydrocortisone was in resident's room and stated it should be removed from the resident's room.

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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. 50801 Based on record review and staff interviews, the facility failed to have Sufficient and Competent staffing due to the lack of RN coverage for eight (8) consecutive hours a day for eight (8) of eight (8) sampled days. Findings included: a) On 03/04/25 at approximately 2:25 PM the administrator reported the facility did not have the eight (8) consecutive hours a day Registered Nurse (RN) coverage for the following sampled days: -Sunday, 07/07/24 -Sunday, 07/21/24 -Sunday, 08/04/24 -Sunday, 08/18/24 -Saturday, 09/14/254 -Sunday, 09/15/24 -Saturday, 09/28/24 -Sunday 09/29/24 The payroll based journal (PBJ) report review revealed there was no RN coverage on the days listed above.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 50801 Based on observation and staff interview the facility failed to ensure the updated staffing information was posted. Facility census: 77. Findings included: a)The facility failed to post an updated staffing report sheet for 03/03/2025. On 03/03/25 at 11:35 AM, Upon entrance to the facility the posted daily staffing report sheet had not been updated for 5 days. The daily staffing report sheet was dated 02/26/2025 actual date of entry was 03/03/2025. 03/05/25 at10:54 AM In an interview with the DON, she acknowledged that on Monday 03/03/25, the Daily Staffing report sheet was dated 02/26/25. The Facility failed to post the census on the nurse staffing data at the beginning of each shift for eight (8) of eight (8) sampled days. Not listed for the 7:00 PM - 7:00 AM shift: -Sunday, 07/07/24 -Sunday, 07/21/24 -Sunday, 08/04/24 -Sunday, 08/18/24 -Saturday, 09/14/54 -Sunday, 09/15/24 -Saturday, 09/28/24 -Sunday 09/29/24 In an interview 03/05/2025 at 10:45AM, the DON confirmed census was not listed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43340 Based on observation, staff interview, and food tray temperatures the facility failed to serve food to residents that was at an appetizing temperature. This failed practice was true for one (1) of one (1) hallways tested for food tray temperatures throughout the Long-Term Care Survey Process. Facility census: 77. Findings included: a) South Side Front Hall Lunch Time Meal Observation During an observation on 03/03/25 at 12:15 PM, it was noted that food carts were brought out of the south side nurses' station. One staff member began to feel cups with the appropriate beverages according to residents' dietary slips. Another staff member began delivering meals. At 12:37 PM, meal service / delivery began on the south side front hall. At 12:43 PM, when four (4) trays were left on the food truck, the Surveyor requested that Nurse Aide (NA) #85 select one tray that would be served last. NA #85 selected Resident #39's tray. On 03/03/25 at 12:49 PM, the Dietary Manager tested the temperature of Resident #39's lunch tray with the following results: -Hotdog: 104.9 degrees Fahrenheit (F) -Fries: 108.1 degrees F -Pineapple Cake: 62.6 degrees F -Yogurt: 59.3 degrees F The Dietary Manager agreed the food temperatures obtained were not considered to be the appropriate desired temperature for the point of delivery to the residents. It was discussed that hot foods would typically be served at 120 degrees F or above and cold foods would be served at 40 degrees F or below. The Dietary Manager stated the food is always 135 degrees or above when it leaves the kitchen and that she was not sure what it ended up being when it was delivered to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on observation, interview and policy review, the facility failed to properly store food in accordance with professional standards. This is true for the facility kitchen and nourishment pantry. This had the potential to affect all residents in the facility. Facility census 77. Findings included: a) On [DATE] at 11:27 AM, during Initial Brief Tour of Kitchen, with Kitchen Account Manager #44 who acknowledged the following in Freezer #1 with no dates: Bag of unopened frozen chicken breasts. Bag of opened fish filets. Bag of opened fish patties. Bag of opened french fries. On [DATE] at 1:00 PM a review facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. b)Freezer #1 also contained frozen foods that KAM #44 reported had belonged to a resident who was no longer in the facility, there were no names written on the food boxes and the best by dates were as follows: Gardein Ultimate Plant based chicken filet with a best by date of [DATE]. Gardein Ultimate Turkey and gravy with best by date of [DATE]. On [DATE] at 1:00 PM a review facility policy labeled HCSG Policy 019, Food Storage: Cold Foods. Procedures, number 5 stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. c)[DATE] 11:30AM Observation of North Hall Pantry: -Oreos and packaging in a ziplock bag in cabinet- not sealed, no date or name -Freezer ziplock bag full of prepackaged cookies and cakes with no date that included *2 fudge rounds- undated *2 gram crackers - undated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*6 [NAME] Soft Baked Sugar free lemon cookies with best by date of [DATE], 5 dated [DATE], and 7 with no date. *2 undated small baggies of animal crackers- undated and not labeled -24 Bowls of dry cereal with lids with no expiration dates On [DATE] at 11:40AM, during an interview with the Kitchen Manager it was reported the kitchen brings new food from the kitchen and it was housekeeping responsibility to dispose of expired food. On [DATE] at 11:50AM, during an interview with the DON, it was acknowledged that the cookies had expiration dates, and the cereal had no dates. She acknowledged that the staff drinks and food should not have been in the pantry. On [DATE] a review of facility policy marked HCSG Policy 018 Food Storage: Dry Goods, listed under procedures number six (6) stated: 'Storage areas will be neat, arranged for easy identification, and date marked as appropriate. d)On [DATE] at 11:33 AM observed Resident nourishment room cabinet contained staff keys, two (2) [NAME] drink cups, three (3) opened canned drinks, an open bottle of soda, a to-go cup with drink, and an open bag of BBQ snacks. On [DATE] at 9:00 AM observed a sign on the outside of the nourishment room that stated: Do not put personal food and drink in the kitchenette. Room is only to be used for food/drink for residents. On [DATE] at 11:50AM, Interview with DON who acknowledged the cookies with expiration dates, as well as cereal with no dates. She acknowledged that the staff drinks and food should not have been in the pantry.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 50551 Based on observation and staff interview it was determined that the facility failed to ensure they disposed of garbage and refuge properly. The facility failed to ensure garbage and refuse containers were in good condition and waste was properly contained in dumpsters or compactors with lids or otherwise covered. This practice had the potential to affect more than an isolated number of residents. Facility census: 77. Findings included: a) On 03/03/25 at 1:35PM during the tour of the facility, the dumpster was observed with one lid open and one lid that was broken and did not fit properly. On 03/03/25 at 1:40PM during an interview with Kitchen Account Manager #44 who acknowledged the dumpster lids should be closed and properly fitting. On 03/06/25 at 1:05 AM, a review of document title HCSG Policy 030, Policy Statement All garbage and refuse will be collected and disposed of in a safe and efficient manner. Procedures # two (2), The Dining Services Director will ensure that appropriate lids are provided for all containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on observations and staff interviews, the facility failed to 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 diseases and infections with regards to the water management, PPE, resident hand washing, resident's personal products and unsanitary practices. This practice had the potential to affect all residents that reside in the facility. Resident identifiers: #26, #24, #30, #40, #46, #53, #70, #74, and #285. Facility census: 72. Findings included: a) Hand Hygiene Prior to Meals An observation on 03/03/25 at 12:15 PM revealed that the resident's on north hall did not receive hand hygiene prior to or during the lunch meal tray pass. During an interview, on 03/03/25 at 12:26 PM, Nursing Assistant (NA) #16 was asked if the residents on the north hall had their hands washed or sanitized prior to the lunch meal on this day. NA #16 stated she was not sure if they had hand hygiene before lunch. NA #16 stated some residents get their hands washed in the resident rooms during AM care, and some residents wash their own hands. During lunch service on 03/03/25 at approximately 12:45 PM, It was noted that Nursing Assistant (NA) #71 did not offer hand sanitizer to Residents # 30, #40, #46, #53, #70, and #74. Upon being asked why the residents had not been offered hand hygiene prior to eating their meal, NA #71 stated Well if I could find sanitizer, I would have used it! During an interview with Licensed Practical Nurse (LPN) #39, at approximately 1:11 PM she stated We have plenty of sanitizer!, and produced two containers of hand sanitizer. LPN #39 confirmed that the residents had not been offered hand hygiene. On 03/03/2025, at 12:48 PM, it was observed, On the south wing of the facility, while delivering the residents lunch trays, CNA # 85 did not wash or sanitize any of the resident's hands. In and interview with CNA # 85, on 03/03/2025 at 12:52 PM, he acknowledged he did not offer to wash or sanitze the residents hands before he served them On 03/05/2025 at approximately 3:30 PM, the DON acknowledged the CNA's should have been offering to sanitize or wash the resident's hands before serving them. b) Water Management Plan (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During facility record review of the water management revealed, the documentation was not maintained to prevent growth of water borne pathogens including description of the building water system. The flow diagram did not Identify the buildings water systems for which Legionella control measures are needed. No documentation was provided for weekly water flushes for dead legs, unused showers, water fountains and bathtubs. On 03/05/25 at 1:07 PM the Maintenance Director verified the facility did not maintain the water management program. He stated that it would be corrected. 