STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525389	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehabilitation Center	1445 N 7th St Manitowoc, WI 54220

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure a resident representative was notified of a change in condition for 1 resident (R) (R4) of 13 sampled residents. R4 was diagnosed with yeast in the urine and had an order for antibiotic treatment. R4's Power of Attorney for Healthcare (POAHC) was not notified of the change in condition or antibiotic treatment. In addition, R4 had low blood pressure readings on 5/10/25 and 5/11/25. R4's physician and POAHC were not notified. Findings include: The facility's Notification of Changes policy, revised 3/31/25, indicates: The purpose of this guideline is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Changes of condition require an evaluation .and ensures proper documentation and notification has been made .2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications, c. Critical lab values. 3. Circumstances that require a need to alter treatment may include: a. New treatment, b. Discontinuation of current treatment due to: i. Adverse consequences, ii. Acute condition, iii. Exacerbation of a chronic condition .Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify the resident's representative, if known .When a resident is mentally competent, a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident . On 6/20/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, diabetes mellitus type 2, and pressure ulcer of sacral region stage 4. R4's Minimum Data Set (MDS) assessment, dated 5/9/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. R4 had an activated POAHC who was responsible for R4's healthcare decisions. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 8:38 AM, Surveyor interviewed R4's POAHC (POAHC-H) who indicated POAHC-H was not informed about the results of a second urine test ordered for R4 or any treatment from the result. POAHC-H indicated the next time POAHC-H was notified of any changes was on 5/11/25 when R4 was going to be transferred to the hospital. POAHC-H indicated POAHC-H did not know when the facility received the results or what the facility was doing for R4's infection. R4's medical record indicated R4 had increased confusion on 5/8/25 that was documented by Registered Nurse (RN)-I. The physician was updated and ordered a urinalysis (UA) and urine culture (UC). R4's medical record indicated POAHC-H was updated on the order to obtain a UA/UC. The UA/UC results indicated R4 had an infection of yeast in the urine. R4's medical record did not indicate POAHC-H was updated on the result. A progress note, dated 5/8/25 at 10:29 PM by RN-J, indicated R4 was prescribed fluconazole (an antifungal medication) 200 milligrams (mg) daily for 14 days for a candidal urinary tract infection (UTI). R4's medical record did not indicate POAHC-H was notified of the fluconazole order. A clinical summary documentation, dated 5/9/25 at 10:15 AM by Assistant Director of Nursing (ADON)-K, indicated R4 had a new order for an antifungal medication due to a candidal UTI. The documentation did not indicate POAHC-H was notified. R4's medical record contained the following low blood pressure readings: ~On 5/10/25 at 5:03 PM - 83/47 millimeters of mercury (mmHg) ~On 5/10/25 at 6:32 PM - 89/52 mmHg ~On 5/11/25 at 8:18 AM - 88/56 mmHg R4's medical record did not indicate R4's physician or POAHC-H were notified of R4's low blood pressure readings. R4's medical record indicated POAHC-H was notified on 5/11/25 when R4 was unresponsive to verbal or touch stimuli and was transferred to the hospital. On 6/20/25 at 12:20 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated POAHC-H was notified of R4's UA, UTI, and treatment which was documented in the facility's McGeer's tracking assessment. Surveyor reviewed McGeer's infection symptom tracking documentation completed by DON-B that was a late entry with an effective date of 5/9/25 and a signed date of 5/19/25. The documentation indicated POAHC-H was notified on 5/9/25. On 6/20/25 at 12:40 PM, Surveyor interviewed DON-B and reviewed R4's low blood pressure readings. When asked if R4's physician and POAHC-H were notified of the low blood pressure readings, DON-B indicated R4's physician and POAHC-H were not notified but should have been. DON-B also indicated the nurse should have questioned the blood pressure readings. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/25 at 3:37 PM, Surveyor interviewed ADON-K who verified ADON-K did not notify POAHC-H of the antifungal order because ADON-K was not the one who received the order. ADON-K indicated RN-J received the order and should have notified POAHC-H. ADON-K verified the physician should be updated if a resident has a low blood pressure reading. ADON-K indicated the facility's standing order on blood pressure is to notify the physician if the systolic number (top) is less than 90 or greater than 180 and the diastolic number (bottom) is greater than 90. On 6/20/25 at 4:04 PM, Surveyor again interviewed POAHC-H who indicated POAHC-H was aware the facility was going to do another UA for R4, however, the facility did not follow-up with the results of the UA and did not notify POAHC-H of any new orders. POAHC-H did not recall DON-B updating POAHC-H on 5/9/25 with the UA results and treatment and indicated POAHC-H would have remembered being notified. POAHC-H indicated the next tine POAHC-H was notified about anything was on 5/11/25 when R4 was transferred to the hospital.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on staff and resident interview and record review, the facility did not ensure adequate supervision was provided for 1 resident (R) (R2) of 1 resident reviewed for elopement. An elopement risk assessment, dated 1/31/25, indicated R2 was at risk for elopement. A WanderGuard (a security device that triggers an alarm if the wearer exits the facility) was placed on R2's left ankle. On 6/12/25 at 3:10 AM, R2 eloped from the facility and was found at approximately 3:55 AM approximately two miles from the facility. An investigation determined R2 exited the facility through the 200 wing door which had an alarm that sounded, however, staff were unable to hear the alarm because they were in residents' rooms providing care. Staff did not respond to the alarm until approximately 3:15 AM. The facility's failure to provide adequate supervision for a resident assessed to be at risk for elopement created a finding of immediate jeopardy that began on 6/12/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 6/20/25 at 3:52 PM. The immediate jeopardy was removed on 6/20/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Elopements and Wandering Residents policy, dated 2/20/23, indicates: .1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner .4 .Adequate supervision will be provided to help prevent accidents or elopements. On 6/20/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including paranoid schizophrenia, epilepsy, panic disorder, anxiety, and depression. R2's Minimum Data Set (MDS) assessment, dated 5/6/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R2 had severely impaired cognition. R2 had a Guardian. A care plan, revised on 6/12/25, indicated R2 was at risk for elopement and wandering. R2 had a WanderGuard due to impaired cognition and exit-seeking behavior. The care plan also indicated R2 was at moderate risk for falls due to the use of assistive devices, decrease in muscle coordination, and a history of multiple falls in the facility. On 6/20/25, Surveyor reviewed R2's nursing progress notes for history of elopement/exit seeking behaviors and noted the following: ~ On 9/16/24, staff responded to a door alarm and noted R2 was attempting to exit and stated R2 needed to get to the parking lot and go home. ~ On 12/27/24, R2 exit sought throughout the day, walked fast to the front of the building, and tried to exit the front door. R2 was difficult to redirect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ On 1/31/25, R2 eloped out the 500/600 wing exit and was found almost a mile away from the facility. R2 had an unwitnessed fall during the elopement that resulted in scrapes and bruising to R2's right knee. ~ On 2/6/25, R2 attempted to open the 200 wing door and stated R2 wanted to leave. ~ On 3/25/25, R2 attempted to the leave the facility for the seventh time and was redirected on several occasions. ~ On 4/20/25, R2 exhibited signs of anxiety, paced back and forth, attempted to exit the facility, and wandered off the unit several times. Surveyor reviewed the facility's investigation which indicated on 6/12/25 at approximately 3:10 AM, R2 exited the facility through the 200 wing door. At approximately 3:15 AM, staff called a code white (missing resident) after determining R2 was not in the facility. Staff searched the immediate vicinity of the facility but were unable to locate R2. At 3:40 AM, NHA-A notified the local police. At 3:55 AM, Registered Nurse (RN)-M located R2 approximately two miles from the facility. R2 was returned to the facility and placed on 1:1 supervision. R2 was unable to answer questions about where R2 was going. According to weatherunderground.com, the temperature at the time R2 left the facility was approximately 55 degrees. Surveyor reviewed a map of the city and noted Lake Michigan was less than 300 feet from where R2 was found. Surveyor noted R2 walked approximately two miles east down a busy four lane street, through a busy intersection ([NAME] Street and Highway 42), and across Highway 42 before R2 was found by staff. On 6/20/25 at 6:36 AM, Surveyor interviewed RN-M who was assigned to the 200/300 wings on the 6/11/25-6/12/25 night (NOC) shift. RN-M stated RN-M was assisting Certified Nursing Assistant (CNA)-L with cares in a resident's room on the 300 wing. CNA-L left the room before RN-M and then came back and stated the 200 wing door was alarming. RN-M verified RN-M could not hear the alarm while in the resident's room because the door was closed and the resident had a ventilator. RN-M instructed CNA-L to look for R2 due to R2's history of exit seeking. When staff noted R2 was not in R2's room, RN-M called a code white and conducted a head count of residents. RN-M stated when NHA-A and Director of Nursing (DON)-B arrived at the facility, RN-M got in RN-M's car to look for R2 and found R2 approximately two miles away on a concrete path next to Highway 42. RN-M convinced R2 to get in the car and took R2 back to the facility. RN-M confirmed that staff should respond immediately to door alarms. On 6/20/25 at 11:12 AM, Surveyor interviewed CNA-L who was assigned the 200/300 wings on the 6/11/25-6/12/25 NOC shift. CNA-L stated CNA-L was on the 300 wing taking care of a resident. When cares were completed, CNA-L exited the room and heard the door alarm on the 200 wing. CNA-L looked out the 200 wing, did not see any residents, and reported the door alarm to RN-M. CNA-L then checked for R2 on the 600 wing due to R2's frequent wandering and exit seeking but could not locate R2. CNA- L was not sure how long the alarm was sounding before CNA-L heard it. CNA-L verified CNA-L was not able to hear the alarm while in a resident's room with the door closed and confirmed that staff should respond immediately to door alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/20/25 at 11:20 AM, Surveyor interviewed CNA-N who was assigned to the 600 wing on the 6/11/25-6/12/25 NOC shift. CNA-N stated CNA-N last saw R2 in bed between 1:00 and 2:00 AM. CNA-N stated CNA-L entered the unit at approximately 3:20 AM, asked where R2 was, and indicated an alarm was sounding on the 200 wing. CNA-N stated CNA-N could not hear the 200 wing door alarm because it was on the other side of the building. On 6/20/25 at 11:25 AM, Surveyor interviewed CNA-O who was assigned to the 500 wing on the 6/11/25-6/12/25 NOC shift. CNA-O stated CNA-O was not aware that R2 was missing until a code white was called at approximately 3:15 AM. CNA-O verified the fire door alarms on each wing (200, 300, 500, and 600) and WanderGuard alarms were hard to hear while in a resident's room with the door closed. On 6/20/25 at 2:14 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P who was assigned to the 500/600 wings on the 6/11/25-6/12/25 NOC shift. LPN-P stated LPN-P was either at the nurses' station or in a resident's room when R2 eloped. LPN-P verified LPN-P would not have been able to hear the 200 wing door alarm which was on the other side of the building. LPN-P stated it is hard to hear any of the alarms when in a resident's room with the door closed. LPN-P stated LPN-P typically leaves room doors open and uses the curtain to provide privacy so LPN-P can hear if an alarm sounds or if anyone needs help. A statement from RN-R obtained by the facility on 6/12/25, indicated RN-R was in a resident's room on the 300 wing administering medication. RN-R stated RN-R did not see R2 on the 200 wing at all. When RN-R exited the resident's room, RN-R heard CNA-L state the 200 wing door was alarming. When staff could not locate R2, RN-R notified DON-B that R2 was missing and began conducting a head count and searching for R2. Surveyor reviewed R2's 1:1 supervision and 15 minute checks documentation and noted R2 was on 1:1 supervision from 6/12/25 to 6/16/25 and then placed on 15 minute checks. Surveyor noted R2's 15 minute check sheets were missing documentation on 6/17/25 from 7:15 PM to 9:45 PM. The facility's investigation included weekly