50795 c) Resident #24 During an observation of wound care on 03/04/25, at approximately 3:30 PM, Wound care was administered to Resident #24 by Nurse Practitioner (NP) #104 and Registered Nurse (RN) #5. During this procedure, RN #5 and NP #104 assessed, turned, and repositioned the resident to be able visualize his wounds. However, neither NP #104 nor RN #5 donned personal protective equipment (PPE) during the process. Resident is a bilateral amputee. The resident's right lower thigh has a ligature scar that is in the process of healing, and his suture line showed an area of dehiscence about 2 inches long, with light drainage. NP #104 stated that she would notify the surgeon that the resident has to be seen immediately. NP #104 and RN #5 continued turning resident in his bed to better visualize and document his wounds. They then continued would care, still without donning any PPE d) Resident #26 On 03/04/25, at approximately 3:25 PM, NP #104 and RN #5 were providing wound care to Resident #26. However, neither NP #104 nor RN #5 were wearing personal protective equipment (PPE) during the procedure. They then proceeded to turn and reposition the resident in order to address the wounds on the resident's back. NP #104 wore an instrument pouch around her waist. She used a pair of scissors to cut the resident's dressing and then returned the scissors to her pouch without cleaning or disinfecting them. During an interview with the Assistant Director of Nursing (ADON) on 03/04/25, at approximately 3:45 PM, it was reported that both Nurse Practitioner #104 and Registered Nurse #5 were not wearing personal protective equipment (PPE). The ADON stated that she would investigate the situation and follow up regarding why the staff were not wearing PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 3:55 PM, the ADON returned and confirmed that NP #104 and RN #5 were performing wound care without following barrier precautions. The ADON noted that NP #104 and RN #5 had not put on personal protective equipment (PPE) because there was no sign indicating that Enhanced Barrier Precautions (EBP) were required outside the doors of Resident #24 and Resident #26. The ADON verified that both residents were under Enhanced Barrier Precautions and stated that she had posted a new EBP notice on the door. She further stated that education on infection control would be implemented immediately. A note by NP #104 on 03/05/25 at approximately 3:55 PM stated: Recommended to ADON to contact surgeon regarding small wound dehiscence with purulent drainage. Dark area to the left of dehiscence is concerning but is covered by eschar. The resident's wound is healing. Continue the current treatment plan. Wound care to follow. e) Resident #285 During an inspection of Resident #285's room on 03/04/25, at approximately 1:20 PM, the bathroom was observed to have a toilet seat in the bathtub, with a brown substance splattered on it. Licensed Practical Nurse (LPN) #107 confirmed that the toilet seat should not have been left in the bathtub. She stated that she would contact the housekeeping department to have it removed. On 03/05/25 at approximately 1:34 PM an inspection of Resident #285's bathroom revealed the toilet seat with the brown substance still in the bathtub. LPN #89 confirmed that it should be removed and housekeeping should be directed to remove the toilet seat. Housekeeping staff removed the toilet seat a few minutes later. f) room [ROOM NUMBER] An observation of room [ROOM NUMBER], which had no occupant, on 03/05/25 at approximately 1:30 PM revealed an IV pump with a tube feed still connected. The tube feed still had residual solution in the bag and tube. The bag was dated 02/23/25. A container one third (1/3) full of tube feed solution was observed on the side table. Further investigation revealed that the resident had been admitted to the hospital on 02/25/25. LPN #89 confirmed that the room should have been cleaned ,and the tube feed discarded. She further stated the tube feed solution could have grown all kinds of organisms. During an interview with the ADON on 03/05/25, at approximately 2:00 PM, the ADON stated the resident was transferred to the hospital, and the bed was being held because he was expected to come back to the facility soon. ADON further stated that the room should have been cleaned after the resident had left for the hospital on 02/25/25. ADON notified the housekeeping department to clean the room immediately. 50801 g) Shower Room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/25 at 09:11 AM, during facility water temperature tests with the Maintenance director, it was observed that several bottles ot hygiene products were left in the shower rooms without labels with names or dates. In an interview with the Administrator and DON present on 03/05/2025, at approximately 4:15 PM, they both acknowledged the bottles of hygiene products should not have been in the shower rooms without labels/dates.