door alarm/WanderGuard audits as well as all staff education which included ensuring staff respond immediately to door alarms and immediately check to ensure no residents have eloped. The education indicated the reaction must be instantaneous and there was no room for a delay in response to an alarm. The investigation indicated random audits would be completed to ensure knowledge and compliance. On 6/20/25 at 2:18 PM, Surveyor interviewed NHA-A who verified staff should respond to door alarms immediately. NHA-A stated NHA-A was not aware staff could not hear door alarms while in residents' rooms. NHA-A stated the only way to make the alarms louder was to install a new alarm system and verified during the survey that there was nothing in process to correct the issue. On 6/20/25, Surveyor observed R2 multiple times during the AM and PM shifts and noted a functioning WanderGuard on R2's left ankle. Surveyor also noted the facility's WanderGuard and door alarm systems were armed and functioning. The failure to provide adequate supervision for a resident at risk for elopement and follow the elopement procedure when a door alarm sounded created a finding of immediate jeopardy. The facility removed the immediate jeopardy on 6/20/25 when it had completed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Assigned staff to post at each nursing station where door alarms can be clearly heard immediately upon activation to ensure timely response. 2. Ordered a Safety Technology International STI-6402 105dB Exit Stopper (Multifunction Door Alarm) to be installed upon arrival. NHA-A and/or designee to complete validation of the alarm volume to ensure staff can hear the alarm sounding in any resident room or area where the doors is closed. Assigned stationary staff will remain in place until validation occurs. 3. Completed an elopement investigation that included review of R2's care plan as well as new BIMS, trauma, skin, pain, and elopement evaluations. 4. Completed elopement evaluations for all in-house residents. 5. Provided staff education on the facility's elopement policy, responding to alarms timely, and 1:1 supervision expectations. 6. Implemented Stop signs on egress doors to deter residents from using exit doors 7. Implemented audits to ensure comprehension of the education and to ensure staff respond to alarms in a timely manner.

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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. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect 39 of the 54 residents residing in the facility. There were 15 residents who received nutrients exclusively via tube feeding. Staff did not wear hair restraints consistently throughout the kitchen. Kitchen equipment and food services areas were not in a clean and sanitary condition. Staff did not follow appropriate hand hygiene procedures when they prepared and served food. Resident food and beverages were not served at appropriate temperatures. Findings include: Hair Restraints: The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 2-402.11 Hair Restraints: (A) Except as provided in (B) of this section, Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens, and unwrapped single-service and single-use articles. The facility's Maintaining a Sanitary Tray Line policy, revised 11/6/24, indicates: .Wear hair restraints (bonnets, caps, nets, to cover hair) when preparing or handling food . The facility's Food Safety Requirements policy, revised 3/26/25, indicates: .Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food .Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad . On 6/20/25 at 7:30 AM, Surveyor observed a sign near the entrance to the kitchen that indicated all staff entering the kitchen must have their hair covered by a hair restraint. On 6/20/25 at 7:31 AM, Surveyor observed [NAME] (CK)-F with a hair restraint on CK-F's head and a beard restraint on CK-F's face, however, the hair and beard restraints did not cover all of CK-F's hair and the back sides of CK-F's beard were exposed while CK-F prepared and served residents breakfast from 7:31 AM to 8:27 AM. On 6/20/25 at 7:31 AM, Surveyor observed Dietary Aide (DA)-G with a hair restraint on DA-G's head, however, DA-G's hair was uncovered on both sides of the hair restraint near DA-G's ears. Surveyor observed DA-G prepare residents' meal trays and move throughout the kitchen with DA-G's hair not fully covered from 7:31 AM to 8:27 AM while breakfast was being prepared and served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/25 at 12:04 PM, Surveyor observed CK-F with a hair restraint on CK-F's head and a beard restraint on CK-F's face, however, the hair and beard restraints did not cover all of CK-F's hair and the front of CK-F's beard net was pulled down which left CK-F's mustache and part of CK-F's beard exposed. In addition, the back sides of CK-F's beard were also exposed while CK-F served residents food from 12:04 PM to 12:29 PM. On 6/20/25 at 12:29 PM, Surveyor interviewed CK-F who verified CK-F's hair and beard should be fully covered. CK-F indicated CK-F could not breathe well with the beard restraint on and forgot to fully cover CK-F's facial hair during lunch service. On 6/20/25 at 1232 PM, Surveyor interviewed Director of Dining (DD)-E who indicated staffs' hair and facial hair should be fully covered while in the kitchen. Cleanliness: The 2022 FDA Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. The 2022 FDA Food Code documents at 4-602.12 Cooking and Baking Equipment: (A) Food-contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. The 2022 FDA Food Code documents at 4-602.13 Nonfood-Contact Surfaces: Non-food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. The facility's Food Safety Requirements policy, revised 3/26/25, indicates: .All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination .Staff shall follow facility procedures for dishwashing and cleaning of fixed cooking equipment . On 6/20/25 from 7:31 AM to 8:30 AM and from 12:04 PM to 12:40 PM, Surveyor observed the kitchen and noted the floors were dirty and contained debris. Surveyor also observed numerous shelves in the cook, prep, and serve areas that contained debris. On 6/20/25, Surveyor reviewed copies of the kitchen's cleaning logs and noted the logs were not thoroughly filled out. Daily tasks were assigned, however, most of the tasks were not signed off. Surveyor noted there were 117 spots assigned (16 daily x 7 days) but only 26 were signed as completed. The assignment sheet for Dietary Aides also contained 117 assignments for the week, however, only 14 assignments were marked as completed. Surveyor reviewed several weeks of cleaning assignments with similar results. On 6/20/25 at 12:32 PM, Surveyor interviewed DD-E who indicated staff should complete their cleaning assignments daily. Hand Hygiene: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 FDA Food Code documents at 2-301.14: Food Employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. The 2022 FDA Food Code documents at 3-301.11 Preventing Contamination from Hands: (A) Food Employees shall wash their hands as specified under § 2-301.12. (B) Except when washing fruits and vegetables as specified under §3-302.15 or as specified in (D) and (E) of this section, Food Employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. The facility's Maintaining a Sanitary Tray Line policy, revised 11/6/24, indicates: .Wear gloves when handling food items, particularly when direct contact between the hands and food occurs or when handling ready to eat foods such as salads, fruits, sandwiches, breads, etc .Use gloves that fit properly .Wash hands before and after wearing or changing gloves .Change gloves when activities are changed, or when the type of food being handled is changed, or when leaving the work station .Change gloves after sneezing, coughing or touching face, hands, or hair with gloved hands . The facility's Food Safety Requirements policy, revised 3/26/25, indicates: .Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects .Staff shall wash hands according to facility procedures .Gloves will be worn when directly touching ready to eat foods and when serving residents who are on transmission-based precautions. On 6/20/25 at 7:31 AM, Surveyor observed CK-F cook and serve breakfast and touch residents' plates with a bare left hand. At 8:06 AM, Surveyor observed CK-F wipe CK-F's hands on CK-F's clothing and continue to serve food and touch plates with a bare hand. At 7:57 AM, 7:59 AM, 8:02 AM, 8:05 AM, 8:08 AM, 8:13 AM, and 8:15 AM, CK-F adjusted CK-F's glasses with a bare left hand. At 8:17 AM, CK-F washed hands and continued to serve food and touch residents' plates with a bare hand. At 8:22 AM, CK-F again adjusted CK-F's glasses and touched a resident's plate with a bare hand. On 6/20/25 at 12:04 PM, Surveyor observed CK-F serve residents lunch with gloved hands. CK-F picked up plates with CK-F's left hand and plated food per residents' meal tickets. At 12:10 PM, CK-F adjusted CK-F's glasses and used then used the same gloved hand to pick up residents' plates. At 12:22 PM, CK-F changed gloves and indicated there was a resident who was allergic to fish. CK-F began to don another pair of gloves with completing hand hygiene, dropped the left glove on the floor, and then picked up the next resident's plate with a bare left hand. After plating food for the resident, CK-F donned a new left glove without completing hand hygiene. On 6/20/25 at 12:29 PM, Surveyor interviewed CK-F who verified CK-F should complete hand hygiene between glove changes. On 6/20/25 at 12:32 PM, Surveyor interviewed DD-E who indicated staff should complete hand hygiene between glove changes and should be aware of the facility's policy. Food and Beverage Temperatures: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 FDA Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, for Hot and Cold Holding: Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 41 degrees Fahrenheit (F) to 135 degrees F too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control . (1) At 135 degrees F or above or (2) At 41 degrees F or less. The facility's Maintaining a Sanitary Tray Line policy, revised 11/6/24, indicates: .This facility prioritizes tray assembly to ensure foods are handled safely and held safely and held at proper temperatures in order to prevent the spread of bacteria that may cause food borne illness .Periodically monitor food temperatures throughout the meal service to ensure proper hot (at or above 135 degrees) or cold holding temperatures (at or below 41 degrees) are maintained . The facility's Food Safety Requirements policy, revised 3/26/25, indicates: .Cooking - foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed .Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed .Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to: .Timely distribution of all meals/snacks. The facility's Food Preparation Guidelines policy, revised 12/17/24, indicates: .Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: .Serving hot foods/drinks hot and cold food/drinks cold .Addressing resident complaints about food/drinks . On 6/20/25 at 7:48 AM, Surveyor observed CK-F temp scrambled eggs from the steamer and record the temperature on the cooking temperature log and the hot holding/steam table log. Surveyor observed CK-F place food in the steam table and noted steam table/holding temperatures were not obtained. Surveyor also observed DD-E ask CK-F for temperatures of the other foods. CK-F indicated the temperature of the pureed eggs was 184 degrees, the pureed sausage was 184 degrees, the sausage was 178 degrees, the bacon was 183 degrees, and the oatmeal was 205 degrees. Surveyor observed DD-E record the temperatures on the cooking temperature log and the hot holding/steam table log. Surveyor noted the numbers reported by CK-F were not actual temperatures because CK-F did not temp the food. During breakfast service, Surveyor noted milk and juice were placed in covered cups in tubs. Surveyor observed pieces of ice on top of the cups and above the fluids in the cups. (The ice pieces did not touch the sides of the cup and there was no ice in between the cups.) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/25 at 12:10 PM while CK-F served food, Surveyor observed the cooking temperature log and the hot holding/steam table log and noted CK-F recorded 176 degrees on both logs for the meat and mechanical soft meat. There were no other temperatures recorded for any of the foods being served. Surveyor observed CK-F finish lunch service and noted CK-F did not obtain or record any food temperatures. During lunch service, Surveyor noted milk and juice were placed in covered cups in tubs. Surveyor observed pieces of ice on top of the cups and above the fluids in the cups. (It appeared as if one scoop of ice was put on top of the cups. There was no ice in the tubs or in contact with the sides of the cups.) On 6/20/25 at 12:29 PM, Surveyor interviewed CK-F who indicated the temperatures were good out of the oven, however, CK-F forgot to temp the potatoes (2 types) and forgot to record the temperatures. Surveyor then observed CK-F record temperatures on the cooking temperature log and the hot holding/steam table log without obtaining the temperatures of the food at that time. Surveyor noted CK-F wrote the same temperature for each of the foods on the cooking temperature log and the hot holding/steam table log. CK-F verified temperatures should be obtained and recorded right away. On 6/20/25, Surveyor noted beverage temperatures were often not obtained/recorded on the logs. On 6/20/25 at 8:51 AM, Surveyor requested and received a breakfast test tray. Surveyor temped the foods and beverages on the tray and noted the following: ~ Eggs - 110.1 degrees ~ Oatmeal - 129.5 degrees ~ Cottage cheese - 55.7 degrees ~ Orange juice - 60.2 degrees ~ Milk - 61.7 degrees ~ Coffee - 139.5 degrees (within range) The hot and cold foods, with the exception of the coffee, were not within the appropriate ranges in accordance with the FDA Food Code and the facility's policy. On 6/20/25 at 12:44 PM, Surveyor requested and received a lunch test tray. Surveyor temped the foods and beverages on the tray and noted the following: ~ Chicken patty - 110.6 degrees ~ Fish patty -139.2 degrees (within range) ~ Mashed potatoes and gravy - 120.7 degrees ~ Potato coins - 117.4 degrees ~ Coleslaw - 60.0 degrees (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Lemonade - 58.4 degrees ~ Milk - 58.8 degrees ~ Cheesecake - 60.8 degrees ~ Coffee - 146.9 degrees (within range) The hot and cold foods, with the exception of the fish patty and coffee, were not within the appropriate ranges in accordance with the FDA Food Code and the facility's policy. On 6/20/25, Surveyor reviewed resident grievances and noted several food concerns regarding cold food served warm and hot food served cold. On 6/20/25, Surveyor reviewed resident council meeting minutes and noted several food concerns including cold food served warm and hot food served cold. On 6/20/25 at 12:32 PM, Surveyor interviewed DD-E who indicated food temperatures should be obtained and recorded at the time they are taken. DD-E indicated it is not acceptable for staff to make up temperatures and record them. DD-E was unsure why DD-E recorded temperatures on the cooking temp log and the holding/steam table temp log for CK-F during breakfast when DD-E saw that CK-F was not taking the temperatures. DD-E indicated staff must obtain oven or cook temperatures as well as steam table temperatures and was aware that was not occurring. DD-E verified there are safety concerns when food and beverages are not served at the correct temperatures and confirmed the importance of obtaining and recording correct cooking and holding temperatures. On 6/20/25 at 4:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was aware of food temperature issues and complaints. NHA-A indicated there had been concerns for as long as NHA-A had been there and there were still ongoing issues. NHA-A verified kitchen staff should follow the FDA Food Code and the facility's policies regarding food temperatures, hand hygiene, kitchen cleanliness, and hair restraints. NHA-A indicated NHA-A saw Surveyor's breakfast test tray that morning and indicated NHA-A would not have eaten the food either. NHA-A indicated the facility is working on getting better food service for residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On [DATE], Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of glottis, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and tracheostomy status. A care plans, initiated on [DATE], indicated R6 had a Clostridioides difficile (C. diff) infection (a highly contagious bacterium that causes diarrhea and colitis) and was on contact precautions. On [DATE] at 1:25 AM, Surveyor observed CNA-R and CNA-S enter R6's room without donning PPE. Surveyor observed a sign posted on R6's door that indicated R6 was on contact precautions. Surveyor observed CNA-R and CNA-S prepare to transfer R6 from bed to wheelchair. CNA-S applied R6's socks and shoes while CNA-R retrieved R6's wheelchair and a gait belt. CNA-R then applied the gait belt and assisted R6 to the wheelchair. CNA-R unhooked R6's trach hose, assisted R6 to a sitting position, then reapplied the hose. Registered Nurse (RN)-M then entered room without donning PPE and straightened R6's bed and tidied the room. When CNA-R and CNA-S exited the room, Surveyor asked if R6 was on contact precautions. CNA-R answered yes and confirmed CNA-R should have worn PPE in R6's room. When RN-M exited R6's room at 1:32 AM, Surveyor asked RN-M if R6 was on contact precautions. RN-M confirmed R6 was on contact precautions and indicated RN-M should have worn PPE in R6's room. On [DATE] at 3:30 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed staff should don PPE for residents on contact precaution. NHA-A indicated contact precautions require staff to don a gown and gloves prior to entering the room. Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 2 residents (R) (R10 and R6) of 2 sampled residents. During an observation of incontinence care for R10, Certified Nursing Assistant (CNA)-C did not complete hand hygiene in between glove changes and prior to applying barrier cream and did not complete thorough pericare. R6 was on contact precautions. On [DATE], multiple staff entered R6's room and provided care without donning appropriate personal protective equipment (PPE). Findings include: The facility's Hand Hygiene policy, revised [DATE], indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .Before applying and after removing personal protective equipment (PPE), including gloves .During resident care when moving from a contaminated body site to a clean body site . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Perineal Care policy, revised [DATE], indicates: It is the practice of this facility to provide perineal care to all incontinent residents .2. Gather supplies .c. Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back .d. Repeat on opposite side using separate section of wash cloth or disposable wipe. e. Clean urethral meatus and vaginal orifice .f. Pat dry .g. Turn resident .h. Clean and dry the anal area . The facility's Transmission-Based Precautions (TBP) policy, dated 2025, indicates: It is our policy to take appropriate precautions to prevent transmission of pathogens based on the pathogens' modes of transmission .1. Facility staff will apply TBP, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission .10. Contact Precautions - A. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment .Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment .Donning PPE upon entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination . 1. On [DATE], Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including myotonic muscular dystrophy, chronic respiratory failure, encephalopathy, and heart failure. R10's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 13 of 15 which indicated R10 had intact cognition. A care plan, dated [DATE], indicated R10 required the assistance of 1 staff for toileting and personal hygiene and the assistance of 2 staff with a full body lift. On [DATE] at 1:28 PM, Surveyor observed CNA-C and Licensed Practical Nurse (LPN)-D apply PPE prior to entering R10's room and observed CNA-C and LPN-D transfer R10 from wheelchair to bed via full body lift. Surveyor noted the blanket on R10's wheelchair was wet and R10 informed CNA-C and LPN-D that R10 had urinated in R10's brief. CNA-C retrieved disposable wipes and barrier cream. LPN-D assisted R10 onto R10's right side while CNA-C removed R10's wet brief, wiped R10's buttocks from front to back, and applied barrier cream to R10's buttocks. CNA-C removed gloves, completed hand hygiene, donned clean gloves, and tucked a clean brief underneath R10. CNA-C assisted R10 onto R10's left side. LPN-D adjusted the brief and assisted R10 into a supine position. CNA-C pulled the brief over R10's anterior peri area without cleansing the area and removed gloves. Without completing hand hygiene, CNA-C donned clean gloves, put on R10's heel boots, and removed gloves. Without completing hand hygiene, CNA-C donned clean gloves, removed R10's soiled gown, and put a clean gown on R10. CNA-C then placed pillows under R10's head and knees and ensured R10's bed was at a 45 degree angle. LPN-D and CNA-C each put a blanket on R10. LPN-D then removed PPE and washed hands. CNA-C removed CNA-C's gown, changed R10's garbage, and removed gloves. Without completing hand hygiene, CNA-C donned clean gloves and cleaned the lift with Sani wipes. CNA-C then removed gloves and washed hands. On [DATE] at approximately 1:48 PM, Surveyor interviewed R10 who indicated it did not seem like CNA-C washed R10's frontal peri area but indicated it seemed to be clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:58 PM, Surveyor interviewed CNA-C who verified CNA-C should have completed hand hygiene between gloves changes. CNA-C indicated CNA-C did not provide full perineal care because R10 was not soiled with stool. CNA-C indicated CNA-C should have donned clean gloves prior to applying barrier cream. On [DATE] at approximately 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated CNA-C should have completed hand hygiene between glove changes and should have changed gloves prior to putting barrier cream on R10. DON-B verified staff should cleanse a resident's entire perineal area during soiled brief changes.